

**MANAGED CARE AND PEOPLE
WITH DEVELOPMENTAL
DISABILITIES: A GUIDEBOOK**

**NATIONAL ASSOCIATION OF STATE
DIRECTORS OF DEVELOPMENTAL
DISABILITIES SERVICES, INC.**

and

HUMAN SERVICES RESEARCH INSTITUTE

MANAGED CARE AND PEOPLE WITH DEVELOPMENTAL DISABILITIES: A GUIDEBOOK

by

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Preface

We live in a time of rapid and momentous change. A year ago, the trend lines for developmental disabilities services seemed clear enough. The census of public institutions would continue to shrink and gradually more and more facilities would close. There would be steady (if sometimes irritatingly slow) progress, nationwide, in the transition of community service systems from facility/program models to more person-centered approaches. Federal aid to states in the form of payments for home and community-based waiver services would continue to grow at a rapid pace, enabling states to expand and enrich their service systems.

Today, this world has turned upside down. The 30-year old Medicaid program is being put out to pasture, to be replaced by fixed payments to states that are best described as a federal health care revenue sharing program. Access to open-ended Medicaid dollars allowed state developmental disabilities systems to implement strategies that counted on ever expanding dollars to broaden supports for individuals and families. This approach will no longer work. Systems will have more or less fixed dollars with which to operate. Systems which today do not satisfy all demand will be even more hard pressed in the future to deal with the steady stream of young adults who are leaving school as well as the very real needs of families who need supports to continue to care for their sons or daughters with developmental disabilities at home. The demise of Medicaid totally changes the framework within which developmental disabilities system have operated for more than two decades.

We began the collaboration that led to this **Guidebook** well before the changes in Medicaid policy had crystallized in Congress. This collaboration grew out of real concerns that service systems would be turned over lock, stock and barrel to for-profit managed care companies that would put their own economic interests ahead of those of people with developmental disabilities and their families. We continue to have that concern. In a more positive vein, we also believed that managed care might offer a sorely-needed framework for service systems to effectively tackle many long-standing problems that have frustrated stakeholders for years -- most notably how to transform program-driven, categorical systems of services for people with developmental disabilities into more consumer-driven person-centered systems of support. We believe that managed care can aid in moving this agenda forward.

Managed care has the potential of speeding up the reconfiguration of developmental disabilities service systems in logical response to the vast changes that are occurring in federal policy and related system financing. With fixed dollars, service systems must focus their energies on securing real improvements in productivity or waiting lists for services will worsen. Managed care provides the means for rethinking how to structure systems to deliver supports to people and their families economically and efficiently.

At the same time, managed care is no "silver bullet". We do not believe that applying managed care to developmental disabilities systems will yield dividends sufficient to offset the nearly 20 percent reduction in federal Medicaid funding over the next seven years that the Congress is poised to enact. The useful and powerful tools that managed care brings to improving system efficiency can mitigate the effects. However, it will not work miracles.

We have come away from several months of looking at managed care models and strategies convinced that this approach has potential advantages. At the same time, we recognize that managed care will truly succeed or fail in developmental disabilities only to the extent that it holds true to the overarching goals of inclusion and self-determination for people with developmental disabilities. The technology of managed care can be used to improve the quality, value, and reliability of developmental disabilities systems or, unless guided by fundamental values, it can set them back.

People with developmental disabilities, their families, service providers, advocates, and others are skeptical of new approaches to the delivery of services. This is understandable because frequently in the past more has been promised than actually delivered. Many new "initiatives" have come and gone that were advertised as the cure for major systemic problems. This skepticism is healthy. It prevents theory from outrunning practicality. However useful managed care might prove to be in helping developmental disabilities systems restructure themselves, its development and evolution will benefit from constructive criticism. At the same time, it is important that all parties recognize that yesterday's rules and assumptions -- the "old order" -- are about to fall by the wayside. As states begin to think about how managed care might be employed, it will be enormously important for all stakeholders to be actively involved in defining the "new order". Active, constructive involvement will lead to system re-engineering that all parties can embrace.

We are concerned that the transition of developmental disabilities service systems into managed care will lead to the treatment of essential publicly-financed supports as mere commodities to be brokered to the lowest bidder. In health care, the dark side of managed care is the buying and selling of "covered lives" and the erosion of physician authority to provide patients proper care. This must not happen in our field. Successfully supporting people with developmental disabilities involves more than buying and selling services. It means keeping family members, friends, and neighbors engaged with people with disabilities. It means maintaining and strengthening ties with communities. The most successful service systems will be those that build and maintain connections between people with developmental disabilities and their communities. Managed long-term support systems must do more than contain expenditures; they must promote the efforts of people with developmental disabilities to have valued lifestyles in their communities.

An earlier "working" version of this **Guidebook** was prepared in conjunction with a managed care workshop that NASDDDS and HSRI co-hosted in Chicago, Illinois in August, 1995. This final version contains extensive revisions and additional materials.

We had considerable help in producing this **Guidebook**. The many agencies engaged in managed care planning and demonstrations (cited in this **Guidebook**) willing shared what they had learned, their thoughts and second thoughts. Throughout, we have had the support and encouragement of the NASDDDS and HSRI leadership. They gave us permission and space to work on this project. Colleagues at both organizations and around the country provided useful input; they listened to our theories, deflating some and refining others. We deeply appreciate all the support we received.

October 15, 1995

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PART ONE

**INTRODUCTION TO
MANAGED CARE**

CHAPTER I
INTRODUCTION

1. Introduction

A year ago, there was little serious interest in how managed care might be used to restructure developmental disabilities service delivery systems. Managed care seemed only relevant to health care services. Today, in a growing number of states, public officials, advocates, people with developmental disabilities and their families, and service agency managers are actively (and sometimes fiercely) weighing and debating the potential opportunities and pitfalls of managed care. Stakeholders are asking questions such as: Will managed care result in higher quality services and supports at a lower cost? Is managed care just a budget cutting device? Will people with developmental disabilities have fewer choices under managed care? Can managed care free service agencies to pursue flexible support strategies by ridding systems of rigid categorical funding rules?

The past three years have seen the states rapidly reconfigure their Medicaid programs by shifting millions of recipients (including people with disabilities) into managed health care plans. Congress is sharply curtailing the growth of federal Medicaid spending in order to reduce and ultimately eliminate the federal budget deficit. The states are virtually certain to react to these cuts by shifting more Medicaid-funded services to managed care arrangements designed principally with cost containment in mind. Given their heavy reliance on Medicaid dollars, developmental disabilities service systems increasingly will be targeted for managed care approaches. Powerful forces are at play that are driving publicly-funded service systems into managed care. These forces cannot be underestimated nor brushed aside.

Powerful forces are at play that are driving publicly-funded service systems into managed care. These forces cannot be underestimated nor brushed aside.

Managed care should not be dismissed or ignored. Beyond external pressures, there are other important reasons why managed care deserves serious consideration. Many developmental disabilities service systems labor under rigid funding rules that pose real obstacles to fostering agile and flexible systems of community supports. There is mounting frustration among people with developmental disabilities, families, service providers, state officials and policymakers with the persistent barriers that prevent systems from operating under a straightforward bottom-line philosophy: deliver the supports people need when and where they need them. Managed care potentially offers a framework for service systems to re-engineer themselves along these lines.

Managed care is at once threatening and promising. Managed care promises quality and cost containment. It also fundamentally alters relationships between payers and suppliers, customers and providers. It can create opportunities to improve productivity; it also can achieve cost containment at the expense of consumers.

In light of the mounting interest in managed care and its potential implications for developmental disabilities service systems, the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS) decided to collaborate in the development of this **Guidebook** for several reasons:

- **First and foremost, we are deeply concerned that some managed care strategies have real, serious potential for undermining the support systems upon which people with developmental disabilities rely in order to take their rightful places as citizens in our communities.** These support systems have taken three decades to put into place. Hundreds of thousands of individuals and families count on them. Managed care strategies -- based on inappropriate adaptations of health care models -- which are being advocated by some policymakers and self-declared experts could gut these systems without achieving any worthwhile cost efficiencies. In our judgment, the economic incentives that drive these models are not applicable to developmental disabilities service systems. Managed care initiatives have been launched without consulting key stakeholders and giving only scant attention to their potentially irreversible long-term ramifications on the lives of people with developmental disabilities. Managed care too often is portrayed as an end in itself rather than as a tool for systems improvement. This is shortsighted.
- **Second, we share the conviction that the way in which service systems are organized and managed must be completely rethought in light of pending federal budget cuts and state fiscal conditions.** For the foreseeable future, funding for disability services will not increase at anywhere near the pace experienced over the past two decades. At best, public dollars available to support individuals with disabilities will barely keep pace with inflation and general population growth. Federal Medicaid funding is being capped. States are unlikely to take up the slack as they struggle with "devolution" and the continued erosion in federal domestic assistance. Today, thousands of individuals with developmental disabilities are on waiting lists for services. The challenge service systems face is continuing to support individuals who presently receive services while also responding to new demands in a fixed-dollar environment. If this challenge is to be met, service systems must be better managed and reconfigured. They must change how they do business. If we do not engage in a candid dialogue about such changes, we will do a terrible disservice to people with disabilities.

Why this Guidebook?

- ✓ Concerns about the inappropriate application of managed health care models to DD systems
- ✓ Need to rethink DD systems in light of changing federal and state fiscal climate
- ✓ Examine how managed care strategies might aid in improving system management
- ✓ Identify how DD systems might transition to managed care
- ✓ Inform stakeholders so that they can participate in shaping managed care strategies

- **Third, well managed service systems promote better outcomes for people with developmental disabilities and their families; we believe that managed care strategies can play a constructive role in improving system management.** The disability community distrusts managed care because adopting the clinically-driven models extant in the health care industry could threaten the hard won right of people with disabilities to exercise fundamental choices about their lives. This distrust is legitimate. Decisions about the supports people receive have a direct impact on each individual's quality of life and personal freedom. People with disabilities and their families should exercise control over their lives. History tells us that, when people with developmental disabilities have been disempowered, they have been abused and neglected, often in the name of "economy" and "efficiency". **Managed care must not repeat this history.**

In light of today's fiscal realities, however, developmental disabilities service systems cannot stand pat. If service systems do not change, there is every prospect that their capabilities will erode. Waiting lists will worsen; quality will yield to expediency. Our focus must be on resolutely improving service system productivity by continually discovering better ways of deploying resources to achieve valued outcomes for people with developmental disabilities. **Managed care provides a new, robust set of tools that can contribute to improved service system productivity.** If managed care strategies are employed appropriately while honoring contemporary values and ethics, such strategies can play an important role in achieving valued outcomes for individuals, including ensuring that people with developmental disabilities and their families exercise real choices.

- **Fourth, developmental disabilities systems must discover their own pathway to managed care.** Furnishing long-term supports to people with developmental disabilities is not the same as providing health care. Experiences in the health care arena teaches us a great deal about the architecture of managed care. In developmental disabilities, the pathway to managed care will take the form of *adapting not replicating* this architecture. This will mean that support systems will operate under different rules and the roles played by key actors will change. This adaptation process must include a thorough examination of the obligations and organization of service systems. All parties must understand that the transition to managed long term support systems will be challenging and complex. **Adapting managed care is system change.**
- **Finally, we firmly believe that disability system stakeholders must be at the table when managed care strategies are being crafted.** The disability community must recognize that the debate concerning managed care is not about "if" but "how" and "when" such changes are to occur. If the disability community is not at the table and prepared to participate in the debate, then there is every likelihood that the resulting service delivery systems will not be designed with the best interests of people with disabilities and their families foremost in mind. **The active and continuing involvement of all key stakeholders is absolutely necessary if**

managed care, in fact, is to be employed in the best interests of people with developmental disabilities. This **Guidebook** is intended to enable stakeholders to be active, knowledgeable participants in crafting new approaches that keep faith with our field's fundamental values.

At stake is the future of publicly-funded supports for people with developmental disabilities. We must strive for better managed systems if individuals and families are to have reliable access to needed supports. Managed care can destroy the hard won gains of the past thirty years or it can provide new tools for ongoing system improvements.

In developing this **Guidebook**, we have been sensitive to the fact that many readers will come to this topic with varying perspectives and differing levels of knowledge about managed care. As a consequence, the **Guidebook** is divided into two parts. Part I provides an overview of managed care. The material covered in this section is intended to offer the reader a working knowledge of basic managed care concepts and strategies as they have evolved in the health care arena. We discuss the ways in which states are employing managed care to restructure their Medicaid programs. The next chapter addresses critical managed health care issues as they affect people with developmental disabilities. The final chapter in Part I introduces the topic of potential managed care application to long-term care and supports, including a description of proposals that states have developed to restructure their developmental disabilities systems employing managed care strategies. Our aim in Part I is to provide a basic understanding of managed care, how it is playing out in the federal-state policy arena, and its potential implications for people with developmental disabilities, both with respect to health care and long-term supports.

Part II of the **Guidebook** includes a more in-depth examination of the potential application of managed care strategies to long-term supports for people with developmental disabilities. This part of the **Guidebook** addresses the question: "if managed care, how?" We begin with a discussion of the critical strategic dimensions of adapting managed care approaches to long-term supports for people with developmental disabilities, including the importance of adopting guiding principles under which such approaches might be crafted. Next, we offer an overview of the steps that need to be taken in developing a managed long term support system. Various managed care models that might be employed in developmental disabilities systems are described in the following chapter. These descriptions outline the features, potential advantages, and disadvantages of such models. Next attention turns to conducting a managed care feasibility study in order to assess the potential for applying

The Guidebook has two parts...

- ✓ Part I provides an overview of managed care, how states are employing it in the Medicaid programs and its relationship to health care and long-term supports for people with developmental disabilities
- ✓ Part II addresses the question, "if managed care, how?" It looks at both strategic and technical issues in developing a "managed long term support system"

managed care to a state's DD service delivery system. The final chapter outlines the detailed steps that should be taken in preparing a managed care plan

Where appropriate, we have included additional materials in the appendices to the **Guidebook**. Among these materials are summary descriptions of several statewide initiatives, which are at various stages of development, that are aimed at applying managed care principles to the organization and delivery of long term services and supports to people with developmental disabilities. The reader also will find a list of various managed care resources which we have found valuable in gaining an understanding of this complex topic.

A final note is in order. The topic of managed care and its implications for long-term supports for people with developmental disabilities is very new. This **Guidebook** includes an initial exploration of this topic. In health care (where there is far more experience and information concerning managed care), managed care continues to be an evolving, highly dynamic, and very complex collection of technologies that continue to change as they themselves alter the service delivery/financing landscape. Managed health care has not settled down. In developmental disabilities, we are only beginning to examine the role that managed care might play. We do not have the benefit as yet of the testing that has and continues to go on in the health care arena. In developing this **Guidebook**, we have been humbled by how much is still to be learned concerning the topic.

CHAPTER II
MANAGED CARE: AN OVERVIEW

II. Managed Care: An Overview

The U.S. health care delivery system has undergone dramatic changes over the past decade. Managed care, which once occupied a small niche in the health care system, has become the most common arrangement through which a continually increasing proportion of the nation's citizens obtain their health care. Today, more than three workers out of every five who participate in employer-sponsored health plans are enrolled in managed care arrangements of one type or another; ten years ago, only about 10 percent of the population participated in such arrangements. In 1994 alone, health maintenance organizations (HMOs) added 6 million members, growing by 13 percent nationwide to over 51 million enrollees. In California, nearly 40 percent of all citizens are HMO members; nearly three-quarters of the insured population participates in a managed health care plan of one type or another. **Managed care has roared out of its small niche to redefine mainstream health care.**

Managed Health Care Is Exploding....

In firms with more than 200 employees, 65 percent of all workers were enrolled in managed care plans in 1994. In 1991, 47 percent participated in such plans.

This massive change in health care has led many states to convert acute care Medicaid services to managed care and to begin assessing the feasibility of employing similar strategies in the long-term care arena. The promise of managed care is lower costs while maintaining or improving the quality of services. This promise is attractive to policymakers at both the federal and state levels, who have seen health care spending consume larger and larger shares of their budgets.

Managed care arose in the health care arena. Understanding its origins is an important step toward understanding how it works. In this chapter, we will describe the transition from "unmanaged" to "managed" care in the health care sector. Attention then turns to describing the topology of managed health care.

Why Managed Care? -- The Big Picture

During the 1980s and into the early 1990s, U.S. health care spending skyrocketed at a double-digit rate that far outstripped the general economic growth rate. Annual national health care spending now tops \$1 trillion, consuming about 15 percent of the Gross Domestic Product (GDP). Left unchecked, health care spending has been projected to climb to nearly 20 percent of GDP by the turn of the century. In other

Topics Covered....

- ☒ **Why Managed Care? -- The Big Picture**
- ☒ **What Is Managed Care?**
- ☒ **Managed Care Organizations/Plans**
- ☒ **Is Managed Care Better?**
- ☒ **Managed Care: Today and Tomorrow**

words, health care spending progressively is claiming a larger and larger share of the nation's goods and services.

This trend is economically unsustainable. In the private sector, rapidly rising health care costs undermine the competitiveness of U.S. firms in the world market place and erode their ability to raise capital. In the public sector, increased health care outlays have been a major contribution to the huge federal deficit while simultaneously wrecking havoc on state budgets. President Clinton's 1994 efforts to secure fundamental, comprehensive health care reform were driven by a recognition that, unless runaway health care costs are reined in, they will undermine the nation's economy and defeat efforts to eliminate the federal budget deficit. Slowing the rate of growth in federal outlays for Medicare and Medicaid services likewise is a central feature of the multi-year plan to balance the federal budget which Congressional Republicans have been pursuing in 1995.

Unsustainable economic trends trigger corrective reactions. Over the past two to three years, the rate of increase in health care spending in both the public and private sectors has tailed off considerably. One reason why the rate of growth in health spending has slowed is that more and more Americans are going without health insurance. Today,

Rising Health Care Costs Have Triggered Two Reactions:

- ✓ A continuing increase in the number of uninsured Americans
- ✓ Purchasers' embracing managed care to contain costs

an estimated 41 million citizens do not have health insurance coverage. This number continues to climb. The rising costs of health care have priced many individuals and their employers out of the health care marketplace.

The second reaction to the unsustainable trend in health care spending has been the growing tendency of private and public purchasers to embrace managed care as a means of slowing the rate of increase in health care costs. Managed care is marketed as quality health care at an affordable (or at least predictable) price. On their

own, purchasers have imposed managed care strategies to contain costs. For example, three out of four large corporations (those with 1,000 or more employees) have dropped conventional health insurance plans in favor of "self-insuring" and interjected themselves into the health care market place in order to secure discounted prices from health care suppliers. In the public sector, the federal

"The laws of physics prevail in management as well as the physical world, and there is a managerial corollary to the Second Law of Thermodynamics ... [which] states that order will proceed toward chaos unless energy is pumped into a system -- entropy; the same holds true for health care delivery. In health care, much of the energy has traditionally been in the form of money. Now that the nation's monetary resources are reaching their limits, the energy that must be pumped into the health care system is in the form of management".

Peter R. Kongstvedt
Essentials of Managed Care

Medicare program adopted new reimbursement strategies to contain costs. State Medicaid programs have intensified utilization controls. The need to contain health care costs also has sparked a massive restructuring within the health care sector itself. Private firms have formed to market health care management services to corporations. Health care suppliers have fashioned new organizations (such as PPOs -- Physician Practice Organizations) to market lower cost services to major purchasers. New HMOs (Health Maintenance Organizations) have formed. The health care marketplace today is very turbulent. The chief force reshaping this marketplace is a new breed of health care suppliers that are attempting to gain market share through the development of managed care "product lines" that they can sell to purchasers in search of lower cost health care. Purchasers are no longer willing to pay whatever providers want to charge for health care.

These changes are in direct reaction to the failure of traditional financing/purchasing schemes to deliver affordable health care services. Understanding managed care begins with looking at the root causes of this failure (i.e., the massive run-up in costs in the "unmanaged" system). Up through the mid-1980s, the health care marketplace was dominated by conventional employment-linked "indemnity" health insurance plans. Employers contracted with insurance carriers for health care coverage. Carriers, in turn, paid health care providers for the covered services that beneficiaries used. The price of such coverage is determined actuarially (by projecting utilization and estimating charges for services). Insurance carriers, in turn, are regulated by state insurance commissions whose principal functions are to ensure that carriers live up to the terms of the policies they write, while regulating premiums to prevent overcharging. Indemnity insurance carriers offered purchasers a limited range of "products". By obtaining coverage through carriers, purchasers avoided having to purchase health care directly and gained the advantage of at least short-term risk indemnification (i.e., the price of coverage was fixed for the contract period). In practice:

"Under a typical employment-linked plan, consumers were free to choose any available provider. Physicians, for their part, were faced with few constraints and practiced more or less as they wished. Insurance companies usually served as passive go-betweens: the intermediary between the employee and provider. With little scrutiny they paid bills submitted to them on a fee-for-service (FFS) basis. For the most part, insurers let providers determine the rates and terms of reimbursement. Like other indemnity-oriented policies, underwriting losses experienced by the carrier were ultimately passed through to the purchaser in the form of increased premiums" (Weiner and de Lissovoy, 1993).

Under this model, health care was practitioner-driven. Health care suppliers (physicians, hospitals, laboratories, and so forth) defined health care practice and set their own prices. This system was underwritten by employers and employees.

The federal Medicare and federal-state Medicaid programs were patterned more or less along the same lines. Medicare was designed as a post-retirement continuation of conventional employer-paid health insurance. In its intent (if not its actual practice),

Medicaid was intended to give low income individuals access to the health care marketplace on an equal footing with individuals who had private insurance. Both Medicare and Medicaid are premised on "beneficiaries" and "recipients" having free choice of any qualified provider to obtain "medically necessary" services. Taxes (employer/employee contributions to the Medicare trust funds and other federal/state dollars) underwrite these systems.

This indemnity insurance model functions acceptably as long as health care costs are stable and, therefore, predictable. Costs, however, destabilized. This destabilization stemmed from many factors, including advances in medical technology/practice, the emergence of specialists and specialty medicine, and a host of complex economic factors. As a consequence, the costs that health insurance carriers passed along to purchasers rose dramatically. In the public sector, Congress forced states to broaden the scope of their Medicaid programs by enacting various mandates and new requirements; as a result, state Medicaid budgets exploded. Medicare spending also continued to grow at a pace that outstripped the dollars flowing its trust funds.

This destabilization sparked many different reactions in the marketplace. Health insurance carriers sought to stem losses by segmenting their markets ("community rating" gave way to pricing insurance products group-by-group and excluding the health care services needed to address "preexisting conditions") and shifting from a passive intermediary role to employing more aggressive care management. Major corporations dropped indemnity plans in favor of self-insurance and directly managing their costs. Medicare changed its reimbursement practices for hospitals in order to contain costs. State Medicaid programs introduced more and more utilization review. Cost destabilization spawned enormous turbulence in the health care marketplace as purchasers scrambled to maintain coverage in the face of exploding costs.

Cost destabilization has spawned enormous turbulence in the health care market place...

This reaction to rapidly escalating health costs is the origin of "managed care". The predecessor system, of course, was not literally "unmanaged care". "Fee-for-service" medicine was managed by practitioners who exercised considerable independence in their practices and their pricing of services. The system also was based on giving consumers the freedom to select the practitioner of their choice.¹ It was very much a system predicated on "the doctor knows best". The system was practitioner-driven.

The emergence of "managed care" is a direct outgrowth of purchasers of health care deciding that suppliers could no longer unilaterally dictate practice and price and that health care consumers no longer could be allowed unfettered freedom of choice. The premise that "doctor knows best" came under increasing scrutiny as a result of studies that found practice patterns that increased costs but did not necessarily lead to better health outcomes. Other studies seemed to confirm that "fee-for-service" medicine created

¹ In the Medicaid program, for example, Section 1902(a)(23) of the Social Security Act prohibits a state from interfering with a recipient's free choice of qualified health care providers.

powerful incentives for health care providers to maximize their income by simply performing more procedures. Large corporations which routinely negotiate with their suppliers through price/performance contracting began attempting to manage their health care costs in the same fashion. In other words, practitioners would no longer be able to name their price. Finally, purchasers looked closely at the potential for directing or influencing consumers to select lower cost alternatives.

The HMO model embodied this development. In 1980, HMOs commanded only 5 percent of the health care marketplace (Weiner and de Lissovoy, 1993). However, they had established something of a track record in delivering health care at a lower price by substituting more cost-effective delivery practices. The HMO model introduced important new concepts to health care delivery, including capitated payment arrangements between health care purchasers and suppliers, care management, and service substitution practices. While the percentage of the population participating in HMOs was small (and continues to command less than a 25 percent market share of the insured population), the HMO model strongly suggested that altering the way in which health care was managed and delivered could result in savings to purchasers.

The answer to the question of "why managed care?" is economic. Public and private purchasers can no longer afford to buy health care in an "unmanaged" marketplace. While economic forces explain the emergence of managed care, other developments provided evidence of its potential. Research showed that the unmanaged marketplace spawned unnecessarily high costs. Large corporations enjoyed some success in pursuing alternatives to traditional indemnity insurance plans. The HMO experience suggested that changing the health care delivery/financing equation could yield lower costs.

Managed care is not merely an "alternative" health care service model. Instead, it involves a complete restructuring of the health care service delivery system. This restructuring is being driven by very large scale market forces that are displacing "doctor knows best" with purchasing/contracting/care management systems that are increasingly price/cost sensitive.

Out of necessity, purchasers are employing managed care to seize control of the health care marketplace.

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Health care represents one-seventh of the nation's economy. It is a fiercely competitive industry; its developments consume more and more space in the business sections of our daily newspapers, where buy-outs, mergers, "alliances", and jostling for "market share" and "covered lives" dominate the headlines. Managing and marketing health care has become a very big business. Exploding health care costs created the market for this business.

What is Managed Care?

"Managed care" is the attempt to control health care spending by affecting the price paid for health care services, inserting economic incentives into the health care service delivery system for suppliers to hold down their costs, controlling/influencing consumer provider selection patterns, better coordinating services, and exercising tighter controls over consumer service utilization.

"Managed care" defies simple explanations. It is not a unitary concept but rather a collection of strategies for containing cost and utilization. Managed care plans employ these strategies in various combinations and permutations. Managed care cannot be equated with a single organizational entity. The HMO is but one form of managed care (and, there are several different kinds of HMOs²). Health care purchasers themselves can function as managed care organizations (as when a state Medicaid agency demands that the need for non-emergency surgical procedures be confirmed by second opinions). Purchasers sometimes buy health care from managed care entities. Some of these entities exercise actual care management responsibilities. In other instances, such entities are alliances of health care suppliers that have joined forces to compete for health care business by charging lower prices (for example, PPOs) in exchange for a purchaser directing more consumers their way. Observers have pointed out that:

"Each managed care variant of the 1980s was dubbed (sometimes by a marketing agent) with a designation that broadcast its unique features. These new monikers included network model plans, preferred provider organizations (PPOs), primary care networks (PCNs), competitive medical plans (CMPs), health insuring organizations (HIOs), triple-option plans (TOPs), exclusive provider organizations (EPOs), open-ended HMOs (O/HMOs), point-of-service (POS) plans, flexible plans, and single-benefit plans. Some have suggested (usually derisively) that because of the proliferation of acronyms, the U.S. health insurance industry became an unintelligible alphabet soup of 'three-letter plans.' Moreover, this soup proved to be primordial; mergers, acquisitions, and tough competition led a fast-paced evolution and hybridization of the first generation of plans, complicating matters further..." (Weiner and de Lissovoy, 1993).

For present purposes, it is better to set aside the "primordial soup" and concentrate instead on the essential features and strategies that underlie managed care. Later, we will return to the topic of how these strategies and features operate under various organizational umbrellas.

Managed care strategies -- singly or in combination -- attempt to alter the three basic factors that drive health care costs: (a) utilization patterns; (b) prices charged by suppliers; and, (c) the share of costs borne by the insured population.

² The earliest "HMOs" were cooperatives formed by consumers on a subscription basis to hire a doctor(s) to serve the membership. Until relatively recently, the bulk of HMO enrollees were members of non-profit plans (e.g., the Kaiser Foundation, which is still the single largest HMO). However, in 1992, for-profit HMOs gained the upper hand in terms of "covered lives" nationwide.

II. Managed Care: An Overview

Here, it is very important to stress that operationally managed care plans might employ one or several different technologies or approaches to hold down costs. There is no single "best" managed care approach.

The costs of health care to purchasers are driven by three factors: (a) service/procedure utilization patterns/rates of the insured population; (b) the prices charged by suppliers (e.g., hospitals, laboratories, and physicians); and, (c) the share of costs borne by the insured population. Under the indemnity insurance model, suppliers operated under their own largely self-defined practice standards and had relatively free rein in setting prices. In the private sector, insurance plans either did not require that consumers help pay the costs of health care or capped their liability for such costs at relatively low levels. **"Managed care" is a collection of strategies which individually or in combination are employed to affect these three factors.**

The chart at the right broadly contrasts the features of "unmanaged" health care with the central concepts that underlie managed care. These are the differences that are most commonly cited. These gross differences,

however, do not fully capture the key concepts that underlie managed care. Rather than simplistic comparisons, it is more useful to discuss in some detail the key managed care strategies. These include:

Unmanaged	v.	Managed Care
Fee-for-service payments		Capitation
Buyer at risk		Supplier at risk
"Doctor knows best"		Utilization management
Free provider selection/		Limited provider choice/
Open market		Gatekeeping

- **Risk Management.** Risk management is an important managed care strategy. In health care, "risk" is defined as the party which bears the burden when costs exceed payments and stands to gain when costs are held below payments. **"Risk" is an economic concept.** Broadly, purchasers seek to minimize or manage their risk by shifting it to suppliers. Suppliers attempt to minimize risk by charging as much as the market will bear or controlling their own costs.

Indemnity insurance plans provided purchasers with short-term cost protection but usually resulted in purchasers shouldering all the long-term risk of health care costs (as noted above, plans passed along cost overruns in the form of higher premiums). Since health care suppliers were not at risk, they had little or no incentives to hold down costs and the prices they charged.

Managed Care Strategies Include....

- ✓ Risk Management
 - ✓ Utilization Management
 - ✓ Care Coordination/Case Management/Gatekeeping
 - ✓ Channeling
 - ✓ Service Substitution/
 - ✓ Supplier Network Control
 - ✓ Bundling
 - ✓ Health Promotion
-

In managed care, purchasers attempt to shift risk to suppliers. Shifting risk to suppliers has two outcomes: (a) the purchaser's costs of obtaining health care become more predictable; and, (b) suppliers have the incentive to hold down costs by providing services as economically as possible (in order to avoid a loss or gain a profit). Transferring risk from the purchaser to the supplier is accomplished mainly through negotiation and pricing strategies. In a competitive market, health plans vie for business by offering purchasers "products" that will minimize their risk.

There are many different strategies for transferring risk. One is *capitation*.³ Under capitation schemes, a purchaser contracts with a managed care organization (MCO) to furnish a range of covered benefits for enrollees at a single fixed price (and, usually at some discount from the average cost of meeting these needs in an "unmanaged" system). If the MCO is able to supply the benefits at a cost less than the capitation amount, then it makes a profit; if not, it incurs a loss. HMOs are paid on a capitated basis. State mental health managed care plans typically employ capitated payments. In turn, MCOs manage their risks in capitated systems by negotiating fixed payment (capitation) contracts with their suppliers or, in the case of a "staff-model" HMO, controlling costs by furnishing care directly through its own employees.

There are other strategies for transferring risk besides capitation. For example, *prospective provider reimbursement methods* "force the provider to control input costs to keep the total costs of providing services at a level less than the prospective price for that service" (Curtiss, 1989). Many state Medicaid programs set prospective rates for hospital services as a means of controlling costs and shifting risk to the hospital provider (thus, furnishing an example of how a purchaser can "manage care" directly).

The aim of risk management approaches is to force suppliers to contain their costs rather than allowing them to pass along higher costs to purchasers. The viability of risk management as a cost containment tool is directly related to the competitiveness of the marketplace. For example, where there is an oversupply of hospital beds, large purchasers have been able to transfer risk to hospitals (in the form of lower prospective rates), by threatening to take their business elsewhere. In reaction, there has been a wave of cost-cutting occurring at these hospitals. When large purchasers operate in markets with many suppliers and excess capacity, risk

³ In Part II, there is an extensive discussion of capitation. Capitation is the payment of a fixed dollar amount per enrolled beneficiary (or household) to a provider in exchange for the provider's contractual commitment to furnish defined services within the scope of the agreement to each beneficiary. Capitated rates usually are set at some discount from the historical/expected cost of these services under a fee-for-service system. In entering into such an arrangement, a provider expects to furnish these services more economically (by applying various other managed care strategies). Capitated rates usually are established for categories of enrollees (e.g., individuals versus families; age group; and so forth).

management can result in substantial cost savings. When the opposite is true, risk management is a less powerful tool.⁴

Explicitly or implicitly, risk management is a central managed care concept.

There are many variations. "**Full risk**" approaches shift all the risk from the purchaser to the supplier. Under full risk approaches, purchasers usually place **utilization management** (see discussion below) in the hands of suppliers. Because full risk plans can create powerful incentives for suppliers to cut costs by compromising the quality or accessibility of services, purchasers attempt to avoid negative outcomes through quality control/assurance/performance monitoring and assessment. Another risk management alternative is a "**partial risk**" arrangement that seeks to encourage suppliers to be efficient but does not shift all risk to them. For example, the supplier might be held at risk for the first five percent of excess costs but the purchaser shoulders a progressively higher share of excess costs above that level. Some managed care approaches do not rely on risk management approaches at all. "**No risk**" contracts, for example, can be designed as vehicles for purchasing care and system management expertise rather than relying on explicit economic incentives to hold down costs.⁵ Better care coordination is expected to yield cost savings. Risk contracts also may be "**risk adjusted**" to take into account differing utilization patterns among subpopulations of enrollees.⁶

"Risk management" aims at altering financial incentives in the health care marketplace. "**Full risk**" approaches place a high premium on suppliers controlling their own costs and actively managing care. Full risk approaches are fraught with the potential for creating incentives for suppliers to cut corners. As supplier risk diminishes (partial or no risk contracts), provider cost containment incentives fade in importance, with utilization management and care coordination rising in importance as tools for holding down costs. Purchasers must weigh the pros and cons of various risk management strategies. Full risk arrangements, for example, might offer the purchaser the greatest opportunity to secure short-term cost savings but can pose other thorny problems (e.g., employee dissatisfaction with limited health care choices).

Risk management arrangements include full risk, partial risk and no risk approaches.

⁴ By and large, health care markets are highly locality specific. This explains why the "penetration" of managed care into the health care marketplace varies considerably among the states and by locality within states. Rural areas are not "ripe" for managed care because there are few suppliers. It also is worth pointing out that suppliers are reacting to purchaser attempts to shift risk to them by consolidating into larger organizations that have stronger bargaining power.

⁵ Purchasers and suppliers also address risk issues in other ways, including what are termed "stop loss" (which are a variation of partial risk arrangements) and "reinsurance" (an agreement to pick up costs in excess of the capitation amount) provisions.

⁶ One form of risk adjustment is to set different capitation rates based on the age of enrollees. Medicaid contracts usually assign different capitation rates based on a recipient's category (e.g., distinct capitation rates for AFDC recipients, SSI recipients, and elderly individuals).

Managed care plans frequently are marketed on the basis of their risk management features (e.g., financial incentives will wring savings out of suppliers without compromising the quality of care). What is not clear, however, is the point at which the systemic reaction to risk management strategies leads to compromising the quality and accessibility of care.

Utilization management is employed to ensure that the services are necessary, efficacious and the least costly available.

- **Utilization Management.** In the "unmanaged" world of health care, physicians had broad latitude in managing patient care within generally accepted practice standards. "Medical necessity" was defined as whatever the doctor ordered. Under managed care, this is no longer true. Utilization management is employed to ensure that the services being furnished are necessary, efficacious and the least costly available. Utilization management takes many different forms, including:
 - **Prior Authorization.** Prior authorization requires a practitioner to obtain approval from the purchaser before certain types of services are furnished to an individual. In the absence of prior authorization, the purchaser will not pay the supplier. Prior authorization requirements are used to: (a) verify the necessity of the service (e.g., is a surgical procedure needed?); (b) subject the efficacy of the proposed procedure to independent review; and, (c) screen for the potential use of other low cost alternatives (e.g., can the procedure be performed on an outpatient rather than inpatient basis). Prior authorization usually is applied to particularly costly services or "elective" procedures. Prior authorization schemes usually are not applied to "routine care" or emergency procedures. A requirement that a *second opinion* be rendered before certain procedures are used is another example of prior authorization.
 - **Concurrent/recurrent review.** Another utilization management technique is concurrent/recurrent review. For example, a treatment plan might be approved for a two month period but be subject to review before the treatment may be continued. Like prior authorization, the aim of these reviews is to evaluate the necessity and efficacy of the treatment being provided. For example, a short-term psychiatric hospital stay might be approved but the extension of the stay requires prior approval (recurrent review). In other cases, each major step in a treatment plan might require review/approval based on how the individual is progressing (concurrent review).
 - **Benefit Limits.** The amount of a particular service that an individual can receive is capped; the delivery of services in excess of this cap requires case review and approval. For example, it is increasingly common to find plans limiting hospital length of stays for child birth to one day unless complications arise. Benefit limits are fairly common in State Medicaid programs (including absolute,

non-appealable limits on physician visits and other types of services). Mental health benefits also are typically subject to limits.

- **Peer/Practice Review.** Peer review usually involves reviewing a practitioner's practice patterns to determine whether they fall within an acceptable range and employ efficacious procedures. Peer review takes at least two forms: (a) the supplier (e.g., a hospital) conducting these reviews as an internal cost containment measure; or, (b) the purchaser performing these reviews in order to identify practitioners who are operating outside "usual and customary" practice boundaries.
- **Retrospective Analysis.** This technique involves evaluating practices and health outcomes in order to construct care criteria or practice standards. Such analysis is aimed at identifying practices that are prone to overutilization (and, hence, warrant prior authorization and/or other types of review) or at identifying particularly efficacious practices. The Kaiser Foundation, for example, has changed its practice standards concerning the scheduling of pap smears based on an analysis of its large patient data base. The number of pap smears has been reduced but early detection of cervical cancer has increased.

All utilization management techniques insert a third-party into the health care delivery equation between the practitioner and the patient. One goal of utilization management is better quality health care: ensuring that patients are receiving the most efficacious form of treatment and are not subjected to unnecessary procedures. Utilization management also is a cost containment tool. Since utilization management reduces practitioner independence, it frequently is criticized by physicians and other health care professionals as "getting in the way of good care".

Utilization management is only sound to the extent that it rests on a solid foundation of information concerning appropriate care criteria and efficacy. Some of the most exciting developments in health care are occurring in the arena of exploiting patient data bases in order to improve the quality and efficacy of services.⁷ Absent such information, utilization management can become little more than the arbitrary, bureaucratic and inconsistent application of rote rules rather than examining appropriateness and efficacy. Improper utilization management is a serious problem in some managed care systems. It takes many different forms,

⁷ David M. Lawrence, the Kaiser Foundation Health Plan's CEO, has observed: "We've gone from celebrating care that benefits people at the margins — such as expensive surgeries for a few — to seeking technologies [that] will allow us to provide superior care at the lowest total cost for populations of people". Another Kaiser-generated example of exploiting patient data bases to improve care was a study conducted in Northern California of members with diabetes. This study revealed that diabetic patients were not having their eyes checked on a routine basis; nor were other diabetes side-effects being monitored closely enough. Kaiser is reviewing its diabetic patient management practices to better detect problems in this population [*Business Week*, "Medicine's New Weapon: Data", March 27, 1995].

including not paying for efficacious drugs by adhering to a restrictive formulary, denying enrollees access to specialists when there is a *bona fide* need, or simply saying "no" to certain classes of services. The issues surrounding utilization management are particularly complex because this strategy directly affects the practitioner-patient relationship and the course of treatment.

- **Care Coordination/Care**

Management/Gatekeeping. In managed care, some forms of utilization management frequently are implemented through a care management or "gatekeeping" system. Gatekeeping systems screen and direct patients through primary care physicians (or other practitioners such as physician assistants or nurse practitioners) who deliver needed services or serve as a point of referral to more expensive specialty services. In the Medicaid program, many states have implemented "primary care case management" systems (see Chapter III). Utilization management also is implemented by requiring practitioners to obtain approval for procedures or referrals from the MCO.

Gatekeeping systems screen and direct patients through the primary care system.

Care managers coordinate treatment strategies on behalf of individuals with particularly complex medical problems.

A more proactive approach that is sometimes employed is specialized care coordination or care management. Care management often is used in order to coordinate the care of individuals having particularly complex medical problems that cut across several care dimensions and disciplines (Weiner and de Lissovoy, 1993). Such care management is conducted by a nurse or other professional who coordinates the treatment strategy. Some states have incorporated this strategy into managed care plans in order to ensure that individuals with disabilities are able to access needed services (see Chapter IV). Care management can be a very constructive means of improving patient care while holding down costs. However, the value of care management strategies relies heavily on the expertise of the care management personnel and the rules under which they operate.

- **Channeling.** Channeling involves directing individuals to preferred health care suppliers rather than giving them free rein in picking providers. Channeling is directly related to **supplier network control** strategies (see discussion on page 24). The objective of channeling is to encourage individuals to select lower cost providers. In health care, one form of channeling is to relieve enrollees of additional financial obligations when they see a physician who is a member of a Preferred Provider Organization (PPO) with whom the purchaser has negotiated a discounted fee-for-service rate but require enrollees who obtain services from other physicians to bear part of the cost "out of pocket". Another channeling method is where employers pay the full cost of certain kinds of health plans (e.g., an HMO

The objective of channeling is to encourage individuals to select lower cost providers.

option) but require employees to pay part of the premiums for other types of plans. At the extreme, channeling mandates that enrollees only receive services within the designated supplier network (e.g., services obtained from "out-of-plan" suppliers will not be reimbursed⁸). The ability of purchasers and MCOs to channel individuals to particular providers strengthens the purchaser's hand in negotiating prices with the supplier.

Channeling, obviously, is aimed at restricting or influencing the consumer's choice of health care providers. Channeling frequently is cited by consumers as the most objectionable feature of managed care plans. For example, when an employer switches managed care plans, an individual may be faced with not being able to go to the doctor with whom he or she has had a long-standing relationship. Some individuals have been forced to enroll in managed care plans because their physicians have sold their practices to the plans. Because channeling reduces consumer choices (and, thereby, erodes their ability to manage the quality of their own care by switching providers), purchasers need to monitor closely the quality of care being furnished by the managed care plan.

Private sector purchasers are leery of channeling. It can place them at the mercy of a large supplier. They face increased burdens in monitoring the supplier and dealing with employee complaints about the quality of care. Consequently, many private sector purchasers offer employees the option of selecting from among many different plans (albeit, employees may face differing "out-of-pocket" costs depending on the plan that they select). Indeed, "point of service" plans have recently emerged as enormously popular with employees and purchasers⁹. Federal government employees have the choice of many different plans that actively compete for business. "Managed competition" (a term prominent in last year's health care reform debate) is an alternative to channeling enrollees to single, exclusive MCOs.¹⁰ In some versions of Medicaid managed care, recipients are offered the choice between enrolling in an HMO or signing up with a primary care physician who exercises care management/care coordination responsibilities.

⁸ As an aside, it is useful to point out that debates concerning health care policy in state legislatures often revolve around what is termed "any willing provider" provisions that are aimed at requiring managed care organizations to reimburse any provider regardless of whether the provider is part of the plan network or not.

⁹ "Point of service" (POS) plans offer "the consumer a choice of options at the time he or she seeks services (rather than at the time they seek to enroll in a health plan)" (Weiner and de Lissovoy, 1993). Sometimes these plans are known as "flexible health plans, mixed-model plans, or hybrid model plans". Consumers have more choices under such plans; they also face different out-of-pocket costs depending on the choices exercised.

¹⁰ "Managed competition" as an alternative to "channeling" is feasible when consumers continue to bear some portion of health care costs (e.g., they shoulder the risks associated with selecting a low cost plan with high deductibles and co-insurance). In cases where consumers are not liable for costs (e.g., the Medicaid program as presently constituted), managed competition can continue to place purchasers at risk.

Channeling has its pros and cons. Since it increases the purchaser's market power, it can leverage lower prices. On the other hand, it increases consumer vulnerability to low quality care.

- **Supplier Network Control/Service Substitution.** In "unmanaged care", purchasers were at the mercy of the health care market place because they could not exercise market power (i.e., threaten to take their business elsewhere). Indemnity plans more or less gave enrollees the ability to obtain services from any provider. Many forms of managed care are designed to enable purchasers to enhance their control over suppliers. For example, an MCO with a large base of "covered lives" in a particular locale is in a far stronger bargaining position with providers because the MCO can deliver a high volume of business.¹¹ In health care, many hospitals are struggling with low occupancy levels. Thus, purchasers can exercise considerable market power (supply exceeds demand). Some MCOs exercise control over suppliers by integrating the provision of care directly into their organizations (as in the case of "staff-model" HMOs). In other cases, MCOs are simply buying out suppliers (purchasing hospitals outright)¹². The more control that purchasers have over their supplier networks, the better able they are to control costs or negotiate favorable prices.

The more control purchasers have over their supplier networks, the better able they are to control costs or negotiate favorable prices.

Another important managed care strategy is **service substitution**: i.e., furnishing lower cost but equally efficacious alternatives to higher cost services. This strategy, of course, is closely tied to utilization management but also is distinctive in that the focus is on manipulating supply so that demand can follow. There are many examples of "service substitution", including performing certain procedures on an outpatient rather than inpatient basis, employing personal assistants instead of obtaining care through home health agencies, using physician assistants and nurses to handle certain classes of medical problems, and so forth. Service substitution can significantly reduce costs. At the same time, the validity of this strategy depends on whether the substitution is legitimate (i.e., the alternative is just as efficacious).

Service substitution is replacing a higher cost service with an equally efficacious but lower cost alternative.

- **Bundling.** In "unmanaged systems", payment for services is based on the delivery of distinct "procedures" (each practitioner activity generates a distinct billing). As discussed earlier, such "fee-for-service" systems encourage providers to increase the

¹¹ Presently, there is a "merger" frenzy occurring among MCOs. This stems, in part, from the fact that the profitability of the organization is directly related to the market power it can exert. In the jargon of managed care, the more "covered lives" an MCO has the more likely it is to be profitable.

¹² MCOs have proven to be highly profitable and frequently have large supplies of ready cash. Buying out suppliers is one way they use this cash.

procedures they perform in order to maximize revenue. Purchasers sometimes attempt to counteract this strategy by holding down rates or by employing utilization management. Frequently, neither of these methods works very well as a cost containment tool.¹³

Bundling substitutes payments for a collection of related services in lieu of paying for each specific

Bundling substitutes payments for a collection of related services in lieu of paying for each specific procedure. In hospital reimbursement, for example, a comprehensive daily rate can be set that wraps around room and board charges, pharmacy costs, and so forth. This "wrap around" or "bundled" rate forces the supplier to control internal costs more closely. In the Medicare program, the Diagnosis Related Group (DRG) reimbursement system "bundles" hospital payments based on pre-established patient conditions (e.g., a hysterectomy). "Capitation" is a broad-based version of bundling.

- **Health Promotion.** A frequent criticism of U.S. health care is that dollars flow in response to illness but not in support of wellness. In managed care, wellness can translate into profit (or, at least, aid in lowering the risk of a loss). Some MCOs stress health promotion as a cost-avoidance strategy (e.g., by providing free flu vaccinations to high-risk enrollees or conducting smoking cessation classes). Some HMOs operate "well-baby" clinics. HMOs offer free flu vaccinations to vulnerable enrollees as a health promotion/cost avoidance strategy. It is interesting to note that many employers sponsor health promotion activities apart from their health insurance plans as a means of holding down their costs.

Health promotion is an important managed care strategy because it is aimed at affecting consumer utilization patterns. In the Medicaid program, for example, in 1989 Congress imposed more stringent requirements on the states in offering Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to children. Such services were regarded as one element of a larger strategy to contain costs.¹⁴ However, not all managed care plans stress health promotion because it can result in short-term cost increases that might only be recouped well in the future (when some of the beneficiaries may have exited the plan).

There are many different variations on these basic strategies.

Many of these strategies overlap. They can be (and are being) applied in different combinations by various purchasers. They are continuing to evolve as experience is

¹³ For example, studies have shown that reductions in Medicare payments to physicians have been offset by increases in the volume of procedures being billed.

¹⁴ Before the 1989 legislation, states were required to offer EPSDT services to children but many states did not take the steps necessary to ensure that such children were receiving periodic health screens. Since the health promotion benefits of EPSDT have long-term implications, the costs of EPSDT services competed with short-term budget priorities. However, several states did implement very aggressive screening and outreach programs in advance of the Congressional mandate as part of "healthy kids" initiatives.

gained in their application. There is no doubt that the unleashing of market forces in health care is spurring very fast-paced changes in the relationships among purchasers, suppliers, and consumers of health care. The marketplace is seeking out combinations of strategies that will deliver lower costs while ensuring access to health care services of acceptable quality.

There are some key points that need to be emphasized concerning all these strategies:

- **Managed care is the application of financially-driven strategies to affect the price and utilization of services; it is not a recipe book.** Managed care is best understood as a restructuring of the health care marketplace rather than as a different brand of health care. Various strategies are relevant in securing such a restructuring. Obviously, restructuring has consequences for all parties in the marketplace.
- **There is no evidence that allows one to draw the conclusion that any single strategy (or specific combination of strategies) yields superior results.** Each strategy provides a set of tools that can effect the cost and quality of health care in the short and long-term. How well they might function (and their possible pitfalls) cannot be understood independent of the market in which they would operate.
- **Finally, managed care navigates treacherous waters where cost containment (and profitability) and quality of care compete as goals.** We do know that cost containment does not necessarily result in lower quality care (as in the case of diverting Medicaid recipients from emergency rooms). Similarly, it makes good economic sense to impose incentives on health care providers to operate more efficiently. At the same time, it is unclear at what point cost containment forces suppliers to cut corners on quality. There is a clear need to obtain a better understanding of how to manage quality (and not just costs) under managed care approaches.

Managed health care is marked by a continuing tension between cost containment and quality.

Managed health care is marked by a continuing tension between cost containment and quality. Each of the various strategies outlined above can be illustrated by examples of how they might contribute to improving the quality of care while lowering costs. However, there also are troubling examples of how various strategies can be misapplied.

Managed Care Organizations/Plans

Managed care strategies are complex. Crafting a managed care plan involves deciding which of these strategies (singly or in combination) are most likely to yield cost containment/cost savings while maintaining quality care. The managed care plan is developed by the purchaser. [N.B., In Part II of the **Guidebook**, the development of a

managed care plan/feasibility study is discussed in considerable detail.] One way the purchaser might decide to implement the plan is buying health care services from an organization that applies managed care strategies. Purchasers also selectively contract with organizations to carry out defined elements of their plans.

There is a tendency to equate "managed care" with capitated payment systems that turn over all care management, arranging for care, and sometimes care delivery to a single organization (the MCO). Most of us still equate managed care with HMOs. HMOs are one way of organizing the delivery of services under a managed care plan. Until most recently, the public sector (Medicare and Medicaid) has directly implemented its own managed care plans (through reimbursement strategies and prior authorization requirements). Some particularly large corporations play a direct and active role in managing care.

Increasingly, however, purchasers are turning to MCOs to implement managed care strategies on their behalf. MCOs emerged because there was a market for their services. Indeed, traditional indemnity health insurance companies have become major "players" in the managed care market. As pointed out above, however, these MCOs have taken on a bewildering array of forms. Moreover, managed care has spawned its own jargon that further confuses matters. Here we turn from strategies to attempting to sort out the various arrangements through which managed care is implemented.

The organizational topology of managed care may be best understood along three dimensions: (a) the breadth of services that fall under managed care; (b) where risk is located; and, (c) how utilization management is carried out. Purchasers (along with state and federal laws) define the benefits that will be provided to employees (or, in the case of the Medicare program, "beneficiaries" and in the Medicaid program "recipients"). One element of a managed care plan is deciding how these benefits will be treated. A purchaser, for example, might decide to solicit bids from managed care organizations to take over the delivery of the full range of benefits. With standard benefit packages, such a solicitation might elicit bids from HMOs (in any of their multiplying forms) or from health insurance firms (which might offer a package of options that include an HMO, a PPO, and a traditional indemnity plan that is subject to tight utilization management, co-pays and deductibles). In this type of arrangement, the purchaser deals with a single organization that takes on full responsibility for all benefit management, either directly or by utilizing a network of providers. In such arrangements, the purchaser deals with one or more large suppliers of health care coverage. These suppliers, in turn, become purchasers in the marketplace. In essence, when this approach is taken, the primary purchaser (the corporation or the State Medicaid agency) removes itself from directly managing payments and utilization in favor of buying care/risk management from large scale health care entities.

Usually, under this type of arrangement, purchasers seek to assign risk to these entities by negotiating fixed price/capitation contracts. These entities then employ managed care strategies to hold down costs and, thus, manage the risk. Responsibility for

utilization management, negotiating with primary service suppliers, and so forth shifts from the purchaser to the MCO. These types of arrangements, of course, have parallels with traditional indemnity plans. The difference lies in the acceptance of risk by the MCO in exchange for the potential of making a profit if the strategies it applies contain costs.

There are many factors that can prompt a purchaser to buy health care from large-scale MCOs. One motive can be to remove themselves from the burdens of managing care themselves. Another is that the MCO, by virtue of its size, might be more cost-efficient. If the MCO supplies health care to many different purchasers (and, thereby, can claim a big market share), it may have a competitive advantage in negotiating with primary care suppliers.

In other instances, the purchaser may decide to "**carve out**" some benefits. These carve outs may be left on a fee-for-service basis or operated through what is termed a "**single benefit plan**". Typical carve outs include mental health care, dental care, and eye care. In turn, the purchaser may contract with a specialty organization to provide these services. Sometimes, comprehensive MCOs contract with these same plans to obtain these services. On a national basis, single benefit providers have emerged in mental health and some other service arenas.¹⁵ The decision to carve out a benefit generally revolves around whether the purchaser believes that obtaining such services through a comprehensive MCO is appropriate or might be best obtained via a direct contract with a specialty organization. In some cases, these specialty providers function as micro-MCOs, employing managed care methods to hold down costs and shouldering risk by accepting capitation payments.

Another managed care option is for the purchaser to contract with a **Third Party Administrator (TPA; a.k.a., an Administrative Service Organization (ASO))**. The TPA is the purchaser's agent in carrying out the plan but the TPA is not held at risk. A TPA may handle enrollment, claims processing and other administrative functions. Some companies specialize in utilization management. When a TPA is utilized, the purchaser usually continues to bear risk but maintains policy and direct quality control over the managed care plan. In the public sector, Medicare and Medicaid agencies employ TPAs as **fiscal intermediaries**. Some TPAs are subsidiaries of health plans; they perform the TPA role for their parent corporation but also market their services to other purchasers. For example, Blue Cross/Blue Shield plans market fiscal intermediary services to public programs.

"Health plans will continue to innovate, evolve, and hybridize; entities that reflect yet unseen organizational and financial arrangements will be a likely result. Categorizing, and even just describing health plans will become ever more difficult".

Weiner and de Lissovoy(1993)

¹⁵ A decade ago, mental health MCOs did not exist. Today they are a rapidly growing, \$2 billion+ industry. These corporations emerged for two reasons: (a) managing mental health care requires very specialized expertise that mainstream health plans usually do not possess; and, (b) many employers found that spending for mental health services was eating up more and more of their health care dollars.

The proliferation of various kinds of MCOs stems from a host of factors, not the least of which has been the turbulence of the health care marketplace. The fact that no single dominant organizational model has emerged offers strong evidence that the health care market is far from settling down. Readers also need to keep in mind that the health care marketplace is local and regional, not national. Comprehensive, full risk bearing HMOs can succeed in "dense" markets. They cannot succeed in a small rural county with a population of 2,000. There is tremendous variation among the states in the extent to which managed care options are available.

The marketplace also is strongly influenced by purchasers. Large-scale MCOs are geared toward large purchasers. Purchasers themselves have varying views regarding the extent to which they are willing to put all their apples into a single health care basket. Many purchasers proceed cautiously in this arena, particularly in agreeing to exclusive contracts. Many firms would rather be able to offer their employees a variety of health care plans by placing such plans in competition with one another.¹⁶

What the future holds is hard to tell. The recent merger/acquisition "binge" in the health care industry has spawned some very large national MCOs/health care firms. It could lead to a health care industry controlled by a relatively small number of health care corporations. A countervailing trend is the emergence of single-benefit (sometimes termed "boutique" managed care) plans that focus solely on the delivery of specific classes of services or manage care for certain categories of individuals. There are both consolidation and specialization forces at play. All that seems certain for the time being is that the turbulence will continue.

The "primordial soup" of managed care entities aside, purchasers retain the final say in how they implement managed care. In particular, the purchaser can:

- Decide to serve as its own MCO and pursue its own managed care strategies;
- Decide to retain some functions while contracting others out;
- Obtain health care by contracting with comprehensive MCOs;
- Use single-benefit plans to obtain some classes of services; and
- Mix and match fee-for-service with managed care approaches.

While not endless, the possibilities for how to organizationally structure managed care are numerous. Selecting one approach versus another depends on such factors as:

- Purchaser size (larger organizations are better able to support their own managed care strategies);
- The pros and cons of the purchaser's bearing risk rather than shifting risk to an MCO;
- "Product" availability;

¹⁶ In last year's health care debate, the concept of sparking "managed competition" among competing plans was an important element of President Clinton's reform plan.

- "Product" fit (can the marketplace deliver the proper combination of service capabilities and price?); and,
- Comfort levels concerning relationships with MCOs.

Each purchaser will sort through these factors differently.

Is Managed Care Better?

The jury is still out on whether managed care on the whole is delivering on its promise of containing costs while maintaining or improving the quality of health care. Managed care frequently is acclaimed as better, more accessible medicine at a more affordable price. These claims must be taken with a grain of salt (since frequently they appear in television commercials that urge individuals to enroll in one plan or another). Evidence remains mixed on whether this claim is true.¹⁷ There is evidence on both sides of this question. There are thousands of managed care horror stories, along with millions of satisfied customers. It needs to be kept in mind that the "unmanaged" system also yields mixed results.

Research concerning the interplay of managed care and health outcomes provides no conclusive evidence of the superiority of managed care versus conventional health care delivery and certainly no evidence that one brand of managed care is superior to another. At best, one can conclude that good and bad medicine takes place in managed and unmanaged systems. Some observers argue that the cost savings arising from managed care are short-term and are being extracted in a fashion that is undermining the long-term soundness of the health care delivery system.

The absence of conclusive evidence regarding the outcomes of managed care raises many cautionary flags. After letting the horse out of the barn, purchasers now are beginning to invest in studies and research to learn more about the results of managed health care. "Score cards" are being developed so that purchasers and consumers can make more informed choices about health care plans.¹⁸ Efforts have been stepped up to

¹⁷ For example, some studies seem to indicate that HMO enrollees are hospitalized less frequently than is true of the general population. These studies have been questioned because it is believed that HMOs attract healthier individuals who are less likely to require hospitalization in any case.

¹⁸ Since 1989, a consortium of group practice HMOs and major employers have been actively involved in developing the Health Plan Employer Data Set (HEDIS). The aim of this effort is to develop performance measures that "document the value of a health plan". In other words, HEDIS results could furnish purchasers with information concerning plan performance that could be evaluated along with a plan's price in guiding corporate decisions in the selection of a plan. One facet of HEDIS development is encouraging health plans to develop common data sets. This effort is continuing under the aegis of the National Committee for Quality Assurance, a non-profit, independent organization that reviews and accredits health plans.

HEDIS is intended to assess five major categories of health plan performance: membership and utilization; quality of care; satisfaction and access; finance; and health plan management. HEDIS "quality of care" indicators include the frequency with which mammographies are being performed on female plan members over age 50 and whether children are receiving immunizations when due. HEDIS is still

evaluate health outcomes.¹⁹ There are now checklists to help purchasers assess how "ready" they are to institute and administer managed care plans.

The rapid-paced growth of managed care also has surfaced new concerns about plan practices, particularly with regard to consumer safeguards. States are taking a hard look at their insurance laws in light of the shift from indemnity plans to managed care plans. The American Medical Association (AMA) has developed a "model" "Patient Protection Act" that includes provisions regarding "plan certification standards, internal/external review processes, criteria for provider selection/termination, and any willing provider and freedom-of-choice".²⁰ States are examining the extent to which managed care plan marketing practices need to be regulated (including better informing consumers about how a plan works), whether there need to be utilization review safeguards, and the extent to which plans must offer enrollees access to "out-of-network" providers.

As will be discussed in greater depth in Chapter IV, there is not very much known about managed care for "special needs" populations. Managed care has unfolded in the private sector as a substitute for employee indemnity insurance plans. Working age adults and their families usually have a comparatively favorable health status. In the Medicaid program, states generally have moved AFDC recipients (younger women and their children) into managed care but deferred enrollment of people with disabilities and elderly individuals. AFDC recipients are not high users of health care services. Managed care is not being used extensively in the Medicare program (although this is likely to change). People with disabilities and elderly individuals exhibit distinctly different utilization patterns than the bulk of the current enrollees in managed care plans. Hence, it is far from clear that experiences with the present population of managed care enrollees will hold true for other population categories.

Determining how the outcomes of managed care compare to those of "unmanaged care" is replete with difficulties. Health care outcomes are the result of the interaction of many different variables in a very complex, rapidly changing service delivery environment.

Managed Care: Today and Tomorrow

Broadly, the experience with and future direction of managed care might be summed up as follows:

evolving. It is frequently criticized as only providing very general measures of performance. Given the complexities involved, this criticism is not entirely fair.

¹⁹ Several states (California, Colorado, Connecticut, Florida, Michigan, New York, Pennsylvania, Utah, and Washington) are developing data systems that are designed to deliver information to consumers and purchasers regarding health plan performance levels.

²⁰ Intergovernmental Health Policy Project, George Washington University (July 24, 1995). *State Health Notes*: "States Seek Safeguards in the Managed Care Marketplace".

- **There are powerful economic forces that are driving public and private health care purchasers toward managed care.** These forces (the most important of which is "cost containment") should not be discounted or underestimated. In very short order, we have seen the rapid transition from "unmanaged" to "managed" systems. The *status quo ante* will not be restored. These forces are still playing themselves out in both the public and private sectors.²¹
- **The market forces that are driving managed care are enormously complex and are spawning massive turbulence.** For the foreseeable future, it is unlikely that the health care industry will "settle down". As a result, managed care is in an evolutionary phase where it is particularly difficult to predict how it all will be finally sorted out. With one-seventh of the nation's economy up for grabs, we should not expect that the industry will stabilize any time soon.
- **It is important to distinguish between managed care strategies and the organizational varieties of managed care.** Managed care strategies can be applied by any purchaser. There are various organizational configurations that can be structured to carry out these strategies, ranging from the purchaser's *steering* the plan (by setting policy) to being heavily involved in *rowing* (i.e., direct involvement in the operational details).
- **Managed care strategies are tools for controlling costs and affecting/redirecting service utilization patterns; the application of these tools has potential consequences for the quality of care.** Whether such strategies should be applied and what the consequences will be cannot be prejudged in isolation from a wide variety of factors, including local market conditions, the validity of utilization management approaches, and potential health outcomes.
- **Managed care has evolved much more quickly than the ability to evaluate its outcomes.** The marketplace has changed more rapidly than the capacity to judge the effectiveness of managed care arrangements across a wide variety of dimensions.

Managed care is not new. What is new is its application on a very large scale and the resulting marketplace turbulence, which is amplified by the rapid pace at which managed care has replaced traditional fee-for-service medicine.

²¹ It is worth noting that the failure to achieve national health care reform is an important factor here. Setting aside which "vision" of health care reform would place the nation on a course toward securing stable health care spending, many of the central objectives of reform were to attack the root causes that underlie the explosion of outlays in this arena. Some reform proposals were aimed at lessening the administrative cost burden under which the health care system labors. Others sought to attack the problem of "cost shifting" which distorted the marketplace (cost shifting drives up costs to purchasers as suppliers seek to cover losses stemming from uncompensated care). The failure to find a global solution has prompted purchasers to seek their own solutions.

CHAPTER III
MANAGED CARE IN THE STATES

III. Managed Care in the States

In fiscal year 1995, state-federal Medicaid spending is expected to reach approximately \$156 billion. Nearly 36 million citizens rely on the Medicaid program to access health and long-term care services, including more than six million people with disabilities. In other words, the Medicaid program serves roughly one citizen in every seven (including one child in every four) and accounts for about 13 percent of all health care spending.

Over the past two years, states have been introducing managed care arrangements into their Medicaid programs at a furious pace in order to contain spending. Between 1990 and 1994, Medicaid spending jumped by roughly 50 percent (at an annual rate in excess of 17 percent). Confronted with skyrocketing Medicaid outlays that are consuming a larger and larger share of their budgets, states are embracing managed care as a primary cost containment tool. In several states, Medicaid cost containment and managed care have been linked to broader health care reform strategies.

States are embracing managed care as a primary strategy for slowing the skyrocketing growth in Medicaid program spending.

Under the Congressional Republican plan to balance the federal budget by the year 2002, the Medicaid program would be scrapped in favor of dispensing federal assistance to the states in the form of a sum-certain "block grant" or "capped entitlement" earmarked for the provision of health and long-term care services to low income citizens. This is an enormous change in federal policy. Under the Republican plan, Medicaid would disappear as an open-ended entitlement (both to the states in terms of federal payments and for most individuals in the form of a basic guarantee of access to health care). States must operate their publicly-financed health and long-term care programs to live within a fixed annual federal allotment.

There is little doubt that this change in federal policy will prompt states to accelerate the conversion of their present Medicaid programs to managed care approaches. Indeed, one of the central premises of the Congressional plan to cut the growth in federal Medicaid spending by \$182 billion over the next seven years is that giving states a freer hand to employ managed care strategies will enable them to slow the rate of spending growth with minimal disruption in the availability of health care services.

The way in which states have employed managed care in their Medicaid programs to date

Topics Covered...

- ☒ Medicaid Program Trends
- ☒ Medicaid & Managed Care
- ☒ Medicaid Managed Care: Present Status
- ☒ Where Does Medicaid Managed Care Stand?
- ☒ Medicaid: The Future

provides an indication of the directions that they are likely to take once the Congressional plan takes effect. In this chapter, we describe the key trends in the Medicaid program that have prompted states to implement managed care arrangements/strategies and how those strategies are being carried out. Finally, we tackle the question of the program's future, particularly in light of federal deficit reduction efforts.

Medicaid Program Trends

Thirty years ago, the Medicaid program was created and designed along conventional health insurance lines. The states were required to offer public assistance recipients a basic set of health care services (inpatient hospital, outpatient clinic, physician services, and so forth -- termed "mandatory" services); they also could offer various "optional services" (e.g., prescribed drugs, physical therapy, and dental services). Medicaid recipients were to be free to choose the practitioners from whom they obtained covered services, and, in turn, these providers would send a fee-for-service billing to the state Medicaid program for payment. The program's aim was to give public assistance recipients (AFDC households and "aged, blind, and disabled" individuals) access to mainstream health care on an equal footing with workers (who had employer-subsidized coverage) and retired persons (who were covered under the federal Medicare program, which also was enacted in 1965).¹

Since its enactment, the Medicaid program has changed in many ways. Congress has mandated that states cover additional services. More and more optional program coverages also have been added.² During the 1980s, Congress broadened program eligibility, culminating in the 1990 mandate that states extend eligibility to low-income pregnant women and children³ (even though these individuals did not qualify for public

¹ The origins of the Medicaid program are recounted in: Robert Stevens and Rosemary Stevens (1974) *Welfare Medicine in America*, New York: The Free Press. Even though the aim of the program was to enable recipients to access mainstream health care, various compromises resulted in a program that gave states considerable latitude in establishing and operating their programs. Unlike Medicare, which was federalized under a uniform set of rules, the latitude afforded the states under Medicaid statutes resulted in a high degree of variability in state programs in terms of: (a) the categories of individuals eligible for program services (because eligibility for state public assistance programs varied considerably); and, (b) the services offered (due to the discretion states had to cover or not cover "optional" services). Furthermore, because states had latitude in establishing Medicaid payments, from the outset they tended to set below-market payment rates that quickly resulted in a "two-tier" system that saw Medicaid recipients having fewer choices of health care providers than other individuals. As a consequence, despite the goal of integrating Medicaid recipients into mainstream health care, 50 different programs emerged. This remains the case today. The 30-year legislative history of Medicaid has been a constant budget-driven, political tug-and-pull between Congress and the states, with states seeking greater latitude in managing their programs as they see fit and Congress attempting to force states to be more uniform and comprehensive in terms of the services available to Medicaid recipients.

² Including, for example, the ICF/MR program in 1971.

³ Throughout the 1980s and culminating in the passage of the Omnibus Budget Reconciliation Act of 1990, Congress repositioned the Medicaid program as the health care safety net for low-income pregnant women and children. This repositioning, which enjoyed broad support on both sides of the aisle, ultimately led to

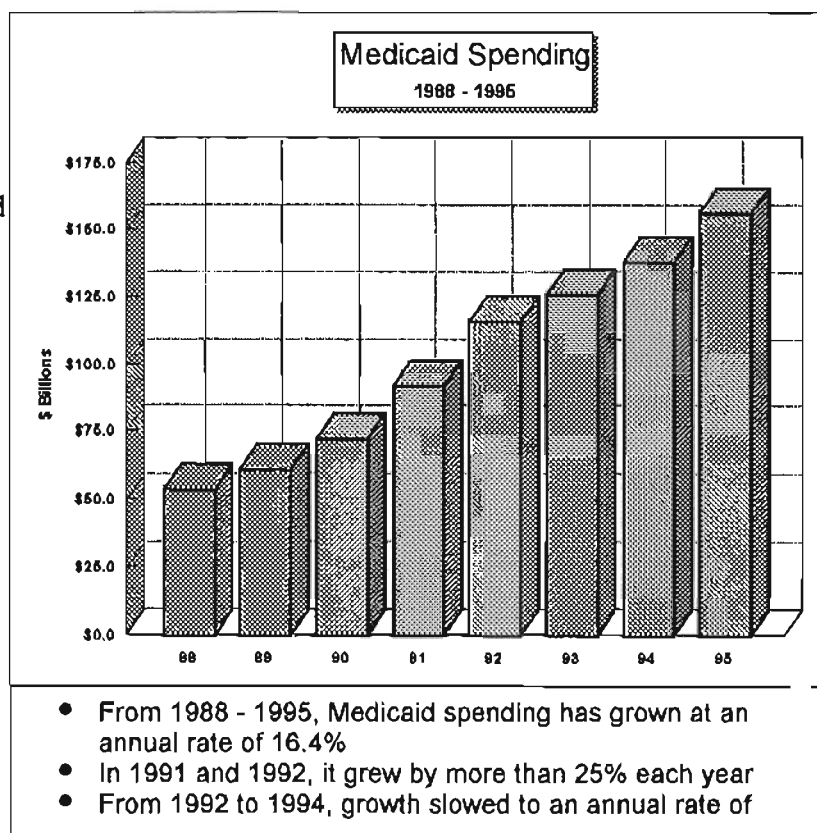
III. Managed Care in the States

assistance) and certain low income Medicare recipients. The cumulative effect of these changes has been to: (a) broaden the types of services for which states could obtain federal Medicaid funding; and, (b) expand program eligibility -- on both a mandatory and optional basis -- well beyond the original required coverage of AFDC and SSI recipients. These "mandates" had the effect of increasing Medicaid spending (including the amount of matching dollars that the states had to raise).

On their own, the states also have pursued strategies to "maximize" federal Medicaid revenues. They have qualified services for Medicaid reimbursement previously funded solely from state and local dollars. While objecting to new federal mandates, the states, nonetheless, have aggressively exploited Medicaid financing to pay for an ever-widening array of health and long-term care services. Medicaid has become the principal financing source

for developmental disabilities services. Mental health systems have qualified for substantial Medicaid funding. States have used "creative financing" schemes to obtain more Medicaid dollars to pay for "indigent" care, including underwriting "healthy kids" initiatives. Medicaid financing has been interjected into school health systems, early intervention programs, foster care, substance abuse, and a host of other program areas. States stepped up their use of Medicaid financing for a variety of reasons, including: (a)

the continuing erosion of other sources of federal domestic assistance for human services (e.g., the Social Services Block Grant program); (b) their inability or reluctance to raise additional state tax dollars to pay for human services; and, (c) the simple fact that federal Medicaid dollars are "open-ended" and, hence, have been a very powerful, unlimited source of funding for various human services programs.



two mandates: (a) all states were required to extend Medicaid coverage to low-income pregnant women and children living in households with incomes up to 133 percent of the poverty level (Congress phased in the mandatory coverage of children by age group); and, (b) all Medicaid-eligible children had to receive all "medically necessary" services (the EPSDT mandate).

Given the forces at play, it is little wonder that Medicaid spending exploded. The combination of federal mandates and state Medicaid "maximization" strategies triggered an unprecedented rate of growth in program spending that began in the late 1980s and only recently has shown signs of abating. Within a very short period, Medicaid became the fastest growing federal grant-in-aid program to the states and, hence, a major contributor to the persistent federal budget deficit. Medicaid spending now consumes roughly 18-19 percent of state budgets. The explosion in Medicaid spending has sparked finger pointing by both state and federal policymakers. Governors lay the blame on the "federal mandates"; federal officials point to Medicaid "maximization" strategies as the source of the rapid increases.⁴ Whatever the causes of the explosion in Medicaid spending, both federal and state policymakers describe the program with the same adjective: "*run-away*".

For many of the same reasons that health care cost destabilization prompted private-sector health care purchasers to turn to managed care, the states are seizing on managed care as a tool for taming Medicaid spending. They have found support in the Clinton Administration which considerably relaxed various rules to enable states to pursue very broad-scale Medicaid managed care strategies as well as employ managed care in more targeted ways. The upshot has been the rapid conversion of state Medicaid programs to managed care.

Medicaid & Managed Care

States have been introducing managed care arrangements into their Medicaid programs at an unprecedented rate and on a very large scale. Present federal law and regulations provide the states with a variety of ways to employ managed care in their Medicaid programs. These options range from implementing limited managed care strategies to the broad-based conversion of entire sectors of state Medicaid programs to managed care. States may implement some of these strategies on their own; in the case of others, they need to obtain Secretarially-approved waivers of federal law in order to proceed. Under the Congressional Republican plan to restructure Medicaid, states will have an even freer hand to pursue managed care options.

In many respects, the evolution of Medicaid managed care parallels developments in the private health care sector. For a considerable period of time, states have used various fundamental managed care strategies on a selective basis in order to contain costs. Examples include:

⁴ In fact, there have been a variety of factors at play, including recipient growth (due partly to economic conditions and partly to new mandates), medical care cost inflation, states exploiting "disproportionate share hospital" (DSH) payments, and so forth. See "Medicaid and Federal, State, and Local Budgets" (The Kaiser Commission on the Future of Medicaid: March, 1995) for a reasonably balanced discussion of the interplay of the various factors underlying the explosion in Medicaid spending.

III. Managed Care in the States

- **Prior Authorization.** Prior authorization is a common Medicaid utilization management tool. States commonly apply prior authorization requirements to non-routine care (for example, the purchase of "durable medical equipment", such as customized wheelchairs or elective surgical procedures).
- **Other Utilization Management Strategies.** Many other common utilization management strategies that are employed in the private sector are used in state Medicaid programs. Several years ago, New York, for example, imposed a requirement that second opinions must be obtained for elective surgeries. Many states contract with peer review organizations which regulate hospital length of stay.
- **Service Substitution.** Since the early 1980s, states have been very active in developing "community care" alternatives (personal care, home health, subacute hospital services, and home and community-based waiver programs) to more costly institutional (nursing facility and ICF/MR) long-term care services.
- **Prospective Pricing.** Most states have implemented prospective payment methods for hospital and institutional services. Frequently, these methods are combined with "bundling" as a cost containment tool. New York, for example, adapted Medicare's DRG hospital payment system as well as "Resource Utilization Group" (RUGs) to regulate payments to nursing facilities.

In one fashion or another, every state Medicaid program employs managed care strategies. The preceding strategies are fairly common and states have the latitude to implement most without requesting special Secretarial waivers. In fact, present federal Medicaid law dictates that states use certain managed care strategies. For example, states are required to maintain "utilization review" programs to ensure that the services being furnished to recipients are appropriate and necessary.

Frequently, however, the application of managed care strategies in state Medicaid programs has been narrowly-focused, piecemeal, incremental and, frequently, starved for resources. Many times, such strategies have been implemented as stop gap measures to slow spending (often in response to a budget crisis). Along these lines, the experiences of states in employing such strategies were similar to other payors. The implementation of a particular strategy provided temporary financial relief until the system adjusted and reacted to the change. For example, state attempts to contain physician payments frequently resulted in Medicaid recipients shifting to very costly emergency rooms to access routine care when physicians dropped their Medicaid participation agreements in response to low payments. States -- like other payors -- have learned that managing health care on a service-by-service, case-by-case basis is at best a difficult enterprise and at worst can exacerbate more fundamental problems.

Broader Medicaid Managed Care Options: Overview

The recognition that narrow strategies often can set off chain reactions that ultimately frustrate cost containment objectives has prompted the states to test and adopt

States increasingly are employing more global, "wrap-around" managed care approaches to contain spending.

more comprehensive, alternative managed care arrangements in their Medicaid programs. In particular, states are shifting from the use of isolated managed care strategies to using more global, "wrap-around" approaches, including capitated payments and care management. Instead of attempting to control costs through fee-for-service payment restrictions, service-specific utilization management schemes, and a complicated array of restrictions on the frequency, duration and scope of services, states are following the private sector into the managed care arena by shifting risk to MCOs and health care providers.

Present federal Medicaid law and regulations provides the states with four principal options for implementing alternatives to standard Medicaid "fee for service" service delivery arrangements. These include:

- A state may contract with HMOs and "prepaid health plans" to provide services to Medicaid recipients who *voluntarily* elect to enroll in such plans. The conditions for such contracts are specified in federal law and regulations. Payments to such plans are made on a capitated basis. Other provisions enable a state to contract with "wrap-around" service providers on a capitated payment basis.
- A state may request a waiver under Section 1915(b)(1) of the Social Security Act in order to implement a "**primary care case management**" system (a "gatekeeper" arrangement).
- A state may request a waiver under Section 1915(b)(4) of the Act for the purpose of restricting the provision of certain services to designated providers.
- Finally, a state may request that the Secretary of Health and Human Services approve a "**research and demonstration**" project under the provisions of Section 1115 of the Act in order to test new service delivery models which require multiple, extraordinary waivers of federal laws and regulations.

Present federal policy, therefore, allows states to contract with MCOs or employ capitated payments on a routine basis. The remaining options, however, require a state to obtain federal approval of statutory waivers⁵ and/or a demonstration project request before it may proceed.

⁵ These waivers should not be confused with "home and community-based services" (HCB) waivers under Section 1915(c) of the Act. The HCB waiver authority permits a state to offer community services and supports to individuals who otherwise could be admitted to an institutional setting. While HCB waiver programs are often based on managed care strategies (principally service substitution), the Section 1915(c)

Under current law, a state must submit a special waiver request when its managed care strategy: (a) entails restricting recipients' freedom of choice as required under Section 1902(a)(23) of the Social Security Act; and/or, (b) its proposed managed care arrangement does not conform to predefined statutory and regulatory requirements. It is important to keep in mind that the Medicaid program was based on the principle that a recipient could obtain necessary services from any qualified provider who agrees to accept Medicaid payment. Any departure from this fundamental principle requires a state to obtain a "freedom of choice" (FOC) waiver. Moreover, current requirements for contracting with HMOs or PHPs generally are relatively restrictive. Hence, employing alternative arrangements also necessitates a special waiver.

The boundary between Section 1915(b) program waivers and Section 1115 demonstrations is somewhat murky. In the context of what have been termed "superwaivers", the boundary is defined principally in two ways (in addition to a FOC waiver): (a) individuals are made eligible for Medicaid-reimbursable services who otherwise would not qualify for such services (a common thread in "comprehensive health care reform" demonstrations); and, (b) the scope and breadth of the waivers a state requires in order to implement its proposal are more extensive.

Each of these options is being used by states in different ways. In some instances, states limit a managed care arrangement geographically (by obtaining a waiver of "statewideness"). In other cases, the arrangement is being used only with certain segments of the Medicaid population (e.g., requiring AFDC recipients to enroll with a managed care organization but not extending this mandate to SSI recipients) or for selected services. Some arrangements are "exclusive": e.g., a recipient may only obtain services through a single provider. Others permit recipients to choose among competing HMOs or select a primary care case management arrangement. A multiplicity of approaches have emerged. As in the private sector, states are testing various ways of employing managed care to contain costs.

Options Available to States Without a Waiver

As discussed above, federal law and regulations permit a state to contract for the delivery of Medicaid services through managed care arrangements without seeking special waivers. States have employed these options to offer recipients alternatives for obtaining

authority does not permit a state to limit recipients' freedom of choice (either with respect to the choice between community and institutional services or the choice of a community provider agency). Section 1915(b) was added to Title XIX of the Social Security Act in 1981 (the same year that the HCB waiver authority under Section 1915(c) became effective). This addition was part of a series of amendments to the Act that were intended to give states greater latitude in managing their Medicaid programs. Section 1915(b) also provides for two other types of special waivers. A Section 1915(b)(2) waiver enables a state to designate a single local entity to serve as a "central broker" in assisting Medicaid recipients to choose among competing health care plans. Section 1915(b)(3) gives states a mechanism to share the cost savings derived from furnishing services in a "more cost effective" manner. The sharing of savings may take the form of increased services, elimination of co-payments, or the removal of service limitations.

health care and other services. These alternatives compete with the fee-for-service system in meeting recipient needs. Options available to a state without a waiver include:

- **Contracting with State or Federally-Qualified HMOs.** For many years, states have had the authority to contract with Health Maintenance Organizations to furnish health care services to Medicaid recipients. Federal requirements governing such contracts are spelled out in Section 1903(m) of the Social Security Act.⁶ In the absence of special waivers, federal law requires that: (a) individuals be offered the free choice to enroll in a contracted HMO or receive services from other Medicaid providers on a fee-for-service basis; and, (b) states may contract only with HMOs in which at least 75 percent of the enrollees are non-Medicaid/ non-Medicare recipients. In other words, Section 1903(m) does not permit a state to mandate that recipients sign up with an HMO or allow contracts with HMOs which exclusively serve Medicaid recipients. States may offer an HMO alternative to recipients but cannot "channel" recipients into such arrangements without a special Secretarial waiver. Nonetheless, by contracting with existing HMOs, a state can gain some of the advantages of capitation (including entering into arrangements that hold the HMO at risk). Historically, most states have not made extensive use of this option due to the federal requirements that must be met. More recently, some states have become more aggressive in signing up HMOs that are willing to serve Medicaid recipients.
- **Prepaid Health Plans/Other Capitation Arrangements.** A state may contract with a "prepaid health plan" (PHP) to furnish one or more Medicaid services under a capitated funding arrangement. Such contracts may hold the provider at-risk or may be a "no-risk" arrangement. A state, for example, can obtain a "bundle" of Medicaid services on a capitated funding basis from a PHP. The capitated rate paid to a PHP cannot exceed what is termed the "fee-for-service" upper limit.⁷ Again, absent other waivers, a state may not mandate that recipients only obtain services from a PHP. Some types of PHPs (comprehensive services entities) face some (but not all) of the restrictions/requirements placed on HMOs.⁸ For less than comprehensive services, a state has greater latitude in contracting for various combinations of services on a capitated risk-bearing basis.
- **Organized Health Care Delivery System.** Federal regulations⁹ also enable a state to obtain services from an "organized health care delivery system" (OHCDS). An OHCDS is defined as a "public or private organization for delivering health services. It includes, but it is not limited to, a clinic, a group practice prepaid capitation plan,

⁶ These requirements also are spelled out in 42 CFR 434 Subpart C.

⁷ Capitation payments to HMOs and "comprehensive service" PHPs must be "actuarially sound". Comprehensive service plans are those which offer hospital, physician, and other basic health care services. In more limited arrangements, the capitation payment cannot exceed average per capita "fee for service" costs which define the "upper limit".

⁸ See also 42 CFR 434 Subpart C for a description of PHP requirements.

⁹ At 42 CFR 447.10(b).

and a health care maintenance organization". An OHCDs must provide at least one service directly to recipients but may offer or arrange for others through contracts with other providers. If payments are made on a capitated basis to the OHCDs, then upper limit requirements apply (e.g., such payments cannot exceed fee-for-service per capita costs). The OHCDs option gives a state the latitude to contract with a variety of organizations that manage the delivery of several services to recipients. Again, absent special waivers, a state may not dictate that recipients obtain services exclusively through an OHCDs; nor may it mandate that providers affiliate with an OHCDs. The OHCDs option provides a tool for states to contract with agencies/organizations for the provision of a cluster of services.¹⁰

These "non-waiver" options permit a state to contract with various types of entities that furnish a full or limited range of services to recipients on a "wrap-around" basis.

Capitation under Medicaid managed care arrangements merits additional discussion because it plays an important role in state strategies. Under traditional fee-for-service systems, a Medicaid payment is triggered by the delivery of a discrete service. With capitation, the MCO is paid a fixed (monthly) amount to deliver "a specific menu of health services to a defined population for a prescribed period".¹¹ In the case of comprehensive services HMOs or PHPs, the capitation payment must be actuarially-based (e.g., it must be determined by examining recipient utilization patterns and service costs). For less than comprehensive arrangements, the payment is negotiated at some discount from the fee-for-service upper limit. We will discuss the technical aspects of capitation in Part II. For present purposes, it is useful to point out some critical features of a capitated payment approach:

- **First, the payment is made to the provider regardless of whether the recipient actually receives a service.** A capitated payment compensates the provider for its willingness to furnish all necessary services as and when they are required. Capitation is best understood as compensation in exchange for the agreement to provide a bundle of services. The vendor must manage these fixed dollars in a fashion that delivers on the promise that recipients will receive needed services at a cost to the vendor that does not exceed the capitation. Vendors do this through service substitution, utilization management, and other forms of cost containment.
- **Second, capitation under Medicaid operates like it does in the private sector.** The "theory" of Medicaid capitation is to employ economic incentives to hold down the cost of services. Under Medicaid, MCOs can earn a profit if costs are less than the aggregate amount they receive via capitated payments. Under some (but not all) arrangements, providers also risk incurring a loss. Capitated payments might initially be based on expected utilization patterns, then adjusted up or down based

¹⁰ This option has been employed by some states in their HCB waiver programs for people with developmental disabilities, particularly to underscore the role of sub-state agencies in organizing local service delivery systems.

¹¹ State Medicaid Manual, Section 2085.

on experience. A state may limit the amount of profit that an MCO might take. States may make capitated payments but not hold the provider at risk. States may "risk share"; "stop loss" arrangements are not uncommon.¹² Except in the case of comprehensive HMOs, states have the flexibility to negotiate capitation and risk-sharing arrangements with vendors as long as the upper limit test is met.

- **Third, capitated payments can give MCOs considerable programmatic and managerial flexibility.** An MCO can use the money it receives in the form of a capitation payment to furnish alternative services to recipients that may not have been or could not readily have been covered directly in a state's Medicaid program. Since the vendor is receiving a "global" payment rather than one based on the provision of distinct services, a capitation system potentially gives the MCO greater latitude in meeting the needs of recipients. Capitation schemes encourage service substitution. In addition, where an MCO contracts with other suppliers to furnish component services, the MCO has a relatively free hand in negotiating payments with such providers. The flexibility that capitated payments afford MCOs can be restricted. States "regulate flexibility" by defining the "care criteria" that the MCO must observe in deciding service protocols or by directing MCOs to contract with certain suppliers (i.e., "essential providers").

In Medicaid, capitation is an important managed care strategy. It is the common thread that weaves through non-waiver managed care options, waiver options and the broader superwaivers.

In summary, these options permit a state to contract with various types of entities that furnish a full or limited range of services to recipients on a "wrap-around" basis. These options may not limit the consumer's freedom of choice. Moreover, a state must guarantee that recipients who obtain services under any of these options continue to have access to the full range of Medicaid services, either through the managed care entity or via referral to other providers. Each of the options enables a state to employ a capitated funding methodology. Managed care entities may be held at full, partial or no risk.

Program Waivers (Section 1915(b))

The non-waiver Medicaid managed care options described above are not particularly aggressive since they depend on voluntary recipient participation. More aggressive managed care strategies can be pursued under the provisions of Section 1915(b) of the Social Security Act, which gives a state the option of seeking "**program waivers**" of federal law to: (a) restrict recipients' freedom of choice; and, (b) limit the providers of Medicaid services. There are two principal ways that states have employed this authority:

Primary care case management is a "gatekeeper" Medicaid managed care model.

¹² Under such an arrangement, the state will compensate the MCO when the costs of serving any particular individual exceeds a predefined contractual threshold above the capitated amount.

- **Primary Care Case Management.** Section 1915(b)(1) of the Social Security Act allows a state to obtain a waiver of recipients' "freedom of choice" requirements from HCFA in order to implement a "primary care case management" (PCCM) system. Under the PCCM approach, a state contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of services to Medicaid recipients.¹³ A PCCM system is a **gatekeeper** model. A state mandates that a recipient select a PCCM (hence, the need to obtain a "freedom of choice" waiver) from among the providers that have agreed to perform this role (states offer physicians (including specialists) the opportunity to sign on as PCCMs, but usually restrict the number of individuals each PCCM may enroll). Such providers are paid a fixed monthly fee (usually \$1.50-3/recipient) to perform PCCM functions. Such providers typically must be available to recipients on a 24-hour basis, provide primary care and make referrals for other health care services.

A state may implement PCCM programs across the entire spectrum of Medicaid recipients, exclude some recipients from such arrangements (often, states exclude long-term care recipients) or may target PCCM to specific subpopulations. *Bona fide* emergency services are not subject to PCCM authorization (recipients retain the freedom to obtain emergency services as necessary). PCCM approaches are used by states for two principal reasons: (a) to cut down the utilization of emergency rooms for routine services; and, (b) to link recipients to primary care physicians/practitioners who provide both primary care as well as coordinate and prior authorize other care. Under a PCCM approach, payments for the direct health care services rendered to the recipient (including those performed by the PCCM) remain on a fee-for-service basis. HCFA may grant a renewable freedom of choice waiver to a state for two-years to implement a PCCM approach.¹⁴

¹³ 42 CFR 431.55(c)(1)(ii) states that "under a primary care case management system the agency assures that a specific person or persons or agency will be responsible for locating, coordinating, and monitoring all primary care and other medical care and rehabilitative services on behalf of a recipient." Section 1915(b)(1) of the Social Security Act also stipulates that the use of a PCCM approach cannot "substantially impair access to services of adequate quality where medically necessary". The PCCM option is distinct from (but shares some similarities with) a state's coverage of "targeted case management" (TCM) services under Section 1915(g) of the Social Security Act. The TCM coverage enables a state to obtain federal reimbursement for providing case management services that assist eligible individuals "in gaining access to needed medical, social, educational and other services". The TCM coverage is frequently used to pay for case management services in developmental disabilities and mental health service systems. While TCM frequently is used to coordinate services and link individuals to non-Medicaid services, it may not include prior authorization of services.

¹⁴ It is worth mentioning that some states also are developing PCCM options that do not entail a waiver of recipients' freedom of choice. Wisconsin, for example, is putting into place a PCCM system for Medicaid recipients who incur relatively high costs. These recipients may opt to obtain care management services from a PCCM (who receives a special payment). The waiver authority is used to limit the types of providers who may perform this service.

- **Specialty Physician Services.** States also may obtain a freedom of choice waiver under Section 1915(b)(4) of the Social Security Act to restrict the provision of certain Medicaid services to "designated providers of such services". Many states have used this option to channel Medicaid recipients to federally-qualified HMOs. This option also has been used by several states to institute managed care arrangements for the delivery of mental health services through contracts with private managed care companies and community mental health agencies. Under such an arrangement, the state contracts with an MCO which then accepts the responsibility (on a risk, nonrisk or partial risk basis) for furnishing a full range of Medicaid-reimbursable mental health services to all recipients statewide (as in the case of Iowa) or within a designated geographic area (as in the cases of Florida and Utah). These specialty organizations usually are classified as PHPs since they receive capitated payments. In order to secure HCFA's approval to institute this type of arrangement, a state must demonstrate that: (a) recipients will continue to have access to needed Medicaid services (including emergency services); and, (b) the arrangement will be cost-effective.¹⁵ Like PCCM, HCFA may grant two-year, renewable waivers to permit a state to operate such a program. These arrangements are more aggressive implementation of managed care than the PCCM approach. Payments are capitated; recipients are channeled to one or more MCOs; MCOs exercise control over their supplier networks.

Section 1915(b)(4) waivers enable states to pursue more aggressive managed care strategies.

Under either option, a state may request that HCFA approve waivers of additional statutory provisions (most commonly recipient freedom of choice but also "statewideness" to geographically restrict the scope of a program and "comparability" to target some classes of Medicaid recipients while exempting others). However, HCFA has limited the types of waivers it will grant under the programmatic authority.

Until roughly two years ago, these program waivers were the principal avenues available to states to pursue more aggressive managed care approaches in their Medicaid programs. These options have proven useful to states that wish to develop alternative service delivery systems or employ managed care approaches on a targeted basis.

Superwaivers

The most noteworthy recent development in the Medicaid managed care arena has been the emergence of what are termed "*superwaivers*" (or even "*megawaivers*"). These

¹⁵ "Cost effective" means that the arrangement will not lead to an increase in Medicaid outlays when compared to the costs that a state would incur under a fee-for-service arrangement. In submitting a 1915(b)(4) waiver request, states typically base such requests on historical costs that have been trended forward and propose to employ a capitation rate that is set at some discount (95 percent is a commonly used figure) from the projected per capita costs in order to ensure cost-effectiveness. The calculations involved are discussed in more detail in the second part of the *Guidebook*.

frequently large-scale initiatives often involve shifting tens of thousands Medicaid recipients into managed care arrangements, and feature the use of managed care to contain costs. They also have been used by states to extend health care coverage to low income individuals who previously were not eligible for Medicaid benefits. For this reason, these waivers also are referred to as "comprehensive health care reform" waivers.

Superwaivers are authorized under the provisions of Section 1115(a) of the Social Security Act, which permits the Secretary of Health and Human Services to grant wide-ranging waivers of federal statutory requirements "in the case of any experimental, pilot, or demonstration project, which in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX [Medicaid], or part A or D of title IV". Section 1115 permits the Secretary to grant such waivers "to the extent and for the period [she] finds necessary to enable such State ... to carry out such a project".

Even though the Section 1115 authority has been on the books for many years, until 1993 it had only been used once on a large-scale basis in the Medicaid program. In the early 1980s, the Reagan Administration approved Arizona's entry into the Medicaid program under this authority.¹⁶ Section 1115 was little utilized in Medicaid due to the tough requirements that HCFA's Office of Research and Demonstrations (ORD) imposed on projects. These programs also are termed "research and demonstration" projects.¹⁷ ORD's policies dictated that state project proposals had to be based on detailed studies and accompanied by sophisticated research plans. Most states regarded these requirements as burdensome, overly academic and too restrictive. Federal review and turnaround times for evaluating such requests were very long. States regarded HCFA's policies as frustrating their attempts to pursue innovative approaches to the management of their Medicaid programs.

During the latter part of the Bush Administration, HCFA began to encourage states to examine the prospects of applying managed care principles to their Medicaid programs. After President Clinton was elected, he spoke at the February, 1993 winter meeting of the National Governors' Association (NGA). The President told the governors that he had ordered HHS/HCFA to streamline the Medicaid waiver approval process in

¹⁶ Until obtaining federal approval for its Section 1115 program, Arizona had been the only state which did not participate in the Medicaid program. The State proposed to enter the program employing a managed-care/capitated payment approach which required securing a wide range of special waivers. Arizona's program continues to operate today under the Section 1115 authority.

¹⁷ There actually are two types of projects that may be authorized under the authority. One type is a "research and demonstration" project for which HCFA makes a grant to a state to test service delivery alternatives. The grant dollars fund data collection and research; program waivers also are approved to permit the demonstration to proceed. These grants are awarded based on research priorities that ORD periodically publishes. The grant dollars available to ORD for this purpose are relatively small. A state also may propose a demonstration project that seeks HCFA's approval of special waivers but does not request grant funds. "Waiver-only" projects, however, must be based on a research design that is acceptable to ORD. The heavy emphasis on research design reflected ORD's stance that Section 1115 proposals should enable the Agency to draw valid conclusions regarding the project's outcomes that potentially could serve as the basis for additional research or more fundamental federal policy changes.

order to encourage states "... to serve more people at lower costs." As a former governor and active member of NGA, Clinton was acutely aware of the barriers that federal policy posed for states that were interested in restructuring their Medicaid programs.

Following Clinton's remarks at the NGA meeting, a joint task force of HCFA officials and NGA representatives developed specific recommendations for carrying out the President's directive. The task force's final report (issued in the Spring of 1993) outlined several steps for speeding up the process of preparing, reviewing and approving waivers under several provisions of Medicaid law. With respect to Section 1115 waivers, the task force outlined several steps for streamlining the development, review and approval of state waiver/demonstration requests. These recommendations subsequently were translated into a series of policy principles which HCFA/HHS would follow "... to facilitate the testing of new policy approaches to social problems". In particular, HCFA/HHS agreed to:

- Work with the states in developing research and demonstration projects consistent with the Department's policy goals;
- Consider proposals that examine alternatives that diverge from established policy directions;
- Grant waivers to test the same or related policy innovations in multiple states; Approve waiver projects ranging in scale from reasonably small to statewide or multi-state in scope; and
- Consider joint Medicaid-Medicare waiver requests.

With respect to the duration of a Section 1115 demonstration project, HCFA agreed to:

- "Approve waivers of at least sufficient duration to give new policy approaches a fair test", recognizing that large-scale, statewide reform projects typically will require five-year waivers¹⁸;
- Provide reasonable time for the preparation of meaningful evaluation results prior to the conclusion of a demonstration project; and
- Recognize that new approaches often require a considerable amount of start-up time plus allowances for implementation delays.

DHHS also agreed to work with the states in translating the results of successful demonstration projects into permanent changes in statutory law as well as consider requests for reasonable extensions of existing waivers. In evaluating such requests, DHHS promised to "be more flexible and project-specific in the application of [its] evaluation techniques than has occurred in the past", especially with respect to health care waivers.

¹⁸ Previously, HCFA had operated on the general rule that Section 1115 projects would be limited duration to three years.

III. Managed Care in the States

While adhering to its long-standing principle that Section 1115 demonstration projects must be cost-neutral¹⁹, the Department agreed to apply this principle "more flexibly". HHS/HCFA said that it would:

- Assess a proposal's cost neutrality over the life of the project, rather than on a year-by-year basis, in recognition of the fact that "... many demonstrations involve making 'up front' investments in order to achieve out-year savings;"
- Consider alternative methods of arriving at baseline Medicaid expenditure projections proposed by a state; and
- Consider alternative cost-neutrality arrangements proposed by the states.

Finally, HHS/HCFA promised to take several steps to streamline the Section 1115 process and minimize the administrative burden imposed on states that apply for research and demonstration projects.²⁰

These changes in HCFA policies allowed states to submit and receive "fast-track" HCFA review and approval of large-scale Medicaid Section 1115 waivers. In May, 1993, for example, Tennessee wrote and submitted a Section 1115 proposal (dubbed "TENNCARE") to convert its entire Medicaid program (with the exception of long-term care services) to managed care and reprogram the expected cost savings to extending health care coverage to uninsured individuals. This proposal was quickly approved and TENNCARE went into effect on January 1, 1994.

The Clinton Administration repositioned the Section 1115 authority to open the door for states to pursue large-scale conversions of their Medicaid programs to managed care.

This repositioning of the Section 1115 waiver authority opened the door for states to pursue large-scale conversions of their Medicaid programs to managed care. By reworking the Section 1115 authority, the Clinton Administration invited states to submit sweeping proposals and "tilted" federal review toward giving the states more leeway and away from rigid research designs. While the Clinton Administration and HCFA itself did not adopt an "anything goes" policy in approving superwaivers, there has been a distinct effort to reduce or minimize the barriers to using the Section 1115 authority. The new policies have enabled states to:

¹⁹ In the context of Section 1115 programs, "budget neutral" has different connotations than the "cost effectiveness" test under Section 1915(b)(4). Budget neutrality is tested at the total expenditure level rather than on the basis of per capita costs. Under a Section 1915(b)(4) waiver, a state's spending can increase due to increases in the number of eligible recipients. Under a Section 1115 proposal, a state agrees to abide by a total limit on federal payments. This total limit is used because Section 1115 proposals typically have included the coverage of individuals who otherwise would not be Medicaid eligible.

²⁰ For a thorough discussion of these changes, see Rotwein et. al., "Medicaid and State Health Care Reform: Process, Programs, and Policy Options", *Health Care Financing Review* (Volume 16, Number 3 – Spring 1995) (U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations).

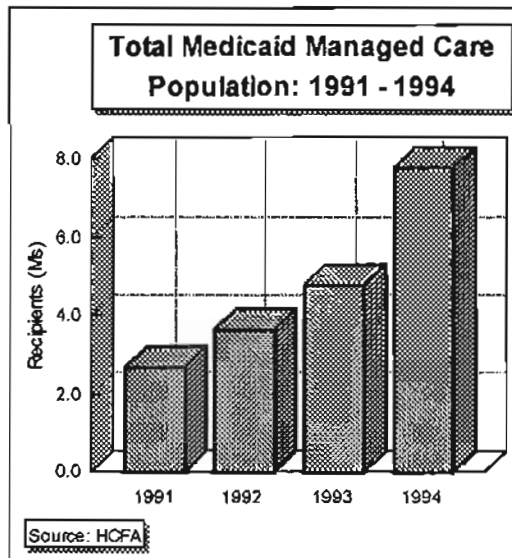
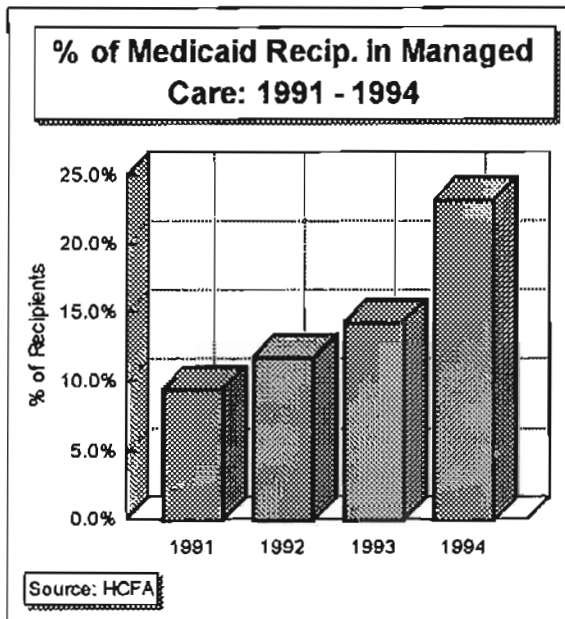
- Mandate that entire classes of Medicaid recipients sign up with MCOs to obtain health care services, rather than merely offering an HMO alternative to usual fee-for-service arrangements.
- Obtain federal approval to contract with managed health care plans that do not fully comply with federal HMO and PHP requirements (including contracting with Medicaid specialty HMOs).
- Extend eligibility to groups of individuals who could not otherwise qualify for Medicaid benefits. Waivers obtained in this arena include: (a) a waiver of recipient asset limitations; (b) establishing higher income limits than otherwise would be permitted under Medicaid law/regulations; and, (c) requiring that newly covered groups pay premiums, deductibles and co-pays that otherwise would not be permitted under federal law.
- Employ capitation payment methods on a far broader scale than ever before.

Such waivers have enabled a growing number of states to restructure their Medicaid programs on a scale that few would have predicted two years ago.

There are several factors that distinguish "superwaivers" from the other avenues available to states through other existing authorities (principally the 1915(b) options) to implement managed care approaches. One of the most important differences is the breadth of such proposals. In a nutshell, the "superwaiver" strategy offers a state considerably more latitude in the types of waivers it can obtain as well as better ability to implement a broad-based managed care strategy than by employing program waivers. When a large-scale managed care initiative is contemplated, the superwaiver option allows a state to lay out and implement a comprehensive strategy.

Another key difference lies in the ability to use the superwaiver approach as one means in pursuing a broader statewide health care reform agenda. Many of the superwaivers have been crafted to reprogram savings from managed care into extending health care coverage to new groups of uninsured individuals. The program waiver options do not support this type of strategy. The relationship between superwaivers and state health care reform strategies is discussed in greater detail below.

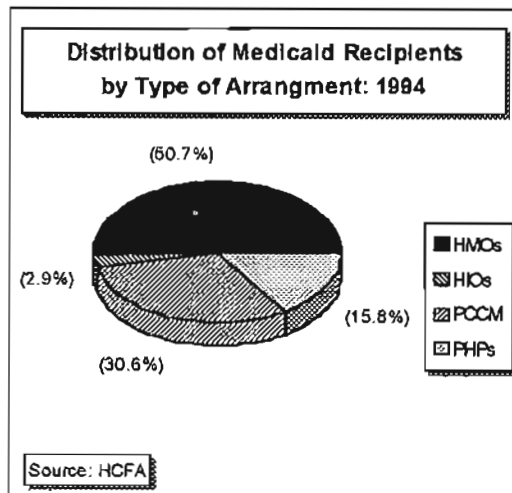
While the superwaiver option has proven attractive to many states, it has not displaced other options; nor are all states rushing to submit Section 1115 waiver/demonstration proposals. The superwaiver option typically has been used by states which already had health care reform initiatives underway (e.g., Oregon, Ohio, and Minnesota) or faced particularly acute budget problems (e.g., Illinois and Tennessee). Other states have been reluctant to jump on this bandwagon, preferring to explore more limited and targeted options.



The Section 1115 authority is not limited to "health care reform" superwaivers.²¹ Some states are employing the authority to craft alternative service delivery systems in a more targeted fashion.

Medicaid Managed Care: Present Status

States have jumped into the managed care arena. The number of Medicaid recipients served through managed care arrangements has soared, tripling between 1991 and 1994 to nearly 7.8 million.²² By 1994, nearly one Medicaid recipient in four was being served through a managed health care arrangement (compared to roughly 10 percent in 1991). The bulk of these individuals were being served in HMO/PHP prepaid capitated arrangements with roughly another 30 percent enrolled in PCCM arrangements. HCFA counted about 340 distinct contractual managed care arrangements in operation in 44 states and the District of Columbia as of June 30, 1994, roughly 50 percent more than 3 years earlier. Since mid-1994, HCFA has approved more state requests to launch "superwaiver" programs as well as other smaller scale plans. There is every prospect that the number of Medicaid recipients served in managed care



The scope of Medicaid managed care arrangements is more limited than first meets the eye.

²¹ In particular, HCFA/ORD regularly invites states to submit research and demonstration proposals to test alternative service delivery approaches that the Agency believes to be particularly promising. Typically, these are more limited projects

²² HCFA Office of Managed Care (1994). "Medicaid Managed Care Enrollment Report".

arrangements will continue to swell. Some observers believe that the number of Medicaid recipients served via managed care plans will climb to 10-11 million in 1995.

Even though Medicaid managed care has grown rapidly, its scope is more limited than first meets the eye. Setting aside individuals who are enrolled in PCCM gatekeeper programs, only about 17.2 percent of recipients were being served through capitation programs in June, 1994.²³ Furthermore, less than 7 percent of all Medicaid outlays were being made through such programs.²⁴ The dollars flowing through managed care programs does not match the number of recipients for a variety of reasons, including: (a) the initial focus of many programs on AFDC recipients (who consume significantly fewer health services than other recipient groups); (b) counting recipients who receive some but not all Medicaid services through specialized plans; (c) the exclusion of long-term care services (which account for roughly one-third of all Medicaid outlays); and, (d) the fact that approved superwaivers were in their initial phase-in period. Only one state (Arizona) operates a fully capitated Medicaid program. From an expenditure standpoint, only a handful of states have reached the point where 10 percent or more of their total Medicaid outlays were channelled through capitation programs.²⁵ Obviously, with HCFA's approval of additional "superwaivers" and program waivers, a greater share of Medicaid spending will shift to capitated arrangements in future years.

The Medicaid managed care landscape is now populated by a diverse array of arrangements, including "health care reform" superwaivers, smaller scale "research and demonstration" projects, "boutique" health plans, special carve outs, PCCM systems and HMOs. This landscape is continually changing. An overview of various types of arrangements is provided below.

Health Care Reform "Superwaivers"

The explosion in health care costs and its resulting fall out (particularly in the form of a growing number of uninsured Americans) has prompted many states to embark on their own health care reform initiatives. For example, nearly all states have enacted insurance reform measures of one type or another to help small businesses obtain health insurance coverage for their employees, mandate "community rating" in setting premiums, bar the use of pre-existing condition exclusions, and facilitate pooled purchasing arrangements. Over the past several years, states have expanded their Medicaid programs to cover more and more low-income children. Some states have passed "universal coverage laws" to phase in access to health care for all their citizens.

Many of these state health care reform initiatives pre-date the 1994 federal debate regarding national health care reform. In several states, realigning the Medicaid program emerged as a critical component in fashioning a comprehensive strategy aimed at improving access to health care for low-income citizens. While Medicaid recipients had

²³ Lewin-VHI, Inc. (1995). *The States and the Private Sector: Leading Health Care Reform*.

²⁴ Ibid.

²⁵ Ibid.

access to health care in the form of an entitlement to Medicaid services, many other low-income individuals do not qualify for the Medicaid program and/or hold jobs that do not offer employer-paid health insurance. These individuals frequently access the health care system through costly hospital emergency rooms or other state/local indigent health care programs which, given the growing number of uninsured, are increasingly strained.

In several states, policymakers and health care planners concluded that the most likely way to tackle the health care access problems of low-income, uninsured individuals lay in developing wrap-around strategies that would integrate both Medicaid and non-Medicaid programs in order to create a coherent approach to service delivery and financing. Applying heavy doses of managed care throughout an integrated system would reduce costs sufficiently to permit offering at least a basic benefit package to a substantial proportion of all low-income individuals, including those who lacked health insurance but could not qualify for Medicaid benefits.²⁶

The opening up of the Section 1115 waiver authority gave these states the tool they previously lacked to pursue such an integrated approach. The strategies that the states wished to pursue clearly meshed with the Administration's broader health care reform agenda which included containing costs by

Profile: MassHealth

Massachusetts' "superwaiver" (MassHealth) provides an illustration of the scope and breadth of a "comprehensive health care reform" program. MassHealth is intended to improve the availability of health care to low-income individuals as part of a broader state strategy aimed at improving access to health care. Savings derived from managed care coupled with: (a) reprogramming DSH dollars; and, (b) recipient cost sharing are expected to yield sufficient savings to extend coverage to medically-indigent individuals who could not otherwise qualify for Medicaid eligibility. In particular:

- ☒ The program targets 580,000 Medicaid recipients (including non-institutionalized elderly and disabled persons) plus 300,000 "medically indigent" adults and children (including all persons with incomes of less than 133 percent of poverty; short-term unemployed individuals; and, "working poor" families with incomes of less than 200 percent of poverty).
- ☒ Maintains the full range of current benefits for traditional Medicaid recipients; provides a more limited range of benefits for newly-eligible "medically indigent" individuals (who also are subject to cost-sharing arrangements).
- ☒ Mandates that all MassHealth participants enroll in a managed care plan.
- ☒ Provides for contracting with "all-Medicaid" HMOs and waives other elements of federal law and regulations pertaining to HMOs.
- ☒ Exempts persons residing in long-term care facilities and long-term care services.
- ☒ Eliminates "disproportionate share hospital" payments and rolls these outlays into the demonstration; also subsumes various state-only health programs under the demonstration authority.

²⁶ A particularly good discussion of state health care reform initiatives and their interrelationships with Medicaid and the demonstration waivers is found in: Trish Riley, "State Health Reform and the Role of 1115 Waivers", *Health Care Financing Review* (Volume 16, Number 3 – Spring 1995) (U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations).

extending health care coverage to more and more uninsured individuals via integrated systems. Hence, the "comprehensive health care reform" superwaiver demonstrations.

At present, thirteen states (AZ, DE, FL, HI, KY, MA, MN, OH, OR, RI, SC, TN, VT) have secured HCFA's approval to operate "health care reform" superwaivers.²⁷ Another ten states (AL, IL, KS, LA, MO, MT, NH, NY, OK, UT) had requests pending before HCFA in July, 1995. At least five other states (CT, MD, NJ, TX, WA) were well along in developing comprehensive health care reform demonstrations. The approved programs share several characteristics, including:

- The extension of health care coverage to low-income individuals who otherwise would be ineligible for Medicaid;
- A heavy reliance on managed care arrangements;
- A focus on the delivery of health care (but not long-term care) services; and,
- Most typically (but not exclusively), targeting managed care to AFDC children and adult recipients and similar low income populations.

The financial strategy that underlies these superwaivers is as follows:

- Requiring Medicaid recipients to sign up with MCOs is expected to reduce significantly the costs of furnishing services to them. In other words, employing managed care arrangements will yield a financial dividend that then can be used to extend coverage to other low-income groups.
- In most cases, the states eliminate "disproportionate share hospital" payments and reprogram the resulting savings into general purpose health care dollars.
- In varying degrees, some states also are shifting other state and local dollars into the matching dollar pool in order to leverage Medicaid dollars to pay for health care services to the low-income, non-Medicaid eligible population.
- States impose cost-sharing arrangements on low-income individuals who are brought under the superwaiver umbrella.

These financial strategies are complex, particularly in light of the requirement that the programs must be "budget neutral".²⁸ The Massachusetts "MassHealth" program profiled on the previous page gives the reader a better sense of the strategies that states are

²⁷ However, only six of these states (AZ, HI, MN, OR, RI, TN) had proceeded to full implementation as of July, 1995. Implementation of Florida's program has been stymied by disagreements between Governor Chiles and the Florida Legislature over the program. Kentucky's program has encountered similar problems. South Carolina has decided to take a second look at its program. The remaining states are slated to implement their programs later this year or in early 1996.

²⁸ However, budget neutrality tests permit a state to show cost-effectiveness by arguing that, in the absence of a waiver, the state would take other steps that would have the effect of increasing its Medicaid spending base.

employing in developing these superwaiver programs.²⁹

There also are key differences among the approved Section 1115 waiver/demonstration programs, including:

- **Target Population.** While all the states have included AFDC recipients, the states vary with respect to whether they include SSI-disabled and elderly Medicaid groups. Arizona and Tennessee operate "comprehensive" programs; Rhode Island's RItCare program serves solely AFDC recipients as well as other low-income women and children. Some states (e.g., Ohio and Oregon) phase-in the coverage of SSI recipients (Oregon began enrolling such persons in January, 1995). The states also vary with respect to the low-income individuals who would be covered under extended eligibility rules. Each state has established different rules concerning income cut-offs for enrollment (ranging from 100 percent of federal poverty guidelines upward), how they calculate income for eligibility purposes, and the amount of premiums, co-pays, and deductibles charged to enrollees. States also differ with respect to whether long-term care service recipients are included in their plans.
- **Scope of Benefits.** All the states include primary health care services in their packages. Most exclude long-term care services (although some are considering their inclusion).³⁰ Some states have elected to keep certain services outside their plans (e.g., mental health services), while others have elected to handle such services under special arrangements. For example, Oregon has carved out mental health and dental services from the benefits that MCOs are expected to furnish in favor of phasing-in special arrangements for delivering such services.
- **Managed Care Arrangements.** While all the states feature managed care as the linchpin of their programs, their specific arrangements vary. Oregon, for example, contracts with more than 25 full-risk, federally-qualified HMOs and partial risk health plans (including dental plans) but employs PCCM/fee-for-service arrangements as a back-up system. Tennessee contracts with 12 MCOs around the state, none of which are federally-qualified HMOs.

The scale and scope of the health care reform superwaivers vary significantly. This reflects underlying differences in state health care reform strategies. In light of Congressional plans to limit increases in Medicaid spending, some states already are rethinking their strategies.

²⁹ Readers interested in learning more about state strategies and experiences in this arena should see: Thome, et. al., "State Perspectives on Health Care Reform", *Health Care Financing Review* (Volume 16, Number 3 – Spring 1995) (U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations).

³⁰ Arizona has included long-term care services since 1988. However, these services are "carved out" into distinctive subprograms that operate independently of primary care MCOs.

Specialty Section 1115 Waivers

There are several **specialized** Section 1115 waiver programs in operation or which have been proposed. Typically, these programs are more narrowly targeted than the "health care reform" superwaivers. These specialty programs include:

- **Frail Elderly Wrap-Around Demonstrations.** Eight states (CA, CO, MA, NY, OR, SC, WI) operate specialized demonstration waiver programs that integrate health and long-term care services for frail elderly individuals (including "dually eligible" Medicare/Medicaid recipients). Minnesota recently secured HCFA's approval to operate a larger scale Section 1115 waiver program to integrate Medicaid and Medicare funding for persons over the age of 65. We will return to these demonstrations in Chapter V.
- **Maryland High Cost User Initiative.** This proposed Section 1115 demonstration program would target "high cost Medicaid users including those with chronic conditions, special needs children, and individuals who have suffered a catastrophic illness".
- **District of Columbia: Children with Special Needs.** The District of Columbia has submitted a Section 1115 waiver proposal that targets SSI-eligible children with special health care needs up to the age of 22. Once in operation, this program is expected to serve 3,000 such children.
- **Rhode Island CHOICES.** Rhode Island has submitted a Section 1115 waiver request to completely restructure its long-term supports for people with developmental disabilities (see Chapter V for a more complete discussion of this proposal).

These narrowly-defined Section 1115 waivers have more targeted objectives in mind than health care reform superwaivers.

Section 1915(b) -- PCCM Systems

Section 1915(b)(1) waivers are in operation in at least 31 states. In 14 states, PCCM is the state's only type of special Medicaid managed care arrangement.³¹ The scope of these programs varies considerably. Some operate statewide across all Medicaid eligibility groups. Others are limited by geographic area or target population. Target population limitations include Medicaid eligibility category (e.g., only AFDC recipients) and some which are condition-related (e.g., Maryland operates a program solely for persons with diabetes; Alabama and Arkansas operate programs that provide enhanced pre- and post-natal care management services for women).

³¹ Lewin-VHI, *op. cit.*

Section 1915(b) -- Specialty Services

Section 1915(b)(4) freedom of choice waivers have principally been employed in the mental health arena. States operating such programs include Colorado, Iowa, Massachusetts (roughly 400,000 recipients), Michigan, North Carolina (children's program in effect; adult programs under development), South Carolina, Utah, Washington and others. More states reportedly have such programs under development. In addition, some of the superwaivers include mental health services but such services have been "carved out" and turned over to specialty mental health managed care organizations.

There are other "specialty services" arrangements in operation or under development. West Virginia has proposed a "behavioral health" Section 1915(b)(4) waiver program that would combine Medicaid-funded mental health and developmental disabilities services into a unified pool that would be managed by a single MCO (see discussion in Chapter V). New York State has a request pending that would permit counties to bid out all Medicaid transportation services to a single comprehensive vendor on a capitation basis. From all indications, over the near-term more of these specialty arrangements are likely to emerge, particularly as vehicles for states to employ "wrap-around" approaches in "carved out" service arenas.

Summary

Numerous variations on the managed care/capitation theme have emerged over the past few years. More are likely to emerge. Again, it is important to emphasize that the large-scale application of managed care approaches within the Medicaid program is in its early stages. States are still going through a testing/exploration period.

Where Does Medicaid Managed Care Stand?

The broad-scale application of managed care to Medicaid programs has been viewed by most states as a way of curbing run-away Medicaid spending. Often, the adoption of new program management models in a few states triggers their spread to other states. This is occurring in the arena of managed care. As experience with managed care accumulates, more and more states are inclined to test the waters. Setting aside the question of possible changes in the Medicaid program, it is virtually certain that 50 percent or more of the states will be operating comprehensive managed health care programs within the next year to 18 months. New York had a goal of enrolling 50 percent of all Medicaid recipients in managed care under the Cuomo Administration. The state has prepared a far more sweeping proposal under the Pataki Administration. While the states clearly are backing away from some of their more ambitious health care reform agendas, managed care already is reshaping state Medicaid programs.

At this juncture, it is difficult to appraise the effects of these initiatives on Medicaid spending and the quality of services that Medicaid recipients receive. Problems already have arisen in some states. For example, in Florida, enrollments in some HMOs/plans was frozen due to serious performance problems. There also have been accounts of plans attempting to increase enrollments by "slamming recipients" (i.e., switching a recipient to a plan without the person's permission or knowledge). A variety of problems have cropped up in Maryland concerning the marketing of managed care plans to Medicaid recipients.

Managed care appears to be containing costs. Massachusetts, for example, attributes its very low rate of growth in Medicaid spending to the broader use of managed care. However, it is unclear whether cost savings are the result of the appropriate application of managed care strategies or simply an MCO's (or the state's) forcing price reductions on providers or refusing to pay for certain services. Massachusetts officials recently admonished providers for underserving recipients. In Tennessee, the growth in Medicaid spending has slowed to roughly 5 percent following the implementation of TENNCARE but health care providers have voiced strong complaints about the low fees they are being paid. In California, there is pending litigation which claims that the rates the state is paying HMOs are too low.

At least to date, the public sector experience with managed care is as cloudy as it has been in the private sector. There have been both successes and horror stories.³² The states that operate superwaivers must commission an independent assessment of their performance. Many of these assessments are underway. However, at best, it will take several years to obtain solid, systematic information about the effects of managed care on state Medicaid programs. As noted in Chapter II, the private sector (which has been much more deeply involved in managed care for a longer period) is still scrambling to develop a reliable technology for appraising the performance of managed care plans. The public sector also is attempting to catch up.

At this juncture, there are several important questions still to be answered about the directions that states will take managed care in their Medicaid programs. These include:

- **What effect will a state's "managed care" readiness have on the extent to which related techniques are employed?** In some states, managed health care is a well-established industry. In others, it is not. Consequently, some states are better able to mount managed care strategies because they can tap into an established supplier base. Observers have pointed to a distinct correlation between the number of Medicaid recipients in managed care programs and the extent to which a state's

³² The TENNCARE program, for example, experienced many problems early on, most of which had to do with the furious pace at which it was implemented. At the same time, one outcome of TENNCARE is that Tennessee presently has the second highest rate (next to Hawaii) of health care coverage of any state in the nation.

general population participates in managed care plans.³³ This factor is likely to affect the overall pace at which managed care is adopted in state Medicaid programs. How important a factor it will be in the future is uncertain, given the rapid spread of managed care arrangements, nationwide.³⁴

- **To what extent will states apply managed care to elderly/disabled populations?**

Most (but not all) states have elected to exclude the SSI population from their health reform plans at least initially. However, Medicaid spending on individuals with disabilities and the elderly (who make up 27 percent of all recipients) accounts for nearly 70 percent of total outlays (including long-term care). The SSI Medicaid population is disparate. Some states have forged ahead in deciding to enroll this population (Massachusetts, Oregon, and Tennessee, although they have excluded recipients of long-term care services).

Others have elected to by-pass these individuals for the time being, either by excluding them from their managed care plans or deciding to enroll them at a later date. We will discuss some of the key issues in employing managed care with respect to people with disabilities in the next chapter.

- **To what extent will states be employing special carve out arrangements to tackle certain specialty service areas or populations versus employing more comprehensive arrangements?**

Carve outs are relatively common in private sector managed care, particularly for dental and mental health services. Some states are employing carve outs in Medicaid managed care; others have decided against the use of carve outs, electing instead to include all services within a single capitation payment. In some states, some services are being put under managed care arrangements independent of whether affected individuals also are being enrolled in general health plans (e.g., managed mental health care has been implemented in some states well in advance of general recipient enrollment into mental health plans). Some "boutique"

"As States convert Medicaid to managed care, traditional relationships with providers must change. Instead of a payer and regulator of services, Medicaid agencies now need to see themselves as partners with health plans, negotiating for services required by their beneficiaries. Contracts between Medicaid agencies and plans and those, in turn, between plans and providers are critical components of assuring quality care and must be skillfully negotiated. Medicaid agencies must also become aggressive payers negotiating with plans for comprehensive care for their clients at capitated payments that will meet the cost of care and assure compliance with the budget neutrality requirements of the waiver."

Trish Riley
"State Health Reform
and the Role of 1115 Waivers"

³³ Lewin/VHI, *op. cit.*

³⁴ Within states, urban/rural considerations also can affect the extent to which managed care is used. In some cases, however, states are attempting to overcome this problem by attempting to "make a market" for Medicaid-exclusive managed care plans, rather than relying on a provider base.

arrangements also have been created that target distinct subpopulations. The pros and cons of comprehensive versus specialty plans are still being sorted out.

- **How will states regulate Medicaid managed care?** Managed care arrangements insert an intermediary (the MCO) between the state and recipients (and the direct service provider). Instead of directly regulating services, the state must regulate the performance of the intermediary in meeting whatever contractual terms that the state has imposed. States have imposed numerous contractual conditions on the performance of MCOs in an effort to ensure that recipients obtain needed services in a timely and appropriate manner. This type of contracting places a special burden on states to anticipate possible problems and provide for appropriate remedies. It is unclear whether states are willing to devote sufficient resources to contract oversight and intervention into problem cases. In addition, these types of arrangements demand a fairly sophisticated financial oversight capacity to guard against excessive profit-taking on the one hand and insolvency on the other. These areas are relatively new to states (at least on a very large scale) and, thus, present new problems in Medicaid administration.
- **To what extent will long-term care services be drawn into managed care?** To date, nearly all states have kept long-term care outside of managed care. Spending for long-term care services consumes about one-third of all Medicaid outlays nationwide. As a consequence, it presents a tempting target. However, there are no private sector antecedents³⁵ for managed long-term care services and serious questions can be raised regarding the applicability of managed care to long-term services. Given the size of Medicaid's long-term care sector (and the fact that, in many respects, it is a very captive market), it may be just a matter of time before new "products" emerge in this arena.

There remains a considerable amount of sorting out the role and applicability of managed care in the Medicaid program. As in the private sector, it is unlikely that this arena will settle down any time soon.

At the federal level, HCFA has been following through on its commitment to work collaboratively with the states in the development of managed care approaches. At the same time, it also is clear that the Agency has stepped up the intensity with which it is reviewing state health reform demonstration proposals and the way in which they are implemented. As a consequence, Section 1115 proposals are taking longer to gain federal approval. HCFA has adopted a "stepping stone" process that strongly encourages a state to submit a "concept paper" for review, followed by a more detailed proposal. After

Congress is poised to radically restructure the Medicaid program.

³⁵ Private sector health plans (as well as Medicare) generally provide only very limited coverage of long-term care services. Typically this coverage is tied exclusively to "post-hospitalization" services (short-term skilled nursing home care, home health or private duty nursing) rather than generic long-term care services. "Long-term care" insurance has never caught on with employers or consumers to any significant degree.

reviewing the more detailed proposal, HCFA issues an approval letter which contains "terms and conditions" that a state must satisfy pre- and post-implementation. This process is more elongated than many states would like. The Agency also is working with the American Public Welfare Association (on behalf of state Medicaid directors) and the National Committee for Quality Assurance in developing a Medicaid version of HEDIS. This adaptation will attempt to take into account differences between Medicaid managed care programs and their private sector antecedents. The Agency's objective is to complete the first stages of this work by December, 1995.

The states entered the managed care arena later than the private sector. Compared to other insured populations (with the exceptions of Medicare beneficiaries), fewer Medicaid recipients are served via managed care plans than in the private sector (although this gap is narrowing). In many different respects, Medicaid managed care is still in its adolescence. It is undergoing fast-paced growth and changing rapidly. To some degree, the states have been able to piggyback on the growth of managed care in the private sector by contracting with established managed care organizations. Still, the Medicaid recipient population and state benefit packages are markedly different from the private sector and, hence, pose unique challenges in the application of managed care. Consequently, states are still feeling their way in using managed care approaches. A critical concern is the capacity of states to manage managed care, including regulating the performance of MCOs.

Medicaid: The Future

As this report is being finalized, the 104th Congress is poised to enact sweeping changes in the Medicaid program. In particular, the House Commerce and Senate Finance committees have approved massive restructuring proposals that contain roughly similar provisions for converting the Medicaid program to a "capped entitlement" while concurrently erasing more than 200 pages of federal Medicaid law in favor of giving the states unprecedented flexibility in designing and managing health and long-term care services for low-income individuals. Even though there are differences between the House and Senate plans, the overall policy thrust of both proposals is quite similar. While undoubtedly these proposals will change prior to final enactment³⁶, it appears likely that the Medicaid program will be reconfigured along the following lines:

- **Deficit Reduction.** Both the House and Senate plans adhere to the Congressional budget resolution for FY 1996 by cutting federal Medicaid outlays by \$182 billion

³⁶ As of this writing (early October, 1995), neither chamber had passed the legislation drafted by the two committees. Once the legislation is approved by the House and Senate, differences between the two measures will need to be ironed out in a conference committee. Both proposals will be part of the massive 1995 budget reconciliation act which also will include many highly controversial changes in the Medicare program as well as changes in tax policy and other programs. The Clinton Administration has voiced very strong objections to many of the provisions that Congressional Republicans plan to include in the budget reconciliation measure. Absent major compromises before the reconciliation legislation hits the President's desk, a veto is highly likely. If there is such a veto, then another round of negotiations will occur.

over the next seven years (FY 1996 - 2002). This savings would be achieved by reducing projected increases in Medicaid spending from 10.4 percent/year to 7.2 percent in FY 1996, 6.8 percent in FY 1997, and 4 percent for each year thereafter. Compared to baseline Medicaid spending, the House and Senate measures would cause an 18.5 percent cut in federal payments to the states over the next seven years. By FY 2002, federal Medicaid spending would be 30 percent below levels projected under current federal law.³⁷ **Cutting federal Medicaid outlays is an integral element in the Congressional Republican strategy to achieve a balanced budget by the year 2002 while concurrently cutting federal taxes.**

- **Capped Payments to States.** To lock in the savings required by the deficit reduction target, federal payments in the aggregate and to each state would be capped. Instead of paying a fixed percentage of a state's outlays for Medicaid services on an open-ended basis (as is the case under current law), total federal Medicaid spending would be fixed and federal dollars distributed to each state in accordance with an allocation formula. The plans that have gained preliminary committee approval would guarantee each state the amount it presently spends for Medicaid services but regulate the share each state receives of the fixed national total under a complex formula.³⁸ **Switching federal Medicaid payments to the states from an open-ended to a capped basis would guarantee that Medicaid spending reductions will be achieved.**
- **State Flexibility.** In order to enable states to live within their federal allocation ceilings, both the House and Senate plan would replace current federal Medicaid statutes (Title XIX of the Social Security Act) with a new Title XXI. Under Title XXI, a state would prepare a state plan that specifies which low-income individuals would be offered health and long-term care services, what those services would be, how they would be obtained and regulated, and how payments to providers would be made and accounted for. Under both proposals, states would have nearly total flexibility in structuring their programs. Most Title XIX mandates governing eligibility and coverage of basic services would be scrapped. Different service packages could be offered to different groups of individuals. Federal institutional service regulations would be scrapped. States would have considerable latitude in amending or changing their state plans. **In other words, states would be able to**

³⁷ As pointed out by Congressional Republicans, their proposals do not mean that Medicaid spending would be reduced on an absolute basis. The proposed reductions are measured against the likely course of Medicaid spending if current law remained unchanged. The projection that Medicaid spending would grow at 10.4 percent per year is based on estimates prepared by the Congressional Budget Office (CBO) that take into account factors such as projected growth in the number of Medicaid recipients, health care cost inflation, and other factors.

³⁸ The formulas developed by the House and Senate committees differ. However, both define a minimum, floor rate of increase and a ceiling. The amount of additional dollars any particular state would receive would depend on factors like per capita spending for Medicaid services, households in poverty, and overall fiscal effort.

directly regulate spending on Medicaid services in order to live within the federal payment cap.

In a nutshell, the proposed changes would convert the Medicaid program to a form of "health care revenue sharing" and transfer nearly total control over the program to the states. The "quid pro quo" involved in securing lower federal Medicaid outlays is the nearly total devolution of program authority to the states.

In part, this massive change in federal policy is rationalized by the argument that giving states flexibility to run their programs will mean greater efficiency and, hence, lower costs. This rationale is supported by many (but not all) governors. One of the premises of the plan is that states would be able to employ managed care strategies more broadly across a wider range of services and recipients and, hence, be able to cut outlays by amounts sufficient to mitigate the federal funding reductions.³⁹

Both the House and Senate plans would do away with the need for states to obtain special federal waivers in order to implement managed care approaches. For example, states would no longer be restricted to obtaining health care services solely from federally-qualified HMOs. They would be able to contract on a routine basis with a greater variety of managed care plans. Only in the case of plans which furnish inpatient hospital and physician services would a state be required to base its capitation payments on an actuarially sound basis. States would not have to obtain special federal waivers in order to restrict recipient freedom of choice and, thereby, channel recipients into managed care plans. Under both plans, states could cover both traditional Medicaid recipients as well as other low-income populations (thus, doing away with the need to obtain a Section 1115 waiver in order to cover low-income, non-Medicaid-eligible populations). Managed care plans would not be subject to special evaluation requirements (although a state's entire program would be). There is little doubt that, if enacted, these changes would allow states to implement managed care approaches far more readily than has been possible in the past. There also is little doubt that, given the depth of the cutbacks in federal payments contained in both plans, many states would accelerate the pace at which they are converting their programs to managed care.

Even though the plan potentially clears the way for states to employ managed care on a very broad basis, it is impossible to predict the extent to which it will accelerate the conversion of state programs to managed care. It is clear that the farreaching changes contemplated by the House and Senate proposals would put enormous fiscal pressure on the states to restructure their Medicaid programs. The caps on spending growth contained in the proposals are well below any reasonable forecasts of recipient growth and health care inflation. Very few states would be able to continue their current Medicaid programs without substantially risking running out of federal dollars. The total reduction in federal outlays over the plan's seven-year time horizon substantially exceeds any reasonable estimates of the possible savings that might be derived from a broader application of

³⁹ In part, the same rationale is used to justify the related proposals to reduce projected Medicare outlays by \$270 billion.

managed care approaches. As a consequence, many states would have little choice but to scale-back eligibility and/or covered services in order to remain within their caps. At best, therefore, the wider-scale application of managed care to state Medicaid programs would only partially offset reductions in federal payments.

If states are to obtain increased Medicaid savings from the use of managed care, they will need to consider seriously broadening the application of managed care to populations and services with which there is relatively little experience in employing this approach. As previously discussed, the elderly and Medicaid recipients with disabilities account for roughly 70 percent of all Medicaid outlays. To date, large-scale state managed care initiatives have focused on AFDC-eligible children and mothers (as well as similar low-income households). Employing managed care for this population has enabled states to save dollars. Whether similar savings can be achieved by extending managed care to recipients with disabilities or who are elderly is not known. Similarly, one-third of all Medicaid spending is devoted to long-term care services, where there is even less experience in the application of managed care strategies. Despite these uncertainties, in all likelihood, states will push the managed care "envelope". The problem they will face is that the Congressional budget timetable gives them only a very short time horizon to accelerate the use of managed care for program areas and populations that most observers believe are the most challenging.

Assuming that final agreement is reached on restructuring the Medicaid program along the lines of the plans that have received preliminary House and Senate approval, it seems reasonable to expect that states will embrace managed care as a primary tool in controlling their spending to match the federal caps. Still, the exact course this change will take is far from clear and, inevitably, will vary from state to state.

Conclusion

Driven by many of the same factors that spawned the massive expansion of managed care in the private sector, states have been accelerating the conversion of their Medicaid programs to managed care. Still, the use of managed care in Medicaid programs is only in its adolescence.

State Medicaid managed care initiatives have taken a variety of forms. Many states rely nearly exclusively on PCCM arrangements. Others have mounted far more ambitious comprehensive health care reform demonstration projects. Still others are employing specialty options or juxtaposing managed care arrangements with PCCM. The states clearly are going through a testing/trial period as they attempt to find which types of arrangements work in particular situations. Here again, there are parallels with the evolution of managed care in the private sector.

Under current federal law, Medicaid managed care arrangements must comply with various federal statutes or the state must seek special waivers. The Clinton Administration opened the door to the submittal of particularly broad-scale state Section

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1115 demonstration waiver requests while concurrently welcoming other types of waiver requests that would permit the greater application of managed care in Medicaid programs. This change in federal policy has stimulated a very rapid growth in the use of managed care arrangements in the Medicaid program.

The 104th Congress is poised to enact a major restructuring of the Medicaid program. This restructuring, once enacted, would give the states a much freer hand in employing managed care to contain spending on health care services for low-income individuals. Undoubtedly, many states would take advantage of this flexibility to pursue managed care arrangements much more aggressively. However, since the substantial majority of Medicaid spending supports populations and services in which there is relatively little experience in applying managed care, it remains to be seen just how rapidly states choose to implement managed care approaches even though they will have greater latitude to do so.

CHAPTER IV

**MANAGED HEALTH CARE
AND PEOPLE WITH
DEVELOPMENTAL DISABILITIES**

IV. Managed Health Care and People with Developmental Disabilities

The rapid conversion of state Medicaid programs to managed care means that a growing number of individuals with developmental and other disabilities are or soon will be relying on MCOs to obtain their health care. Many of these same individuals also receive long term services and supports through the specialized developmental disabilities service system. Health care and long-term supports interact in complex ways. Thus, changes in health care delivery can have consequences in the arena of long term supports.

The primary focus of this **Guidebook** focus is on the possible application of managed care to long-term supports for people with developmental disabilities. However, it would be a mistake to ignore the possible implications of managed health care for people with disabilities, both in its own right and with regard to its relationship to long-term supports. In the states, people with developmental disabilities and providers who support them are likely to first encounter managed care in accessing health care.

People with developmental and other disabilities are most likely to encounter managed care in accessing health care. This has implications for the health care they receive and the interaction between health care and long-term supports.

This chapter addresses two interrelated topics:

- Issues and concerns that have arisen regarding the manner in which people with developmental and other disabilities fare under managed health care systems; and,
- Key issues concerning the interface between managed health care and developmental disabilities long-term supports systems.

The chapter concludes with suggestions concerning the way in which developmental disabilities system stakeholders should assess and seek to influence the development of managed health care plans.

Overview: Managed Care and People with Disabilities

Managed care first emerged in the private sector as an effort by employers to bring their health

Topics Covered...

- ☒ **Managed Care & People with Disabilities**
- ☒ **Addressing Problem Areas**
- ☒ **Interfaces with Long Term Support Systems**
- ☒ **Advice/Observations**

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care costs under control. As such, managed health care came to be configured around what might be loosely termed "primary care" or "acute care" medicine for working-age adults and their families. Compared to other populations, these individuals typically enjoy good health status. Their health care needs principally revolve around primary/acute care rather than specialty services. Hence, most private sector managed care plans are geared to meeting the health care needs of "average healthy people". Plans do not ignore the need for specialty services; however, their orientation is primary care medicine.¹

Critics often charge that managed health care inappropriately reduces member access to specialist services and poses difficult problems for individuals whose health care needs fall outside of mainstream primary care medicine. Consumers report problems getting past primary care personnel to receive specialty services, difficulties in making appointments with plan specialists, and obstacles in obtaining services from specialists who are not members of a plan's "panel". Since specialty services are expensive, critics also charge that MCOs purposefully suppress their utilization in order to maintain profitability.

As we observed in Chapter III, one of the reasons that many states have confined mandatory managed care enrollment of Medicaid recipients to the AFDC eligibility group is that the children and younger adults who compose that group are most akin to the individuals who typically are enrolled in MCOs. On a per capita basis, AFDC recipients consume relatively modest amounts of health care; their principal needs are standard, routine primary/acute care. Typical "managed care products" must readily fit the needs of these individuals.

Many (but not all) people with developmental and other disabilities do not fit the "managed care mold". While they have primary health care needs, some have disabilities that stem from a chronic condition (e.g., multiple sclerosis) that demands constant management from a specialist who is well-versed in treating and monitoring the condition and its related potential complications. For such individuals, "primary care" is best managed by a specialist, not a general practitioner. Some conditions are relatively rare. Because they are rare, primary care systems have great difficulty in developing the capacity to address them. Frequently, the best treatment is available from highly specialized centers. In the case of some people with cognitive disabilities, primary care may be their predominant health care need but care delivery can be complicated by the fact that the individual may have difficulties communicating with health care professionals. Hence, meeting the individual's primary care needs can necessitate greater involvement on the part of caregivers plus an allowance of more time for office visits. In this sense, such consumers do not fit the mold either.

Problem areas like these have alarmed the disability community and raised serious questions about the capability of managed health care plans to meet the health care needs of many people with disabilities. Some of the serious concerns that have been expressed include:

¹ Conversion to managed care has significantly affected the role and importance of specialists in health care. Their "market" has dropped off considerably in several areas of the country.

- **The possibility that managed care will reduce or eliminate access to preferred health care providers.** For example, if an individual with a disability has a relationship with a physician who knows his or her history well, the relationship might be severed if the physician is not affiliated with the new managed care plan or the physician sells his or her practice to a health plan that his or her patients may not be able to join.

"Will health plans that are constructed to control access to specialists provide appropriate access for the severely disabled? Will health plans that predominantly care for persons without disabilities have contracts with practitioners who are expert in caring for a variety of relatively uncommon disabilities? Will health plans that primarily manage acute care be able to manage chronic care as well?"

Richard Kronick, Zhiyuan Zhou
and Tony Dreyfus
"Making Risk Adjustment Work
for Everyone"

- **There are serious concerns that MCOs lack the expertise to serve individuals with severe disabilities and other chronic conditions adequately and appropriately.** The primary care, "healthy member" orientation of many MCOs might lead them to overlook or ignore the needs of many people with disabilities or chronic illnesses or even avoid enrolling such individuals in their plan.
- **Many are concerned that managed care will lead to a trade-off between quality and the cost of care.** Consequently, individuals with "heavy care" needs, the argument goes, are particularly vulnerable to being short-changed by managed care plans. Since plans are capitated, there can be powerful financial incentives for them to keep a lid on specialty services or employ narrow medical necessity criteria that deny payment for specialists or other services that are integral to meeting the health care needs of people with disabilities.

These concerns parallel many of those voiced by the general public about managed care. In the case of some people with disabilities and chronic illnesses, these concerns are amplified by the severity of their disabilities.²

At the same time, managed care may offer important benefits to people with developmental and other disabilities. These potential benefits include:

- **Individuals enrolled in a managed care plan have guaranteed access to health care.** In many communities, people with developmental disabilities face persistent problems in locating physicians that are willing to treat them. Since Medicaid physician payment rates typically are very low, practitioners are reluctant to take on

² Appendix A contains Congressional testimony by the Consortium for Citizens with Disabilities concerning some of the central, generic issues that revolve around managed care and people with disabilities/chronic medical conditions.

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patients who might require more intensive services. Enrollment in a managed health care plan can help individuals link up with the health care system.

- **The care coordination features of most managed care plans are potentially an improvement over the hit-or-miss health care that many individuals receive today.** Some conditions require long-term management. People with such conditions are ill-served if they must turn to emergency rooms for care. Like other Medicaid recipients, people with disabilities potentially will benefit from enrollment in a comprehensive health plan with an established provider network. For Medicaid recipients with disabilities, the present fee-for-service system by no means guarantees high quality health care.³
- **Over the long-term, people with developmental disabilities are likely to receive better health care if they are integrated into the mainstream health care delivery system.** Unless such individuals are viewed as an integral part of the mainstream health system, they may find themselves marginalized on the fringes of health care. Some observers have expressed concerns that individuals who are left out of state managed care plans will have greater difficulties in accessing needed services in a what will become an increasingly truncated fee-for-service system.

Other observers also have pointed out that sound practice in meeting the health care needs of people with disabilities and chronic illnesses has the "greatest potential for generating savings through prevention of secondary conditions".⁴

For people with disabilities (like their fellow citizens), managed health care might prove beneficial or simply serve as yet another obstacle to living a rich and rewarding life. More seriously, bad health care has serious implications for the well-being of many of these individuals and exposes them to severe and potentially life-threatening secondary conditions.

It is inappropriate to make blanket statements concerning the appropriateness of managed health care for people with disabilities. As with other citizens, people with disabilities are vulnerable to improper treatment under a managed care system (just as they are in a fee-for-service system). Systematic information about the effectiveness of managed health care services for people with developmental disabilities (as with the general health care arena) is sorely needed. Moreover, people with disabilities cannot be

³ State Medicaid programs, for example, impose questionable prior authorization/medical necessity criteria on specialized services. They rarely pay for specialized care coordination services for individuals with conditions that demand such coordination. Physician fee schedules are rarely adjusted to take into account the additional time that might be needed to treat an individual with cognitive disabilities.

⁴ Bob Griss (June, 1995). "Key Challenges for Managed Care from a Disability Perspective". Griss is with the Center on Disability and Health in Washington, D.C.

stereotyped in terms of their health care needs.⁵ For many, the primary care orientation of managed care plans is acceptable. However, it is clear that the possibility exists that the standard "healthy person" managed primary care model will fail to address the needs of some individuals with disabilities who have special health care needs.

Addressing Problem Areas

There are various safeguards that public and private managed health care plans can take to protect the interests of people with disabilities in a managed care environment. Some of these steps apply to all forms of managed care; others apply to managed care under the Medicaid program. These safeguards also provide a framework for evaluating the disability-related implications of a managed health care plan.⁶

Before discussing specific safeguards, one comment is in order. Managed health care plans are constructed with the "average" member in mind. As such they usually are not designed to accommodate exceptions. The safeguards described here amount to special rules that would apply to various classes or subpopulations of enrollees for whom the primary care model is unlikely to work well or is inappropriate. These exceptions or special rules do not necessarily mean that people with disabilities should be kept out of managed care as a class. It does mean that it is important that managed care plans be designed with the objective in mind of ensuring that people with disabilities who participate in such plans will be afforded the accommodations they need in order to obtain high quality health care.

Among the accommodations that might assure better health care for individuals with disabilities under managed care plans are the following:

- **Risk Adjustment Features.** Capitation frequently is criticized for giving MCOs incentives to underserve heavy users of health care services. There are various ways to avoid this problem, including:
 - **Risk-adjustment.** Rather than employing a single capitation rate across all individuals participating in a plan, distinct rates can be established based on the presence of specific conditions. Risk-adjusted capitation rates recognize that certain classes of individuals are likely to consume more health care resources

⁵ Griss (see above) points out that the "majority of persons with a disability are relatively low users [of health care]". For instance, people with developmental disabilities who participate in the home and community-based waiver program generally have per capita health care costs in the range of \$1,500 - \$2,000/year or about the same as adult AFDC recipients. Studies indicate that people with mental retardation use health care services at a somewhat higher rate than other non-disabled adults, but at a lower rate than individuals with cerebral palsy or persons who have diabetes or multiple sclerosis. As in the general population, a small percentage of individuals tend to consume a disproportionate amount of health care services.

⁶ These points are distilled from the materials covered in Appendix A as well as the Griss material and other sources.

than others. One simple but fairly common form of risk-adjustment is to base the rate on a plan member's age. Risk-adjustment is used principally as a tool to give plans incentives to enroll members whom they might otherwise exclude (or seek to exclude) due to their expected costs. Risk adjustment counteracts incentives to underserve high-end users, although this outcome is not necessarily guaranteed⁷.

- **Reinsurance.** Reinsurance mechanisms compensate an MCO when the costs of serving an individual enrollee exceed a pre-established threshold. Potentially, reinsurance schemes make it less likely that a plan will underserve an individual with high care needs since its extraordinary costs would be compensated. Reinsurance reduces the plan's risk and decreases the pressure on plans to ration care on a person-by-person basis. However, if the reinsurance threshold is set at too high a level, then its value is diluted.
- **Physician Risk.** Some managed care plans place physicians at financial risk. They risk reduced compensation if the individuals they serve consume more health care than expected. A recent survey indicates that average physician salaries rise or fall by as much as 12 percent under such risk-sharing plans. Hence, some advocate banning this practice because it creates incentives for physicians to underserve all enrollees in a plan.
- **Gatekeeping.** Gatekeeping is a central feature of managed health care plans. Many plans are structured so that gatekeeping is performed by primary care personnel. Some consumer advocates recommend that plans be required to employ or contract with specialists to perform the gatekeeping function for members with specified disabilities/chronic illnesses. Specialists are more likely to be attuned to the needs of such members. Some Medicaid PCCM systems provide for the enrollment of all physicians as gatekeepers (and, hence, allow specialists to perform gatekeeping functions). Others limit enrollment to general practitioners, internists, and obstetricians/gynecologists.
- **Enrollment Exemptions.** One way to avoid the mismatch between people who require specialized health care services and the primary care orientation of MCOs is to exempt such individuals from mandatory enrollment, thereby permitting them to continue to access their health care on a "fee-for-service" basis. As discussed in Chapter III, several states have decided not to apply managed care to SSI-eligible disabled and elderly recipients. Individuals receiving long-term care services frequently are exempted as a class, based on the belief that their health care needs are likely to be atypical. Exemptions can be structured in one of two ways:

⁷ As Griss points out, risk-adjustment that is not accompanied by special requirements concerning MCO performance can lead to windfall profits for an MCO that accepts individuals who carry a risk-adjusted rate but fails to change its care practices. In addition, it is worth pointing out that risk adjustment is only feasible when it can be based on sound information about the utilization patterns of various classes of individuals. Risk adjusters are being employed in the Medicare program to a limited extent.

(a) prohibiting individuals from signing up with an MCO; or, (b) giving individuals the choice of signing up with a managed care plan or remaining part of the fee-for-service system.⁸ However, it needs to be pointed out that such exemptions mean that individuals who consume disproportionate amounts of health care (and, therefore, account for a significant share of overall spending) remain in the "unmanaged system". This reduces the potential savings that a purchaser might achieve through managed care approach.

- **Boutique/Specialty Plans.** "Boutique" or "specialty" managed care plans limit enrollment to individuals with certain defined conditions. Such plans are designed specifically to ensure that individuals with these conditions are being served by organizations that are sensitive to their particular needs. Boutique plans may be paid a comprehensive capitation rate or may function as specialized gatekeepers. For example, Maryland operates a diabetes care program for roughly 2,800 Medicaid recipients that pays a \$20/month stipend to specialized gatekeepers to

Massachusetts: Community Medical Alliance

The Community Medical Alliance (CMA) is a Boston-based for-profit managed care firm that concentrates on health care for individuals with severe disabilities and chronic conditions. CMA serves 15 percent of Medicaid recipients with late-stage AIDS in the Boston area and "more than half of those with chronic multiple handicaps" (including individuals who have had a spinal cord injury, have severe degenerative multiple sclerosis, ventilator dependent individuals and persons with cerebral palsy). CMA's program has five major elements:

- ☑ Primary care physicians are fully in charge of individual care planning. These physicians are paid above average fees.
- ☑ Physicians are teamed with nurses and social support professionals to plan and deliver care. "Nurse-coordinators furnish primary care (usually in the home), provide health education and self-care teaching, respond to new medical problems and coordinate medical and social services. A majority of medical decision-making visits take place in the home".
- ☑ Both consumers and clinicians have 24-hour "one-call" access to a nurse-coordinator to relay information as well as schedule services with contracted providers.
- ☑ CMA furnishes or arranges for physician, hospital (including long-term hospitalization), home health, private duty nursing, case management, durable medical equipment, home health and various other services. Individuals served by CMA obtain other services (personal care, pharmacy, and dental services) on a fee-for-service basis through the Massachusetts Medicaid program.
- ☑ Medicaid monthly capitated payments to CMA are diagnosed-based (i.e., risk-adjusted). CMA's contract with the Massachusetts Medicaid program is a shared risk/shared savings arrangement with a stop-loss provision for hospital services. "CMA uses the flexibility of capitation to offer new models of primary care and a creative mix of hospital alternative services."
- ☑ "Clinic standards require that all home-based services must be available within two hours of a physician's order."

Robert Wood Johnson Foundation
Advances (Spring, 1995)

**Wisconsin:
Independent Care**

The Wisconsin Independent Care (I-Care) managed care plan was created to serve exclusively Medicaid recipients with disabilities. The plan operates in Milwaukee County through a partnership between the Wisconsin Health Organization (an HMO) and the Milwaukee Center for Independence, a non-profit rehabilitation and adult day care provider. Medicaid recipients with disabilities who are between the ages of 15 and 64 may choose to enroll in I-Care or sign up with a PCCM. The I-Care plan has an enrollment ceiling of 3,000 individuals. The plan features:

- ☒ A network of more than 200 providers "allowing most enrollees to stay with current care givers";
- ☒ Care coordinators "who work with community-based providers to improve clients' health status and quality of life";
- ☒ The plan does not include long-term care services as part of its benefits package;
- ☒ People with disabilities "and their advocates ... actively participated in the formation of I-Care". One of the project's goals is to "develop models for formalizing consumer involvement" in the operations of the plan;
- ☒ Outcome data will be employed extensively to determine the appropriate mix of benefits and services;
- ☒ The Wisconsin Medical Assistance programs makes capitated payments to I-Care via a risk-adjustment, case-mix methodology that is based on enrollees' previous Medicaid claims history. The plan bears limited risk (only for 2 percent of costs incurred in excess of the capitated payment) and may retain no more than 2 percent of any savings.
- ☒ The plan is undergoing extensive external evaluation by the Human Services Research Institute.

manage the care of individuals with diabetes. Actual care and treatment services, however, are paid for on a fee-for-service basis. Massachusetts has contracted with the Community Medical Alliance (CMA) on a capitated basis to provide health care to late-stage AIDS patients and individuals with chronic multiple handicaps.⁹ In

⁸ In broad brush, Medicare operates in this fashion. Beneficiaries may elect a qualified HMO or continue to exercise free choice among qualified providers. Individuals who sign up with an HMO may experience lower out-of-pocket expenses (and, often, more covered benefits) but reduced choices. There difference of opinion regarding whether Medicare HMO policies and practices encourage healthier beneficiaries to sign up with HMOs (and also encourage HMOs to market to such individuals).

⁹ With funding provided by the Robert Wood Johnson Foundation and the Pew Charitable Trusts, CMA's affiliate, The Medicaid Working Group, is managing projects in six other states (including the Wisconsin I-Care Project described above) that are designed to "provide cost-effective, home and community-based HMO care" to individuals with chronic conditions or multiple disabilities. In Ohio, for example, the project, entitled Accessing Better Care (ABC), involves establishing collaborative relationships between HMOs and providers "who have expertise in serving people with disabilities". ABC is up and running in the Columbus and Cleveland areas, with a third site scheduled to begin operations in the Fall of 1995. The Columbus project links an HMO with the Ohio State University Medical Center. Recipient enrollment in ABC is voluntary. According to the sponsors, "through greater access to primary and specialty care and more flexible benefits, the plans are expected to attract enrollees with a wider range of physical disabilities". Another project involves working with the New York State United Cerebral Palsy Association to qualify clinics operated by affiliates as preferred primary care providers under a partially

Wisconsin, another "boutique" plan (I-Care) is employing a managed care approach to serve roughly 2,200 individuals with disabilities (with the expectation that 3,000 individuals will be enrolled when the project is fully operational).¹⁰ Assuming that this pilot program is successful, Wisconsin officials intend to launch similar plans in other localities. Rhode Island is planning to pay a high premium to cover adults with developmental disabilities under its Rite Care Plan and to establish a special group to oversee the provision of care to this population. In New Jersey, a Developmental Disabilities Health Alliance is being formed in anticipation of the State's expected conversion of its Medicaid program to managed care. This managed care network is being designed specifically for people with developmental disabilities.¹¹

Specialty plans offer some promise of serving as alternatives to general purpose MCOs for individuals with severe disabilities or chronic conditions. Such plans, however, are in their infancy. Observers point out that the widely varying health needs of consumers with disabilities means that each specialty plan may have to develop different service delivery structures and reimbursement strategies. Specialty plan capitation/risk arrangements are particularly difficult to develop when a plan serves a relatively limited number of enrollees. Finally, it is unclear how many of these plans may emerge and, hence, whether they will prove to be a viable alternative to mainstream primary care plans.

- **Benefit Design/Care Criteria.** The expansion of managed care has exposed the need for purchasers to pay more attention to benefit packages and the "medical necessity"/care criteria that plans employ in order to ensure that people with severe disabilities and chronic conditions are served appropriately and effectively. For example, health care plans often place severe restrictions on the coverage of equipment/assistive technology that can contribute to personal independence and to fewer complications down the road.¹² As managed care expands, purchasers (public

capitated managed care plan. Also, recently, the Commonwealth of Massachusetts has expanded its contract with CMA to enroll individuals with disabilities and chronic conditions (SSI-recipients), statewide, as a capitated health care provider under MassHealth. In this expansion, Medicaid recipients may elect to obtain health care from CMA or another managed care plan.

¹⁰ Intergovernmental Health Policy Project (February, 1995). *State Health Notes*: "Wisconsin's I-Care is a "boutique" managed care model for the disabled".

¹¹ In particular, DDHA "is a network of primary care physicians, specialists, hospitals and other health care providers who have joined together to assure that people with exceptional health care needs have access to quality health services wherever they live in New Jersey". DDHA will seek a direct contract with the New Jersey Medicaid program and/or contract with other HMOs to serve persons with developmental disabilities on a capitated basis. DDHA will furnish continuing education programs to affiliated network providers in the arena of the special health care needs of people with developmental disabilities. DDHA builds on the experience of the Developmental Disabilities Center at Morristown Memorial Hospital which pioneered a primary care coordination model for the delivery of health care services to this population. FMI: Ted Kastner, M.D., President, DDHA, 45 Park Place South, Suite 275, Morristown, NJ 07960.

¹² Griss, for example, cites, as an illustration, an HMO which is willing to pay for expensive hip-replacement surgery but limits payments for wheelchairs to no more than \$1,500.

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and private) will need to exercise greater oversight to ensure that plans do not base care criteria on shortsighted financial objectives.¹³

- **Plan Choice/Point-of-Service Options.** One way of avoiding some of the problems that managed care might entail for people with disabilities and chronic illnesses is to ensure that they have choices among managed care plans (and thus can opt for the plan that will best meet their needs). Generally, for comprehensive health care services, Medicaid recipients must be afforded the choice of at least two plans. However, frequently the available options might not meet their needs, which strongly suggests that Medicaid managed care plans need to be subject to more sophisticated requirements when they are designed to encompass services to people with disabilities. Some argue that all plans should contain a "point-of-service" option so that people with disabilities and chronic conditions can obtain care outside the managed care plan in which they are enrolled. Others support the enactment of "any willing provider" legislation so that managed care plans are required to sign up all physicians who wish to participate; thereby increasing the chances that existing relationships can be maintained between people with disabilities and their physicians. The Medicare program is being modified to encourage the expansion of such options.¹⁴
- **Essential Providers.** In certain localities, individuals with certain conditions rely on specialty centers to obtain care. Some of these centers are university-based. Some advocate that managed health care plans be required to contract with such centers to ensure ongoing access for members. This is termed an "essential community provider" requirement. Some plans contract with such centers; others are reluctant to do so because of the costs involved.
- **Quality of Care/Outcomes Management.** In Chapter II, we noted that the technology of evaluating and monitoring the quality of care furnished by managed health care plans, at best, is in its infancy. Most outcome tools examine plan performance in treating high prevalence conditions. There has been relatively little focus on measuring the performance of plans in addressing the needs of individuals with severe disabilities and various low-incidence chronic conditions. Clearly, as more people with disabilities are served through managed care plans, the need for performance measures in this area will increase. Such measures are particularly important in Medicaid managed care arrangements which serve economically disadvantaged individuals with severe disabilities. Moreover, given the vulnerability of some individuals with disabilities, additional attention needs to be paid to plan grievance procedures and appeals mechanisms.

¹³ Preventive health services have long-term pay-offs. The MCO, however, may not benefit from such pay-offs if the person subsequently switches plans.

¹⁴ Generally, the POS option permits consumers to access "out-of-plan" providers as long as they are willing to pay more out-of-pocket. This is feasible for some Medicare beneficiaries. In Medicaid, POS generally is regarded as infeasible due to restrictions on recipient cost-sharing. However, New Hampshire is considering using a POS option in its comprehensive health care reform demonstration waiver program.

There are other potentially useful approaches to ensuring that the needs of people with severe disabilities and chronic illnesses are accommodated adequately in a managed care plan. However, it is too early to tell which approaches will prove most beneficial. Again, given the diversity of needs among the population with disabilities, an entire constellation of approaches ultimately may be necessary.

Griss has observed that "people with disabilities are a **litmus test** for managed care [because]: (1) [they are] most vulnerable to cost containment strategies without proper safeguards; (2) most aware of the limitations of acute care bias in [the] health care system; [and] (3) [have] the greatest potential for generating savings through prevention of secondary conditions".¹⁵ It is too early to tell how well managed care will fare when this test is applied.

As state Medicaid programs extend the reach of managed care to more and more recipients with disabilities and special needs, it will be vital that conventional approaches be modified to ensure that: (a) proper safeguards are established; (b) cost containment objectives do not encourage plans to underserve individuals; (c) the pros and cons of alternative configurations are carefully weighed; and (d) greater attention is paid to establishing sound care criteria/utilization management practices. All parties must recognize that the broad-based application of managed care to people with disabilities and chronic illnesses is largely uncharted territory. There remains much to be learned.

It is worth pointing out that the federal Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) has launched a wide-ranging research initiative that will explore several dimensions in the application of managed care to people with disabilities.¹⁶ ASPE's research agenda includes: (a) defining and measuring disability in a health care system; (b) analyzing the impact of managed care on access to health care services, use and expenditures; (c) assessing the impact of managed care on individual outcomes and other quality indicators; (d) financing and reimbursement incentives which encourage/impede participation in managed care; and (e) organization of the delivery system for disabled populations enrolled in managed care plans. Some \$800,000 has been set aside to conduct this research, which undoubtedly will contribute to gaining a better understanding of disability-related issues in managed care.

Interface with Long Term Supports for People with Developmental Disabilities

The majority of individuals (especially adults) who receive long-term supports through state developmental disabilities service systems obtain their health care through the Medicaid program. Medicaid dollars purchase a wide variety of basic health care

¹⁵ Griss, *op. cit.*

¹⁶ This initiative is being conducted by ASPE's Office of Disability, Aging and Long-Term Care Policy and is generally described in a paper: "Managed Care for People with Disabilities: Developing a Research Agenda" (January, 1995).

**Possible Managed Care/
DD Long Term Supports System
Interface Problems**

- ☑ Breakdowns in long-standing relationships between individuals/agencies and physicians and other health care providers
- ☑ Reduced access to some key services due to altered "medical necessity" rules
- ☑ Changes in service prior authorization processes
- ☑ Coordination of medication regimens
- ☑ Difficulties in obtaining physician/health professional participation in support planning

services for these individuals, ranging from routine physician services to in-patient hospitalization. Absent Medicaid, these individuals would have no health care coverage. As state Medicaid programs change over to managed care, the access of Medicaid-eligible persons with developmental disabilities to the health care system will be altered.

Today, most individuals access health care through "fee-for-service" arrangements. Provider agencies, for example, establish relationships with community physicians who furnish health care to individuals residing in group homes and other community living arrangements. Other individuals frequently have long-standing arrangements with community physicians (e.g., the individual's family physician). The advent of managed

care can disturb these relationships. For example, if a person's physician opts not to join the health plan in which the individual is enrolled, then the person will need to find another provider who will not be familiar with his or her history and specific conditions. Alternatively, an individual may have to join a particular health care plan in order to retain a relationship with his or her physician of choice.

Long term supports interface with health care through a State's Medicaid program in other ways as well. For example, some services require a physician's approval. In most states, the provision of personal care services under the state's Medicaid plan fall into this category. The advent of managed care means that the plan's physician must become involved in decisions that relate to supports and not just strictly health care. For some individuals, drug therapies are an integral element of their treatment plans. The switch over to managed care can add new complications both in terms of securing needed drugs and necessary authorizations. On some occasions, a physician or another type of health care professional must be consulted during the supports planning process. However, the managed care plan might not be willing to accommodate such consultations.

Thorny problems also can arise when certain services previously available on a fee-for-service basis through Medicaid are folded into a managed care plan's capitated rate. Services that may have been relatively accessible now fall under the plan's overall cost-containment/utilization management strategy. "Medical necessity"/prior approval criteria may render such services less accessible. For example, in some states, DD service systems rely on the Medicaid state plan coverage of physical and occupational therapy to obtain these services for people with disabilities. Another important area is durable

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medical equipment (including customized wheelchairs and some forms of assistive technology). If these services become less readily available, then there are relatively few alternative sources to fill the resulting gap.

These "cross-over" services also highlight another potential problem area in the interface between long-term support systems and managed health care plans: cost-shifting between the two systems. If managed care plans establish high prior authorization/"medical necessity" thresholds, then community DD service agencies may be forced to absorb the additional costs of providing services that fall below such thresholds.

It is not a foregone conclusion that managed care necessarily makes it more difficult for individuals served by developmental disabilities systems to obtain needed health services. However, it also is clear that, when people served in DD systems are drawn into managed care arrangements, unanticipated problems can emerge. Relationships and system "rules" change; these changes are bound to have an effect on people served in community DD programs and the provider agencies that assist them.

Some states seek to avoid these problems by excluding long-term care recipients from enrollment in managed health care plans, thus allowing them to continue to receive their health care services on a fee-for-service basis as well as explicitly excluding some services from prior authorization requirements.¹⁷ However, as states widen their use of managed care, it is uncertain whether such exclusions or special carve-outs will continue.

State Experiences

Some states are devoting special attention to ensuring that people with developmental and other disabilities are appropriately served in a managed health care environment. Oregon officials, for example, have taken several steps to accommodate the needs of people with disabilities under the Oregon Health Plan (see Appendix B). Pennsylvania (Appendix C), New York and other states have devoted special attention to needs of people with developmental disabilities in designing and implementing their respective Medicaid managed care plans. In Appendix D, an Oregon official who has been very involved in the design and implementation of the Oregon Health Plan offers her

¹⁷ For example, New York State's proposed Section 1115 demonstration waiver proposal (The Partnership Plan) excludes from mandatory managed care enrollment: (a) ICF/MR residents; (b) individuals enrolled in HCB waiver programs for people with developmental disabilities; (c) individuals who are dually eligible for Medicare and Medicaid services; and, and, (d) individuals who have characteristics similar to ICF/MR residents or HCB waiver participants. The proposal stipulates that such individuals may voluntarily enroll in an manage care plan if they so choose. Persons with developmental disabilities that do not meet these criteria, however, will be required to enroll in a managed care plan. The plan also provides that various specialized services (day treatment, comprehensive case management, and habilitation services) furnished through the State's developmental disabilities service system will continue to be furnished on a fee-for-service basis and will not be subject to prior authorization by the managed care entity. In addition, case managers within the developmental disabilities system "will coordinate with managed care physicians and other health care providers to see that they know about the long care services that ... consumers receive outside the managed care system".

observations concerning various issues in serving people with disabilities in a managed care framework.

Distilling experiences in these and other states yields some useful insights concerning the way in which long term supports and managed health care systems might operate in tandem. In particular:

- **Exceptional Need Care Coordination.** In Oregon and New York, managed care organizations have been required to designate "exceptional need care coordinators" who are responsible for addressing the needs of individuals who may require more specialized care.¹⁸ Appendix B contains Oregon's specifications for this role. These coordinators function as specialized gatekeepers and have liaison responsibilities with community DD service agencies/long term support coordinators. The requirement that plans have such personnel is included in state contracts with the MCOs.
- **Training.** Oregon and Pennsylvania in particular have placed a major emphasis on offering training to: (a) health care plan personnel; (b) community MR/DD agency personnel; and, (c) consumers and their families. The New York State Office of Mental Retardation and Developmental Disabilities plans to furnish information and training to community DD agencies, individuals and families once the State's managed care Partnership Plan is launched. The aim of such training is to ensure that all parties understand the key features of the State's managed care plan and particularly those aspects of the plans that are relevant to meeting the needs of people with developmental disabilities in a managed care environment. Each state has recognized up front that the changeover to managed care is likely to have ripple effects throughout their disability service systems.
- **Encouraging Local Dialogue.** Pennsylvania has been particularly active in encouraging community provider agencies to develop working relationships with managed health care plans prior to implementation. One useful result of these dialogues has been that community MR agencies are learning more about how to interact effectively with health care personnel and managed care plans.
- **Involvement in the Design Phase.** In each instance, state DD agency personnel were involved in the design of the state's managed care approach. This participation enabled key interface issues to be addressed before the fact.
- **RFP Specifications/Contractual Provisions.** The experiences in all three states highlights the importance of making sure that disability-related/DD system concerns are included in a state's solicitation (RFP) for managed health care plans and in the contracts that are entered into with MCOs.

¹⁸ Boutique and specialty plans feature care coordination. Exceptional care case management creates a somewhat similar capacity within a non-specialty plan.

Experiences in these states (and others) underscore the importance and potential benefits of having DD system personnel ultimately involved in the plan development/specification phase of launching Medicaid managed health care systems that will be serving people with developmental disabilities.

Advice/Observations

There appears to be little doubt that more and more people with developmental and other disabilities will be drawn into Medicaid managed health care plans over the next few years. In many respects, the questions are "how?" and "when?", not "if?". Obviously, there are legitimate reservations concerning the capacity and commitment of managed care health plans that are organized around "acute care" medical service delivery to treat many people with complex, chronic disabilities. Despite these concerns, the "managed care train is on the tracks".

The complexity of managed care is daunting. It is foreign territory for most stakeholders in the developmental disabilities service system. It is all too easy to be intimidated by the jargon of managed care. However, it is important to keep two key facts in mind: (a) good health care is an important ingredient in any individual's quality of life; and, (b) a shift to managed care in a state's Medicaid program will have important consequences for how people access health care and what they will find available. Hence, it is enormously important for all stakeholders to be informed about and participate as much as possible in the development of managed care systems that will serve people with developmental and other disabilities. Our advice along these lines is as follows:

Advice/Observations

- ☒ Be at the table
- ☒ Ask lots of questions
- ☒ Don't be too quick to fight for the status quo
- ☒ Be proactive in establishing linkages to the new system
- ☒ Facilitate and encourage linkages at the local level

Be at the Table. Too often, the design and implementation of a state's Medicaid managed care initiative is treated as a technical undertaking reserved for Medicaid officials and health care consultants. Frequently, plan development occurs at a frenzied pace. Yet, as discussed above, the best time to address disability-related/DD systems concerns and issues is during this planning phase.

As a consequence, it is critical for system key stakeholders and state DD authorities to secure representation as early in the plan development process as possible. This also means that state officials and others must dedicate time and resources if they are to achieve meaningful levels of involvement and be prepared to come to the table with a clear idea of what they hope to achieve for individuals with disabilities in a managed care environment.

Ask Lots of Questions. Any managed health care plan has very real, practical implications for people with disabilities. However, many of these implications involve considerations that may not be evident to plan designers. It is important, therefore, that the disability community articulate its concerns and probe to understand how the plan could affect the way in which people with disabilities will access health care and what types of care they will be entitled to receive.

Along these lines, there are a number of important questions that should be asked about managed health care plans:

- Are the goals and objectives of the State's managed care initiative spelled out in state law? Is there a consumer bill of rights?¹⁹
- How will gatekeeping be performed under the plan? Does the plan provide for specialists to perform this gatekeeper role? Under what conditions?
- What strategies will be used to attract the participation of as many physicians and other health care professionals as possible? What, if any provisions, are there in the plan for exceptions, so that enrollees can maintain existing relationships with health care professionals?
- What requirements does the plan place on MCOs in terms of including specialists in their networks or permitting out-of-plan referrals?
- Will MCOs be required to contract with specialized treatment centers?
- Does the plan provide for exceptional needs care coordination? Under what circumstances?
- Does the plan provide for contracting with specialty plans to address the needs of certain target populations?
- How will the plan handle "cross-over" benefits that are presently accessed as components of individual treatment plans/community support strategies?
- How will health plan care managers interact with long term system support coordinators?
- What safeguards does the plan contain to ensure that physicians and health care professionals can practice good medicine without being financially penalized?
- How are plan grievance and appeal mechanisms structured? Do they provide for timely resolution of disputes? Does the plan provide for surrogate decisionmakers to enter grievances and appeals on behalf of an individual? Will the state provide

¹⁹ See Appendix B for Oregon's bill of rights.

Ombudsman services?²⁰

- What requirements will be placed on MCOs in terms of providing information about plan benefits and operating rules?
- Does the plan contain any requirements concerning pre-implementation transition planning between MCOs and long-term support agencies?
- What choices will enrollees have in selecting an MCO or a managed care arrangement? Under what circumstances can an individual or group of individuals be exempted from enrollment?²¹ What are the implications of such an exemption?
- Under what circumstances can an individual change plans?
- Has provision been made to monitor performance of MCOs with respect to services provided to individuals with chronic disabilities?

Other questions can be asked as well. The main point is that it is enormously important for the disability community to analyze the proposed managed health care plan carefully in order to identify potential weaknesses, gaps, and operational issues.

Don't Be Too Quick to Fight for the Status Quo. All of us are naturally inclined to argue for the *status quo* when confronted with complex changes. In the case of proposed managed care initiatives, this tendency can take the form of advocating that people with disabilities (or subclasses of the DD population) be exempted from enrollment. Clearly, if a managed care plan poses a clear threat to the quality of health care such individuals receive, it behooves all stakeholders to advocate for exemption until the plan is changed.

At the same time, it is important to recognize that: (a) many people with disabilities today do not receive appropriate or effective health care; and, (b) individuals who continue to receive health care on a fee-for-service basis continue to be vulnerable to alternative cost-containment strategies.

Properly designed managed health care plans can help to address some of the problems that people with disabilities encounter today. For example, "boutique" health plans appear to offer substantial opportunities to overcome many of the shortcomings of fee-for-service systems in furnishing well-coordinated, comprehensive care to individuals with specialized needs. These plans offer opportunities to: (a) save money but (b) allow the delivery of health care to be restructured along more constructive, "disability friendly" lines. Consequently, the movement to managed care can provide real opportunities to explore new configurations. Boutique plans and other alternatives (e.g., "extraordinary needs care

²⁰ See Appendix B for a description of the ombudsman services available under the Oregon Health Plan for people with disabilities.

²¹ See Appendix B for Oregon's process for granting exemptions.

coordination"), for example, should be put on the table as part of the overall mix of managed health care options.

Be Proactive in Establishing Linkages to the New System. Involvement in managed health care should not stop once the plan has been designed. It is important for state DD authorities and other system stakeholders to continue to be active participants in implementing the plan and monitoring its performance. Implementation frequently results in a continuing series of modifications in the original plan. The ongoing involvement of state MR/DD agencies in New York, Oregon, and Pennsylvania in the managed health care initiatives in those states has had many positive benefits. In Florida, State officials secured funding through the Developmental Disabilities Planning Council so that the Medicaid agency could add a staff position that concentrated on the enrollment of people with developmental disabilities in managed health care plans. This staff person also has helped to resolve care coordination issues and developed informational materials.

Ongoing involvement can take other forms as well, including securing representation on oversight bodies and taking an active hand in monitoring and evaluating plan performance. Stakeholders are well advised to collaborate in the development of strategies to ensure that disability-related issues are attended to on a continuous basis.

Facilitate and Encourage Linkages at the Local Level. "All services, like all politics, are local". Ultimately, the success or failure of managed health care initiatives in meeting the needs of people with developmental disabilities will depend on whether local service agencies that furnish long-term supports to people with developmental disabilities and MCOs are able to forge constructive relationships that permit an individual's health care needs to be appropriately addressed. In the absence of such relationships, there can be serious breakdowns in the care delivery process.

One important lesson learned from the implementation of managed health care in some states is that most MCOs are willing to collaborate with community MR/DD agencies and other groups to establish positive working relationships and discover mutual solutions to common problems. For example, health care professionals frequently complain that people with developmental disabilities show up in their offices unaccompanied by basic, essential information. Gathering such information is time consuming and costly. In Pennsylvania, dialogue between the staffs of HMOs and community mental retardation agencies has led to the latter agencies changing their practices to ensure that relevant health information accompanies the individual on his or her visit to the HMO. In turn, community MR agencies have been able to better sensitize HMO personnel to the special considerations associated with supporting people with mental retardation.

Conclusion

The transition to managed health care can prove beneficial or harmful for people with severe, chronic disabilities. There is a great deal still to be learned about the best ways of ensuring that managed care entities furnish high quality health care services to

IV. Managed Health Care and People with Developmental Disabilities

such individuals. This discovery process is underway now (even though, in many respects, it is being conducted "on the fly"). In some states, specialized or "boutique" managed care plans for people with disabilities have emerged. Networks are beginning to form that are specially designed with people with disabilities in mind.

There appear to be a number of potentially useful steps that can be taken to safeguard the interests of people with disabilities. Experiences in some states suggest the ways in which these safeguards might be constructed, including how the interface between managed health care systems and long-term support systems might be best designed. At the same time, it is evident and imperative that DD system stakeholders assert a strong role in ensuring that managed health care plans are designed and implemented to the benefit of people with disabilities.

CHAPTER V

**MANAGED CARE AND
LONG TERM CARE/SUPPORTS**

V. Managed Care and Long Term Care/Supports

Having tested the waters in the managed health care arena, states are assessing the potential for employing managed care in long term care services and supports. A few states have submitted proposals to HCFA which call for applying managed care approaches in their mental retardation/developmental disabilities systems. Other states are seriously examining this possibility or have study/development initiatives underway. With the likelihood that Congress will cap federal Medicaid funding and in light of the fact that long-term care spending consumes about one-third of state Medicaid budgets, states are taking a hard look at how their long term care systems can be altered in order to permit them to live within these limitations. Managed care, of course, frequently surfaces as a potential option for system restructuring.

Part II of this **Guidebook** contains an in-depth examination of possible managed care applications in the arena of long-term supports for people with developmental disabilities. This chapter provides an overview of the topic area, including the potential uses of managed care and its pitfalls. We also summarize proposals that states have developed thus far in the developmental disabilities arena as well as managed care approaches that are being taken in long-term care arenas for other populations.

Long-Term Supports and Managed Health Care: Parallels and Mismatches

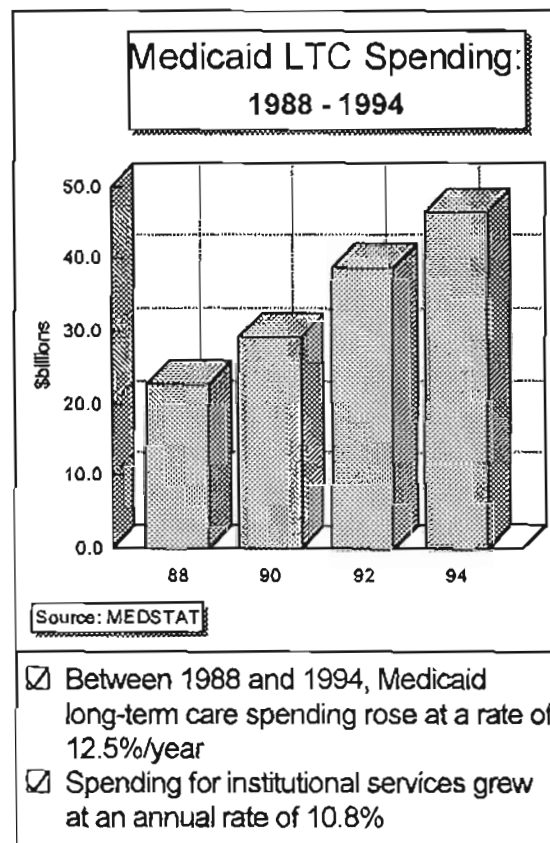
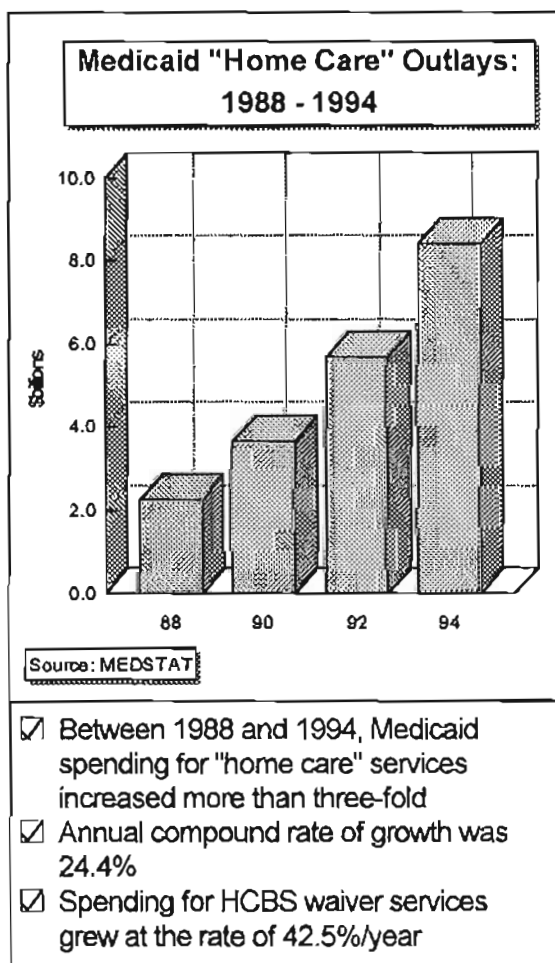
Does managed care fit long-term services and supports? The answer is: clearly not without major accommodations on both sides. There are parallels between health care service delivery and meeting the long-term care/support needs of individuals with chronic disabilities. Many of the same factors that propelled the emergence of managed health care are present in long-term care/support systems. At the same time, health care and long-term care/supports are not the same type of enterprise. **Hence, there is good reason to be suspicious of any claim that managed health care approaches simply can be transferred, wholesale, into long-term care/supports systems.**

Some parallels between long-term care/supports and health care suggest the potential applicability of managed care approaches to long-term care:

Topics Covered....

- ☒ Long-Term Supports and Managed Health Care: Parallels and Mismatches
- ☒ S/HMOs and Other Integrated Services Models
- ☒ Developmental Disabilities: Initial Explorations
- ☒ Managed Care and Long-Term Supports for People with Developmental Disabilities: Status

- While less dramatic than other sectors of the Medicaid program, spending for long-term care/supports has increased at a rapid pace over the past several years. Between 1988 and 1994, spending grew at an annual rate of 12.5 percent. This high rate of growth in spending has principally been the result of three factors: (a) cost inflation in institutional services¹; (b) vastly expanded state utilization of Medicaid "home care" coverages



(including the home and community-based waiver program, personal care, and home health); and, (c) a more relaxed federal regulatory climate that has enabled states to leverage more dollars for "community care". Even though Medicaid spending for long-term care/supports has grown at a considerably slower rate than overall Medicaid spending, it nonetheless has been increasing at a substantial rate.

- In nearly all sectors of long-term care/supports, states face rising demand. DD service systems have

¹ Over the past several years, the number of individuals served in Medicaid-certified ICFs/MR and nursing facilities has remained relatively constant but spending on such services has grown at a rate of 10.8 percent/year. Institutional per capita costs have risen for a variety of reasons, including: (a) changes in federal nursing facility requirements enacted by Congress in OBRA-87; (b) changes in federal ICF/MR regulations, which went into effect in 1988 but were preceded by increased state and federal scrutiny of such facilities; (c) litigation over state institutional rate setting practices; and, (d) other factors.

long waiting lists for services. Population trends point toward increased pressure to expand long-term care services for the elderly. Meeting this demand will strain state budgets.

- **Despite the recent rapid growth in community services and supports, spending for long-term care remains concentrated in costly institutional services.** This imbalance between institutional and community spending has parallels in health care, where hospital spending historically has dominated. Managed health care has brought such spending down considerably in recent years.
- **In long-term care, there is clear evidence that community care/supports are less costly than institutional services.** This suggests that "service substitution" strategies can aid in containing the costs of long-term care. Again, there are precedents for such service substitution strategies in managed health care.
- **Long-term care systems are bifurcated: community supports run in parallel, rather than in tandem, with institutional services.** The expansion of Medicaid-funded community services/supports has had an effect on the utilization of institutional services.² At the same time, various current federal policies have not permitted states to directly coordinate the management of both service sectors.³ Systems that operate in parallel and serve the same target population spawn their own forms of inefficiency. This appears to support the notion that "gatekeeping" could result in the more cost-effective provision of services.
- **Medicaid managed care options offer the states an opportunity to obtain waivers of federal requirements that increase costs.** Managed care offers potentially greater flexibility in overall system management, ratesetting/reimbursement, and utilization management. In many different respects, long-term care services are very heavily federally regulated and, therefore, difficult to cost contain. Managed care options sanction alternative approaches.
- **On the surface, long-term care appears susceptible to the systematic application of utilization management and other managed care strategies.** Service substitution is but one example. In many long-term service/support systems,

² As noted above, the overall total number of individuals receiving institutional services has not grown for roughly the past 10 years. Rapid growth in "home care" services has absorbed new demand. This is particularly true in developmental disabilities systems where ICF/MR utilization has been more or less stagnant since 1982, but the number of individuals participating in home and community-based/DD programs will reach 158,000 this year (about 10 percent more than the number of persons served in ICFs/MR, large or small, public or private).

³ In the HCB waiver program, potential participants must be afforded a choice between community services and institutional placement. Institutional services remain a state plan "entitlement" even though HCB waiver services operate under utilization and spending caps. While states employ "certificate of need" and similar devices to control institutional bed capacity, it remains difficult for them to directly manage the supply of such beds or admissions into such facilities. If, for example, a state narrows its institutional admission criteria, it finds that eligibility for HCB waiver services must be narrowed concurrently.

there are wide differences in provider costs/charges and service delivery practices. In developmental disabilities systems, for example, it is not uncommon to find provider agencies being paid substantially different rates for roughly comparable group home services. Recipients with apparently comparable characteristics receive different mixes of services. In light of these and other factors, service systems often appear to be "unmanaged".

Broad brush, long-term care/support systems appear "ripe" for managed care. Spending has been growing at a double-digit pace. There is an apparent overallocation of system resources to costly "inpatient settings" (i.e., institutions), even though "outpatient" services (e.g., community supports) are less costly and possibly just as efficacious. Current provider reimbursement practices seem inefficient and service delivery practices inconsistent. As in the realm of managed health care, it also seems clear that long-term care services could be delivered more efficiently if states were able to obtain waivers of certain federal requirements.

On the other side of the coin, there are significant potential mismatches between managed health care models and long-term supports/services. These include:

- **There are virtually no private sector and very few public sector long-term care antecedents upon which a state might base a managed long-term care plan.**

Managed care is rapidly gaining accendency in Medicaid acute care services because the private sector blazed the trail, thereby not only spawning a "managed care industry" but also accumulating experiences that could be applied in developing public sector counterparts. This has not occurred to any significant degree in the long-term care services arena. Experience with private sector managed long-term care by and large remains fairly "short-term" by public sector standards.⁴ Since employers only rarely have offered long-term care insurance, the private sector does not have large payers to whom to market "long term care products".⁵ Individual consumers are the largest purchasers of long-term care. However, due to the expense of long-term care services, many such individuals ultimately obtain services through public programs. Public programs (Medicaid in particular) are the dominant purchasers of long-term care services. In developmental disabilities, public financing is particularly pronounced. This absence of antecedents is important since there is no developed industry that can be employed and little private sector experience upon which to rely.⁶

⁴ For example, "subacute" care, nursing home care, and home health services are tied to hospital stays and are medically oriented.

⁵ However, it is useful to point out that CALPERS (California's public employee retirement system) is in the process of adding long-term care to its retiree benefit package. CALPERS has a very large membership base. While the benefit it is offering is relatively restricted, it will be offered under a managed care approach.

⁶ The importance of antecedents is further illustrated by the application of managed care to publicly-funded mental health services. Managed mental health care found a market in the private sector because corporations and private insurance plans covered mental health benefits (usually as a result of state

- **Secondly, many states already have in place system controls that contain spending for long-term care services.** Spending for many types of services is controlled through a state's appropriations process. Spending for HCB waiver services is controlled via limits on state matching funds and participant caps. Certificate of need processes -- however clumsy -- are used to control the supply of institutional beds. Developmental disabilities systems typically are "slot managed" and, at least historically, have been less vulnerable to entitlement-driven cost increases. Though far from perfect, these control systems are embedded in cost-contained systems.⁷
- **Third, some features of managed care already exist in long-term care service/support systems.** Community care case management systems have been in place in many states for a number of years. Many are organized as "single-point-of-entry", "gatekeeper" models. Frequently, very costly service settings are subject to tight utilization controls (e.g., admissions to high cost public facilities for persons with developmental disabilities frequently require multiple approvals). Developmental disabilities service systems already are managed in most states to emphasize community services and supports.⁸
- **Fourth, there is by no means fundamental agreement concerning the practice standards and care criteria under which long-term care/support systems should operate.** Managed health care is anchored by sanctioned practice standards, care and medical necessity criteria. A particular illness or condition prompts relatively clearly understood care/treatment responses by health care professionals. While these standards and criteria are not rigid and continue to change, they nonetheless define how the health care system responds to individual needs. In many long-term support systems, there are competing standards and criteria. Many "models" co-exist. In the absence of an agreement concerning practice standards and care criteria, it is virtually impossible to adapt conventional managed health care models, where care criteria define plan obligations, to the provision of long-term supports.

insurance laws that direct plans to offer at least minimum coverage). States are contracting for managed mental health services with many of the same MCOs that were created initially to serve the private sector market.

⁷ One of the most important imperfections lies in the institutional rate setting arena as a result of various interpretations by the courts of the so-called Boren Amendment provisions of Title XIX. These interpretations have had the effect of limiting state discretion in institutional rate setting. Under Congressional proposals to restructure Medicaid, however, the Boren amendment would be repealed.

⁸ Over the past several years, the number of individuals served in large publicly-operated facilities has declined at a steady rate of 4-5 percent a year. These facilities typically are the most costly service sector to operate. In the majority of states, overall ICF/MR utilization has declined; nationwide, ICF/MR utilization also appears to be dropping. States have expanded their Medicaid home and community-based waiver programs at a very rapid pace over the past five years.

- **Fifth, there are significant problems in attempting to project service demand and, hence, resource utilization in long-term care systems.** Individuals with similar characteristics may have different service consumption patterns. Service consumption patterns also are strongly influenced by the mix of available services. In addition, consumption patterns are affected by a host of factors that are very difficult to quantify, including the breadth and depth of individual support systems. In many systems, demand has been suppressed or only partly satisfied which makes it very difficult to project consumption patterns. The net effect of these considerations is to enormously complicate plan design, the selection of covered benefits, and, ultimately, the establishment of capitated payment rates. This contrasts to health care where consumption patterns (and, therefore, costs) are relatively predictable.
- **Sixth, long-term community support systems interweave paid, natural, and community supports in very complex ways.** While health care is by no means a simple enterprise, it principally revolves around care delivery transactions where needed services are delivered and payments rendered. In long-term community support systems, there are other factors at play: the willingness and availability of family members and friends to help affects costs but cannot be readily controlled by a managed care organization. The availability and accessibility of other community resources also needs to be factored in to the equation. Managing the "paid system" is only one piece of the support providing equation.

"The key choices for most persons with developmental disabilities are about getting a life, not about a kidney stone, sore throat or heart murmur."

John Ashbaugh
Human Services Research Institute

- **Seventh, supports are only partially clinical in nature; thus, clinically-defined managed care approaches do not align well with the support delivery process.** While it is true that for some people with chronic disabilities clinical considerations can be overriding, for most individuals they are but one of many components in a broader support strategy. For people with developmental disabilities, such strategies weave together housing, work, participation in community activities and related areas of community living. Nearly all extant managed care models are clinically based: they revolve around health care treatment.
- **Eighth, most managed health care plans incorporate features that limit the latitude of enrollees to select providers; by contrast, support systems usually place a high value on giving consumers latitude in the provider selection process.** A key feature of managed health care is controlling the supplier network. Managed care plans typically operate on a "closed panel" basis in order to control costs. In support systems, giving the consumer the ability to choose among a wide range of qualified providers is regarded as important, both as a fundamental "right" but also because it contributes to achieving support system outcomes. In supports

systems, achieving a favorable match between the consumer and the provider is a key ingredient in making sure that the goals of the support strategy will be achieved.

- **Ninth, long term support systems often have too few suppliers and, hence, may not yield the same degree of savings that have occurred in managed health care.** Managed health care savings stem in part from the fact that the health care marketplace is highly competitive and has excess supply. In community support systems, frequently the opposite is true. This raises questions concerning the extent to which managed care can wring savings out of support system suppliers.
- **Finally, there are very deep concerns about conceding decisionmaking to a managed care organization when such decisions have major life consequences for consumers who need supports.** Decisions about what supports are offered under particular circumstances affect entire dimensions of an individual's life. For example, a care criterion that dictates that individuals who require a particular level of support be cared for in a congregate care facility has enormous implications for that individual and his or her life choices. While such a care criterion may be beneficial to a managed care organization (by holding down costs), it would have serious lifestyle consequences for the individual. In health care, clinical practice standards form the basis for such criteria; they arbitrate questions regarding the course of treatment which is likely to be most efficacious. Health care professionals have standing in making decisions regarding the treatment of illness. Supports, however, are multi-dimensional and, due to their effects on a person's lifestyle, cannot and should not be arbitrated purely on "clinical" grounds or economic considerations. Indeed, the evolution of support systems is one marked by the transition from "treatment-based" systems to social and personal support models.

Thus, there are a number of reasons to be skeptical about the adaptability of managed health care models to long term support systems. Support systems are not clinically-based; nor are they closed systems that are easily managed. The community is inherently "messy". Supports are less susceptible to management by defining condition-based care criteria. The emphasis increasingly has shifted to the use of "personalized support strategies", which are premised on a mutuality of interests and shared decisionmaking between the consumer and the service system. Helping people to "get a life" is decidedly different than treating a cold.

However, it is too facile to simply reject managed care as "irrelevant". Long-term care systems do face many of the same problems that stimulated the emergence of managed health care. While there are parallels between the way in which long term care systems are structured and some components of managed health care, many of these parallels are superficial. Today's long-term care systems grew up around federal Medicaid policies that few observers believe permit managing dollars to the best benefit of consumers. These systems are populated by program models that have not been reconciled with system mission statements. Even though supports are not clinically-centered, long term support systems do buy clinical services and these services

are susceptible to managed care strategies. For some individuals, clinical considerations are dominant. Finally, support systems are entering an era when there will be a large premium on systems being more tightly managed.

Thus, while it makes little sense to import managed health care models on a wholesale basis into long-term support systems, managed care should be examined from the perspective of whether particular strategies and approaches might improve the productivity, cost-effectiveness and efficacy of long term support systems. The question is improperly framed if it is posed as: managed care or unmanaged care? Instead, it is better understood as "What would managed long-term supports systems look like?" This is the focus of Part II of the **Guidebook**.

In the remainder of this chapter, we examine several initial examples of how managed care approaches (sometimes loosely defined) are being employed in the long-term care arena. These approaches help us to understand the various dimensions of applying managed care principles to the delivery of long-term care/supports.

S/HMOs & Integrated Services Models: Managed Health and Long Term Care for Elderly Individuals

There are several programs/projects in operation around the country that employ a managed care approach that features the integration of health and long-term care services. Until recently, this integrated care model has been used mostly (but not exclusively) to serve "frail, elderly individuals". However, recently HCFA approved a Section 1115 demonstration waiver submitted by the State of Minnesota which would apply an integrated care model across a broader spectrum of individuals who are elderly.

S/HMOs and other integrated services models use managed care to furnish principally health care services to individuals who also require supplementary in-home care in order to avoid institutionalization. These models generally have targeted frail elderly individuals.

Generally (but not universally), the premise of these integrated care projects is that, with certain populations, if serious, complex health conditions are not treated on a continuous, focused basis, they can lead to premature institutionalization (hospitalization or a nursing facility placement) but treatment alone is insufficient to address satisfactorily all the problems associated with such conditions. With the frail elderly population, for example, health care is a paramount issue. However, if such individuals are to remain in their homes and communities, health care services must be supplemented with other in-home services. Care coordination is enormously important with these populations. In addition, managed care arrangements can reduce expenditures by avoiding cost shifting among multiple payors (e.g., Medicaid, Medicare, and private insurers).

These integrated services programs sometimes are referred to as "social/health maintenance organizations" (S/HMOs). More precisely, S/HMOs are one approach to integrated managed care services. Examples of such programs include:

- **The Program for All-Inclusive Care for the Elderly (PACE).** The PACE demonstration is a "fully integrated model that incorporates all acute and long term care services available through Medicare and Medicaid under full provider financial risk. Enrollment is limited to the frail elderly who are either dually entitled [to Medicaid and Medicare] or have the financial resources to pay a premium equal to the Medicaid capitation rate".⁹ The dollars used to make capitated payments to MCOs under such projects include Medicare capitation payments, state Medicaid dollars, and participants' own Medicare premiums. Participants receive the Medicare HMO-benefit package and, as needed, nursing facility/community care services. Presently there are nine PACE demonstration sites in operation across the country (including On Lok in San Francisco). The Robert Wood Johnson Foundation has earmarked grant dollars to determine whether a "PACE-like model can be tailored to meet the service and financing needs of various non-elderly disabled groups."¹⁰ These frail elderly demonstrations were crafted specifically with the "dual eligible" population in mind. The Medicaid program has far more comprehensive long-term care service coverages than the Medicare program.¹¹ As a consequence, Medicare beneficiaries who need long-term care services frequently can access such coverages only through admission to Medicaid-financed nursing facilities. The PACE projects integrate Medicare and Medicaid funding on a capitated basis to enable the managed care organization to conduct care coordination and arrange for services in a more "seamless" fashion. Both Medicare and Medicaid dollars can be used more flexibly to meet individual needs.
- **Social/Health Maintenance Organizations.** S/HMOs are similar to the PACE demonstrations except that they were designed solely with "single eligible" Medicare recipients in mind. Under this arrangement, "the existing Medicare benefits package available through [Medicare participating] HMOs [is supplemented] with expanded benefits such as prescription drugs and long-term care benefits such as homemaker, transportation and home health services".¹² However, community care benefits are relatively limited. Payments to S/HMOs are made under a pre-paid capitation arrangement that combines Medicare dollars, S/HMO participant premiums, and Medicaid dollars (although these dollars are very limited because very few Medicaid recipients participate in this type of arrangement). There have been four S/HMOs in existence since 1985. HCFA has selected six organizations to participate in a second generation demonstration called S/HMO II which will focus on "refining the

⁹ HCFA Office of Research and Demonstrations, Division of Aging and Disability.

¹⁰ Ibid.

¹¹ Medicare only pays for a limited number of days of "post-hospital" nursing facility services or home health services following hospitalization. Personal care, homemaker, and home health aide services are not covered Medicare benefits.

¹² Ibid.

targeting and financing methodologies and benefit design of a Social HMO, with an emphasis on geriatric care and the expansion of the model to special populations, including the non-elderly disabled, beneficiaries living in rural settings, and those who are dually entitled to Medicare and Medicaid".¹³

LTCOP is the first large scale attempt to apply managed care to fully integrate health and long-term care services for elderly individuals.

- **Minnesota Long-Term Care Option Project.** The Minnesota Long-Term Care Option Project (LTCOP) is a Section 1115 demonstration waiver program design to integrate Medicaid/Medicare funding in order to furnish integrated acute and long-term care services to dual eligibles. Unlike the PACE and S/HMO programs which have been actively sponsored by HCFA as part of the Agency's own program development and research agenda, LTCOP is state-originated. LTCOP was recently approved by HCFA/HHS to go into effect in January, 1996. The development of LTCOP was assisted by a Robert Wood Johnson Foundation grant. The ground work for the proposal was laid through an extensive series of meetings with key stakeholders and pre-proposal collaboration with HCFA.

While LTCOP is similar to the PACE and S/HMO programs, there are important differences. LTCOP is based on the premise that "health services to the elderly should be coordinated across provider type, settings, time, and funding source for maximum cost effectiveness and clinical results".¹⁴ LTCOP targets is inclusive of all dually eligible (Medicare and Medicaid) individuals age 65 or older rather than being restricted solely to the "frail elderly". The objective is to furnish all these individuals with "seamless" access to health and long-term care services.

Dual eligibles would have the choice of enrolling in LTCOP or enrolling with a managed health care-only plan under the State's Prepaid Medical Assistance Plan (PMAP). Integrated service networks (ISNs), community integrated service networks (CISNs; smaller ISNs) and HMOs would be selected to serve as LTCOP MCOs. C/ISNs are "provider networks responsible for providing or arranging for the full range of acute and preventive care to a defined enrollee population for a pre-determined, capitated premium ... C/ISNs may be formed by health maintenance organizations, insurers, hospitals, providers, local government, purchasers, or by some combination of those entities".¹⁵ C/ISNs are not peculiar to LTCOP; instead they are generic MCOs that are being formed under the State's broader health care reform initiatives.

Capitated payments to LTCOP plans will be composed of: (a) Medicare Part A and B dollars capitated at 95 percent of beneficiary fee-for-service costs; (b) an

¹³ Ibid.

¹⁴ "Updated Summary: Long Term Care Options Project", Minnesota Department of Human Services (April, 1995).

¹⁵ Ibid.

adjustment for those beneficiaries who qualify for nursing facility care; (c) the Medicaid FMAP rate; and, (d) an actuarially determined capitated allowance for community care services furnished under Minnesota's elderly waiver or in nursing facilities. Capitation rates are to be "risk adjusted" based on the recipient's status (current nursing facility residents, people leaving nursing homes, individuals who are eligible for nursing facility placement but live in the community, and other community-based recipients). These rates also will be refined further to break them down by age, sex, county or geographic area. LTCOP will operate as a "full risk" managed care plan.

LTCOP C/ISNs will be responsible for managing the full range of health care, community care and nursing facility services. Within LTCOP, individuals will still be required to meet the State's present Preadmission Screening Criteria in order to receive community care services (i.e., elderly waiver services) or be admitted to a nursing facility. LTCOP C/ISNs may contract with existing long-term care providers to furnish services or obtain them from alternative sources. Case management responsibilities for services will shift from county human services agencies to C/ISNs.

The decision to structure LTCOP around C/ISNs stems principally from the fact that, from an overall cost perspective, health care spending accounts for a far greater share of total expenditures on behalf of this population than spending for long-term care services.¹⁶ Consequently, C/ISNs were regarded as most likely to be willing to enter into a risk-sharing arrangement. Under LTCOP, C/ISNs are not mandated to contract with existing long-term care providers. State officials note that the "task for long term care providers will be to position themselves to offer services which can substitute for acute care services and/or provide the expertise and resources needed to meet the needs of managed care organizations as they expand the services covered in their capitations in response to purchasers such as state and federal governments or retirement plans. Long term care providers including local government agencies providing or managing home and community based services will need to decide what their role should be in this evolving system. They may want to provide their services as contractors, or to explore various partnerships, including those based on shared risk."¹⁷

LTCOP is the first large scale application of full-risk capitation across the entire spectrum of health and long term care services for dually eligible elderly individuals. It is designed to serve a central programmatic goal: "seamless" integration of health

¹⁶ In the case of dually eligible recipients, a state pays the Medicare beneficiary's premiums, co-pays and deductibles but Medicare pays for the bulk of health care expenses through Parts A and B of the program. Medicaid also pays for benefits covered under the Medicaid state plan which are not covered by Medicare (e.g., prescription drugs and non-hospitalization related long-term care services). When considered from a total cost standpoint, combined Medicaid and Medicare health care outlays are far larger for the entire group than long-term care outlays (even though such outlays loom very large in state Medicaid budgets).

¹⁷ DHS, *op. cit.*

and long-term care services for the target population. The demonstration uses full-risk capitation as a primary cost containment measure. It is designed to share savings between the state and the federal government. However, LTCOP integrates services through the primary health care system by capitating costs through MCOs, where physicians will have primary decisionmaking authority. This approach is driven by considerations associated with the target population. In the case of other long-term care target populations, generally long-term care costs dominate health costs, suggesting that integration should occur through the long-term term care rather than acute care system.¹⁸

Integrated service models have emerged for elderly individuals for several reasons. While their principal focus is health care (a critical area for the elderly), they also serve legitimate programmatic ends in the arena of long-term supports for this population. However, it is important to keep in mind that these models also are designed to resolve the problems that emerge for this population in light of their dual eligibility status. Medicare and Medicaid coverages and rules differ, making it particularly difficult to synchronize the provision of care and avoid cost-shifting between the programs.

To date, these integrated service programs/models are the only operational examples of managed long-term care services. As noted above, there is interest in applying this model to other long-term care populations, including "special needs" populations. By and large, however, these models are tailored primarily to meeting the health care needs of individuals, with long-term care services playing a secondary, complementary (albeit still important) role in fashioning strategies to support individuals in their homes and communities.

In developmental disabilities, the application of managed care to the delivery of long-term services and supports is only in its initial stages.

Developmental Disabilities: Initial Explorations

Strictly speaking, there are no operational examples of full-blown managed care systems for developmental disabilities services at the moment. While many developmental disabilities service systems incorporate various managed care strategies (e.g., case management "gatekeeping"), none of them have contracted on a risk basis as yet with a managed care organization to assume responsibility for the delivery of comprehensive services and supports a defined population of such individuals. One state (Arizona) operates a Section 1115 demonstration program that includes long-term care and supports for people with developmental disabilities. Other states have submitted Medicaid waiver proposals to HCFA that would shift their service systems to managed care, sometimes in tandem with the state's mental health service system. Still others are weighing the pros

¹⁸ For example, in the case of HCB waiver programs for people with developmental disabilities, the average annual cost of waiver services and supports is roughly \$27,000/year, while health care costs generally fall in the range of \$1,500-\$3,000/year.

and cons of employing managed care to restructure their developmental disabilities service delivery systems.

In the remainder of this chapter, we will summarize these initial state efforts to link the technology of managed care to developmental disabilities services. In most instances, these summaries are supplemented with more detailed descriptions of state-specific initiatives in the appendices to the **Guidebook**.

ARIZONA LONG TERM CARE SYSTEM

Since 1989, Arizona has received federal Medicaid dollars for developmental disabilities services under the umbrella of the State's Section 1115 demonstration waiver program. The Arizona Long Term Care System (ALTCS) remains the only example of a state's operating its entire Medicaid-financed long-term care system under such a demonstration. Arizona's program is described in greater detail in Appendix E.

Often cited as a prototype for the application of managed care to long-term care services, the ALTCS program (at least with respect to developmental disabilities services) is probably best understood as an approach which relies on front-end eligibility determination as a caseload control device and prior authorization by "gatekeeping" case managers as a utilization control mechanism to contain costs, rather than as a full-fledged managed care system. At a practical level, however, Arizona's developmental disabilities system operates in a manner similar to the DD service systems in other states, including the use of categorical payment mechanisms. ALTCS has enabled Arizona to establish a unified approach to the management of its DD community-based service system.

TENNESSEE: PROPOSED TENNCARE MR SYSTEM

In April, 1995, Tennessee officials submitted a first-cut proposed amendment to the State's Section 1115 TENNCARE "superwaiver" that would have folded long-term services and supports for people with mental retardation into the State's Medicaid managed care system. State officials proposed that this amendment take effect on January 1, 1996. In August, 1995, the proposal was withdrawn in order to permit HCFA to concentrate on reviewing other proposed changes in TENNCARE. While the future prospects for this proposal resurfacing are unclear (particularly in light of the momentous revisions to the Medicaid program that Congress is considering), it warrants discussion because it illustrates one approach to structuring the delivery of long-term care services for people with developmental disabilities. The Tennessee proposal is profiled more fully in Appendix F.

While the proposal submitted by Tennessee was not fully developed, it outlined a system with the following features:

- The State proposed to enter into an exclusive MCO contract (i.e., it would contract with a single for-profit entity). The MCO would have received capitated payments

(see below) with which to purchase services/supports through its contracted provider network. However, the service coordination/support plan development functions would have been performed by independent service coordination agencies. Consequently, the proposed MCO would have functioned somewhat like a **Third Party Administrator/Administrative Services Organization (ASO)** by arranging and paying for services/supports specified by the support coordination network. "Care coordination" (and, thus, utilization management) would not have been a direct MCO responsibility.

- However, the proposal specified that the MCO would assume financial risk. Since the MCO would be at risk but not perform utilization management, its primary risk management tool would have been managing the supplier network through payment negotiations and, potentially, shifting some of the risk to that network. In addition, while the MCO was portrayed as the "implementor" of the individual support plan (ISP), the proposal also provided that the MCO could dispute the ISP, thereby giving the MCO standing in questioning the cost-effectiveness of a person's plan. Conflicts between the MCO and service coordination agencies would have been resolved through mediation in order to ensure that economic interests would not override programmatic objectives.

The construction of the proposal dictated that the MCO, rather than the service coordination entity, would assume the financial risk. Since the MCO would control 97 percent of the dollars in the system, manage payments, and contract for the supplier network, service coordination entities could not be placed at risk.

- The proposal would have configured capitation payments to the MCO in the form of "clustered monthly rates" based on enrollee characteristics. This is a form of "risk adjusted" capitation. When the proposal was submitted, however, the methodology for developing these rates had not been worked out. Service coordination entities would be responsible for conducting assessments and evaluations that would result in individuals being categorized by cluster group. While these rates would form the basis of capitation to the MCO, they were not portrayed as limitations on the amount of services that a particular individual might receive.
- The proposal would have fully wrapped around Tennessee's mental retardation service system, including its state-operated developmental centers. The proposal anticipated that Tennessee would no longer offer ICF/MR services but instead operate its developmental centers under alternative standards while shifting privately-operated ICFs/MR to generic residential services regulations. The ICF/MR-related waivers requested by Tennessee were unprecedented and, hence, probably would have faced intense scrutiny by HCFA.
- Under the demonstration, Tennessee proposed to operate its program under an enrollment cap. Such enrollment caps, of course, are a common feature of Section 1915(c) home and community-based services waiver programs. Tennessee

operates its TENNCARE managed health care program under such a cap; however, that cap is structured so that the State has discretion to halt the enrollment of individuals who otherwise would not be eligible for Medicaid if additional enrollments exceed its overall spending limits. It is uncertain whether HCFA would permit Tennessee to operate this component of TENNCARE under a similar cap.

- The proposal would have given the Tennessee Department of Mental Health and Mental Retardation several roles in the arena of quality assurance/quality enhancement. However, the Department would have had a much reduced role in terms of direct management of the State's community services network.
- The proposal would have created a consumer board with system oversight responsibilities.

Tennessee's proposal would have combined an exclusive, comprehensive MCO arrangement with the safeguards potentially afforded by an independent service coordination system. This approach placed a high premium on tight controls over the supplier network and payment rates exercised by the MCO in order to achieve cost-containment objectives. Conceptually, the State's proposal also was heavily premised on consumer service plans staying within the boundaries of the clustered capitation payments. To the extent that plans pushed costs above these boundaries, the MCO would have to challenge plans in order to contain costs. From a practical standpoint, it is difficult to see how this sort of arrangement would work without imposing some type of limitation on the latitude of service coordination agencies in developing ISPs since these agencies would not have been at risk. In other words, absent some set of overriding controls, the feasibility of the proposed arrangement is open to question. At the same time, it is important to point out that Tennessee's proposal was a "first cut" and, hence, probably would have undergone significant changes.

WEST VIRGINIA: PROPOSED BEHAVIORAL HEALTH SYSTEM

In March, 1995, West Virginia officials submitted a Section 1915(b)(4) "freedom of choice" waiver request to HCFA in order to replace categorical Medicaid funding of various mental health, substance abuse and developmental disabilities services with a managed care system. Under the State's proposal, a single, statewide MCO would receive capitated payments in exchange for furnishing "behavioral health" services to all eligible Medicaid recipients. While other states have gained HCFA's approval to operate their mental health systems under this type of arrangement, this is the first instance in which a state has proposed wrapping together mental health and developmental disabilities services under a unified managed care approach. West Virginia's proposal is described in greater detail in Appendix G.

The West Virginia plan shares some similarities with the Tennessee Section 1115 demonstration proposal, but there are important differences as well:

- West Virginia elected to use the Section 1915(b)(4) authority instead of the Section 1115 demonstration waiver avenue. Unlike Tennessee, West Virginia did not propose to limit the number of individuals who could receive behavioral services; nor did it seek waivers of ICF/MR regulations.
- West Virginia's proposal is unprecedented in the sense that it would span all "behavioral health services", including service for people with developmental disabilities, people who are mentally ill, and substance abuse services. The proposal is unclear regarding the extent to which these services would be integrated or whether they would operate as subsystems within a larger system.
- Like Tennessee, West Virginia proposes to create an exclusive MCO arrangement. However, unlike Tennessee, the West Virginia MCO would have both care coordination and utilization management responsibilities.
- West Virginia proposes to use a Medicaid population-wide capitation methodology while Tennessee would use a target population-specific capitation methodology. The Tennessee proposal would regulate the number of enrollees while the West Virginia proposal does not; this difference influenced each state's selection of a capitation methodology. Since the West Virginia proposal does not include a limitation on the number of Medicaid recipients who may receive services that the MCO is obligated to deliver, it raises questions regarding the projection of service demand. Such questions are difficult to answer in terms of developmental disabilities services. However, the proposal does not request a waiver of the need for institutional services test. This presumably means that admission to an ICF/MR would still require a level of care determination; Tennessee requested a waiver of this requirement.
- The West Virginia proposal indicates that the State and the MCO would negotiate "care criteria" after the MCO is selected. This raises several questions, principally with regard to the MCO's obligations in furnishing services.
- Finally, in developmental disabilities services, the fiscal viability of the proposal hinges on reduced ICF/MR utilization. Since West Virginia already plans to close Colin Anderson Center, the State's only large public ICF/MR by 1996, future ICF/MR utilization reductions would need to be achieved in the private ICF/MR sector. The proposal relies on the availability of other options to draw individuals out of ICFs/MR or managing admissions to divert individuals from placement. The Tennessee proposal would have ended ICF/MR services.

In many respects, West Virginia's proposal is an attempt to adapt the general framework that other states have employed in placing their mental health systems under managed care to wrap around a broader range of services. Key differences between the delivery of mental health and developmental disabilities services raise questions concerning the

potential advantages of operating a "seamless" behavioral health system, including whether the needs of one population group might overwhelm the needs of the other.

THE GEORGIA BEHAVIORAL HEALTH PLAN

In August, 1995, Georgia officials submitted to HCFA an interwoven package of waiver requests intended to pave the way for the State to employ managed care approaches in the delivery of mental health, substance abuse, and mental retardation services. The package was composed of a Section 1115 demonstration waiver request that would alter the delivery of mental health/substance abuse services and a Section 1915(b) freedom-of-choice waiver request that would apply to Medicaid-reimbursable mental retardation services. The State also submitted an amendment to its HCB waiver program for persons with mental retardation in order to expand the scope of the existing program, modify its service coverages and make various changes in the manner in which the program is operated. These requests were designed to promote a more integrated, decentralized system of services in Georgia. Georgia's requests are described in greater detail in Appendix H.

As in the case of West Virginia, the Georgia Behavioral Health Plan is based on achieving a "seamless", integrated mental health, substance abuse, and mental retardation (MH/SA/MR) service delivery system. However, the Georgia plan departs from the West Virginia approach in several respects. These include:

- The State's network of non-profit Regional Boards would be responsible for establishing local policy directions. Georgia created these boards in 1992 in order to decentralize the management of its MH/MR/SA system. The waiver requests would permit the State to channel behavioral health dollars to these boards. On the other hand, West Virginia's proposal would not have relied on local, substate agencies. Instead, an MCO would be authorized to manage service delivery on a statewide basis.
- Under Georgia's approach, Third Party Administrators (TPAs) would act as the policy implementation arms of the Regional Boards, which would have policy-making responsibilities. Regional Boards would select a TPA (from a list of two or more eligible entities) to manage payments, provider agency selection, and utilization management activities. The TPAs would bring their management expertise to the table and, hence, relieve the nineteen Regional Boards from having to develop such expertise from the ground up¹⁹.

¹⁹ Generally, Georgia's existing Regional Boards have not developed the capabilities needed to manage a provider network, make payments, or conduct utilization management. In some respects, the Georgia Behavioral Health Plan is designed to enable the boards to outsource these capabilities to private sector firms. For example, existing for-profit TPAs would be able to supply functional payment and date processing systems that the Regional Boards presently lack.

- Georgia's proposal envisioned a shared risk arrangement between each Regional Board and the TPA it selects. Such an arrangement would mean that the TPA and the Regional Board would have to collaborate in system management.
- Under Georgia's plan, service agencies would act as the point of entry into the service system. In West Virginia, the MCO would be expected to play this role.
- Georgia stopped short of placing mental retardation services under a capitated, managed care arrangement. The State's proposal acknowledged that determining an appropriate capitation rate would necessitate additional analysis.

CHOICES departs from conventional managed care technology by featuring "consumer managed care" as its central strategy.

The Georgia Behavioral Health Plan, then, seeks to combine a decentralized approach to system management and policymaking with managed care and the use of private-sector TPAs in order to contain the growth in systemwide costs.

THE RHODE ISLAND CHOICES PROPOSAL

In March, 1994, Rhode Island submitted to HCFA a Section 1115 demonstration waiver proposal -- entitled CHOICES -- that was aimed at substantially restructuring its service system for adults with developmental disabilities. The CHOICES proposal departed from conventional managed care approaches by featuring "consumer managed care" as its central strategy. [N.B., "Consumer managed care" is discussed in more detail in Part II.] Appendix I contains a detailed profile of the CHOICES proposal. Readers unfamiliar with the proposal should review this profile.

For present purposes, CHOICES is discussed from the perspective of how it differs from other approaches; in addition, some of its key features were highlighted. In particular:

- As is the case with the Arizona's ALTCS/DD as well as the Tennessee and West Virginia proposals, CHOICES seeks to use the Medicaid waiver authority to decategorize Medicaid funding for specialized developmental disabilities services. One of the key premises of CHOICES is that the categorical regulations associated with various Medicaid funding streams create inherent inefficiencies in program management and subvert the State's ability to achieve desired outcomes for people with developmental disabilities. Decategorization, the drafters of the proposal argue, would permit "*single-stream*" funding under a unified set of program regulations, consumer support planning methods, and quality assurance/enhancement strategies.

- Second, unlike West Virginia, but like the Arizona ALTCS/DD program, a public agency would serve as the "MCO" in Rhode Island. The State would not employ a private sector entity to manage its system.
- Third, in lieu of using conventional utilization management techniques to contain costs, the State proposes an entirely different model. People with developmental disabilities would have the option of self-directing their care, including making decisions concerning the amount of various kinds of services to purchase and from which provider(s). The State proposes to assign capitated dollars among primary consumers and families. The State's cost-containment strategy is a "market competition" model driven by customer demand. Under this model, large provider agencies would compete for business based on price, quality, and responsiveness to customer demands. These providers would act as well as *de facto* MCOs, providing care coordination/network management in response to consumer demand. Individuals would seek to maximize the value of the service dollars available to pay for their services/supports by shopping for what they need and using natural/other community supports in order to conserve service dollars.

Since individuals and families would be able to use dollars flexibly, the model is expected to reduce costs by enabling consumers to tailor supports to their particular needs and circumstances, thereby increasing the value of the service dollar. The proposal would permit an individual to broker his or her own services; ask others to assist; access professional service brokers to perform this function; or, permit the system to broker services on his or her behalf. On the provider side, the model is expected to spark both innovation and continuous quality improvement in response to market forces. In this respect, Rhode Island's proposal departs from conventional managed care models by not relying on utilization management furnished by the "system" and instead depending on primary and secondary consumers to direct their supports. *As a result, the Rhode Island proposal is more firmly planted in a "social supports" framework than other managed care plans which place a high premium on "care management" and "utilization management" with their attendant clinical overlays.*

- Rhode Island's proposal is influenced by the nature of the State's current developmental disabilities service delivery system. Historically, the State's DD system has been generously funded in comparison to similar systems in other states; also Rhode Island has almost an incidental waiting list for services. This gives State officials confidence in proceeding with a proposal that does not necessitate an enrollment cap nor pose the likelihood that costs would increase as a result of greater flexibility.
- Rhode Island's proposal also contains provision for CHOICES participants to obtain health care services through a specialized managed health care plan. The proposal also would require employees of service provider agencies to enroll in this plan in order to increase its market size (and thereby give the plan more market "clout") as

well as to enable individuals with disabilities to participate in a managed health care plan that also is being used by individuals without disabilities.

Many observers regard Rhode Island's CHOICES proposal as an exciting departure from conventional managed care approaches. More broadly, the proposal is based on a systems change strategy which has potentially powerful implications.

At the same time, as State officials are quick to admit, translating the key principles and concepts upon which the CHOICES proposal is based into operational terms is a daunting task. At this writing, there are various dimensions of CHOICES that remain to be finalized. One of the central problem areas lies in the arena of individual capitation. When CHOICES was originally proposed, State officials expected to assign fixed amounts of dollars to individuals based on a seven-tier capitation system. HCFA challenged the validity of this approach. Rhode Island officials changed their proposal to set individual capitation at current expenditure levels, conduct additional research and then use a tiered approach to assign capitation limits to new system entrants. HCFA has questioned this approach by pointing out that it might discriminate against new entrants or result in some current recipients having lower resource levels than new entrants. In addition, the individual capitation approach raises questions regarding the availability of services when the individual has exhausted his or her capitation. These capitation issues are very thorny. On the one hand, capitation is necessary if the system is to operate in a predictable fashion and individuals are to shoulder more responsibility for managing their own supports. On the other hand, it is difficult to devise a capitation approach of this type while avoiding the problems that HCFA has raised.

It is useful to point out that conventional managed care plans capitate to an MCO which then manages the dollars across the entire spectrum of enrollees. The risk of capitation is mitigated by serving a large number of enrollees where disparate utilization patterns cancel one another out. Capitation at the individual level means that the individual rather than a large scale MCO bears the risk. From an individual perspective, risk arises in two ways: (a) if the person fails to manage the capitation well; or, (b) the person requires more services than the capitation will support. These risks are the ones that HCFA and Rhode Island have grappled over in an effort to balance the advantages of consumer self-direction versus the ongoing need to ensure that individuals can access needed services and supports.

Since CHOICES breaks entirely new ground, Rhode Island and HCFA officials have engaged in a particularly prolonged series of negotiations and discussions concerning the proposal. HCFA awarded Rhode Island a demonstration grant to assist the state in working out solutions to various problems that HCFA has identified with the plan. At this writing, it remain unclear when all these issues will be resolved. With the Medicaid program slated to undergo major changes, ultimately Rhode Island may be able to proceed with the implementation of CHOICES without having to secure the waivers it requested.

CHOICES stands alone as a relatively well-developed approach to adapting managed care technology to fit contemporary developmental disabilities service delivery principles. It employs capitation as a cost containment tool; however, the capitation methodology emphasizes consumer control. It is designed to spark competition among service providers to hold down costs, improve quality, and create incentives for individuals and families to access natural and community supports.

OTHER STATES

Several other states are beginning to take a serious look at revamping their developmental disabilities systems by employing managed care strategies. States with efforts underway include:

- **Colorado.** In August, 1995, the Colorado Office of Developmental Disabilities Services released its *Proposed Blueprint for Change*. The *Blueprint* outlines a strategy for converting the State's developmental disabilities service system to a managed care approach in order to achieve single-stream funding employing capitated payments. The State's network of local/regional non-profit Community Centered Boards would take on the role of managed care organizations. The *Blueprint* (which is profiled in greater depth in Appendix J) is based on the recognition that the State's DD service system is unlikely to receive additional funding in the foreseeable future and, therefore, must be significantly restructured in order to meet the needs of individuals presently on service waiting lists. A modified version of the proposed *Blueprint* will be considered during the 1996 session of the Colorado General Assembly. While the *Blueprint* will need to be fleshed out considerably, it outlines a managed care system that would be organized around locally-based, non-profit MCOs.
- **New Hampshire.** In September, 1995, New Hampshire officials submitted to HCFA an initial concept paper²⁰ for a Section 1115 research and demonstration program that would replace the State's present Medicaid system. [N.B., New Hampshire had previously submitted a Section 1115 waiver request -- dubbed the "Granite State Health Plan -- which had a more limited scope.] Contained in this concept paper is the proposal to adopt an integrated services model for populations which need long-term care/supports. The concept paper proposes to "integrate the resources needed to meet the complex needs of this population" by serving "the preventative, primary and acute care needs through the Point of Service model ... along with an enhanced, locally designed and managed community based support system and more traditional forms of residential care". In this plan, "the emphasis ... is to utilize greater flexibility in consumer choice in choosing community-based care and to limit the provision of more costly institutional care only to those who are incapable of remaining safely in the community even with home and community based supports. We hope to enhance this flexibility even further by the use of

²⁰ New Hampshire Department of Health and Human Services (September, 1995): Integrated Health Care Systems Concept Paper

community based entities as designers and managers of this integrated long term care system".

The concept paper is based on the assumption that "community-based service networks are best positioned to identify the care needs and preferences within their areas. With their knowledge of local resources, especially informal care networks, they are best able to design effective interventions to address these needs We propose to evaluate whether community-based collaboratives or consortiums can achieve meaningful change in the State service delivery infrastructure which would integrate acute and long-term care in a cost effective manner Our long-term goal will be to merge the multiple elderly and disabled care systems into a consolidated management network or entity having the ability to appropriately manage the full spectrum of acute and long-term care services".

The approach outlined in the concept paper is an adaptation of the "integrated services" or S/HMO model. However, the design places far greater emphasis on employing existing community long-term services and supports networks as the starting point for shifting the system toward an integrated services model than has been the case in other renderings of this approach. The concept paper envisions primary care and localized long-term supports networks working in tandem rather than assigning primary management responsibility to health care managed care entities. In short, existing community services networks would serve as the building blocks of an integrated system. New Hampshire has been awarded a Robert Wood Johnson Foundation grant to assist it in fleshing out the developmental disabilities component of this system. Even if the Medicaid program is replaced by a block grant program, State officials intend to proceed with the development of the approach contained in this concept paper.

- **Texas.** During its 1995 session, the Texas Legislature directed the Department of Mental Health and Mental Retardation to launch pilot programs to test the application of managed care to mental retardation services. Key stakeholders have been meeting in Texas to set up these pilots, potentially in 1996.

Other states with managed care plans under discussion or in development include Washington State, Iowa, Minnesota, and North Carolina. Many observers believe that the imminent capping of the Medicaid program will prompt many more states to seriously explore the application of managed care in developmental disabilities service systems as a cost containment/system change strategy.

Managed Care and Long Term Supports for People with Developmental Disabilities: Status

States have begun to test the waters in the application of managed care approaches to long-term supports for people with developmental disabilities. Various states have taken different directions in applying managed care concepts to the delivery of such

services. There is mounting interest in this topic, particularly in light of the growing prospects that federal Medicaid payments to the states will be capped.

Several observations can be made about these initial explorations:

- Some approaches have been heavily influenced by managed care approaches used in mental health services, particularly in designing systems around large-scale for-profit managed care organizations. In mental health service systems, several states have contracted with such entities in transforming their systems to managed care. There are several private sector companies that regularly compete for state mental health managed care contracts. Some state developmental disabilities system proposals are based on the assumption (however questionable) that the technology these firms have developed in managing mental health care can be readily transferred to long-term support systems for people with developmental disabilities.
- With the exception of the Rhode Island CHOICES proposal, full-blown managed care approaches grounded in the basic ideological framework of developmental disabilities services have yet to emerge. Along these lines, the plans under development in Colorado and New Hampshire appear to offer some promise in crafting relevant strategies that recognize: (a) the central role played by community agencies in supporting people with developmental disabilities (and, hence, the advantages of organizing a managed care plan on a decentralized basis); and, (b) avoiding the pitfalls associated with basing an approach on principally clinical criteria.
- In other Medicaid arenas, one central factor which has driven states to managed care has been the effort to contain the growing costs of entitled programs. In developmental disabilities, where Medicaid waiver "slots" are capped and the supply of ICF/MR beds are more closely regulated, state developmental disabilities service systems are far less vulnerable to cost overruns. As a consequence, consideration of managed care strategies has lagged other Medicaid program sectors. Instead, states have focused on expanding their home and community-based waiver programs, including leveraging additional federal Medicaid dollars to expand their systems. The focus has been on expansion rather than cost containment.
- The absence of operating managed care systems -- either in developmental disabilities or in other long-term care sectors -- also has left states without a "template" upon which to model their own initiatives. In addition, present Medicaid waiver options for embarking on a managed care initiative do not fit very well with the basic structure of developmental disabilities systems. This has been one of the central issues that has affected federal review of the Rhode Island CHOICES proposal.
- Finally, it is evident that launching a managed care initiative in developmental disabilities systems involves far-reaching system changes that necessitate a

fundamental reconsideration of the essential principles under which these systems operate. As a consequence, importing managed care into developmental disabilities systems involves not only the development of the appropriate technologies but also securing agreement among multiple constituencies concerning an entirely new approach to delivering services and supports.

Today, a limited number of states are exploring ways in which managed care might be applied to developmental disabilities service systems. In some cases, consideration has been given to importing available technologies (frequently, from the mental health field). In other instances (Rhode Island, Colorado, and New Hampshire), states are in the process of developing their own approaches to managed systems of long term supports.

The pending Congressional restructuring of the Medicaid program intersects with the growing interest in the application of managed care to developmental disabilities systems. While the details of the pending legislation remain to be worked out, its overall framework is largely known. Certain features of the restructuring will influence the extent to which states decide to pursue managed care strategies more aggressively in the developmental disabilities services arena. In particular, it now appears that:

- The Medicaid program will be terminated in favor of fix sum federal dollars allocations to the states. In developmental disabilities systems, this means that the strategy of continuing to expand services by leveraging or maximizing federal dollars will no longer be available. To cope with the growing demand for services and supports, states may turn to managed care as a tool for improving the operating efficiency of their present systems. In this context, managed care would emerge less as a cost containment devise to hold down spending than as a tool to increase overall system productivity (e.g., attempt to serve more individuals from a fixed pool of dollars).
- At the same time, the impending federal policy changes are likely to remove the current entitlement features of the Medicaid program. Those entitlement features have been a critical driving force in the conversion of state Medicaid programs to managed care. In health care, managed care will loom very large in state strategies to maintain health care services to low income populations in the face of limitations on federal financial participation. In long-term care, however, states may seek to address these limitations by directly regulating the supply of options and controlling prices, both of which, at least in the short run, would satisfy the need to control expenditures.
- Under the Congressional Medicaid restructuring plan, the need for states to seek federal approval of special waiver requests in order to implement managed care approaches would disappear. The plan removes the need for waivers by giving the states nearly *carte blanche* in terms of defining target populations, service benefits, limiting recipient freedom of choice, developing capitation schemes, and so forth.²¹

²¹ The Congressional Medicaid restructuring plan contains minimum requirements concerning state contracts

In developmental disabilities services, this means that many of the issues that states would have had to address in developing either a "program" waiver or a Section 1115 demonstration/waiver request will no longer be a factor in developing managed care approaches. As a consequence, state development of these approaches may accelerate. States will be better able to define their own approaches to managed care based on specific goals and objectives without having to navigate complex federal requirements. While states will have greater freedom to proceed with the design and implementation of managed care initiatives, the removal of the federal policy impediments to such experimentation does not resolve the underlying systemic and technical questions associated with employing managed care in developmental disabilities systems. States will be better able to focus on defining their own approaches but still must resolve thorny design and implementation issues.

The Congressional Medicaid restructuring plan, then, could prompt states to accelerate the development of managed long-term support systems for people with developmental disabilities, particularly in light of the caps on federal payments to the states. The flexibility afforded states to deploy federal dollars under the so-called "Medigrant" block grant approach also will substantially simplify the development and implementation of managed care approaches. At the same time, some states may decide to respond to these policy changes in other ways (for example, accelerating the reduction in their reliance on costly ICFs/MR in favor of stressing home and community-based services). Federal policy changes aside, the extent to which managed care is used in developmental disabilities systems will depend a good deal on the development of technologies that fit those systems better than the technologies that have emerged to date in the health care sector.

Conclusion

What is to be made of managed long-term care/supports? At present, the following appears to be a fair assessment:

- There are possible fits between managed care and long-term support systems. There also are many unanswered questions. Wholesale adaptation of managed health care models is inappropriate. The adaptation process will need to come to grips with the central differences in the delivery of health care and long-term supports.
- To date, the principal operational examples of the use of managed care in the long-term care arena lie in projects and demonstrations serving individuals who are elderly. These projects employ integrated services approaches. Their primary focus is health care and clinical issues.

with "comprehensive" HMO and MCOs. However, these requirements would not apply in the case of a state that is interested in employing managed care in the delivery of long-term care services on a carve out basis.

- In developmental disabilities, there are only limited examples of managed care approaches that have been implemented or even proposed on a systemwide basis. Some of these approaches borrow heavily from other sectors; few have come to grips with the unique features of developmental disabilities systems.
- The policy changes that Congress is likely to adopt will place enormous pressures on the states to improve the cost-effectiveness of their developmental disabilities service systems. States will have greater latitude to explore a variety of managed care approaches independently. States still will need to address many as yet unresolved issues in the development of managed long term support systems.

Despite the concerns and reservations regarding managed care, the fact remains that states face hard times in managing their long-term support systems. The prospects of federal budget cuts demands that states take a serious look at the way in which such service systems are presently managed and how managed care approaches might be employed. It is this topic that occupies our attention in Part II.

PART TWO

FROM THEORY
TO PRACTICE

CHAPTER VI
MANAGED CARE AND
LONG TERM SUPPORTS FOR PEOPLE
WITH DEVELOPMENTAL DISABILITIES:
STRATEGIC ISSUES

VI. Managed Care and Long Term Supports for People With Developmental Disabilities : Strategic Issues

"Managed care is coming". "Managed care won't work". "I don't want my care managed". "Who manages the care?" "Managed care is a rip-off". "Managed care will save us money". "It works elsewhere, why won't it work for your system?" "Get on the managed care train or be run over". "Managed care: right answer, wrong problem".

There is a lot of confusion and latent controversy about managed care and its potential migration into developmental disabilities systems. The managed care "threat" is real. Developmental disabilities systems are enormously reliant on Medicaid; many policymakers believe that managed care is the most likely way to tame runaway program spending. There is the real possibility that systems will be forced to fit into the "managed care mold" even though the fit is imperfect. About nine percent of all state-federal Medicaid spending flows into developmental disabilities systems. On a per capita cost basis, such service systems consume a large amount of resources. This makes them a tempting target for cost containment initiatives. The prospect that Congress will trim Medicaid spending will mean that no systems will be sacrosanct.

Yet, 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 that developmental disabilities systems will face a far different fiscal landscape in the foreseeable future than has been true over the past decade. These systems have expanded at a rapid pace; this expansion has been mainly fueled by federal Medicaid dollars. This altered fiscal landscape has enormous implications for the health and vitality of these systems and even more profound implications for 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.

It is important to be candid about the potential marriage of managed care and long-term supports. This means acknowledging the following:

- **Long-term supports are not the same as health care.** Consequently, organizing

Topics Covered...

- ☒ The Strategic Climate
- ☒ The Case for Managed Care
- ☒ Managed Care and Long-Term Supports: The Question Marks
- ☒ Managed Care: Cautions
- ☒ Planning for Managed Care
- ☒ Guiding Principles and Ethical Issues

long-term support systems in accordance with managed care principles will entail more than importing existing health care technologies. Some elements of system reform may be similar; others may be entirely different. **Developmental disabilities systems will need to find their own way along the managed care path.**

- **Changing how systems are managed has enormous ramifications.** In long-term supports, it would be a serious mistake to assume that managed care merely involves doing the same job a little differently. It does not. A shift to managed care will affect the complex web of interrelationships that define today's developmental disabilities systems. These consequences cannot be ignored; they are at once threatening and promising.
- **There are thorny conflicts between managed care and important values that undergird developmental disabilities systems.** At the heart of these conflicts are individual choice and self-determination on the one hand versus many of the central features of managed care strategies. Resolving these conflicts will not be an easy proposition by any means.

It is important to recognize these fundamental issues, not sweep them aside. Satisfactorily addressing these issues will prove to be challenging.

This part of the **Guidebook** takes a serious look at how managed care might be employed in developmental disabilities systems. We will delve into models and managed care feasibility studies and plans as well as other topics over the next several chapters. Before turning to these details, it is important to discuss some of the key strategic issues that are involved.

The Strategic Climate

State developmental disabilities service systems today command roughly \$20 billion. About \$13.5 billion takes the form of federal-state spending on ICF/MR and home and community-based (HCB) waiver services. State/local DD systems furnish services to an estimated 600,000 to 700,000 individuals with developmental disabilities. Of this population, approximately one-half receive services through the ICF/MR and HCB waiver programs; many more obtain non-health care services (case management, personal care, and so forth) that are financed with Medicaid dollars. Over the past decade or so, DD service systems have been blessed with a relatively healthy rate of growth in funding, made possible in large part by access to Medicaid dollars. The number of individuals receiving ICF/MR and HCB waiver services grew at an annual compounded growth rate of about 9 percent between 1990 and 1995. State-federal Medicaid spending for these services grew at a rate of 10 percent annually. States have been particularly aggressive in employing the HCB waiver program to pay for community services and supports. During the period of 1990-1995, the number of individuals participating in MR/DD home and community-based waiver programs grew at an average annual compounded rate of slightly

over 28 percent; Medicaid outlays for HCB waiver services increased at a rate of nearly 38 percent/year.

The past five years also has seen the continuation of other long-term trends, including the steady decline in the number of individuals served in large public facilities as well as virtually no growth in the overall number of individuals served in public and private ICFs/MR. States have pursued a strategic agenda of focusing new dollars on non-ICF/MR community services. Gradually, the substitution of HCB waiver services for more costly public facility and ICF/MR services has stabilized overall per capita costs. A second agenda also has had significant influence: the changeover of service systems from those based on "program models" to more flexible support models.

Central to both agendas has been the HCB waiver program. The federal regulatory climate under which the waiver program operates underwent significant changes that gave states substantial opportunities to access more federal Medicaid dollars for community services at the same time that they were unable to use those dollars more flexibly. As a consequence, by 1995 more people were receiving services through the HCB waiver program than in more costly ICFs/MR.

In short, the states have been operating in a strategic environment where the use of Medicaid financing (such as "leveraging" or "maximizing" federal revenues) could be employed to fuel system expansion as well as target dollars along lines that complemented other goals (e.g., public facility downsizing and diversifying community supports).

Despite the healthy rate of growth in funding, states typically have struggled to reduce long waiting lists for services. Substantial increases in available dollars and the other changes that states made typically have been insufficient to absorb new demand for services. In many states, growth has added new services/programs to those already in existence. Service systems have changed at the margin rather than being re-engineered. For example, despite sometimes spectacular growth in the number of individuals receiving supported employment services, the number served in sheltered workshop and other day-time facility-based programs changed very little. The expansion of HCB waiver programs has had the effect of diverting demand for ICF/MR services, but, until recently, there has been a minimal effect on the total number of ICF/MR beds in operation nationwide.

Hence, system growth has been directed toward preferred support options but has had less effect on the scope of pre-existing programs. While the strategies that states have pursued yielded growth in the number of individuals receiving publicly-funded supports, states simply have had to run harder in order to keep from falling further behind.

Over the next five years, state developmental disabilities service systems will face a significantly altered fiscal climate. The deficit reduction plan that is under consideration in the 104th Congress is designed to reduce the overall rate of Medicaid growth to one-half or less of projected spending increases. Between 1996 and 2002, Congress is attempting

to hold the growth to roughly 5 percent annually over the next seven years. While the details of this plan have proven contentious, Medicaid as an "open-ended" entitlement is slated to be replaced by fixed-dollar allocations to the states.

In the best of all lights, this means that state DD systems are likely to face a budgetary climate in which there will be little or no growth in either state or federal funds. State officials will not have the latitude to leverage additional federal dollars in order to sustain the relatively high overall rates of growth they have enjoyed in recent years. Moreover, given the wide-ranging cuts in federal domestic assistance that form the core of the Congressional deficit reduction strategy, DD service systems will be unable to count on state dollars to make up for reduced federal Medicaid dollars. Systems will transition from a climate of high growth to flat-funding.

This change in climate has parallels in health care arena and the resulting movement toward managed care. As discussed in Chapter II, the changing economic climate in which the health care system were forced to operate during the late 1980s and early 1990s had a good deal to do with the emergence of managed care. Businesses would not or could not afford to keep footing the health care bill. Managed care was the tool they seized upon in order to keep health care available to their employees while regaining control over the cost of doing business. Managed care, in turn, forced health care suppliers to change the way in which they operated. Developmental disabilities systems are facing much the same dynamic: following a particularly rapid period of growth, they must modify the manner in which they operate in light of a substantially poorer fiscal climate.

Fundamentally, managed health care is an intense effort to squeeze more productivity out of the health care dollar. For developmental disabilities systems, the question is whether managed care can have the same result and, hence, play a key role in keeping service systems healthy and vital in the face of a dramatically altered strategic climate? This is an important question. If the answer is "no", then DD service systems face an uncertain future that likely will see waiting lists continue to grow and quality deteriorate.

The Case for Managed Care

There are various reasons why managed care might promote increased productivity in developmental disabilities systems¹. These include:

- **Today's systems continue to be populated by service models that many (but certainly not all) observers believe to be obsolete and overly expensive.** The most costly of these models -- the ICF/MR -- is more than 20 years old yet continues to command over 45 percent of all system spending while serving fewer

¹ See also Appendix K which provides a perspective on several of the issues revolving around this topic. The Appendix contains a speech by Dennis Harkins, who heads up Wisconsin's Office of Developmental Disabilities Services.

than 25 percent of all individuals. In some respects, the ICF/MR's position in developmental disabilities systems is akin to that of the hospital in health care. Managed care has had a substantial effect on both hospital utilization as well as costs. To the extent that the ICF/MR sector is "over built" -- as some contend -- then closer management of this sector (coupled with regulatory changes) could result in significant savings. Similar arguments can be made concerning other existing DD service models.

- **Current service utilization patterns have been influenced more by the supply of service openings than by the actual needs/preferences of consumers.** A frequent criticism of developmental disabilities service systems is that they employ facility/program-based funding methods that lock dollars into specific models and, hence, skew utilization patterns by forcing the referral of individuals to "available openings" rather than desired supports. For example, a person may not be able to leave a sheltered workshop because there is no opening in a supported employment program. States continually struggle with this problem, a problem that often is exacerbated by legislative budget restrictions and categorical federal programs that can defeat efforts to manage systems as a whole. To the extent that utilization patterns in fact are skewed, then a managed care approach designed to align services/supports with needs/preferences would be likely to yield cost savings.
- **In some respects, DD service systems are overmanaged and, hence, unlikely to be maximally productive.** ICFs/MR, for example, operate under a particularly comprehensive set of regulations that -- according even to facility operators -- frequently add costs but not value. Even though state quality assurance systems are beginning to stress outcomes rather than process, there remains a long road to travel in this regard. Reimbursement systems often are too tightly drawn (in the name of accountability), thereby making it difficult for service agencies to manage flexibly. To the extent that a managed care approach can embrace more flexible system management strategies, it may be possible to mitigate some of these problems.
- **Systems remain wedded to fee-for-service reimbursement methods with all their attendant problems.** Fee-for-service is the stock in trade of developmental disabilities reimbursement systems. Current federal Medicaid policy generally dictates a fee-for-service (unit billing) method. This method leads to budgetary controls that do not always make sense. States frequently superimpose arbitrary utilization controls, cost caps, and other contractual restrictions in order to ensure that spending does not exceed appropriations. These controls can distort service/support pattern. As in health care, fee-for-service methods can encourage overutilization and discourage the substitution of less costly options. Even though there are pitfalls associated with the capitated funding methods employed in conjunction with managed care, they have several potential advantages, including avoiding overutilization, holding down costs and giving provider agencies greater latitude to respond to consumer needs in creative ways. In developmental disabilities service systems (particularly in light of the growing acceptance of the

"support paradigm" as an organizing principle), there is an increasing level of agreement that replacing present categorical fee-for-service funding systems with a single stream approach represents a critical step toward achieving flexibility and, hence, cost-effectiveness. Capitation is a single-stream funding approach.

- **DD service systems are likely to benefit from more focused care and utilization management strategies.** Current systems feature case management but frequently have limited care management capabilities. Costly services are authorized but rarely subjected to review to assess their efficacy. Systems often are not effective in managing supports for individuals who have complex, multi-dimensional needs that require intensive coordination. Utilization management involves matching individual needs with the right mix of services and supports. Often, utilization management in developmental disabilities systems involves placing an individual into an available "slot" or employing make shift strategies to tackle "crisis cases". Systems frequently lack the data needed in order to make sound judgments regarding the efficacy of particular approaches. Consumers and families complain that the "system" does not deliver what they want when they need it. Thus, better "support management" offers the prospect that quality and efficacy can be improved and systems operated more efficiently.
- **Developmental disabilities systems do not encourage partnerships and alliances among service agencies.** One of the most interesting outgrowths of managed care in the health care sector is the impetus it has given to suppliers to seek out partners in order to remain competitive and hold down costs. Alliance building removes duplicative capacities and encourages partners to focus on their strengths. Alliances can cut costs in several areas, including "back office" operations. Developmental disabilities systems encourage service agencies to operate in isolation from one another. Agencies are encouraged to develop "comprehensive" capabilities. Each agency operates its own back office. Resource sharing is discouraged. In part, this phenomenon is the outgrowth of fee-for-service payment systems that encourage agencies to operate in isolation from one another. It also is the result of the way in which systems developed. Fee-for-service structures make it difficult to finance important systemwide capacities such as crisis stabilization and assistive technology centers. Capitation and alternative payment arrangements offer considerable promise in allowing the constructive re-engineering of existing service systems along lines that place a high premium on competitive and competency-based alliances as well as establishing an environment that encourages efficient operations.
- **The federal Medicaid policy changes that Congress is likely to adopt will make it far easier to craft managed care strategies in developmental disabilities systems.** States will be better able to design managed care strategies that fit and build upon their already existing service systems, rather than force such strategies into the mold of the Medicaid waiver options that are presently available. Even though states have been adept at employing these options in a variety of ways, fitting developmental disabilities service systems into these options is difficult. As

discussed in Chapter V, the policy changes that Congress is likely to adopt will present states with major opportunities to pursue managed care approaches that depart from traditional health care service models.

- **Managed care approaches offer the opportunity for state MR/DD authorities to refocus their roles.** Today, state authorities expend the bulk of their energy on managing the service vendor network. State authorities are contractors, regulators, "super" case managers, resource developers, and referees. Despite the exhortation that such authorities "steer not row", many state MR/DD agencies are mired down in the day-to-day business of managing the details of highly complex service systems. An adoption of a managed care approach potentially offers the opportunity for such state authorities to refocus their attention on system performance and how it might be improved. Traditional state functions such as contracting, quality assurance, and bill paying can be assigned to the managed care organization or contracted out to other organizations.

For these and other reasons, operating in a managed care framework does offer developmental disabilities systems important opportunities to restructure service delivery in ways that hold considerable promise of solving some longstanding problems.

At the heart of the case for managed care in long-term support systems is the potential it offers for operating service systems against the bottom-line of quality and value. Current systems are the products of evolution and incrementalism. They have been enormously influenced by federal Medicaid policies that enabled systems to grow but also required that they conform to regulatory and procedural requirements that distorted system development. Managed care offers a possible way of substituting an alternative framework for systems to correct their course using consumer choice as the beacon.

In this context, it is important to recognize that managed care is, in fact, a system change strategy as much as it is a technological change. Managed care requires a commitment that service systems operate under altered rules and relationships. Managed care is not simply doing the same things in a slightly altered fashion. Its potential benefits will only be secured by "walking the managed care walk": constantly seeking quality and value through restructuring at all levels. The managed care framework is dynamic, highly turbulent and threatening. At the same time, it offers opportunities to cut through to the bottom-line: quality and value.

Obviously, many of the problems that a managed care approach might help to resolve can be addressed by other means. States have been steadily restructuring their MR/DD service delivery systems in recent years. High cost service models are being replaced with lower cost alternatives. It is possible to cure some of the ills of fee-for-service payment schemes with alternative approaches to reimbursement. Many of the obstacles to building partnerships and alliances are imagined not substantive. State authorities can (and, in some instances, have) privatized or spun-off some of their functional responsibilities. Clearly, managed care strategies can be adopted without

moving to a full-scale managed care system. However, there are important advantages to be gained from a systemwide approach to managed care that are not possible under more piecemeal approaches.

Managed Care and Long-Term Supports: The Question Marks

However conceptually powerful the case may be for restructuring developmental disabilities systems along managed care lines, the question remains: how can this be accomplished while steering clear of the problems that managed care can pose, thereby avoiding the substitution of one set of problems for another. Earlier, we pointed out that long-term supports are not the same as health care. It follows that managed care in long-term supports cannot be simply a further iteration of health care models. It will have to find its own path.

Along this path, some critical questions will need to be answered. It is important that those questions be put on the table at the outset. In the chapters that follow, we suggest how some of these questions might be answered. Others, however, are best addressed through dialogue among key stakeholders. These questions involve both issues related to the technology of managed care as well as more fundamental questions that revolve around the essential premises under which such systems operate. Both sets of questions are outlined below.

Technology Questions

There are several critical technological questions that must be addressed in operating a long-term support system under a managed care approach:

- **One important question revolves around the issue of how service systems might be capitated.** Capitation lies at the heart of the potential advantages to be gained from the application of managed care to a service system. It enables single stream funding, alters system incentives, and sparks restructuring. However, capitation is wedded to risk management strategies which can influence the provisions of services and supports.

A capitated payment approach establishes a contract between the purchaser and the managed care organization under which the MCO agrees to deliver the services/supports an enrolled consumer requires at a fixed price. Undergirding capitation is the notion that the amount of the payment can be determined in some systematic fashion that ensures that it is sufficient to accommodate consumer needs while concurrently giving the managed care organization incentives to minimize costs. Health care capitation is facilitated by: (a) knowledge about the utilization and cost patterns of the population to be served; and, (b) the existence of a highly competitive marketplace. In developmental disabilities, utilization and cost patterns have been affected by what is, rather than what should be; the "market place" is not

particularly competitive. Studies that attempt to correlate the characteristics of people with developmental disabilities and resource utilization patterns have found rather weak correlations.

If developmental disabilities service systems are to be capitated, some important questions must be resolved. These include:

- Should capitation rates be "risk adjusted" to take into account differences in consumer resource utilization patterns? In other words, should capitation take the form of multiple rates rather than a single payment amount? If risk adjustment is used, what is its basis upon which differential payments are made?
- Should capitation be linked to "full risk arrangements" or should "partial risk" strategies be employed? Each approach has its potential benefits and pitfalls.
- What is the nature of risk in developmental disabilities service systems with and without managed care? This is an important question. In health care, risk is defined by the potential that enrollees will use more services than can be supported by the capitated payment. Historically, developmental disabilities systems have managed risk in two ways: (a) controlling the supply of service system openings; and, (b) controlling the supply of particular types of services (e.g., the number of beds available in high-cost public institutions). These systems are not high-risk and what risk exists, exists at the state level. With managed care, the risk commonly shifts to the consumer, the MCO or the provider, who can be afforded more freedom in fashioning long term supports, but must do so within a fixed payment level. The increased discretion yields increased opportunities but also higher risks. The financial risk can be minimized through improved fiscal management, fund reserves, and crisis resources (e.g., emergency placements to designated crisis facilities). Where risk does exist, it lies with the destabilization of individual placements or in maintaining some capacity to respond to crises. In formal and informal ways, service systems respond to these risks by maintaining a pool of crisis resources (e.g., emergency placements to state facilities). In constructing capitated payment models (and, thus, in managing overall system resources), it is important to understand the nature of system risk and how it might be best accommodated.
- To what extent, if any, should capitation payments serve as guidelines in regulating resource utilization at the individual consumer level? Capitation can serve as simply a tool for making payments to the MCO while leaving care management totally in the hands of the MCO. Alternatively, capitation can serve as a benchmark against which to design consumer support strategies (including self-directed strategies). Using capitation in the latter fashion, however, can shift risk from the MCO to the consumer level.

- **Should a state employ a single MCO or should it encourage the formation of locally-based MCOs or multiple competing MCOs?** The arguments for a single MCO revolve around: (a) economies of scale; (b) the advantages of managing risk across a large population versus the problems of managing risk with a very limited population; (c) the market power the MCO would have over all suppliers; and, (d) simplifying contract management. The arguments for encouraging the development of locally-based MCOs derive from the fact that developmental disabilities service systems are less "statewide systems" than they are amalgams of locally or regionally-based systems. As in health care, the actual "marketplace" is local and, hence, a managed care strategy might work best through a network of local/regional MCOs rather than attempting to centralize system management. Locally-based MCOs would be more akin to the way in which MR/DD service systems operate today in many states. The notion of multiple competing MCOs offers the potential for realizing some of the benefits that have accrued in the health care marketplace as the result of fierce competition for market share. However, such competition only occurs in larger markets and leaves open the question of how rural low density markets would be served.
- **Can appropriate care (support) criteria be developed to serve as an acceptable basis for utilization management?** In health care, MCO utilization management protocols can be related to practice standards. That is, how the MCO responds to a health care needs ultimately is bounded by recognized clinical practices as implemented by qualified practitioners. In developmental disabilities systems, there is: (a) less emphasis on clinical practice standards; and, (b) less willingness to accept the use of standardized, routine service/support protocols. Supporting people and families in their communities is inherently "messy". Since care criteria define the fundamental obligation of an MCO to provide or arrange for services, they must be specified. In long-term support systems, it seems likely that care criteria will involve forging some mix of clinical standards, support standards, and, potentially, consumer-determined standards. But, at the moment, this standards mix does not exist.
- **What are the appropriate performance and contractual requirements needed to regulate an MCO responsible for overseeing the delivery of long term support?** Under managed care, the purchaser's role shifts from overseeing the direct service delivery system to managing the MCO. In this vein, it is enormously important that contractual requirements be thought through very carefully. Managed care contracting in the health care arena offers some guidelines but far from a "template". Contractual requirements must cover disparate areas, including MCO payment practices with primary suppliers, appeals/greivance procedures, sanctions for nonperformance, the development of handbooks for consumers, and a host of other topics. It is clear from the health care experience (including Medicaid managed care) that developing the appropriate contractual requirements is a complex undertaking.

- **What types of data/information systems need to be established to gather information concerning system performance?** In health care, data systems have emerged as an absolutely critical managed care tool. They undergird effective utilization management strategies; they are an important tool in assessing plan performance. Present MR/DD authority management information systems were not built with managed care in mind. Different data systems will be required, particularly in assessing the efficacy and outcomes of services.
- **To what extent should certain system functions be assigned to an MCO, contracted for with other entities or retained by the state authority?** In this vein, the exhortation to "steer not row" is overly facile. Certain functions necessarily devolve to an MCO (contracting with and paying service providers; exercising quality control; most aspects of utilization management). Others do not (e.g., licensing providers and the investigation of abuse/neglect). Some functions can be shared; others may best be handled by entities outside the control of the MCO. To illustrate, MCOs usually are required to establish grievance/appeal mechanisms that consumers may use if they believe that the MCO has not properly dealt with their health care issue. Such mechanisms can be expected to lead to an appropriate resolution of most problems through direct negotiation between the consumer and the MCO. However, appeal mechanisms usually are accompanied by safety valves that enable a consumer to pursue an appeal beyond the MCO. In long term support systems, the state authority can serve as the final arbitrator of the appeal or it may mandate that unresolved disputes be settled by an independent arbitrator/mediator.
- **Consideration needs to be given of the extent to which an MCO's management of the supplier network will be subject to state approval/review.** Acting as a purchaser, a state obviously will want to set forth requirements concerning service accessibility/availability on a geographically dispersed basis. Consumers should not be required to travel long distances to see a support coordinator or obtain routine services and supports. In adopting a managed care approach, a state also will need to consider the extent to which it will intervene in MCO decisions not to contract with existing providers or MCO service pricing strategies. In some cases, a state may wish to specify that an MCO contract with an "essential provider". How these issues might be addressed is difficult to prejudge in developmental disabilities systems. The supplier base is largely populated by non-profit entities which operate solely within the developmental disabilities marketplace. Since there are limited numbers of such providers, they have some measure of market power; however, their dependence on a single buyer -- the state -- weakens their market power.

These and other questions will need very careful attention as states embark on managed care approaches.

Systemic Questions

Equally important are more fundamental systemic questions that must be addressed in considering managed care approaches. These include:

- **Who manages the care?** The mistrust of managed care lies in the prospect of transferring authority over care/supports from the individual and family (as well as professionals) to a third party who makes decisions regarding the appropriateness and costs of proposed services. This change is an ongoing source of tension in managed health care systems. It will be an even more critical dimension of managed long-term support networks. To some degree, the problems in this regard can be dealt with through the development of care/support criteria which can serve as the foundation for safeguards and by establishing the necessary checks and balances within a managed support system. Still, managed approaches probably will need to be designed that leave the door open for consumer/family-directed support management. It may be that developmental disabilities path into managed care will be a hybrid that combines self-direction/self-determination with more conventional utilization management technologies being applied to certain high-cost services or high-cost support strategies. For stakeholders, this will mean defining a system which triggers managed care responses at pre-agreed levels.
- **Choice.** Developmental disabilities service systems assign a high value to giving consumers and families choices among available service providers and support strategies. Managed care operates under a contrary logic: choices are narrowed in order to secure cost savings. The question of choice is intertwined with the question of "who manages care?" as well as supplier network management strategies. It seems likely that the application of managed care in developmental disabilities will limit certain types of choices. For example, under the HCB waiver authority, individuals are afforded a choice between HCB services and an institutional (ICF/MR) placement even though the costs associated with each choice may be substantially different. If managed care is to yield cost savings in developmental disabilities systems, then necessarily it must entail closely regulating the utilization of high-cost service settings and, thereby, impose systemic restrictions on certain choices.

To illustrate, ICF/MR placement might be restricted to very defined circumstances, rather than serving as a freely selectable alternative to HCB services. Tightly regulating such placements may simply mean that ICF/MR admission will: (a) only be triggered in certain circumstances; but, (b) other community supports also might become available as an alternative to placement.

Managed long term supports need not be constructed along bipolar lines (i.e., choice/no choice). However, it is clear that developing a managed care strategy entails thinking systematically and carefully about the choices offered to all consumers/families as a matter of course and those which might be limited in order

to prevent over-utilization or inappropriate utilization of certain services. Today's service systems also limit choices; they do so implicitly rather than explicitly. Developing a managed long term support system will involve developing an alternative choicemaking framework.

- **Need.** Present day developmental disabilities service systems are premised nominally on delivering services and supports based on consumer "need". When systems were based on the "care and treatment" model, professionals were expected to certify needs and prescribe the services necessary to satisfy such needs (via a treatment plan). In many jurisdictions, the "care and treatment" model has been displaced by the "supports paradigm" where consumer preferences and desired lifestyles have become the central focus of developing support strategies, with professionals playing an important but not a controlling role in the process. Need has shifted from being "individualized" to being "personalized".

Managed care criteria are need-based (e.g., condition "x" sparks response "y"). If supports are to be personalized and people with developmental disabilities are to have a role in defining "need", then it will be important to identify how a managed system responds to and accommodates this key dimension. In the design of a managed long term support system, this issue will have to be confronted.

- **Centralization v. Local Control.** Community systems draw strength from their ties to local communities. There are technical issues in system designing concerning the selection of a single MCO versus local or multiple MCOs. There also are important systemic issues that will need to be addressed, including how systems can maintain and cultivate community ties. In this vein, non-profit, mission-driven MCOs may have advantages over corporate models. Alternatively, hybrid models (mission-driven public MCOs linked to private sector Third Party Administrator models) may offer a way to gain the best of both worlds.
- **Consumer Involvement.** In health care, consumers typically have the latitude to opt out of MCOs with which they are dissatisfied by selecting an alternative health plan. If developmental disabilities systems rely on exclusive (either statewide or locally-based) MCOs, opting out would not be possible and a variety of issues would arise in terms of ensuring that a plan is operating in the best interests of consumers. Some of these potential problems can be addressed contractually. Others might be best addressed in other ways, including directly involving consumers and families in MCO performance evaluations, requiring MCOs to establish consumer advisory boards, mandating that consumers be integrated into the plan's governing structure, and so forth. This is another area where stakeholders should focus their attention. In health care, for example, Wisconsin has been very aggressive in inviting consumers into plan design and evaluation; as a result, Wisconsin officials believe that managed health plans perform better.

Strategic Questions

As states seriously consider the use of managed care approaches, they also will need to address various strategic questions. These include:

- **Scope.** Should a managed care system wrap around all services and supports for people with developmental disabilities or should some sectors be excluded (i.e., subject to different management approaches)? For example, folding institutional services into a managed care plan might make sense, particularly in states with large numbers of persons served in such facilities. However, if institutional services already are very limited in scope or if they are being phased out, then it might be simpler to keep such services outside the plan and deal with their fate more directly.
- **Models.** There are various possible alternatives for structuring a managed care system. We discuss these models in a subsequent chapter of the **Guidebook**. Strategically, the key question for any state will be: which model is most apt to yield the desired level of cost savings within the parameters established for the managed care system? Secondly, which model is likely to prove most feasible given a state's present service delivery system and its capabilities? Finally, which model is most congruent with the principles under which the state's plan will operate? Finding this fit involves a variety of strategic considerations.
- **Opportunity Areas.** If the aim of managed care is to hold down costs, it is important that a state's managed care strategy focus in on those areas where significant cost savings can be achieved and maintained over the long haul. This dictates that a state size up which sectors account for disproportionate costs, assess their susceptibility to managed care methods, and craft a strategy accordingly. In other words, what are the opportunity areas for applying managed care?
- **Pace.** Another key strategic issue is the pace at which a state attempts to implement a managed long term supports system. The temptation is to design and implement a full-blown system in order to secure cost savings as rapidly as possible. Since managed care approaches entail very major shifts in relationships and operating rules, however, the faster the pace of implementation the more likely it is that large scale problems will be encountered. In an ideal world, the implementation of a managed care plan should be preceded by testing systems on a smaller scale to uncover their inevitable flaws. However, rarely are conditions ideal. For states, the question of pace must attempt to balance the capacity of the service system to absorb change, the capacity of the state itself to handle the transition to managed care, and the strategic goals and objectives (including securing cost savings) of the managed care plan itself.

Since managed care foments system change, it is important to recognize that it has policy implications that extend well beyond the technical issues posed in designing a plan.

Addressing the preceding questions, therefore, is integral to the development of a managed care strategy.

Managed Care: Cautions

There is no doubt that managed care potentially offers a powerful framework for restructuring a service delivery system. Managed care concepts and strategies are robust. Viewing a service system through the prism of managed care helps spark new thinking about how systems might perform better. Developing a managed care plan pushes all parties to be concrete and bottom-line oriented.

At the same time, it is important to keep in mind that managed care is merely a tool that can assist in the reconfiguration of service systems. The objective is not simply to "do managed care" but rather to craft a managed care strategy that is designed to serve larger goals and objectives. The strategy should advance the goals and not take on a life of its own. It is very easy to become caught up in the jargon and complexity of managed care and lose sight of the ends it is supposed to serve.

Probably the central admonishment concerning managed care is to avoid the wholesale importation of managed care technologies (and their purveyors) from other sectors. For instance, managed health care deals with a different marketplace and different "products". Systems and organizations that have evolved in that sector are the products of that market place. Since managed health care has had such high visibility, it is often taken for granted that importing managed care into developmental disabilities systems can only be accomplished by establishing the same structures and using the same technologies as have evolved in the health care arena. This would be as serious mistake.

More to the point, there is no particular basis for believing that the specific managed care technologies that are being employed in primary health care or mental health services are appropriate to or would lead to beneficial outcomes in long term support systems. Nor is there any reason to believe that corporate experience in one sector of managed care is readily transferable to another service system, even though it may be represented as such.

Another important caution is that all parties must recognize that applying managed care strategies in a long-term supports environment will be inherently more complex than in other sectors, principally because support systems themselves are very complicated. A good deal of this complexity stems from how these systems are interconnected to natural and community supports. Acknowledging this complexity is critical. We do not believe, however, that this complexity should be regarded as a reason to avoid managed care since the alternative -- maintaining systems as they are today -- is by no means a satisfactory response to the challenges that they face. This complexity, however, will mean that the shift to managed care in long-term support systems will involve trial and error until an acceptable technology emerges through successive iterations. Hence, embarking on

managed care should be regarded less as a search for the single "best" system than as a continuing process of testing and change.

In the health care arena, large investments are being made in the technology of managed care. Data systems -- acquiring and employing information -- are very important tools in improving performance and containing costs. Absent the willingness to make significant investments on a continuing basis, the application of managed care in developmental disabilities service systems will not yield similar outcomes. As has been the case in other human services arenas, developmental disabilities systems have suffered from an underinvestment in technology.

Lastly, the success of a managed care plan or strategy will be very dependent on the capability of public agencies to oversee the activities of managed care organizations. While managed care carries with it a change in public agency responsibilities and focus, public agencies nonetheless must be equipped to evaluate the performance of managed care organizations and intervene as needed. Hence, we strongly caution against adopting managed care approaches unless careful attention is given to ensuring that the systems and resources are in place to continuously gauge MCO performance.

Planning for Managed Care

In a later chapter, we discuss how to develop a managed care plan/feasibility study. For present purposes, it is important to point out that the commitment to shift to a managed long-term supports system must be accompanied by an intense commitment to system design. There is very little that can be rolled directly "off the shelf" in designing a managed long-term supports strategy. In Chapter V, we discussed the Minnesota LTCOP demonstration for integrating acute and long-term care services for dually-eligible (Medicare/Medicaid) seniors. This demonstration was preceded by very intensive and broad-based dialogue across all service systems as well as other planning activities. The designers of this demonstration project were able to draw from experiences in Minnesota and elsewhere in attempting to achieve the same fundamental aims. While LTCOP is not necessarily a "model" for a managed long-term support system, the way in which it was developed may well be.

In addition, we would point out that systemwide change strategies frequently prove unsuccessful, particularly in an arena where there are enormous uncertainties about the consequences. As a result, it is important to consider questions of scope and pace in implementing a managed long-term supports strategy. Stakeholders/planners should give serious consideration to strategies that test various models and approaches, apply managed care strategies to some populations but perhaps not all initially, and foster an open "active learning" environment. With some exceptions, managed care has unfolded both in the private sector and in state Medicaid programs on an "evolutionary" rather than a "revolutionary" basis. Indeed, the wholesale, "one fell swoop" approach to implementing managed health care approaches usually has lead some states to scramble to deal with the unintended consequences.

It may well be that the radically altered fiscal environment that state systems will find themselves in shortly means that experimentation and active learning might be unaffordable luxuries. We hope not. If they are, however, then that is all the more reason to make a strong commitment to "do it right the first time".

Guiding Principles and Ethical Issues

Embarking on any major system change without agreement on the principles that should guide such change is a dangerous enterprise. The overriding aim should not be to implement a managed care system. Instead the aim should be: to achieve a system driven by quality and value(s). Managed care offers some promise in helping achieve such outcomes.

The National Association of State Directors of Developmental Disabilities Services has issued a policy statement on managed care and long-term supports (see Appendix L). This statement was developed to help frame the principles under which a state might organize the transition to a managed long term support system. Principles and ethics must serve as the cornerstone of a managed care strategy. The NASDDDS policy statement is but one way to structure such a framework. We believe that it is enormously important that all stakeholders be involved in defining the principles under which managed care will unfold in a state. Decisions about managed care ought to be driven by such principles.

Conclusion

In the following chapters we offer suggestions and advice about "how" to set up a managed long-term supports system. As a prelude to this discussion, we wish to stress the following points:

- Long-term support systems will need to develop their own path toward managed care. They will borrow and learn from other experiences; but, ultimately they will have to find their own direction if they are to succeed in a fashion that is acceptable to all stakeholders.
- Many problems found in present day MR/DD service delivery systems suggest that managed care offers a way to resolve those problems by changing the way in which service systems operate.
- In order to employ managed care, both technical and more fundamental issues will need to be resolved.
- To the extent possible, the implementation of a managed care approach should be preceded by intense planning and testing.

- The shift to managed care must occur within a framework of principles that guide the entire endeavor.

If there is any critical fact to be gleaned from the experiences with managed care to date, it simply is that "it is a journey, not a destination".

CHAPTER VII
PUTTING THE PIECES TOGETHER

VII. Putting the Pieces Together

There is no developmental disabilities system today that operates as a fully "managed care system" as the term is commonly understood. Managed care technology is a potentially robust framework for system restructuring that may enable states to secure increased system productivity during a period in which they face enormous challenges in meeting consumer demand with shrinking resources. The question for states is how to harness this technology in a fashion that balances cost containment objectives while adhering to the central goal of furnishing people with developmental disabilities with the supports they need to lead everyday lives in their communities.

As discussed in Chapter V, we are beginning to see the first attempts by states to introduce managed care into developmental disabilities systems. In some cases, these first steps have involved attempts to adapt the technology of physical/mental health managed care to developmental disabilities services. In other cases (the Rhode Island C.H.O.I.C.E.S. proposal and the Colorado *Blueprint*), efforts are being made to design a managed long-term support system that is based more resolutely on the essential values, premises, and mission of developmental disabilities systems. The aim is not to layer a prefabricated managed care approach on top of an existing system but rather to figure out how managed care techniques might be employed usefully to promote key goals and objectives while recognizing that existing service systems must change in order to improve their productivity.

However promising managed care might be as a tool for helping service delivery systems re-engineer themselves, a basic question remains: how can this technology be harnessed appropriately? The next three chapters of this **Guidebook** address this topic. Chapter VIII discusses the pros and cons of various managed care "models" that might be employed in developmental disabilities systems. Chapter IX lays out the steps that should be followed in conducting a managed care feasibility study. Chapter X discusses the components of a managed care plan. Before delving into those topics in detail, however, it is useful to lay out some fundamental points regarding the "how to?" question.

The Essentials

Since HSRI and NASDDDS began their collaborative effort to explore how managed care might be employed in developmental disabilities systems, we have been invited to make presentations at many different conferences and meetings and engage in dialogues with key stakeholders concerning the topic of managed care. Almost invariably, the participants already have assumed that managed care means

Topics Covered....

- ☒ The Essentials
- ☒ Models
- ☒ The Managed Care Feasibility Study and Plan
- ☒ Medicaid

contracting with a for-profit corporation that will exercise control over the state's DD service delivery system. "Getting ready for managed care" translates into attempting to predict the rules this unnamed corporation will superimpose on the service system. In some states, provider agencies already are forming networks in order to amass market power so that they will be in a better position to negotiate with the yet unnamed corporation.

The view that managed care means the takeover of the service system by a corporation is understandable. The frame of reference for managed care is health care; managed health care has become a fire fight among managed care corporations and health care providers, with both sides attempting to gain the upper hand by securing increased market share and gaining control of more "covered lives". Certainly, there is a strong possibility that developmental disabilities systems might be put out to bid; several managed care companies are developing "products" that they are beginning to market to state decisionmakers. The subject products are based on the "managed care expertise" which these companies have acquired and assurances that cost savings will be delivered. These products can seem attractive, even though they are entirely untested.

Underlying the assumption that managed care means system takeover by a corporation is the notion that existing managed care technology is readily transferable from physical/mental health systems to developmental disabilities service systems. Some managed care strategies are likely candidates for application in developmental disabilities systems; however, there is no basis for believing that the way in which these strategies have been employed in other sectors is how they should be employed in long term support systems. As we have pointed out repeatedly, adaptation not replication must guide this process.

At this stage in the consideration of the role that managed care might play in developmental disabilities systems, it is important for all stakeholders to keep some basic points in mind:

- **First, the payor is the most important "player" in the managed care equation.** The payor is well-served only to the extent that it clearly defines the terms and conditions under which it will contract with any entity to perform the MCO role. Certainly, in the health care arena, private sector payors (businesses seeking health care coverage for their workers) are not inclined to accept any product that is put in front of them. The payor is in the driver's seat. In developmental disabilities, states are the payors. Nearly all services and supports are underwritten with dollars that states control. This means that a state is in a position to dictate the roles and responsibilities of MCOs in developmental disabilities services. Hence, before "going to market", it behooves a state to define the "product" it wishes delivered. One of the instructive lessons about managed care that can be derived in other service sectors is that the failure to give considerable thought to the desired managed care "product" can lead to enormous problems down the road. Hence, the exploration of managed care options should not mean that a system must accept

whatever is offered. The "product" should meet system specifications, not *vice versa*. The processes described in Chapters IX and X for conducting a managed care feasibility study and preparing a managed care plan address this topic.

- **In any managed care system, some entity must serve as the MCO; many different kinds of entities, however, can play this role.** Corporate MCOs have certain advantages; they also bring with them problems, not the least of which is that some dollars will flow out of the system rather than being reinvested in it. In Chapter VIII, we will discuss the pros and cons of for-profit MCOs, non-profit MCOs, and public agencies playing the MCO role. We also discuss the pluses and minuses of using a single, statewide MCO versus locally-based MCOs. It is important to stress that no single model is demonstrably superior to another. The selection of one type over another can be driven by a variety of factors, including non-economic factors (such as the desire to ensure that the MCO has close ties to the community in which it operates). Various types of entities can be accommodated. The decision to select one over another should be weighed against fundamental system goals and objectives.

Beyond the pros and cons of various MCO alternatives, it is vital to keep in mind that, in order to promote improved systemwide productivity, the MCO must have both the authority and standing to rigorously pursue a cost-effectiveness agenda. Pressure must be maintained on the system to eliminate unnecessary outlays and spark productivity improvements, while still adhering to the bottom-line of achieving high quality. In many different respects, the MCO's role is to continuously take a hard look at performance and intervene to hold down costs and improve provider agency performance. Hence, it is important that the MCO (however constituted) have a very bottom-line orientation. The understandable (and even legitimate) tendency will be to curb the authority of the MCO out of fear that it will act inappropriately. This tendency must be balanced against the benefits of driving the system based on bottom-line thinking.

- **Managed long term support systems can be designed so that individuals and families retain (or begin to enjoy) increased command over decisionmaking.** Again, it is usually assumed that managed care inevitably means that the MCO must control all decisionmaking throughout a system, including the mix of services and supports which every individual or family receives as well as the providers they must utilize. In Chapter VIII, we describe a "consumer managed care" model that would yield predictable outlays and contain costs while still enabling individuals to exercise a considerable range of choices. Appendix O also contains an illustrative prototype of a hybrid consumer managed care model. In addition, we would also point out that, in private sector managed health care plans, the "hottest" current products are "point-of-service" plans that are designed to offer enrollees increased options to obtain services outside the MCO's provider network. The "consumer managed care" model offers at least as great a potential of achieving cost savings as more bureaucratic "gatekeeper" models. In some respects, "gatekeeper" models may

prove more difficult to engineer and tougher to regulate than the consumer managed care model. Hence, we do not believe that the assumption that managed care means that no or very limited choices should be accepted by stakeholders.

- **Managed care is cost containment; cost containment expectations must be realistic.** The aim of employing managed care is to achieve systemwide savings, contain costs and improve productivity. Bottom line thinking ("what's needed, nothing more") is the core of managed care. In developmental disabilities systems, savings can be achieved through service substitution, by ensuring that the services and supports being furnished are efficacious, promoting flexibility, and streamlining systems. How much savings can be achieved, however, is difficult to predict. In systems that rely extensively on expensive congregate models, significant savings may be achieved. Some state DD service systems, however, already have de-emphasized such models. The initiation of a managed care approach should start with an appraisal (a feasibility study, as described in Chapter IX) of the "opportunity areas" where savings can be achieved. However, it must be kept in mind that achieving savings will be the outcome of fundamental system change that occurs over an extended period of time. It also must be pointed out that the vast majority of developmental disabilities services are inherently labor intensive. As a consequence, in some services, only marginal cost savings may be achievable. In certain services (e.g., family supports), costs already have been boiled down as low as they can go. It is important that managed care be implemented with realistic cost savings objectives in mind. One of the reasons for conducting the managed care feasibility study described in Chapter IX is to develop reasonable expectations regarding the impact of introducing managed care practices in a service system. Achieving such savings will require the multi-year application of managed care strategies. Maximum savings will not be achieved overnight.
- **In developmental disabilities, one of the most critical and yet most difficult aspects of designing managed care systems will lie in defining the "benefits package" that an MCO is to administer and manage.** In managed health care plans, benefit packages are described in the context of "medical necessity": conditions trigger more or less well understood responses. Benefit packages tend to be similar and relatively well-understood. Capitation payments wrap around the benefit package. In developmental disabilities, there is a weaker consensus regarding how a system should respond to the needs of individuals and families (as witnessed by the continuing debate over the viability of the "support paradigm" in meeting the needs of individuals with complex conditions). Generally, service systems have governed systemic responses to individual need by controlling the supply of "program" openings rather than by relying exclusively on need-based criteria. In managed care, "care criteria" define the MCO's obligation to respond to the needs of plan enrollees. Absent the clear delineation of care criteria (i.e., the required system response to a presenting condition), designing a managed care system is difficult; evaluating and regulating system performance are virtually impossible. One of the most basic challenges in introducing managed care into

developmental disabilities systems, therefore, will lie in securing agreement concerning care criteria. These criteria must be concrete.

- **To obtain increased productivity, service systems must be managed under different economic and performance parameters than is the case today.** In health care, a fiercely competitive marketplace has emerged that is driving down costs to payors. This competition is both price and product-based. Making a profit, "market share", and basic survival are the driving forces in the health care marketplace today. In developmental disabilities, the current marketplace is heavily regulated and frequently overmanaged. It is a "fee-for-service" marketplace, with all the attendant problems. An issue that must be faced squarely in transitioning developmental disabilities systems to managed care is the introduction of economic risk into such systems. Economic risk sparks changes in system behavior, including improving efficiency and spurring service substitution. Rhode Island's C.H.O.I.C.E.S. proposal (described in Chapter V and further discussed in Chapter VIII) introduces risk by proposing to use a managed competition model (i.e., provider agencies can gain or lose market share based on their performance). Capitation accompanied through shared risk arrangements also is a way of changing the economic parameters under which systems operate. Consumer managed care models introduce risk by shifting purchasing from what has been described by Joe Campbell as a "wholesale" (slot/provider-based contracting) model to a "retail" model where providers compete to supply services and supports to consumers and families. Absent the introduction of risk, service systems are unlikely to change to any substantial degree. Competition, risk, and tight cost controls (in the form of capitation) must be considered in order to spark cost-efficient behavior.

The second key change necessary for a managed care strategy to work is the substitution of managing toward outcomes for the close regulation of process. If system rules do not change, then costs cannot change. Regulating systems by outcomes is integral to the "bottom-line" mentality of managed care. Defining outcomes in concrete terms is necessary in order to gauge efficacy and make decisions about the appropriateness of service substitution strategies. Care criteria must be crafted with desired outcomes in mind. Outcomes form the basis for evaluating MCO performance and should be the basis for MCO management of the provider network. Consequently, the transition to managed care must be preceded or at least accompanied by a substantial commitment to securing agreement concerning desired outcomes and putting the systems into place to measure the extent to which agreed upon outcomes are being achieved. Adopting outcomes as the central regulatory strategy must be a critical feature of a managed care strategy. At the same time, as discussed in Chapter X, the development of meaningful, measurable outcome standards is only in its early stages.

- **Next, it is important to recognize that DD service systems should transition to managed care, not leap into it.** Managed care entails major systemic changes at all levels. Major changes inevitably give rise to unintended or unforeseen

consequences, however well-planned the changes may have been. Hence, there is much to be said for piloting managed care approaches or phasing in the implementation of managed care strategies in order to ensure that there is enough breathing room to evaluate impacts and make continuous adjustments. For example, it may make sense to start with no-risk arrangements in order to focus attention on implementing utilization management strategies with the intention of phasing in risk-sharing at some later date. Similarly, it may be necessary to phase in regulating by outcomes, particularly given the "state-of-the-art" in this arena. Data systems must go through a shake down period. A baseline set of outcome data must be collected in order to develop performance norms. A strategy based on transition rather than attempting to unfold the entire new system all at once is likely to yield sounder results in the long run. Service systems will not change overnight. There is a balance to be struck between seizing upon managed care as a possible savior in resource-tight systems and avoiding the chaos that inevitably results from hasty implementation.

- **Finally, involving key stakeholders throughout the process is critical.** The goal is to build a service delivery system that maximizes benefits to individuals with disabilities and their families. The managed care system will largely rely on the existing network of providers. These stakeholders and others possess a wealth of knowledge that should be tapped throughout the development process. It makes no sense to develop a system in isolation because doing so deprives the development process of valuable information and eliminates important sources of feedback concerning proposed strategies.

The preceding discussion highlights important points to keep in mind when attention turns to the question of how to frame a managed care strategy.

Models

Chapter VIII describes five managed care "models". Even though we make the point in that chapter that such models are not mutually exclusive and undoubtedly will be used in combination, the reader should approach Chapter VIII with that basic point in mind. In fact, we believe that a state should embark on a managed care development plan with the expectation that ultimately it will design a system that includes features of all the models. The central question is not whether to adopt one model to the exclusion of all the others but instead to find the proper balance among the strategies embodied in each of the models.

We also point out by way of preface to Chapter VIII that models are far simpler to construct in the abstract than to outline in concrete operational terms. With regard to utilization management, for example, it makes a good deal of sense to regulate many kinds of services based on their likely efficacy: namely, to furnish them when the result is more or less certain to be the achievement of a certain outcome. In reality, efficacy is not well-documented in developmental disabilities services today. Instituting a utilization

management system will require the convening of expert panels and focus groups to suggest standards. These standards will need to be tested and recalibrated. Similarly, "consumer managed care" is an attractive concept to many because of its empowerment features. Unless an acceptable basis for developing capitation amounts can be developed, however, the "consumer managed care" model can prove enormously problematic (since it shifts risk to individuals and families who are in the least favorable position to bear risk). Moreover, there is the danger that such a model might amount to little more than an elaborate rationing scheme. This does not argue against the use of the model; however, it does point out that it is a more difficult model to translate into concrete terms than first meets the eye.

The various models described in Chapter VIII are intended to be informative rather than prescriptive. They are designed to help readers understand the various dimensions of managed care and its possible applications in developmental disabilities service systems.

Feasibility Studies and Plans

Chapter IX describes in general terms the steps and processes that should be followed in conducting a managed care feasibility study. Even though this chapter (despite its length) only skims the surface of the topic, admittedly the content is complex. Again, by way of preface, it is perhaps useful to point out that the aim of the feasibility study is to assess, in a disciplined fashion the potential financial effects of employing a managed care strategy in a developmental disabilities as well as to examine various other dimensions with regard to system "readiness". We believe that conducting a feasibility study is an important first step in sizing up the applicability of managed care to a service system. It helps to avoid the problems which inevitably arise when systems are devised based on untested assumptions concerning the existing system's costs and capabilities.

In Chapter X, we will discuss the basic elements of a managed care plan which is aimed at setting forth the concrete specifications under which the system would operate. The feasibility study points out opportunity areas and assists in distinguishing between approaches that are promising and those which are unlikely to work. The plan contains the specifications for the alternative that is selected and moves the process from the conceptual to the concrete. Actually preparing a managed care plan will prove to be an intensive undertaking because it must address many different dimensions. Since the planning process is intensive, it only should be undertaken based on a commitment from decisionmakers and stakeholders to devote the time and attention that will be required. Developing managed long term support system specifications, in fact, involves rethinking the current service system and the relationships among key players in the system from ground zero. All parties must recognize that the "devil is in the details" and be prepared to devote the time needed to construct a satisfactory plan. The plan construction process will be aided enormously by securing agreement concerning the principles under which the system will operate (including the key "non-negotiables"), holding proposed features up to the glaring light of reality, and continually involving all key stakeholders in the process.

Medicaid

When this **Guidebook** was originally conceived, we expected to devote at least an entire chapter to the development of the waiver requests that are presently required in order to place Medicaid-reimbursable services under a managed care approach. In light of pending Congressional action to replace Medicaid with a new program that gives states considerable flexibility in establishing health and long-term care programs for low income citizens (including individuals with developmental disabilities), we decided to drop this chapter (even though, as the reader will discover, in some instances we do tackle certain topics in light of present federal requirements while also acknowledging that the rules are likely to change radically).

We assume that Congress will replace the present Medicaid program and that the replacement will be structured in more or less the same form that passed the House and Senate in late October. There are differences in the details but not the general approach in these versions. With regard to developing managed long-term support systems, the following features of this legislation must be considered:

- States would no longer need to obtain federal waivers in order to institute managed care strategies. This change would remove some of the factors that have complicated the application of managed care to developmental disabilities systems.
- In particular, states would have the latitude to channel particular groups of recipients into managed care plans and regulate the operation of those plans under guidelines and principles that each state (and, hopefully, key stakeholders) believes to be appropriate. Instead of describing its managed care plan in a waiver request, a state simply would have to incorporate it in its Medicaid (or "Medigrant") state plan.
- While the federal changes make the construction of a managed care plan more straightforward, readers should keep in mind that there still will be complications. Instead of developing a plan within the framework of the state's current Medicaid program (including recognizing and taking into account the availability of certain benefits that the state is providing), at least in the short run such plans will have to be developed in an environment where states may be changing many features of their current service delivery systems. The transition is likely to be very turbulent over the next one to two years.
- Even though federal policies are changing, a state still will need to rely on current Medicaid information systems and policies to inform its development of a developmental disabilities managed care plan.
- During the development of such a plan, there are certain federal policy changes that may have particular relevance, including the greater latitude that states would be able to exercise in designing co-funding strategies, structuring payment systems,

including the potential of using vouchers and other strategies that can affect system financing considerations.

- Probably the most important aspect of the federal policy changes to keep in mind with respect to managed care strategies is the potential they would offer for unifying funding streams under a common set of rules and regulations. While federal dollars would have to be identifiable, the federal policy changes would make it much easier for states to adopt "single-stream funding" strategies than do present policies (even with a waiver in effect).

There is little doubt that the impending federal policy changes have momentous implications (including increasing the strains on developmental disabilities systems). From the standpoint of managed care strategies, these changes create the potential for states to pursue highly innovative (and, inevitably, variable) approaches.

Conclusion

In embarking on the development of managed long term support systems, all parties are well advised to keep in mind the basic considerations discussed above. Managed care systems can be constructed in many different ways, including the use of organizational and design features that are not common to managed health care plans. The trick will be to balance critical principles and values against various approaches to managed care.

CHAPTER VIII
MANAGED CARE MODELS

VIII. Managed Care Models

A "managed care" system defines the framework within which a service system's three principal players (the payor, the service providers, and consumers) interact. A "managed system" is distinguished from an "unmanaged system" by defining these interactions globally rather than in a piecemeal fashion. A managed system is organized to achieve key goals and objectives in a systematic fashion. These goals and objectives typically include cost containment, improved productivity, and better targeting of resources.

In the health services arena, managed care has changed the delivery system by emphasizing the interests of the payor in containing costs. Managed care has altered the health care marketplace. In the arena of long-term supports, the application of managed care strategies also will engender fundamental changes in the way in which support systems operate. A "managed long term support" system will define new relationships among the system's key actors in order to pursue overarching systemwide goals. **It is important to keep in mind that managed care is no more or less than structural reconfiguration in pursuit of key system goals.**

As discussed previously, there are important mismatches between managed care as it has emerged in the health care sector and the scope and character of long term supports. Importing managed health care models directly into long term support systems is likely to engender problems. Long term support systems will need to find their own pathway by which managed care is appropriately adapted to the central objectives and premises of long-term support systems.

Managed care models describe the integration of financing and service delivery under definitive rules.

In this chapter, we will outline various managed care "models" that might serve as the basis of a "managed long term support" system. Each of these models involve the integration of financing and service delivery where the "system" operates under definitive rules that establish the conditions under which services and supports will be provided and for how long through designated managed care organization(s) and/or consumers. Some of these models have their roots in managed health care. Others have no health care precedents (e.g., consumer managed care). We will outline how such models might be fleshed out, including their potential strengths and weaknesses. We also will examine variants of the basic models.

Five models and variations thereof are identified: (a) managed care organizations (MCOs); (b) consumer managed care; (c) utilization

Topics Covered...

- ☒ Managed Care Organizations
- ☒ Consumer Managed Care
- ☒ Utilization Management
- ☒ Service Substitution
- ☒ Consumer-Centered

management; (d) service substitution; and, (e) consumer-centered capitation. They are defined separately although they may be employed in combination.

Managed Care Organizations (MCOs)

Definition: *Formal arrangements whereby distinct organization(s) are made responsible for managing a network of services and supports and are accountable for network performance. These operational responsibilities are separate and distinct from the policy-level responsibilities of the public agency charged with governing the system. As a rule, managed care organizations are responsible for keeping spending within established limits (caps). Private managed care organizations may bear financial risk for cost overruns.*

Underlying assumption: *Managed care organizations (MCOs) with specific network operational management responsibilities, relatively free of political obligations to interests vested in the current system, relatively free of traditional regulatory constraints and equipped with competent management and state-of-the-art management tools are in a much better position to develop and implement networks of services and supports than existing government agencies can.*

In health care, the MCO plays a pivotal role in the implementation of managed care. It manages the delivery system on behalf of the payor by delivering essential health care services at a cost the payor can afford. In order to play this role, the MCO must serve as a conduit through which all funds are channeled. The MCO organizes the supplier network, imposes rules on its operation, and serves as the service system's fiscal intermediary. Usually the MCO receives a fixed amount of dollars from the payor to perform these functions and, thus, has a strong economic interest in being a tough negotiator with suppliers, ferreting out overutilization, and improving systemwide productivity.

The MCO manages the delivery system on behalf of the payor in order to deliver to the payor essential services at a cost the payor can afford.

When the term "managed care" is used, it nearly always brings to mind making payments to a private-sector MCO (or MCOs) in exchange for a promise to deliver an agreed upon array of services at a fixed price. The MCO becomes the "delivery system". The role of the payor is to manage the MCO(s) in order to ensure that the "product" is being delivered and that the charges are not excessive.

Some argue that the MCO concept lies at the heart of achieving managed care's cost containment and other objectives. Absent single stream funding and holding a single entity at risk and accountable, they contend, it is virtually impossible to create the dynamics that will yield the outcomes desired by payors. In other words, managed care is more or less synonymous with using MCOs.

When used in conjunction with long-term supports, a variety of topics must be considered in applying the MCO concept. These topics include the scope of the MCO's responsibilities and various terms/conditions that the MCO must meet in order to perform acceptably. More specifically, system designers must decide:

- **Whether the MCO will be expected to serve all individuals or whether some will be kept outside the agreement.** A managed care approach can wrap around the full range of persons served in a system or it can be designed only to address the needs of predesignated populations (e.g., "people who require 24-supervision") with the needs of other individuals addressed through alternative configurations.
- **The scope of benefits, services, and supports that an MCO will be contractually obligated to deliver to individuals.** This benefit package defines the contractual obligation of the MCO to the payor (the state). In determining the scope of benefits, the payor must decide whether some services/supports will be placed outside the agreement (e.g., "carved out") and thus be paid for separately.
- **The conditions under which the MCO must furnish contracted benefits to its enrollees.** These are sometimes referred to as "care criteria". Such criteria may take many forms. In essence, however, they define the core of the system's response to consumer needs. These criteria describe the MCO's obligations under its contract with the payor. Care criteria also serve as the basis of MCO utilization management activities as well as service substitution strategies.
- **The payor must decide whether it will contract with a single MCO or multiple MCOs and the criteria it will use in selecting such organizations.** There are various pros and cons in using a single MCO versus multiple entities.
- **The payor can decide to restrict its contracting to nonprofit entities.** It also may impose other requirements (including consumer representation/involvement in the MCOs governing structure).
- **The payor must specify its economic relationship with the MCO(s).** This relationship will have at least three dimensions: (a) determining the amount of the capitated payment to the MCO(s), including whether to use a single rate or multiple rates geared to potential differences among enrollees; (b) deciding the extent to which the MCO(s) will be held at risk; and, (c) imposing additional contractual terms and conditions, including limits on profit-taking, sanctions for non-performance, and any special incentives that might affect payments.
- **The payor must specify its expectations concerning the manner in which the MCO will organize, manage and operate the provider network.** Such expectations can include: (a) maintaining a sufficient supply and distribution of providers to ensure that consumers have ready access to needed services; (b)

directing the MCO to contract with specified "essential providers"; (c) MCO monitoring of provider agency performance; (d) the extent to which the MCO may limit the number of providers with which it contracts ("open" versus "closed" panel); and, (e) the extent to which an MCO may shift risk to network providers (in the form of its own payment policies).

- **The payor will need to specify how consumer appeals/grievances will be addressed, including provisions governing the filing of appeals with a party not controlled by the MCO.** The MCO model delegates major system responsibilities to a single organization. Consumer appeals/grievance mechanisms represent a critical "check and balance" when such delegation occurs. These mechanisms must be defined. Provision also must be made for consumer appeals/grievance resolution when a satisfactory resolution of the issues cannot be reached between the individual and the MCO.
- **The payor must decide how it will monitor and assess the performance of the MCO and network providers.** This may include specifications directing the MCO to file regular and periodic management reports, a requirement that the MCO itself operate an internal quality assurance system, provision for an independent assessment of MCO performance, consumer satisfaction surveys, and independent regulatory oversight of network providers.

The preceding considerations are "generic" when thinking through MCO-based strategies. They take on added complexities, however, when translated to the long-term support arena.

Despite the complexities, the potential case for the use of an MCO model in long term support systems is based on the following considerations:

- **Global funding is superior to categorical funding.** The MCO model offers the potential of cutting through the maze of service categories and special funding rules in order to operate a system that is based on a "what's needed, nothing more" philosophy. In this vein, the MCO model can serve as the organizational structure through which to achieve this outcome. The structure potentially could internalize what present systems often achieve only imperfectly: person-centered support coordination across multiple programs/providers.
- **With delivery systems for persons with disabilities increasingly operating in the consumer-driven supports mode as opposed to the provider-driven, facility-based model, local service network management becomes increasingly important.** There is more consumer movement from one support to another that must be arranged. Coverage responsibilities and fiscal allowances must be negotiated to accommodate individual consumer preferences and needs (e.g.,

¹ An "essential provider" is one that the payor deems as having vital capabilities and expertise and which the provider believes must be available to enrollees.

individuals remaining at home rather than attending scheduled day activities; individuals working in the evening hours).

- **In addition, contract monitoring is easier when accountability for network performance is assigned to a single entity.** The MCO model may enable public agency payors to "steer, not row", rather than being placed in the position of having to directly manage (often with inadequate resources) the entire service delivery system at a detailed level.

At the same time, the MCO model raises a variety of potentially thorny issues, including:

- **Managing a system through an intermediary poses a whole range of potential problems that states have little experience in addressing.** Employing MCOs is not the same as contracting with individual service providers to deliver discrete services. The MCO itself becomes the service providing "system". How it performs as a whole must be the focus for payor oversight activities. The more that a state agency attempts to regulate MCO performance in a detailed, heavy-handed fashion, the less likely it is that the benefits of a managed care approach can be realized. We know from experiences in Medicaid managed care (including the mental health field) that managing MCO performance effectively is an extremely challenging undertaking for state agencies.
- **It is unclear how to balance the cost containment interests that underlies the MCO model with the overriding concern that individuals served by the organization are having their needs met.** One central concern associated with the use of the MCO model is that profit-taking and risk management create a bias to underserve. Yet, both factors play a large role in triggering the dynamics that potentially yield improved cost effectiveness. Finding this balance will entail very careful, concrete specifications governing the care criteria that the MCO is expected to follow in responding to individual needs/circumstances. Absent well spelled out care criteria, it will prove nearly impossible to determine the extent to which the MCO is meeting its contractual obligations.
- **There is as yet little agreement regarding how long-term support systems might be capitated and how risk should be assigned when employing the MCO model.** There are pros and cons to various approaches to capitation as there are to risk assignment. They all have important implications for the way in which MCOs operate and thus for how they interact with service providers and consumers.

In the subsections that follow we will explore two these areas in greater detail: (a) capitation and risk management; and, (b) organizing an MCO-based system.

Capitation and Risk Management

If a state decides to use the MCO model, then one of the central tasks that it must tackle is determining how payments will be capitated to the MCO and what risk-management rules it will use in its relationship with the MCO. These areas interact. In the following chapters, we will discuss these topics in somewhat greater detail. For present purposes; however, let us focus on the central questions associated with each area.

A. Capitation

In capitation, the state as payor faces some fundamental choices. These include:

- **Single Rate/Multiple Rates.** Under a single rate approach, the State pays the MCO(s) the same fixed amount per enrollee without regard to the enrollee's characteristics or expected service utilization patterns. Single rate systems are relatively easy to construct (divide current service dollars (i.e., for services included in the scope of the benefits package) by the expected/allowed number of enrollees discounted by the number of such individuals the service system is expected to accommodate with such dollars). A single rate system is capitation at its most "global" (and crude) level. The chief problem with a single rate system is that it creates implicit incentives for the MCO to seek to avoid serving individuals who are expected to consume high levels of resources.²

A multiple rate system assigns different capitation amounts to individuals based on the expected differences in their utilization patterns. Multiple rate (risk adjusted) systems are employed in three basic circumstances: (a) there will be multiple MCOs which may serve disparate populations; (b) new individuals may be added to the system who differ markedly from persons already being served in the system; or, (c) subcomponents of the system will operate through different networks (e.g., children's versus adult services). Multiple rate systems can be difficult to develop since they hinge on the availability of data that can serve as a valid basis for constructing what are termed "rate cells". However, the potential advantage of multiple rate systems is that they enable a managed care system to be "fine tuned". "Risk adjusted" capitation is conceptually appealing, however difficult to develop.

- **Scope of Capitation.** Comprehensive, all inclusive rates are the most global. Capitation can wrap around all benefits that an MCO is expected to provide or may exclude some categories of benefits. Where some services are kept out of the capitation (and possibly retained on a fee-for-service basis even though managed by the MCO), the payor wants to ensure that the MCO (or primary providers) will not suppress their utilization. Keeping some services outside the capitation rate also is a risk-management strategy, particularly when the utilization of these services is

² One way to avoid serving such individuals is to attempt to refer them to other service systems (e.g., cost-shifting). This has been an issue in mental health managed care systems where a public system continues to operate independent of the MCO.

unpredictable.

- **Capitation as a Benchmark.** In health care, capitation simply describes the manner in which a payor decides the amount to pay an MCO to provide the scope of covered benefits to enrollees. There is no expectation that each individual enrollee will receive the specified level of service; services furnished are demand-driven. Some enrollees may not need any services; others may need a considerable amount. In long-term supports, the dollars available influence demand and service/support planning³. Hence, one key issue to be confronted in capitating a long-term support system is whether the capitation amount itself (or some discount from the capitation) will establish a dollar benchmark that each enrollee may access in order to construct a support plan. Quite obviously, such a benchmark approach would substantially alter the relationships between enrollees and the MCO, including the MCO's role in utilization management.

This notion that capitation may serve as a benchmark is played through in the discussion of the next model (consumer managed care).

B. Full-risk, Partial Risk and No-risk MCOs

One way that managed care organizations are commonly differentiated is in terms of the amount of risk that they assume. There are three models: full risk, partial risk, and no risk.

- **Full Risk.** An entity (usually a private for-profit organization) assumes a full-risk, capitated contract for plan eligibles. The organization is responsible for any costs above the agreed upon capitation amount. When an MCO is placed at full risk, almost by definition it must have relatively wide-ranging authority over nearly all dimensions of system operation (utilization management, control over the supplier network, establishment of payments policy). The narrower the MCO's range of authority, the higher the risk that it will not be able to manage the system within the capitated amount.
- **Partial/Shared Risk.** Unlike the full-risk model, the MCO's liability is limited by excluding some expenditures from the cap (by reimbursing for them on a fee-for-service basis), or by limiting the MCO's liability for expenditures above a pre-determined cap with the payor (state) usually covering the excess costs.

Stop loss or reinsurance provisions typically hold the contractor (MCO or provider) liable for the full cost of services to an individual or group of individuals up to a set dollar amount. The contractor is then liable for a percentage of any expenses above the cap up to a ceiling beyond which the contractor has no liability⁴.

³ That is, service planners will write plans to the dollars available.

⁴ The higher the amount at which the stop-loss protection kicks in, the greater the pressure on the MCO to contain costs. Conversely, if the stop-loss takes effect at a relatively small increment

- **No Risk.** Managed care organizations (MCOs) that assume no risk to their base funding may also be known as third party administrators (TPAs) and administrative service organizations (ASOs). These organizations typically assume some, not all, of the responsibilities of a managed care organization and are not fully accountable for the performance of the service delivery system. A no-risk arrangement amounts to purchasing managed care/administrative expertise. Cost savings are achieved via the application of this expertise rather than the economic incentives inherent in risk-bearing arrangements.

State agencies designated as MCOs may be full- or partial-risk MCOs to the federal government (HCFA), but, by definition, can only be no-risk MCOs to the state and state taxpayers since overexpenditures presumably would be covered through additional appropriations. County agencies designated as MCOs by a state might be full- or partial-risk MCOs to the state, but can only be no-risk MCOs as far as county taxpayers are concerned. The Arizona Division of Developmental Disabilities is a full-risk MCO from the perspective of the Health Care Financing Administration under the provisions of the State's Section 1115 Waiver. However, from the State's perspective, it is a no-risk MCO since the State is responsible for covering all expenditures beyond the federal cap set for people with developmental disabilities under the Arizona Long Term Care System.

The question of how risk is assigned in a system is independent of how systems may be capitated, although there are some interrelationships. A state, for example, can contract with an MCO on a single capitated rate basis but decide not to hold the MCO at risk. In such an instance, the state is hiring the MCO to manage the system under a particular set of rules but insulates the MCO from risk. The state agrees to pay the MCO a fee for its management of the system and also may agree to an arrangement under which the MCO might be able to earn a "profit" if it achieves certain results. However, the state bears risk for service costs in excess of the capitation amount.

Partial risk arrangements attempt (sometimes imperfectly) to achieve the best of both worlds (the gains from employing capitation and the performance outcomes that emerge as a result of operating in a fixed funding environment versus avoiding the problems that are encountered when MCOs are confronted with very high cost cases in a fixed dollar environment). A partial risk plan can be constructed side-by-side with a single comprehensive capitation rate. A state also can decide to carve some services out of the capitation rate as a "partial risk" strategy. Consequently, capitation and risk assignment sometimes are different sides of the same coin.

When considering the use of the MCO model, it is important to consider both sides concurrently. One way to do so is to think about the way in which risk might arise in a service system. In managed health care, for example, there are three kinds of risk: (a) the risk that service utilization patterns of enrollees will change; (b) the risk that the payment

above the capitation amount, an MCO may have reduced incentives to tightly manage utilization.

itself is not correct (i.e., it is "market driven" rather than related to the true costs of serving enrollees); and, (c) where enrollees have several plans to choose from, their selection patterns will result in one plan ending up with a different case mix than expected. MCOs attempt to gauge these risks against the potential for profit.

In long-term support systems for people with developmental disabilities, some of these risks may be pertinent but others may arise as well. Today's DD support systems manage risk by regulating the supply of available "slots", the availability of some kinds of services (e.g., by limiting the supply of group home beds), and superimposing unit of service limitations. In some respects, these systems have very low risk by virtue of these features. There, of course, are negative outcomes to achieving this low risk status (including under and over-serving certain individuals with developmental disabilities).

Adopting the MCO model may entail greater risk. For example, the substitution of definitive care criteria as part of the MCO's contractual obligations creates a substantially different service environment than one in which obligation is qualified by availability. In order to contain its risk, an MCO (understandably) will demand a good deal of say in defining the care criteria themselves, expect to have considerable authority in managing the service provider network, and must stress utilization management. An MCO probably will want to shift some of its risks to the provider network (by capitating its payments to them) or to the state (by arguing for a partial risk arrangement). In pursuing the MCO model in long-term support systems, a state needs to carefully think through the question of risk, how it is linked to the capitation strategy, and its possible implications for consumers.

Public and Private MCOs

An MCO might be a government, non-profit or profitmaking agency. Some entity must serve as the MCO (the central point for organizing the system and applying managed care strategies). There are pros and cons to the selection of one type of entity to act as the MCO versus another.

Though agencies of state and local government might be designated as MCOs, it is important to recognize that public entities are limited in a number of respects in the extent to which they can operate like their private sector counterparts. By definition, public agencies cannot assume financial risk and, thus, behave in a self-interested fashion (e.g., employee compensation and job security cannot be used to encourage cost conscious behavior). Public agencies frequently are hindered by cumbersome personnel and procurement procedures. They are democratic institutions, more than business enterprises. In addition, sometimes they move slowly.

Unlike private MCOs, public MCOs cannot be insulated contractually from the pressures of various political interests. As a result, the hard system-change decisions that an MCO must make if managed care is to yield cost savings or improved productivity stand a greater chance of being delayed or avoided. On the other hand, public agencies

have statutorily defined missions, including the charge to achieve critical outcomes on behalf of the individuals they serve.

Profit-makers are more business-like, but the profit motive itself makes the organization's efforts to contain the costs of services furnished to a vulnerable population suspect. In the disabilities field, as in any service field, the morale of direct service workers is critically important to the health of the system. It is unlikely that any managed care organization, given its known preoccupation with cost containment, will be widely welcomed and embraced by the labor force on consumers of service. On its face, this is not a mission that motivates service workers or endears them to consumers. Add to this the fact that such MCOs would be profiting while the delivery system itself might be cutting back. Even a sterling record of service in the field would not be enough to convince most workers or advocates of the purity of their intent and give them the credibility and support needed to lead the transition to a leaner service system.

Engaging a for-profit MCO also means that a state must recognize that a certain percentage of the dollars earmarked for services will be drained out of the service system in the form of profit. This drain has to be juxtaposed against the prospect that the MCO will achieve sufficiently great increases in overall cost-effectiveness to offset the amount of money siphoned out of the system. This requires a careful appraisal of the potential sources of cost savings so that limitations can be crafted that avoid excessive profit-taking⁵.

Another key consideration lies in the nature of the provider agencies that make up most state service networks. Generally, they are non-profits. Some observers suggest that subjecting such non-profits to "management" by a for-profit entity would trigger a whole range of problems, including undermining the willingness of non-profits to pursue the fund-raising that enables them to complement public sector dollars with their own resources to "make the system work". In addition, many non-profit agencies operate near the edge of financial solvency and, hence, would be in a weak bargaining position when facing off against an MCO in payment negotiations.

For these reasons, a non-profit MCO may be preferable for long-term support systems.⁶ Non-profits can be motivated to contain costs, not in the name of profit but in the interest of both survival and fulfilling their organizational mission. They have shown themselves to be concerned for the public good, and less likely to deliver low quality care (Schlesinger and Dorwart, 1989). They are more amenable to requirements for public participation and representation on their boards. At the same time, the establishment of an MCO can be an expensive undertaking. The proprietary sector has a competitive advantage in raising capital and incurring short-term losses in exchange for long-term

⁵ Such limits are not uncommon. Another frequently used strategy is to require that cost savings be shared between the MCO and the state.

⁶ The case for a localized, citizen-led, non-profit MCO structure is laid out in Stephen Hall's article, found in Appendix M. Hall also points out the importance of linking managed care strategies to the "supports paradigm".

profits. In some states, where managed care is actively being discussed, existing developmental disabilities providers are assessing the feasibility of setting up new corporations that would enable them to bid to become a system's MCO. There is some measure of precedent for this approach in mental health systems (where community mental health agencies in some instances have linked up with a for-profit MCO to create a hybrid organization).

To the extent that non-profit MCOs might prove to be the arrangement that avoids the pitfalls of a public agency or a for-profit corporation assuming the MCO role, various issues will need to be acknowledged and addressed. These issues include questions of financial solvency and strength (which affect the feasibility of the MCO's bearing risk), access to resources to pay for data systems and other managed care infrastructure, and possible conflicts between a non-profit agency's essential mission and its willingness to make the hard decisions necessary to extract cost savings. There are a variety of ways these questions might be addressed, including phasing into a full managed care approach by transitioning from no/partial risk arrangements to full-risk contracts, making loans/grants to non-profits to assist them in covering their start-up costs, and closely specifying performance requirements.

Statewide and Local MCOs

One MCO or many? When managed care is discussed there is a tendency to conceptualize it along the lines of a "single exclusive" arrangement that places all service delivery responsibility under the umbrella of a single entity. This approach commonly is advocated for a variety of reasons: (a) large scale MCOs are most likely to be able to achieve the greatest savings in administrative expense by eliminating duplicative overhead; (b) a large-scale MCO is better able to internalize risk (the smaller the MCO the higher the risk); (c) the bigger the MCO the more market power it will have; (d) it is easier to attract for-profit bidders for large-scale MCO contracts than smaller contracts; (e) it is easier to deal with one MCO than several; (f) relatively speaking, long-term support systems are not very large (when compared to health care markets) and may not support multiple MCOs; and, (g) MCOs are unlikely to serve predominantly rural regions. As discussed in Chapter V, both Tennessee and West Virginia are proposing the establishment of a single statewide MCO in the managed care plans that they have sent forward to HCFA. Other states are considering the same approach.

There also are arguments against creating single, exclusive arrangements. Such MCO's can perform overall system administrative functions, but cannot (and probably should not attempt to) centrally manage the operation of community-based long-term service and support networks. This is true today and will be more true tomorrow as consumer-driven supports come to represent a larger and larger segment of state service delivery systems. Centralized management, with power emanating from the top, leads inescapably to a "command and control" approach with a surfeit of rules and procedures (e.g., prior authorization) designed to eliminate surprise and uncertainty (e.g. cost overruns). Centralized managed care approaches are inherently distant from the people

served and are likely to grow increasingly so as they envelop and isolate consumers in the bureaucratic web. They are inherently non-individualized with rules that substitute for reason. They frustrate innovative, problem-solving behavior among front-line staff and discourage community involvement that has been shown to generate savings, improve provider morale and increase consumer satisfaction (Ashbaugh, Bradley and Blaney, 1994).

Arizona, the state MCO (Division of Developmental Disabilities) delegates some provider network management functions to its District Offices. In Rhode Island, the C.H.O.I.C.E.S. Waiver promises to decentralize MCO authority even further. Providers will become the *de facto* managed care organizations, each managing and providing its own network of services and supports for consumers. The providers would compete to provide services and supports to eligible consumers and provide these services and supports to each consumer under a capitated contract. This approach is well suited to Rhode Island since its service system is comprised mainly of large providers offering a relatively wide range of services and supports. As implementation approaches, one would expect to see smaller providers in Rhode Island aligning with one another in order to offer the full range of services and supports that consumers can be expected to demand.⁷

Managed care organizations are central to managed long term care. More so than traditionally organized government agencies, managed care organizations can be empowered, positioned and equipped to manage and administer service systems in a cost-effective manner. They also can enable the federal, state and local government to serve a given consumer population for a predictable and controllable price.

Hence, in looking at the options for employing managed care in long-term support systems, the single "exclusive" MCO arrangement may not be the best fit. Alternative arrangements merit consideration. For example, a state may wish to consider repositioning its current array of substate agencies to serve as catchment-area based MCOs but retain a statewide Third Party Administrator to carry out cross-cutting functions (e.g., paying providers, operating a data system and so forth). Such an approach is inherently more "messy" than an exclusive MCO model. At the same time, this decentralized model (or variations on it) might be the best fit in long-term support systems, given their beneficial ties to local communities and the benefits of decentralized system management.

The MCO Model: Summary

The MCO model is the closest possible parallel to replicating the health care sector's experience with managed care in a long-term support system. There is little doubt that this model brings with it many of the possible benefits that its use in health care has delivered. It is an entrepreneurial model (whether formed along for-profit or non-profit

⁷ In some respects, the Rhode Island C.H.O.I.C.E.S. proposal is akin to a "managed competition" model. Under managed competition, consumers select from among available alternatives based on their perceptions of price and value.

lines) and, hence, is oriented to the bottom-line.

Importing this model into long term supports forces state officials to think through the way in which the service system might be operated through one or more intermediaries. There are enormous challenges associated with mapping out such an approach. The MCO model requires careful thinking about capitation strategies and risk arrangements. Thought needs to be given to whether for-profit entities will be solicited as the MCO(s) or whether a state instead will seek "mission-driven" nonprofits to serve this role. While there are potential advantages to operating a system through a single-exclusive arrangement, other more distributed, decentralized arrangements may fit better in long term support systems. Finding the correct path in any state will involve carefully weighing the pros and cons of the model (its potential benefits and shortcomings) as well as keying decisions to critical system goals.

Consumer Managed Care (Controlled Competition)

Definition: *Consumer managed care describes managed care arrangements whereby each individual with disabilities and his or her family or guardian has the power within pre-defined limits to decide how funds should be expended in supporting the person with disabilities.*

Cost Containment Assumptions: *This model operates under two interrelated assumptions: (a) consumers working on limited budgets will spend more prudently in order to obtain the most value for their money⁸; and, (b) this consumer-driven arrangement will spawn a market economy in which providers, new and old, representing the most value to consumers will survive.*

Person-centered planning and budgeting approaches are utilized to involve the person and/or his/her family as a planful customer mindful of costs. The person-centered planning is typically some variant of Mount's personal futures planning or Smull's lifestyle planning. Person-centered planning strategies are designed to help consumers identify where they would like to take their lives and to figure out how to make the most of the resources available to take them there.

Consumer managed care shifts the locus of support management from an organization into the hands of families and individuals. Cost containment is achieved by prioritizing supports within the confines of an individualized budget.

A personal agent/broker acts as a knowledgeable guide and advocate who assists with the preparation of the person-centered plan and budget. The personal agent also serves as a broker searching for ways through informal and formal support systems to meet the individual's desires and representing the person's interests in dealing with

⁸ Agosta, J. (1995) Supplemental Security for children with disabilities: An exploration of child and family needs and the relative merits of the cash benefit program, *Testimony*; Marcenko, M & Myers, J. (1994) How families of children with severe disabilities choose to allocate cash subsidies. *Jour. of Mental Health Administration*. 21 (3), 253-261.

providers. The agent/broker may be the person with a disability, a chosen family member or friend, or a paid professional.

Intermediaries serve as administrative conduits between the payers, consumers and providers, seeing to it (at a minimum) that bills are paid and services are accounted for. Funds to implement the plans are capped and managed individually (see later section on consumer-centered capitation).

Discussion

In some respects, a good deal of the tension that surrounds the possible application of managed care to long-term supports lies in its potential for subjugating individual needs to "system goals". Consumers and providers would be managed so that cost containment would be achieved. Inherently this means that system rules rather than individual choices and preferences would be dominant.

The consumer managed care model (upon which the Rhode Island C.H.O.I.C.E.S. demonstration is based) would turn conventional ideas about managed care on their head. Under this model, consumers would manage their own care, with "cost containment" being achieved by requiring them to live within a fixed budget (with the aid of a "broker" if needed). "Cost-effectiveness" and "quality" would be achieved by provider agencies vying for "market share", competing with one another on the basis of quality and value. In this context, an intermediary would serve as a clearinghouse for provider agency billings, drawn against each individual's "support budget". The state authority would define the necessary safeguards to ensure that individuals are secure and not vulnerable to exploitation.

This model is appealing for many different reasons:

- It would put consumers in the driver's seat and, hence, overcome many of the objections associated with conventional managed care models (as well as present day service systems).
- Equipping individuals with a fixed budget would create positive incentives for them to: (a) maximize the use of community and natural supports in order to conserve hard service dollars; and, (b) give them a direct means of converting their needs and preferences into an action plan. Increasing the use of natural and community supports is a frequently cited, albeit difficult to realize, goal of DD service systems.
- A "market based" approach has the potential of addressing many of the long-standing criticisms of current systems, many of which revolve around how to ensure that individual needs are responded to in systems that fund "programs" and "fixed service" models through contracts between the state and service providing agencies.

- The individual "supports paradigm" is inherently premised on achieving a "customer-driven" system. The consumer managed care model, by introducing market place concepts, fits this approach.
- There is evidence that giving individuals control over resources that can be employed flexibly results in: (a) significant shifts in resource utilization patterns; and, (b) lower overall costs (when compared to conventional service delivery models). Such results have been achieved in family support programs. In New Hampshire, the Robert Wood Johnson Foundation is sponsoring a "Self-Determination" project which is being operated by Monadnock Developmental Services, a quasi-governmental, non-profit area agency for developmental disabilities in New Hampshire. Under this project, a consumer-directed managed care model is being tested. Very preliminary results indicate that costs can be lowered and satisfaction increased when individuals have control over support dollars. Several existing family support programs are organized along these lines and have proven enormously popular with families and advocates.
- Market advocates make the point that competition is a powerful quality enhancement tool. Gaining or losing business is a central force in an organization's continuing efforts to improve quality and competitiveness, a force that is frequently absent in overmanaged, over-regulated human services systems.

There also are several questions that arise about the viability/appropriateness of this model. They include:

- Giving consumers a budget with which to work implies that there is a fair, equitable and appropriate way to determine the amounts required to meet consumer needs under varying circumstances. In other words, there must be a capitation/funding distribution methodology. Capitation is challenging enough at a systemwide or provider level; it can pose even more challenges when carried down to an individual level. For a consumer-based capitation strategy to work (i.e., result in the outcomes described above), the individual budget must be firm and not subject to manipulation. At the same time, the firmer the rules, the more likely very high levels of risk would be shifted to individual consumers when such budgets prove inadequate to address key needs. As with any approach to managed care, risk ends up being located somewhere in the system. With consumer managed care, it would be located with the individual/family rather than an MCO.
- Current developmental disabilities long term support systems operate with relatively few "suppliers". A market-based system operates under the assumption that there are ample suppliers (or at least that suppliers will enter the market place when they sense an opening) and that they can differentiate their products sufficiently in order to attract market share. Whether the benefits of a market-based system can be achieved in supply-short systems is an open question. To what extent will providers respond to or be compelled to accede to consumer demands and preferences?

- "Shopping for supports" presumes that reliable and plentiful information will be available to consumers upon which they can base intelligent decisions about where to find the best supports for the money they have to spend. This can be hard for people to do on their own.⁹
- Some observers admit that consumer managed care might prove viable for large numbers of individuals but question its applicability in the case of persons who require very intensive levels of complex, clinical services. It can be hard to predict the costs of such services. There is logic to their being managed by individuals who understand the potential benefits and pitfalls of such services.
- Some observers are concerned that individuals and families may not act prudently, thereby confronting funders with some difficult problems. For example, one concern is that individuals might spend down their budgets too quickly, leaving them without the resources needed to carry them through the entire budget period. Another concern is that individuals/families would use the dollars available to them to purchase questionable goods and services.
- Still others are concerned that a "shopping for supports" model exposes service providers to considerable uncertainty and could exacerbate problems in maintaining a healthy supplier base.

Despite these concerns, this model clearly is one that resonates with contemporary thinking about the "supports paradigm", personal empowerment and self determination, and giving people real choices about the supports they receive.

Consumer Managed Care Model: A Second Look at the Key Issues

Conceptually, there are potential pros and cons to the consumer managed care model. The viability of this model as an alternative to conventional managed care models hinges on whether certain critical issues can be addressed in a satisfactory fashion. These issues merit additional discussion.

- **Capitation.** The model is premised on the development of capitation rates that can serve as the basis for giving consumers a budget from which they can purchase services and supports which they deem "necessary" to complement whatever other supports they might have available to them. There are two models for developing such capitation:
 - **Individual capitation.** In conjunction with C.H.O.I.C.E.S., Rhode Island officials are developing a scheme whereby a fixed amount of funds will be

⁹ It is worth pointing out, however, that two states (Utah and Oklahoma) are publishing "consumer reports" that assemble information concerning provider agency performance.

allocated to each consumer on the basis of their assessed needs for supervision and support. Reserves will be established to cover certain types of expenditures and certain individuals with extraordinary needs that cannot be covered within capitation levels established. Under this model, capitation amounts will be tied to consumer "need" but risk to the consumer would be reduced by holding some dollars in reserve to address extraordinary or unforeseen needs.

- **Group capitation.** New Hampshire is developing a scheme whereby a fixed allocation of funds would be made by the state to area developmental disabilities agencies to cover all services and supports for a specified number of individuals within each agency's catchment area. The area agency would be free to spend more to support any given individual and less to support another so long as total expenditures did not exceed its allocation.¹⁰ A group capitation approach reduces the risk to individual participants by spreading risk across the full complement of consumers served by a particular area agency.

Under either approach, the individual risk associated with a fixed spending limit would be dealt with on a pooled basis (either by reserving dollars to supplement individual budgets or managing risk across many service consumers). The individual capitation approach hinges on the precision of the needs assessment device in linking service needs to capitation levels, understanding that the desired outcome is a process in which sufficient dollars are assigned to each person to address his or her "usual and customary" requirements. The group capitation approach inherently is less exacting and demanding; however, it potentially begs the question of the amount each individual would be entitled in the first place. The New Hampshire Self-Determination Project works around this issue by keying the amounts available to each person to a discount from their present service costs and pooling the remaining dollars to address problems or, if no problems arise, to expand services to additional individuals. Risk pooling is a way of addressing some of the key concerns associated with this model. Indeed, arguably it is a necessary feature if individual risk levels are to be kept within reasonable limits for a clearly vulnerable, low-income population. At the same time, obviously it is necessary to define clearly the conditions under which pool dollars are to be used and exercise discipline over its use or the benefits of employing a fixed consumer-centered budget approach could be rapidly lost.

- **Changes in Capitation Over Time.** Another key issue is the way in which capitation amounts would change over time. In particular, if an individual underutilizes the amount available under his or her budget, will the excess capitation be "reclaimed" or will the person remain "entitled" to the original amount? What circumstances would trigger a permanent change in an individual's capitation? Under this model, variances between actual utilization and capitation amounts

¹⁰ Note: if and when the area agencies are capitated, New Hampshire's model might be viewed as much as a case management model as described under Utilization Management as a Consumer Managed Care model.

suggest the need to establish a "risk reserve".¹¹

- **Personal Agent.** This role is most prominent in MDS' Self-Determination Project. Here the personal agent is described as the "linch pin" of the approach. He or she organizes the person-centered planning process, including the creation of a circle of support, helps the person to locate and arrange all relevant plan and supports and calculates the individualized budget. The personal agent approach builds in certain safeguard against the development of budget plans being developed that are unrealistic.

The Rhode Island C.H.O.I.C.E.S. project describes such agents as available within the state unit but urges that the person him or herself either act as their own agent or seek out an agent among family or friends. The state is planning to establish four resource centers, one administered by the state, another by a consumer organization, another by the University Affiliated Program and another by a family organization. These centers will provide technical assistance and information to aid consumers, families and other personal agents.

The financial question raised by the personal agent approach is whether the costs associated with such agents are a claim on the consumer's budget or should be a general cost to the "system". There are pros and cons to each approach.

- **Allowability.** Concerns about the possibility that individuals and/or families might decide to use their allocated resources to purchase questionable goods and services are legitimate (even though frequently such concerns are blown out of proportion¹²). Undoubtedly, most policymakers would be unwilling to support a model that offer consumers *carte blanche* controls over the use of public dollars. This implies that rules and guidelines will need to be established that define the allowable uses to which consumer/family budgets might be put. The critical question is whether such uses can be defined in a fashion that does not unnecessarily tie the hands of individuals/families.
- **Cooperatives/Collaboratives.** Another variation on consumer managed care might be to enable families and/or individuals to pool their individual dollars by establishing a cooperative or collaborative through which members agree to abide by collectively determined rules. Such a collaborative might use support brokers/personal agents. The collaborative would establish and manage its own risk pool. They would be consumer-governed and could include arrangements whereby

¹¹ If budgets are not adjusted from period to period, it will be necessary to estimate the expected utilization of dollars that represents the difference between the last period's budget and actual outlays and set dollars aside in order to guard against changes in utilization patterns. If capitation amounts are adjusted from period to period, however, it can promote a "use it or lose it" mentality.

¹² In cash subsidy family support programs, for instance, families have been found to use their dollars to purchase patently appropriate goods and services.

members also agree to make in-kind contributions, in the form of taking care of day-by-day administration or staffing an office. This collectivist model could realize some of the advantages of consumer managed care while also serving as a vehicle for addressing risk and giving individuals and families another way to take command. Appendix N outlines a support brokerage approach that incorporates some of these features.

- **A Mixed Model?** Another key issue is whether this model might be linked to more conventional managed care approaches under some type of hybrid arrangement. Under such a hybrid arrangement, the aim might be to have most consumers directly manage their supports, but, when certain circumstances arise (e.g., the individual requires high levels of clinical interventions), the "system" would play a far more proactive role in care/support management. For example, the "system" might very closely manage certain costly services (e.g., therapeutic services) in order to ensure that they are efficacious or might manage support delivery more tightly when overall costs rise above a designated threshold. Such a hybrid model might parallel the emergence of specialty managed care plans in the health care sector to address the deficiencies of the primary care system in addressing the needs of persons who have extraordinary needs that can benefit from focused care coordination. Appendix O outlines a prototype of such a model.

Summary: Consumer Managed Care

The consumer managed care model involves a substantially different approach to managed care than other conventional models that revolve around MCOs. It resonates with contemporary values. In certain respects, it defines a "managed competition" rather than a "managed care" approach. Its ability to "cost contain" might be just as strong as an MCO approach while avoiding the complications of the MCO model. At the same time, converting to a consumer-directed approach that would assign fixed budgets to participating consumers (even with predefined "safety valves") would be a major (although not necessarily unwelcome) change in the way in which current DD service systems operate. There are thorny issues that need to be addressed under this model (although they may be no more difficult to resolve than the issues that arise under the MCO model). Certainly, while unconventional, consumer managed care could prove to be a robust and ideologically more satisfactory managed care model in developmental disabilities long-term support systems.

Utilization Management

Definition: *Planning and Coordinating services and supports, and reviewing and approving planned services and supports for particular individuals in the interest of cost effectiveness and cost containment.*

A utilization management model is designed to root out unnecessary services and test the necessity of services against their efficacy.

Cost containment assumption: *The planning, coordination and review of the efficacy of services and supports for individuals by experienced professionals can lead to more cost-effective long term care arrangements for people with disabilities.*

In one form or another, "utilization management" is a pervasive concept in managed care. Under the MCO model, utilization management is critical to managing the care delivery process in accordance with budget constraints and achieve savings by cutting back on the delivery of inappropriate services. In the consumer managed care model, individuals would manage their own utilization in order to maximize the personal value of their support budgets.

Now, we will examine utilization management in its own right and, therefore, the extent to which it might serve as a distinct "managed care model". In many ways, the "ills" that managed care might help resolve have their origins less in the economics of service systems than in the way in which the supports delivery process itself is managed. This discussion also helps illustrate some of the dimensions that utilization management might take under other managed care models as well.

There are four basic types of utilization management activities that might be undertaken as part of managed care arrangements: (1) prospective reviews; (2) concurrent reviews; (3) retrospective reviews; and (4) case management/triage.

- **Prospective reviews** take place prior to service delivery. They are commonly referred to as gatekeeping activities. The aim is to control the use of services and supports. Individuals are subject to review by a person or group authorized to admit, certify (approve) or refer them for service.

The enrollment or certification criteria and process may govern participation in a managed care system as a whole, or in particular services and supports. The criteria may be relatively rigid affording little latitude to the reviewers making the admission decision, or relatively loose affording a great deal of latitude.

Nurse practitioners are commonly employed to screen, serve and refer patients seeking general physician services in health maintenance organizations. Likewise, general practice physicians typically are employed to screen, serve and refer patients who may be candidates for specialty services.

Judgments concerning the probable cost-effectiveness of long term services and supports must be made in view of the informal supports available to the individual as well as the individual's level of functioning (supervision and support needs). In the Rhode Island C.H.O.I.C.E.S. project, medical necessity criteria (defined from a health and safety perspective) are to be used in deciding whether there is a need for out-of-home supportive living and day services (e.g., as a result of homelessness, abuse/neglect, caregiver incapacitation, death or abandonment, or criminal

behavior). As discussed later, still other criteria would be used to assess the level of supervision and supports required and the corresponding capitation rate deemed sufficient to underwrite their cost.

In a managed long-term support system, alternative models of prospective review would serve the purpose of attempting to match each individual to the array of supports and services that are most likely to meet his or her needs as opposed to assigning individuals to available "slots". For prospective reviews to have the desired outcome of reducing costs/improving efficacy, the service system itself would need to be agile and flexible. Moreover, the prospective review mechanism must enjoy considerable credibility (e.g., its "rules" and "processes" must be regarded as valid and trustworthy).

- **Concurrent reviews** take place during the course of service delivery. Common examples of concurrent reviews include continued stay reviews for residents of ICFs/MR and reviews by designated authorities to determine whether to continue a particular plan of therapeutic treatment. Such reviews may be scheduled at periodic intervals during the course of the service or support, or triggered by particular events (e.g., the expenditure of a certain amount of money).

Review schedules should be in keeping with the nature of the expected outcomes and costs. Reviews of therapeutic services and other treatments and supports, the effectiveness of which vary from individual to individual and approach to approach, should be scheduled relatively frequently. Continued residential stay reviews for individuals whose functioning is relatively stable and who would not be expected to improve to a level where less supervision and support might be appropriate should be scheduled relatively infrequently. Providers can be relied upon to signal the need for a review of individuals whose functioning has declined to a point where a more intensive level of support may be warranted.

For some types of services and support, concurrent review might play an important cost containment role. This may be particularly true for relatively high cost services which demand disproportionate amounts of system resources on a case-by-case basis. Continually testing the usefulness of such services by assessing their efficacy is an essential management care strategy.

- **Retrospective reviews** take place after the service or support has been delivered. A retrospective review usually involves a data-based process that is designed to surface service and support patterns among particular providers that appear to depart from accepted patterns and to be cost-ineffective. Providers might be counseled, trained and even restructured in an attempt to eliminate these patterns. Service and support contracts might be directed away from providers that persist in using disfavored practices. Retrospective reviews also might be used to identify patterns of underutilization (e.g., a low rate of placement of individuals into integrated employment positions).

In developmental disabilities systems, frequently there are disparate patterns of service delivery among provider agencies. There can be valid reasons for these differences (including case mix, the availability of other community resources, and legitimate differences in support strategies). At the same time, some differences can suggest problems in the way in which supports are being managed and the provider performing. Retrospective review is designed to separate legitimate differences from questionable practices in order to improve systemwide performance.

- ***Case Management.*** The aim of case management is not to restrict access to particular services and supports but to plan, seek and negotiate a mix of services and supports for an individual that will be cost-effective in the short and long run. Case management activities are more professionally directed than the broker/personal agent activities described under consumer managed care, with consumer preferences and choices subordinate to cost-effectiveness considerations. Unlike prospective, concurrent and retrospective review procedures, which are reactive in nature and which relate to a specific service or support, case management mechanisms are proactive and may address any number of services and supports. The case management agenda need not be confined to the procurement of formal supports available through the managed care system but can involve planning and accessing informal supports as well.

There are a number of such case management models that are part of managed care arrangements for people with developmental disabilities, including the proposed arrangement in Tennessee and operational system in Arizona. The case management function in Arizona is organized as part of the managed care organization. As proposed in Tennessee, case management would be handled apart from the managed care organization. As part of the managed care organization, case managers have an inside position in helping consumers negotiate with the participating service network. However, it may be difficult at times for these inside case managers to look first to the consumer rather than the MCO for direction. Working outside of the MCO, case managers have only one set of interests to serve, those of the consumer.

A model common to managed health care is the Primary Care Case Management model. Most states now have such programs for Medicaid recipients (although their scope varies considerably). The primary care case manager (PCCM) is paid to manage the health care of Medicaid enrollees on a fee-for-service basis. The PCCM, traditionally a physician, assumes no risk (i.e., he or she is not responsible for keeping expenditures below a fixed cap; however, there may be incentives designed to encourage cost-effective referral patterns). States vary in the extent to which they monitor and control referral patterns. The proven cost containment value of this model, at least as applied in the health care field, has been minimal (NIHCM). Still, it is worth mentioning since, with possible adaptations, it may have some applicability for allied health and specialty services.

Increasingly nurses and non-medical personnel are serving as PCCMs, with a focus on planning and referrals to specialized, non-medical care. As described in Chapter 4, there are a number of such programs now underway for people with chronic illnesses and disabilities (e.g., Massachusetts' Community Medical Alliance; Wisconsin's Independent Care).

Another approach is to concentrate case management services on those individuals who demand an extraordinary amount of care in order to tightly manage the delivery of their supports and, thereby, achieve greater cost-effectiveness and service efficacy. Such an intensive case management or service coordination model has been used for some time in HMOs. These models are usually termed "large case management" or "catastrophic medical management." They are being used more and more in serving persons with severe mental illness, often patterned after Test's and Stein's Program of Assertive Case Management (PAC). Similar models are being employed in serving persons with developmental disabilities who present many challenges (e.g., one-on-one programs; wrap-around service models; etc.). The logic of such approaches is that by applying intensive care management to high cost cases, it is possible to reduce short and long-term costs.

Where case management is proposed as a utilization management tool, the key premise is that better, more focused "care coordination" will provide greater assurance that support dollars are being used consistently to achieve desired effects. The considerations in this regard are two-fold. As a general matter, developmental disabilities service systems probably would benefit from qualitative improvements in their general purpose case management systems. At the same time, experiences in the health care sector suggest that there also are important benefits to be reaped by creating more specialized care management capabilities to provide focused and intensive approaches, particularly when individuals have complex needs that cut across disciplines and services.

Utilization management is a common feature of managed care arrangements. Its chief value lies in focus attention on "what's needed, nothing more".

It is important to recognize that utilization management can turn into a bureaucratic rat maze. Indeed, it is one of features of managed health care that is cited as the most problematic for both consumers and practitioners. The validity of utilization management approaches rests on establishing concrete and appropriate criteria against which judgments can be made regarding the appropriateness of a particular course of service delivery. In turn, this means that there must be solid information concerning the efficacy and cost-effectiveness of various approaches. In developmental disabilities services, there has been a serious underinvestment in amassing information regarding efficacy and cost-effectiveness; there also are major disputes regarding appropriate practice protocols and support strategies. Since utilization management plays a large role in achieving cost savings through the application of managed care to a service system,

these problems will need to be addressed in a proactive and constructive fashion.

Utilization Management: Observations

The upside of utilization management is that it can do as much to promote improvements in the quality of services and supports as it can to promote cost containment. The downside is that poorly conceived review procedures and criteria, or inept reviewers and case managers can hurt as much as help the consumer as well as the bottom line.

Utilization management can serve as a stand-alone "managed care model", particularly if it is coupled with system changes that permit results to be tied more resolutely to the actual services and supports that people will be receiving (i.e., a commitment to cut off ineffective services or tightly police providers that practice outside acceptable boundaries). To be effective, there would need to be wide-spread agreement that the rules under which a utilization management system is operating are necessary and appropriate. Utilization management also can be a feature of other managed care models.

Service Substitution

Definition: *Lower cost service and support arrangements of comparable quality and efficacy are developed or supported in lieu of higher cost arrangements. The funding attached to the more costly arrangements is freed and shifted to less costly arrangements and to support additional consumers.*

Service substitution is the resolute replacement of high cost service models with lower cost, equally efficacious alternatives.

Cost containment assumption: *The resolute substitution of low cost alternatives for high cost service models would have major implications for improving the cost effectiveness of service systems.*

Historically, in developmental disabilities service systems, most states have used new funds to develop innovative, more cost-effective service and support arrangements. However, this strategy changes delivery systems only at the margins. If managed care is to make a difference, existing delivery systems must be recast to offer more cost-effective alternatives.

The principal long term cost of supporting people with developmental disabilities is outlays for "supervision" and support. Decades ago (in what is aptly labeled the custodial era), the predominant service options for people with mental retardation and other developmental disabilities were large, facility-based, congregate residential and day training programs. Savings were realized by packing individuals into these programs, effectively diluting the level of supervision and support afforded to each participant. The

era ended following media exposes and public outcry over the abuse and neglect that resulted.

Today, supervision and routine support remain the major cost and largest potential source of savings, but there are now a wide variety of supportive living and employment arrangements which allow supervision and support to be rendered more cost-effective. Natural supports can be used in lieu of paid staff. However, there are systemic barriers to realizing the potential cost savings that could be achieved if these models were employed more broadly. A "service substitution" model, in effect, is an effort to remove these barriers.

Discussion

At one end of the system reconfiguration spectrum is the competitive model. Providers may compete for individual consumers on the basis of service and price, as is the plan under Rhode Island's C.H.O.I.C.E.S. proposal, or they may compete to serve a particular group of individuals on the basis of price and service. Competition has been proven time and again to be the ultimate force for system change. Competition is known to be an important force in containing costs. Thus, in organizing managed care systems, it is important to promote -- not eliminate -- competition. (e.g., in Rhode Island, which has many large providers, the plan is to treat them as MCOs and promote competition among them). Alternatively, competition could be promoted among providers within the supplier networks that are being managed by the MCO(s).

A prerequisite for the competitive model, of course, is the availability of qualified and interested competitors. Competition among providers of services and supports for people with developmental disabilities is limited in many areas, however, owing to the domination of a few large providers, limited financial incentives, labor shortages, and other factors.

Where providers are competing to enroll individual consumers, one would expect them to be especially responsive to the needs and preferences of the individual. However, they will need to have sufficient financial reserves to absorb the revenue losses associated with consumer disenrollments and to adapt their service offerings as necessary to attract consumers and the related revenues needed to survive. The state or MCO can stabilize the situation for providers by establishing a reasonable set of preconditions that must be met or by limiting the frequency of enrollments and disenrollments.

As has been the history with HMOs, one also should expect some creaming in cases where providers are inclined to accept only those consumers for whom the revenue/cost ratios are favorable, while rejecting others.

Creaming can be discouraged if the managed care organization issues a request for proposals to qualified providers to establish alternative, less costly service and support arrangements for a particular group of individuals that includes more challenging as well

as the less challenging individuals in the group. This approach should also lead to a more stable revenue stream from which providers can manage their operations. However, the fact that the bid is structured for a group of consumers mitigates somewhat the influence of individuals within the group.

If under either of these competitive approaches to restructuring, providers are able to reject applicants, the MCO or state must be prepared to step in to negotiate acceptable payment and/or other features necessary for providers to accommodate such individuals, or they must be prepared to develop the needed services and supports for these individuals themselves, at least until another option can be found or the developed service or support arrangement can be spun off. This has long been the practice in a number of state and area DD authorities across the country (e.g., NH and CO) where interested and qualified providers could not be found.

Another possible downside to a purely competitive model is that some valued providers unable to bear the costs of converting from existing service and support models to the services and supports specified by the managed care entity may be forced out of operation. Consumers may be hurt in the shift from one set of providers to another if done too abruptly and without consumer safeguards as well as some fiscal and technical assistance.

At the other end of the reconfiguration spectrum is the non-competitive model, where the managed care organization works with and supports the efforts of existing providers to changeover to more cost-effective modes of service. In a service agency where quality depends heavily on the attitudes and motivation of front-line workers, provider agency leadership is crucial. The leadership must decide to transform the organization and take ownership of the process.

Many providers are unlikely to change unless and until they are convinced that the alternatives are economically viable and that their survival depends on it. In the absence of competition, other inducements must be found. A managed care plan which is aimed at promoting changes in the service and support mix may be enough to persuade some providers to changeover; still, others will act only when it is clear that their agency's funding is truly at risk. In other words, it may take a specific directive indicating scheduled shifts in funding, consumer populations and referrals to achieve more cost-effective alternatives.

One problem with the planned market model is that the costs for some providers to convert to new services and supports are far higher than the costs to starting up entirely new programs, particularly for providers that are heavily invested in facilities. Some established providers are structurally ill-suited to furnishing certain types of services (e.g., providers relying heavily on full-time, full-benefit employees are unlikely to be able to compete with secondary wage earners providing in-home respite and personal attendant services). Finally, after all the time and expense, some agencies may not be able to make the transition from one mode of service provision to another.

In practice, network management is likely to involve both models. Existing providers, for political and programmatic reasons, may be grandfathered in for a period of time (e.g., such an arrangement was negotiated in Tennessee for mental health providers). New providers emerge to offer those services and supports which existing providers prove incapable of, or are not interested in, providing. Eventually new providers may compete head on with existing providers.

If existing providers are to survive, they must be allowed a reasonable amount of time to restructure. Some providers, mostly smaller providers, may need assistance in forming alliances with other organizations to form comprehensive service and support networks. Other providers, mostly larger providers, may need assistance in converting to the provision of different services and supports. The most difficult aspect of an agency's conversion rests with the front-line and middle management staff. It is these staff who may have to change their fundamental approach to service provision, who may be subject to increasing oversight that effectively limits their programmatic independence, and who may have to alter their relationships with consumers from one of caregiver and "interpreter of the rules" to one of customer support.

Recognizing this, a number of state DD authorities and Planning Councils are actively supporting leadership training and assistance in organizational development to help providers make the transition. For example, the Oregon Office of Developmental Disabilities Services, through a contract with the Oregon Rehabilitation Association, has sponsored leadership training to promote the shift from segregated day programs to supported employment and integrated community activities for a number of years.

Providers also may need short-term fiscal assistance. Payment schedules may have to be devised to help cover the costs of conversion (e.g., the costs of facility divestment, revenue losses associated with low occupancy and staff development during the transition period, and the costs of supportive living and employment (often buried in the costs of facility-based residential and day programs). In Colorado, a number of ICFs/MR and the State Office of Developmental Disabilities were able to negotiate the assisted conversion of ICFs/MR to other, less structured more cost-effective living arrangements.

Service Substitution: Observations

In most states, potentially the biggest savings that might be achieved through managed care lie in the area of service system restructuring. This is also the most difficult to accomplish politically since the interests vested in the current service structure frequently have been powerful enough in many states to gridlock system reconfiguration.

Service substitution is a "managed care" model. Broadly speaking, it is one with which states have the most accumulated experience (e.g., particularly in the shift away from ICFs/MR to tailored supports under the home and community-based waiver program). As a stand-alone managed care model, "service substitution" involves

systemwide reconfiguration. Mechanically, such reconfiguration is simpler in systems that do not operate under multiple funding streams. In systems where current funding streams are distinctive and subject to differing rules, implementing a service substitution model means restructuring such funding streams along single stream lines. Today, a state must seek special federal waivers to pursue such reforms. Under the Medicaid restructuring proposals pending in Congress, achieving single stream funding would be accomplished in a more straightforward fashion.

Attaching service substitution to another managed care model, sanctions its use as a system management tool. Service substitution is an implicit feature of the consumer managed care model. It also is an important consideration in equipping an MCO with the authority it needs to contain cost while maintaining quality. In utilization management, service substitution also can prove to be an important tool.

Capped, Consumer-Centered Payments

Definition: *Funding to MCOs, consumers or providers is capped in order to ensure cost-conscious spending and efficient operations. The caps are set on a client-centered as opposed to a cost-centered basis in order to allow MCOs, consumers and providers the flexibility needed to perform effectively.*

Capitation both creates incentives for economical operation and increases the flexibility available to providers by avoiding the pitfalls of categorical funding.

Cost containment assumption: *MCOs, consumers and providers will operate more cost consciously if they are at some risk for cost overruns, and can operate more cost effectively if not constrained and burdened by cost-based reimbursement rules and payment systems that are linked to existing service approaches.*

To quote the designer of one such system in Kansas, once a provider himself, "[providers] can and do overserve clients ... if allowed to do so. Such a situation leads to vast differences in the services clients receive based, not on the consumers' needs, but on the provider's willingness to expend funds. This means that some clients may be receiving extremely high levels of training and supervision when lesser levels would be sufficient to meet their needs and allow the facility to remain fully certified. This also means that there is a significant motivation to keep clients in highly restrictive, intensive and expensive service models when they do not need such levels of service" (Shults, 1991, p. 2-3).

The case for capitation in developmental disabilities systems closely parallels the one that applies in health care. The use of fee-for-service payment methods creates powerful incentives to increase revenues by increasing the volume of services provided. States frequently attempt to blunt this incentive by imposing clumsy rules governing the volume of services that can be furnished. Capitation creates incentives to contain costs and obviates the necessity to control costs by micromanaging the service delivery process.

Capitation methods permit both the payor and the supplier to focus on achieving outcomes.

The capitation model can be employed as a vehicle for making payments to an MCO or it can serve as a tool that prompts service agencies or consumers to behave more like an MCO would and, thus, gain the benefits of "managed care" in a different way. Capitation thereby can serve as a "model" or be an integral feature of a broader managed care strategy.

Discussion

There are two basic consumer-centered payment schemes: (1) **individual capitation**; and, (2) **group capitation**:

- In an *individual-capitation system*, there is a dollar amount attached to each recipient of services/supports. These systems require intermediaries to help manage the funds and payments.
- In a *group capitation system*, there is a total dollar cap established for all of the individuals who are furnished a particular service or support or who are served by a particular provider or managed care organization. Group capitation schemes are workable only in the case of larger providers or MCOs serving enough consumers so that assessment errors and rate biases can average out. In keeping with the presumption of self-interest in capitation, serving organizations should have the ability to assume some risk as a motivational device for keeping overall expenditures within budget or their cap. They also should have a real-time budgeting and expense control system sufficient to avoid cost overruns.

There is an important distinction between consumer-centered capitation payments and the budgets derived from individual plans as discussed under *consumer managed care*. Individual budgets reflect the consumer's interest; capitation rates, the payor's interest. The capitation rates should be sufficient to meet consumer needs for supervision and support. However, the rates must be structured to support practicable, cost effective approaches, which will not always be the approaches that consumers prefer.

Under an individual capitated payment arrangement, the consumer could be forced to modify his or her plan and budget to fit within the cap, or to appeal for a higher rate. Under a group capitated payment arrangement, the MCO might decide to support the individual's higher-cost plan using savings available under the cap from the lower-cost plans of other individuals in the mix -- or it might not.

As a rule, these caps should be used to cover only those individuals, services and supports where the appropriate types and intensities of services and supports can be predicted for at least six months, better yet, one year. This rules out the use of specific caps for such services as physical therapy, occupational therapy and behavioral

interventions, the cost effectiveness of which needs to be reexamined more frequently. It rules out specific caps for crises management and other expensive and unpredictable short term interventions as well. It also warns against the use of caps for individuals whose needs are extraordinary and for whom service and support patterns are not reasonably stable. As a practical matter, under either type of consumer-centered capitation system, there must be provision for the negotiation of individualized rates and payments for persons with extraordinary needs. There also must be a rate adjustment procedure that allows for rate changes where there is a marked change in the individual's capacity to function or in the capacity of the natural supports upon which he or she depends.

Under either payment system, there must be reserve funds within the MCO and/or state to cover these costs. The greater the number of individuals, services and supports the cost of which cannot readily be predicted and capped, the larger the reserve funds must be to cover such unpredictable costs.

Service-Specific and Comprehensive Rates

Capitation rates may be specific to a particular type of service or support, or they may cover the full complement of services and supports that might be provided to consumers.

- **Service- and support-specific rates.** Capitation rates may be specific to a particular type of service or support, or they may cover the full complement of services and supports that might be provided consumers.

Consumer-centered capitation rates might be established for residential services, foster care, in-home supports, and day services individually. As explained below, the appropriate types of arrangements and required level of supervision and support can be fairly well predicted based on an assessment of the individual's level of functioning. It is also possible to come up with reasonable costs for each of type of arrangement and level of supervision and support.

However, the going costs are not always reasonable. The amounts paid for residential and day services in many states are heavily a function of the availability of funds, the collective and individual rate negotiation power and skill of the providers, and the vagaries of the fund allocation and rate setting schemes that have been employed in the state. Moreover, the costs of coverage for persons in supportive living and employment arrangements are often hidden within the operations and budgets of residential and day providers.

Thus, if the state or MCO wishes to establish consumer-centered rates having a more rational foundation, it will have to adopt a more normative than actuarial approach. **The most straightforward and economic way to come up with target costs for the different types of residential, day and other types of long term services and supports is to construct models of each type of service.** These

costs are also more easily understood and defensible than the costs generated through actuarial methods. It is possible, with the help of an experienced group of providers, contract and program administrators to develop such cost models within a matter of days (assuming that participants come prepared for the task at hand). Staff can help inform the effort by bringing applicable cost surveys and reports: national, state and provider-specific. Staffing standards, as contained in federal and state regulations, may be helpful, though they are regulatory minimums and invariably lower than what is actually required.

The modeling process for each service should begin with a brief profile of the offerings as a basis for establishing the model budget. For example, in the case of a supervised residential arrangement, "each resident will receive awake supervision before and after returning from a six hour day activity, prepared meals, laundry, home maintenance, supervised trips twice each week, transportation to and from day activities, medical appointments and other out-of-home activities, daytime coverage in the event that it is required due to illness." These profiles are central to the rate determination process.

For services and supports delivered by a staffed agency, it is helpful to break service costs into five areas: (1) direct service personnel; (2) program management/support; (3) direct operating expenses; (3a) facility-related and (3b) other; and, (4) administrative/indirect expenses.

Direct service staff include residential and day workers, attendants, job coaches, vocational trainers, therapists, counselors and others who spend virtually all of their time working directly with consumers. Some of these workers may have staff supervisory responsibilities as well. The model building for each service should begin with the numbers of direct service staff and consumers and the corresponding ratio of full-time equivalent (FTE) staff-to-consumers desired. This ratio is then inflated as necessary to allow for: (1) coverage across shifts; (2) sick and annual leave, vacation time, holidays and training time, and (3) for any added programmatically-driven and consumer-driven supervision and support needs.

Direct service wages and benefits (compensation) should be set at the level deemed necessary to attract and retain qualified staff. The preponderance of research shows that wages and turnover among front-line workers are inversely related. In many states, judging by reported turnover rates upwards of 70 percent among direct residential workers in private facilities across the United States (Mitchell and Braddock, 1991), it is safe to say that model compensation levels should be set far above current levels, certainly not below.

Based on studies in hand, hourly wage and benefit rates (as a percent of wages), and program management/support rates, direct operating expenses and administrative/indirect expenses (as a percentage of direct wages and benefits), can vary widely depending on the type of service, service variation, employee turnover, extent to

which the complement of direct service workers is made up of contract workers and part-time staff, the relative number of public versus private employers, reimbursement requirements and constraints, area cost-of-living, and a variety of other factors. These ranges are indicated below.

- Direct service staff - Average hourly wage \$5.25 to \$10.00
- Employee benefits - Paid absences ranging from 16 to 29 days. Paid benefits for part-time employees from 2 to 15 percent. Paid benefits for full-time staff from 14 to 24 percent.
- Program support - 12-30 percent of wages and benefits
- Operating costs - 10-49 percent of wages and benefits
- Indirect costs - 11-18 percent of wages and benefits

These base models should then be modified to suit the different types of consumers they would be expected to support. The most expeditious way to accomplish this is to derive a limited number of consumer profiles representative of the range of consumers that would be expected to utilize the service or support. Our experience indicates that the number of consumer-centered model variations will end up between three and seven depending on the service or support and the characteristics of the consumer population using it. However, given the dynamics of group process, it may be necessary to start with a greater number and work down. The basic consumer groups commonly used by HSRI for purposes of cost analysis, budgeting and rate setting are described in Chapter IX.

It makes sense to limit the number of capitation rates between 3 and 7 in the interest of administrative ease and economy. As important, resolving differences between payors, consumers and providers over consumer classifications and corresponding payment amounts is accomplished more easily with fewer more rates. The more rates there are, the finer the distinctions that must be made between one group and another. The finer the distinctions, the weaker and more arguable they become.

There are a number of consumer-centered prospective rate payment systems currently in operation for residential services for people with developmental disabilities. In Kansas, the Developmental Disabilities Profile Instrument (New York Office of Mental Retardation and Developmental Disabilities) is used to classify residents into five groups, each carrying a different payment amount. Facility payments amount to the aggregate of the rates carried by each resident adjusted to reflect facility size and associated economies of scale (Ashbaugh and Langer, 1991). In Ohio, the classification instrument was developed specifically for purposes of differentiating the staffing and special support needs of ICF/MR residents. Six classification/payment levels were initially established by an "expert panel" of providers and administrators for purposes of paying for ICF/MR direct care costs. This was eventually reduced to four levels based on the results of a work measurement study and discriminant analysis showing that four groupings

were sufficient to differentiate residents for payment purposes (Ohio Department of Human Services, 1991).

- **Comprehensive Rates.** Capitation rates may be structured to cover the full complement of services and supports that an individual would be authorized to receive (e.g., day services and other supports, and residential services, foster care, or in home supports). Comprehensive rates are an essential element of the consumer managed care approach.

The overall cap must be set based on a mix of services and supports deemed appropriate for an individual. Thus, in addition to the level-of-functioning criteria used to classify an individual into one of a limited number of rate groups for each service in the mix, criteria must be developed governing the type(s) of living, day and other support services should be available to the individual. For example, Rhode Island is preparing criteria relating to homelessness, abuse/neglect, caregiver incapacitation, death or abandonment, and criminal behavior to decide whether an individual should have a cap sufficient to cover the cost of out-of-home residential services.

Again modeling should be used in developing these capitation rates. However, the modeling will be system level modeling like that described for use in the feasibility study (Chapter IX). As described in Chapter IX, the model should be used to compare the projected costs under the proposed capitated payment schemes to current costs or more specifically to projected revenues. Of course, the capitation scheme must project costs no higher than the funding available under the managed care arrangement. Nor can it project costs that are far below current levels, which is typically the case when modelers shape the caps to reflect service and support patterns that are more ideal than real. As indicated in Chapter IX, initially rates must be set to more closely reflect current service and support patterns. Over time the state or MCO might adjust rates downward to encourage the move to more cost effective arrangements.

As this is done, it is critically important to monitor the system for indications that the payment rates are insufficient to support acceptable practice and avoid provider insolvency. Indicators such as staff turnover and vacancy rates, ratios of part-time to full-time staff, provider shortages, compensation relative to that of workers in other industries recruited from the same labor pools, and numbers of rate appeals (in the case of individual caps) should be used to signal rate inadequacies.

The consumer-centered capitation methods can be administratively burdensome given the consumer assessment and classification requirements. Add to this the costs of the appeals that come with the individual method, and the tighter budgeting and expenditure control systems that are required with the group method.

Capitation: Observations

Capitation as a managed care strategy is integral to overcoming the legion of problems that attach to traditional categorical fee-for-service funding systems. Capitation can be employed as a tool to change the resources that made available to providers or individuals. The benefits of capitation emerge from the revised incentives to manage the whole rather than the parts. In this vein, the case for capitation parallels the reasons why it is used in managed health care. However, there are pros and cons concerning various approaches to capitation (as there are in any payment system that is designed with cost containment in mind).

Capitation also is integral to a state's contracting with an MCO or operating a consumer managed care system. Capitation is the engine for system cost containment.

Conclusion

Each managed care "model" has its own distinctive characteristics and considerations. Some are very different. Some might operate independently or be included as components of others. In long-term supports, the introduction of "managed care" will be a process of deciding which of these models to use (singly or in combination).

CHAPTER IX
MANAGED CARE FEASIBILITY STUDY

IX. Managed Care Feasibility Study

Much of the preceding discussion has been conceptual in nature. Laying out design principles and models is one thing; operationalizing them, quite another. The purpose of this chapter and the one following it is to lay out activities and steps through which to move from the theoretical to the practical realm of managed care, as well as to introduce important considerations that should be addressed during the process. The first stage in the process is to prepare a **managed long term supports feasibility study**; the second stage is to develop a **managed long term supports plan** (which is described in the next chapter).

The aim of the managed care feasibility study is to identify which managed care approaches might be pursued, how and to what effect.

The aim of the feasibility study is not to decide whether to pursue a managed approach to providing long term supports for people with developmental disabilities. Rather, the aim is to identify which managed care approaches might be pursued and how -- more specifically, what models/mechanisms are economically feasible (e.g., likely to have the greatest payoff) and what types of conditions and organizational capacities are most likely to foster successful implementation. In other words, the feasibility study is concerned with identifying the most promising managed care approaches and assessing the "readiness" of the system to pursue them. It is designed to point decisionmakers in the right direction and serves as a foundation for the managed care plan that: (a) defines the system's purpose and scope; (b) specifies the cost containment and quality assurance and improvement mechanisms that will be employed; and, (c) lays out the corresponding information system/operational requirements.

Wherever possible, a feasibility study should precede the preparation of the actual managed care plan. Such a study allows for the explication and systematic examination of alternatives. The resulting analysis can point to sensible approaches free of the political factors that could undercut the process were they to first surface, as a *fait accompli*, in the managed care plan. The feasibility study can be completed in a relatively short period of time, an important feature if it is to be considered amidst the rush of managed care ideas being advanced in a number of states. The power of

Topics Covered...

- ☒ **Formulating the guiding principles**
- ☒ **Defining the potential scope of the managed care system**
- ☒ **Estimating and projecting available funding**
- ☒ **Projecting and comparing the costs of services and supports with and without alternative managed care arrangements**
- ☒ **Estimating the impact on administrative costs**
- ☒ **Assessing organizational capacity to assume responsibilities under a managed care system**
- ☒ **Reporting the results of the feasibility study**

the feasibility study lies in its focus on costs and organizational/management capacity -- the central concerns of most state policymakers.

The feasibility study may be conducted by a small number of staff or consultants, but they should seek input from the many stakeholders who will be affected by the changeover to managed care: consumers, advocates, providers, and administrators. This input is an indispensable part of the system modeling that is required to determine the estimated cost implications of alternative managed care approaches that are described in Step 4 below. *We strongly suggest the establishment of a modeling committee.* At its core, this committee should include a group of providers who have first hand experience in furnishing services and supports to the target population, current and planned. In order to represent any service and support models not currently in place in the state, experienced hands from outside of the state might be invited to participate. It is common practice to employ experts in building a model. Their knowledge is more practical than theoretical, and will better assure the development of realistic model projections -- e.g., they might reflect the time and effort required to build supportive living arrangements, to recruit and train home care providers and job coaches. The input of a broad range of key informants also is essential in gauging the capacity of existing organizations to function as part of contemplated managed care alternatives.

There are seven activities involved in conducting a managed care feasibility study. The first is formulating the general design principles that should govern the managed care arrangement. The second is establishing the scope of the contemplated managed care system. The third involves estimating and projecting the funding available to underwrite the managed care system. These first three activities circumscribe the range of managed care alternatives to be considered as part of the feasibility study.

The fourth activity is estimating the potential savings/losses associated with changes in service utilization patterns and rates of payment that are expected to be achieved with the implementation of the contemplated managed care mechanisms. The fifth activity encompasses estimating the probable increase or decrease in administrative costs associated with the implementation of the different managed care mechanisms. The sixth activity is assessing the capacities or "readiness" of different organizations to assume responsibilities entailed under a managed care system. The seventh activity involves preparing and presenting a report containing the results of the feasibility study.

Activity 1: Formulating the Guiding Principles

The first activity is as basic as it is essential: spelling out the general design principles under which a managed long term supports system for people with developmental disabilities will be shaped. These principles might be similar to those contained in the NASDDDS position statement on this topic (see Appendix L) or locally developed. It is absolutely critical that these principles be articulated in collaboration with key system stakeholders as well as policymakers and budget officials. These general design principles should guide the process. They should clarify the central goals that will

be pursued and the "non-negotiables" that must apply (e.g., assuring that individuals and families continue to exercise critical lifestyle choices, promoting inclusive support strategies, maintaining linkages to communities, and establishing parameters concerning risk). Embarking on managed care without anchoring the system in such principles invites chaos and confrontation down the road. Managed care is system change. Collaboration among all key stakeholders is essential for any system change initiative to succeed.

Activity 2: Defining the Potential Scope of the Managed Care System

The second step is to define the potential scope of the managed care arrangement(s) to be considered. This step will limit the scope of the feasibility study and, thus, the time and expense required to complete it. The scope should be defined in terms of the target population, organizations, jurisdiction(s), and services/supports that the arrangement will encompass. The general *model-based* considerations involved in circumscribing the managed care feasibility study and plan are discussed in Chapter VIII. This step involves translating them into operational boundaries by zeroing in on the most logical components of a managed care system in the state.

Defining the scope of the arrangement involves deciding which services and supports will fall under the managed care arrangement.

- **Jurisdiction(s).** As a rule, managed care arrangements should be launched on a geographically limited, pilot or demonstration basis in order to obtain information concerning how the particular arrangement works in practice. Indeed, if feasible, it might be instructive to test different managed care approaches in each of a limited number of jurisdictions.

However, going into the feasibility study, the jurisdictional framework should be statewide. It makes sense to start at the most global level. Limiting the feasibility study to particular area(s) at the outset would make sense only where there are some urgent reasons that dictate that managed care arrangements should be first developed in particular areas (e.g., a court-order closing a state facility that serves a particular region of the state). Excluding jurisdictions from consideration would make sense only where it is clear that managed care arrangements could not be introduced in these areas for political or practical reasons (e.g., in some rural areas where the lack of administrative and service capacity would make it difficult to establish an effective managed care administrative organization and render managed care approaches of little demonstrable value; or in areas where the service systems and consumers regularly cross area boundaries, thus making it difficult to circumscribe a managed care effort). As the managed care development process unfolds, jurisdictional limitations might be considered for various reasons, including testing various approaches, phase-in considerations, and so forth.

- **Organizations.** There are any number of organizations within a state that might play instrumental roles in managed care arrangements. The purpose here is to limit

consideration to those organizations that are politically possible and acceptable. As explained in Chapter VIII, private non-profits have a decided advantage as managed care organizations. However, there may be political considerations that work in favor of particular public or private for-profit organizations. In considering the potential for different organizations serving as managed care entities, it is important to think of them not in isolation but in terms of how they might work in conjunction with other prospective managed care entities.

- **Target Population.** The target population should be defined as including at least all persons currently receiving services over which the managed care organization is expected to have control. It should also include, conditioned on the availability of funds, persons awaiting services and meeting the state's eligibility criteria. As discussed in Chapter VI, the feasibility of including other disability groups can be considered as well; however, only to the extent that key design principles are not compromised. In a practical vein, it probably will prove necessary to treat children and adults as separate target populations as the managed care models appropriate to each can be quite different. Additional observations concerning whether it might be better to develop separate strategies for adults and children are offered below. The target population may be redefined as the feasibility study proceeds and more is learned.
- **Services and Supports.** As discussed in earlier chapters, the managed long term care arrangement may encompass some services and exclude others for a variety of reasons. Medical services probably should be excluded since they already are or will be covered under other managed care arrangements. Some rehabilitation services may be excluded given the inability to gain control of the funding. While ultimately it may be decided that some services should be excluded from the plan, it is generally best to include all mainstream services when conducting the feasibility study.

During the course of the feasibility study, the general rule is to be as inclusive as possible at the outset. As the study unfolds, the scope may narrow for any of a variety of reasons. These reasons can be reported to policymakers and decisionmakers when the study results are presented.

Activity 3: Estimating and Projecting Available Funding

Payors employ managed care to put their expenditures for services on to a predictable track. In health care, private sector payors look at the amounts they are paying for coverage and set cost reduction targets. Then, they negotiate with health plans and MCOs to achieve those targets, invite bids to find the plans that will help them achieve the target, or check out other available "product lines". In other words, the payor has in mind the amount it is willing to spend for coverage and uses this cap to guide its purchasing in the health care marketplace.

In order to assess the potential effects of a managed care approach, the feasibility study must be based on solid information concerning present and future system costs and resources.

Public sector purchasers of long-term supports have to engage in the same basic process when launching a managed care initiative. Their dollars are limited (by appropriations or the overlays that other funding sources place on them). Since managed care plans typically are multi-year, public agencies must understand not only what it is they spend today but also the extent to which the funds in the system might grow over time. This can be a complicated process -- indeed one that is far more complex than faced by private sector buyers. In the private sector, the total amount available to spend for health care is the sum of what the employer is willing to spend and how much employees are expected to contribute. Long term support systems usually have multiple funding sources (federal, state, local, and consumer), each of which has its own peculiarities in terms of how dollars enter the system.

Despite these complications, a state's entry into the managed care arena must be preceded and guided by determining the funding "cap" under which the system will operate over the time horizon in which the managed care plan will be in effect. This cap is the amount that the state can garner to underwrite a managed long term care system for people with developmental disabilities. These are the dollars to be managed. They are the baseline against which the managed care plan or strategy is developed. Since a managed care arrangement is a major undertaking, it makes sense to develop a managed care plan that extends over a five year time horizon. Absent a clear sense of what the baseline is, it is impossible to construct a realistic managed care plan.

The Baseline

Determining the baseline or the cap obviously is directly related to decisions concerning the scope of the managed care system: which programs, services, or supports will be delivered through the managed long term support plan/system and which will remain outside the plan/system. It also is directly related to which target populations will be served through the managed care arrangement. A managed care plan can be structured narrowly or broadly. "Boutique" specialty health plans serve a narrow slice of the SSI population. Many of the Medicaid "superwaivers" offer a very broad scope of coverage (all Medicaid acute care services furnished to all recipients). **Hence, the step that precedes determining the baseline is deciding which services are to be furnished through the plan to which target populations (including whether the plan's operation will be geographically limited).**

Developmental disabilities systems are "composite" systems. They combine Medicaid and non-Medicaid dollars to support their target populations. Under present Medicaid law, these dollars are tied directly to the system's service population: they may only be spent on services/supports for people with developmental disabilities. Examples of these earmarked dollars include HCB waiver funds, ICF/MR outlays, and state only funds under the control of the state's developmental disabilities authority. Other dollars/funding sources (which, depending on the state, may be large or small) are accessed on an availability basis to supplement specialized dollars. Such dollars may

include vocational rehabilitation funds, "generic" Medicaid benefits (such as physical therapy services that are often available through a state's Medicaid program), and general purpose state supplements to federal SSI public assistance payments.

As a general rule, a managed care plan should wrap around all the dollars that are available to support the specified target population, for the following reasons:

- The benefits of a managed care approach are more likely to be realized when a plan can draw on all available funding sources in order to construct unified support strategies for individuals. Managing only a slice of the dollars complicates and fragments the support delivery process. A key motivation for managed care in developmental disabilities support systems is to achieve single-stream or "seamless" funding of supports, free of categorical, rigid restrictions. Capitulating only one part of the developmental disabilities service system would limit the effectiveness of the managed care arrangement, since it would represent yet another fragmented approach to addressing the long term support needs of this population.
- When significant service sectors are left out (e.g., left in the "unmanaged system"), then the potential for "cost shifting" arises. The MCO might deny benefits based on their purported availability from other systems; other systems might deny services based on the presumption that they are available through the plan.¹ If state-funded services are included but locally-funded supports are not, plan operation also becomes complicated.
- When services/dollars are left outside the plan, they are vulnerable to changes that can affect the plan itself. For example, if Medicaid personal care dollars are left outside the plan but subsequently cut back, then the financing of the plan itself can be undermined (i.e., the plan may be forced to make up for the generic dollars that are lost). A managed care plan is less risky when it can operate independently.

As a practical² matter, the services/supports and their associated dollars that can be included in the plan cannot be completely comprehensive for a variety of reasons. For example, if a plan's target population is adults with developmental disabilities, the inclusion of vocational rehabilitation dollars (including dollars for supported employment) would make sense. However, management of these dollars cannot be literally delegated by the state's rehabilitation agency to another entity to be used as it sees fit or under rules that are at odds with federal requirements. Probably the best that can be achieved in this circumstance is negotiating an agreement between the rehabilitation authority and the

¹ This problem has been encountered in mental health when a managed care system is run in parallel with a public mental health system that is obligated to serve as the "safety net".

² Where the managed care population is receiving services and supports funded outside of the cap and where an agency is serving both members and non-members of the managed care population, the state should draft agreements with the agencies funding these services and supports to guard against the shifting of costs to or from the managed care fund.

developmental disabilities authority that delineates the terms and conditions under which plan participants are referred for rehabilitation services. A possible alternative might be a contractual agreement through which the rehabilitation authority makes a grant to the DD authority to arrange for employment services for a specified number of plan participants. Dollars/benefits can be coordinated but they cannot literally be managed by the DD managed care plan.

Similar issues can arise with other funding sources. For example, some state SSI supplements are general in nature (e.g., all individuals with disabilities qualify for them). Some are specific to people with disabilities (e.g., supplements that are tied to a person's residing in a designated specialized living arrangement). The dollars tied to general purpose supplements cannot (and probably should not) be managed by the plan. Earmarked supplements (particularly when tied to specific living arrangements) probably should be brought under the plan in order to achieve single stream funding.

It is useful to point out that achieving single stream funding for adult populations is a less complicated task than with children's services. In the arena of children's services, there are a multitude of federal funding streams (including Medicaid EPSDT, Titles IV-B and IV-E of the Social Security Act, and Parts B and H of the Individuals with Disabilities Education Act (IDEA)), as well as multiple state and local funding streams for child welfare and education services. While there are potential benefits to single stream, global funding in this arena, it would be necessary to forge a very complex web of agreements among multiple agencies and funding sources. This does not necessarily mean that a managed care approach for children's services is infeasible or would not be beneficial. However, it may well mean that the scope of such an initiative will necessarily be limited and that specialty plans rather than broad-based plans will prove to be the most feasible.

If a managed long-term supports plan targets primarily adults with developmental disabilities, then its practical scope should include:

- Outlays for public and private ICF/MR services, including large public facilities;
- Outlays for services purchased through HCB waiver programs that target people with developmental disabilities;
- Outlays for Medicaid "targeted case management" services for people with developmental disabilities;
- "State-only" outlays for daytime habilitation and vocational services;
- Other state appropriations/outlays for services/supports that will be included in the plan's scope of benefits (e.g., family support services for adults living at home);
- Federal Social Services Block Grant dollars earmarked for services to this population; and
- Local tax dollars spent on these services, provided that the local contribution is mandatory. Discretionary local dollars only can be included in the plan to the extent that the local government agrees to do so.

The plan should exclude "one-time" only dollars since they are not part of the continuing baseline.

Determining the baseline becomes more complicated when certain Medicaid benefits/services that play a direct role in supporting Medicaid recipients generally (i.e., they are not reserved exclusively for people with developmental disabilities). Examples of such benefits/services include (depending on the state) therapeutic services, durable medical equipment, personal care, home health, and so forth. In each case, people with developmental disabilities are but one population group that uses the benefit. Hence, drawing these dollars under the plan is not as simple as including specialized services/supports that are solely earmarked for people with developmental disabilities. It is worth pointing out that the changes in the Medicaid program that Congress is likely to enact could make it easier to shift these resources into a comprehensive managed care plan.

Moving "generic" Medicaid service dollars under the plan involves dealing with a variety of considerations, including:

- **First, it must be feasible to pinpoint the generic service dollars that are spent on behalf of the plan's service population.** This can be difficult because generally Medicaid data systems routinely tag outlays only by very broad eligibility categories (e.g., "adult disabled" recipients) rather than by subcategory. However, data reporting requirements under the HCB waiver program dictate that states track utilization and spending for Medicaid services that are being accessed by both ICF/MR and HCB waiver participants. If a plan's scope is broader than the present HCB waiver and ICF/MR populations, however, a state will have to conduct special analyses of Medicaid expenditure data in order to determine baseline spending levels for generic benefits. This can be accomplished by sampling techniques as explained in the *Medicaid Baseline* section (see below).
- **Second, putting the dollars associated with a generic benefit under the managed care plan means that the benefit will only be available to plan participants through the plan.** The plan becomes responsible for furnishing the benefit; the individual's Medicaid card no longer entitles the person to the benefit on a free standing basis. Where a benefit is employed routinely by a large portion of the plan population, drawing it under the plan makes sense. Where a benefit is not used routinely or for reasons not directly associated with the aims of the plan, it may make little sense to bring it under the plan. An example of a benefit that might be better excluded is home health services when such services are used for post-hospitalization care. If a plan will serve only a segment of the population (e.g., adults who require out-of-home residential services), additional complications can arise.
- **Third, generic services should never be drawn under the plan if the plan cannot exercise control over them, including determining their price or**

applying utilization management to them. Any benefit inserted into a plan that the plan cannot control directly (predict reliably) adds risk.

In the arena of generic Medicaid services, it makes sense to include in the plan the services and supports that are directly related to the ability of the plan to deliver essential services and supports to the target population (for example, Medicaid clinic or rehabilitation services dollars that undergird funding for daytime services) and exclude those that are more tangential.

It also is worth pointing out that the feasibility of drawing some generic services under a plan will be affected by a state's other Medicaid managed care initiatives. If the benefits that a state would like to include in its managed long term supports plan have already been included in another managed care initiative, it may not be feasible to extract them or particularly complex analyses or negotiations might be necessary.

An option that may be considered is the integrated services approach: the state's plan wraps around both long-term supports and all other health care services. Rhode Island and Arizona have decided to take this course. There are many good reasons to consider an integrated services approach, including the value of coordinating physical health services and long-term supports. At the same time, broadening a plan to include physical health services introduces its own complexities (e.g., Will the plan purchase physical health services from generic HMOs? Will it encourage the development of specialty HMOs or managed health plans? Will it develop special rules concerning trade-offs between physical health expenditures and long-term supports?). An integrated services plan might make sense; however, adopting such an approach places significant additional demands on planning for a managed system and requires specialized expertise.

The baseline (in most instances) will have three major components:

- Federal and non-federal (state and local) Medicaid outlays for services to the target population that will be furnished **exclusively** through the plan;
- State and local outlays for services/supports to the target population that should and can be placed under the management of the plan in order to achieve integrated, single stream funding; and,
- Funds that the plan cannot manage directly but which play an integral role in financing plan services (e.g., room and board obligations for individuals who are served in group living arrangements). These dollars are swirled into the equation in order to obtain a picture of the total dollars that will be financing the long term support system.

At a minimum, these component funding sources should be projected forward over a five year period. In most states, where system expenditures have been increasing at a rate above inflation, it is best to trend these expenditures forward. The expenditure

increases, past to present, will be a function of increased demand as well as increased prices. In some respects, this projection process parallels the process states have used in preparing HCB waiver requests/renewal applications.

These projections might be altered to reflect any special circumstances. For instance, the cap might be adjusted to include the expensable portions of any major capital expansion or improvement that will have to be completed during the planning period for reasons of health and safety and/or a legal mandate. It might be adjusted to reflect other recent or expected changes in system costs that are not fully reflected in the projections, such as the costs of increased staff required to maintain the certification of a large state ICF/MR. It might be adjusted to reflect a sharp increase in "non-refusable" demand coming from consumers who can no longer be supported by aging parental caregivers.

Service system configurations, funding sources, data sources and corresponding data collection, compilation and analytic approaches to arriving at a rate will necessarily vary from state to state. Most of the cost figures can be obtained in aggregate form from fund allocation records and provider expenditure reports.

The Medicaid Baseline/"Post-Reform Considerations"

Under current federal law, Medicaid expenditures must be tracked and analyzed separately. A comprehensive managed care plan will require a state to submit either a Section 1915(b)(4) freedom of choice or a Section 1115 demonstration waiver proposal. Regardless of the waiver option chosen, a state must be able to demonstrate that its waiver program will be cost-effective (in the case of a Section 1915(b)(4) request) or budget neutral (in the case of a Section 1115 demonstration request). The starting point for either demonstration is the Medicaid-funded services baseline (i.e., how much would be spent on currently covered services if a managed care approach were not instituted). The basis for these projections must be fully documented. Usually, the starting point for such documentation lies in actual program expenditures during some base period, with the state's projections based on expected changes in costs and utilization over the waiver period.

As discussed above, gathering the pertinent documentation is easier for some services (earmarked DD benefits) than others (generic Medicaid benefits). Expenditures for other services covered under the state plan and claimed individually are available only through the analysis of Medicaid claims data (e.g., therapeutic services). If these expenditures are to come under the planned long term managed care arrangement, an analysis of paid claims data must be undertaken. The most efficient way to do this is to: (a) identify the Medicaid I.D. numbers of a representative sample of consumers, stratified -- data permitting -- by age, disability level (e.g., level of mental retardation), and living situation; (b) obtain an extract of the claims paid under these numbers over the past three to five years; (c) summarize the expenditures by type of service code, using look-up tables to group related service codes by type; and (d) then inflate these expenditures to represent the baseline

expenditures of the overall client population. The analysis of Medicaid claims is a complicated and involved undertaking. It makes sense to have it done by experienced staff or consultants. The customary capitation amount is set at 93 to 97 percent of current and projected expenditures.

HCFA tests (but does not rigidly regulate) state waiver proposals against various benchmarks, including the state's own historical utilization and expenditure trends as well as nationwide trends. These tests vary depending on what waiver option is being employed. A Section 1115 demonstration, for example, in essence is a grant to a state and HCFA naturally will be cautious about committing itself for more dollars than are needed. Under a Section 1915(b)(4) waiver, however, the test of cost-effectiveness is more straightforward (e.g., is the proposed capitation amount below current and projected per capita costs?).

The important consideration to keep in mind is that the Medicaid baseline must be kept separate because the state will be negotiating with HCFA over only that segment of the plan's scope.

With the changes in the Medicaid program being contemplated in Congress (which are virtually certain to be enacted), there would be less need to keep these expenditures separate. States would be required to seek special waivers in order to implement managed care arrangements. Federal and state dollars could be more readily blended together to achieve single stream funding. However, to the extent that the ultimate plan might envision folding in dollars used to pay for certain "generic" benefits, many of the steps described above in terms of extracting and compiling information still will need to be taken, since funding reallocations will need to be negotiated with the agency that presently controls these dollars.

Conclusion

Determining the baseline is the first critical step in developing a managed care plan. The baseline spending and projections serve as the umbrella under which the plan would operate. The baseline can be affected by decisions that are made during the actual development and feasibility testing of the plan itself. For example, decisions might be made to exclude certain service populations or categories of services. As such decisions are made, the baseline changes. The baseline or cap determination is simply an application of the old planner's rule: it is impossible to figure out where one is going if one is uncertain about the starting point.

Activity 4: Projecting and Comparing the Costs of Services and Supports with and without Alternative Managed Care Arrangements

The fourth activity is projecting the expected impact that the managed care mechanisms would have on service and support costs by type, by resource-related group for each subpopulation and overall. The cost estimates may be made on a statewide basis

or for specified sub-state areas. Since these cost estimates could be used to decide the most appropriate managed care alternatives to pursue and in formulating budget requests for managed care implementation, they should be "in the ballpark". They need not be highly refined.

The next step is estimating the potential effects on system costs of implementing various managed care arrangements.

Both time and effort can be saved by focusing only on those variables expected to have the greatest effects on costs. The cost estimation process is one of model building where key variables are captured and used to estimate the probable costs associated with alternative managed care schemes. The study should look first to existing services and supports for relevant cost information upon which models may be built.

As important as the actual dollar figures are the *de facto* policies and events assumed in generating the figures. These need to be stated clearly in order for policymakers and budget officials to understand their basis. It also is important for them to recognize and appreciate the difficult political decisions some of the assumptions represent (e.g., changes in the professional practice rules; restricting ICF/MR admissions; and restructuring case management services).

There are four steps involved in projecting service and support costs with and without the initiation of alternative managed care strategies: (a) structuring the model; (b) simulating the demand for, utilization and costs of services and supports currently being offered (without managed care); (c) simulating the expected demand for, utilization and costs of services and supports under alternative managed care arrangements; and, (d) comparing the projected demand, utilization and costs of services and supports with and without managed care.

Step 1: Structuring the Model

The projections can be made using simulation models available through almost any common spreadsheet software (e.g., Lotus; Excel). There should be separate models (i.e., spreadsheet or set of tables) for each managed care subpopulation of interest, as defined by jurisdiction or type of jurisdiction (e.g., urban, rural), age (e.g., children and adults), or service status (e.g., receiving services or waiting for services). Each model should be structured to represent service demand, utilization and cost data by type of service and support and by resource-related group (i.e., groups for whom different levels of supervision and support are indicated). The services should include the full array of existing and alternative service and support arrangements to be considered under managed care.

The specific tables used to represent: (a) the status quo or *without managed care model* or spreadsheet; and, (b) the *with managed care model(s)* should include at least those listed below for each subpopulation under consideration. The tables represent the fundamental service delivery system, expressed as:

Total Costs (outputs) = (Demand) x (Service and Support Utilization Rate) x
(Service and Support Costs) (inputs).

The status quo tables represent the current system; the managed care alternative tables reflect the changes that the managed care alternative is expected to yield in terms of demand, utilization, unit costs and total costs. The input tables representing alternative (managed care) approaches are defined in percentage terms since modelers find it easier to frame the alternatives relative to the status quo.

Tables representing the without managed care alternative:

Input tables:

- Demand: Number of consumers by resource-related (functional level) group
- Utilization: Percent of consumers utilizing services and supports by type of service and support, by resource-related group
- Utilization: Average units of service per user by type of service and resource-related group
- Cost: Average service unit costs by type of service and resource-related group

Output table: Total costs by type of service and resource-related group

Tables representing the with managed care alternative(s):

Input tables:

- Demand: Percentage change in the number of consumers by resource-related group
- Utilization: Percentage change in the number of consumers utilizing services and supports by type of service and support and resource-related group
- Utilization: Percentage change in the average units of service per user by type of service and resource related group
- Cost: Percentage change in average service unit costs by type of service and resource-related group

Output table: Total costs by type of service and resource-related group

The total costs for each subpopulation then can be added to arrive at the overall costs across all subpopulations.

The modeling committee should agree at the outset upon the consumer subpopulations (geographic, age, functional), service definitions, and unit cost measures to be used in the tables to represent the system. Generally speaking, the service definitions should be those in common use in the state and by which existing utilization and cost data are organized. They might be broken into subtypes where necessary to reflect significant

differences in utilization and costs, current or projected (e.g., differentiating congregate living arrangements into size categories sometimes makes sense for costing and policy reasons). The modeling committee should further agree on the principal data sources to be used in simulating the delivery system as well as the basic assumptions used in making the projections (e.g., population growth). Inflation adjustments are generally immaterial to the comparison of managed and non-managed care options (since inflation is likely to have similar effects in both systems) and thus unnecessary.

Classifying the population into groups expected to have marked differences in the types and levels of service and support needs is central to the modeling task. Assigning individuals to resource utilization groups based on their characteristics is grounded in the premise that such characteristics serve as predictors of cost. Employing such groupings helps to controlling for case mix differences, both for individuals presently receiving services and those who may be waiting for services. It also aids in spotting instances when there is a malalignment between current resource consumption and that which a model might predict.

There are a number of assessment instruments that can provide a picture of the functional abilities of consumers and, hence, may be used to classify consumers by level of functioning. Some of the most widely used are the Adaptive Behavior Scale (ABS), Behavior Development Survey (BDS), the Inventory for Client and Agency Planning (ICAP), and the Developmental Disabilities Profile (DDP). Rhode Island and Utah are developing their own instruments. These instruments and others cover roughly the same domains and include variations of the same skill and behavior items.

Having modeled service systems through the years for various planning, budgeting and rate setting projects, HSRI has found that consensus can be reached in terms of which resource related groupings best differentiate populations of persons with mental retardation and other developmental disabilities in terms of their need for supervision (e.g., monitoring and direction) and support (physical, medical, and behavioral intervention). The classification scheme that has evolved -- the Resource Associated Level of Functioning Scale (RAFLS) -- classifies consumers along three dimensions (adaptive, medical, and behavioral). Four to six groupings may be created, depending on the richness of the consumer data available to support the classification, the nature of the population, and the preferences of the modeling committee.

The RAFLS groupings are:

- **Persons with low adaptive skills.** These individuals have few or no self-care skills and require 24-hour assistance and supervision, including assistance in such areas as positioning, mobility, toileting, dressing, and eating.
- **Persons with moderate adaptive skills.** These individuals are either unable to attend to some of their own personal care needs or are unable to perform most activities required for independent living (e.g., keeping house, food preparation,

money management and competitive employment). They require less than 24-hour supervision and support.

- **Persons with high adaptive skills.** These individuals are able to attend to their own personal care needs and to handle most activities of daily living. They require intermittent supervision and support.
- **Persons with overriding behavioral challenges.** These individuals exhibit dangerous and destructive behaviors that demand high levels of supervision and support. The behaviors threaten loss of body function or disfigurement to oneself or to others and the substantial destruction of property. These behaviors require close oversight.
- **Persons with Chronic Behavioral Challenges.** These individuals exhibit aggressive, self-injurious, disruptive and withdrawn behaviors that demand an extra level of supervision and support.
- **Persons with Chronic Medical Problems.** These individuals have medical conditions that demand special medical supervision and support (e.g., parenteral therapy, suctioning, medication, respiratory therapy).

This classification scheme is not intended for clinical use³, but it is refined as needed to for making system-level estimations. It is most useful for differentiating consumers in terms of their general need for supervision and support; it is not useful for differentiating the needs of consumers for acute care and particular specialized services. Where there is uncertainty about the group in which to place some individuals, the rule should be to classify the individual in the most challenging (costly) of the groups.

Step 2: Simulating the Existing Service System

The purpose of this step is to model the existing system as a baseline from which to project the service utilization and cost differences expected with each of the managed care mechanisms to be considered. As indicated in the listed input tables, data is needed to define demand, utilization and unit costs by resource-related group and type of service and support for the managed care subpopulations of concern.

We recommend grouping consumers according to the RAFLS or a similar classification scheme using the best available data. Where consumer groups already have been defined for purposes of planning, residential and/or day program payments, it generally makes sense to use these groupings. It is unlikely that they will differ significantly from the RAFLS scheme, and the probability is high that they will better fit the existing service utilization and cost data.

³ That is, the classification system is not intended to arbitrate the specific types of services and supports that should be delivered to individuals who fall into the various groupings. Again, the system is used to predict or model resource consumption levels.

In some states, level-of-functioning information is reported and available in computer-readable form for most active consumers. Often, it is located in consumer records but is not available in computer readable form except for consumers in certain settings (e.g., public facilities) and in selected communities where it has been compiled for special purposes. Where there is complete information available in computer readable form for consumers, the computer can be programmed to make the classifications. Where complete assessments are available for limited segments of the population but incomplete assessments are available for all consumers, the consumers for whom complete assessments are available may be grouped according to the RAFLS or an alternative classification scheme, and the size of the groups inflated to the overall population cells formed from common descriptors for the overall population.

Where data is not available for some segments of the population (e.g., that segment not receiving residential and day services and the waiting list population), a small representative sample of consumers may be drawn. Principal caregivers may be asked by mail or phone to classify the individuals according to the RAFLS scheme. A one page, three minute telephone survey usually is sufficient.

Service utilization and cost data are generally easier to obtain than the consumer level-of-functioning data. As indicated earlier, service system configurations, funding sources, data sources and corresponding data collection, compilation and analytic approaches to arriving at a rate will vary from state to state. Most cost figures can be obtained at the aggregate level from fund allocation records and provider expenditure reports. Where there is little systemwide data, figures may be derived from the expenditure reports of a select number of representative providers. There are some expenditures available only through the analysis of Medicaid claims data.

Detailed expenditure data for some of the myriad of supports that might be provided as part of family support, in-home support, employment support and other support arrangements often is not available. Nor is it needed. The average amounts allowed or paid under these support programs to consumers or families for the overall bundle of supports is sufficient. Where current utilization and expenditure data is unavailable or of questionable accuracy, a focus group of knowledgeable informants (who supply expert judgment) should be used to generate the base figures. Where there has been the opportunity to later check these estimates against actual expenditure figures, we have found them to be quite close.

The overall accuracy of these baseline figures can and should be cross-checked prior to use. This is done by comparing the total known costs of the existing service system to the total cost as computed through the simulation model: i.e., number of consumers by resource-related group X percent of consumers utilizing each service X average units of service per user X average cost per unit of service. Actual cost figures should not vary from modeled costs by more than two to three percent.

The existing system simulation produces a picture of current resource consumption patterns by groups of consumers. It shows how resources are distributed across the "unmanaged" system based on the characteristics of individuals being served by the system.

Step 3: Simulating the expected demand for, utilization and costs of services and supports under alternative managed care arrangements

The purpose of this step to project the service utilization and costs under each of the managed care arrangements being considered. In other words, how would various managed care approaches affect the existing distribution of resources described by the simulation conducted under Step 2?

These managed care arrangements may be operationally defined by the staff or consultants responsible for completing the study or by the modeling committee. The modeling committee then will assess the probable impact of each managed care scheme in terms of demand, service and support utilization patterns and unit costs. Information regarding the following areas should be considered: (a) the effects on service utilization and costs of similar mechanisms applied within the field and without; and, (b) contextual information indicating factors which would be expected to enhance or diminish the effect (e.g., labor force constraints, projected revenues, judicial decrees, union protections, state and county administrative capacity; community service capacity and the political will to cede the power to the MCO necessary to effect the arrangement). Below, we offer some thoughts and possible sources of information on the service utilization and cost effects for each type of managed care mechanism. These factors should be noted as they surface during the deliberations and are included in the feasibility study and plan.

Though the managed care schemes or models are discussed separately in terms of projecting their impacts, in fact they probably will be employed in combination. To the extent these combinations can be projected, the costs/savings estimates should be done in combination and not alone.

We offer the following observations concerning the potential impacts of employing the managed care models described in Chapter VIII.

- **Managed care organization.** Even though the MCO model per se is not one which will be simulated in its own right (since the MCO will function as the organizational entity through which various other models -- e.g., service substitution and utilization management -- are operationally combined, some observations are in order. Under the MCO model, system costs are most likely to be affected by the imposition of "rationalization" strategies: e.g., managing the system to operate more uniformly in terms of the utilization of various types of services or seeking to manage the cost of services around "norms". To the extent that the MCO possesses the authority to manage the system, it would strive to employ standardized pricing schedules and devote considerable attention to assessing support strategies where

the amount of resources being used departs from expectations. An MCO, for example, will be inclined to examine situations in which consumers who have roughly similar needs are being served in settings with significantly different costs (and, hence, pose opportunities for service substitution). From a simulation standpoint, then, the MCO model would be expected to affect costs most directly by reducing substantial variations in costs within each grouping.

- **Consumer managed care.** One would expect changes in both service patterns and rates, particularly in the case of supports for persons living in their own homes. Where consumers and families have had the latitude to procure personal supports from individuals, they have been able to do so at a lower cost than when they are purchased through an agency. In terms of the effects of the consumer managed care model on costs, the central question will revolve around how quickly the marketplace for services will restructure itself. This involves considerations concerning the willingness/ability of existing providers to revamp their operations (e.g., shifting from facility/program models to more agile support strategies) and the extent to which new suppliers would enter the marketplace. Since changes must occur in the marketplace before there are significant impacts on costs and the availability of substitutes, assessing the impact of this model requires an appraisal of how quickly these changes might unfold. This will depend on the jurisdiction.

As explained in Chapter VIII, in discussing the setting of comprehensive consumer-centered rates, the challenge lies not so much in identifying less costly services and supports that would be appropriate for different segments of the consumer population, but in projecting the extent to which these alternatives in fact might be substituted for current services over time, thus allowing for consumer choice and the willingness of current providers to respond to consumer demands or the emergence of new providers. The modeling committee must project the extent and pace at which new providers will develop these alternatives and existing providers will convert to these alternatives. The speed at which providers could be expected to convert from facility-based service operations to non-facility based support strategies will depend on how rapidly disinvestment from facilities can occur. We would point out that the many types of supports are less capital-intensive than some traditional service models and could emerge relatively quickly in the right circumstances.

- **Utilization management.** In the case of residential and day services, a large measure of which entail supervision and support, the modeling committee should have a relatively easy time agreeing upon the services appropriate to each resource related group. The difficult task is taking into account the effects of consumer choice, the availability of service alternatives, and political factors that may constrain the impact of any utilization management scheme. In many respects, the gains to be derived from utilization management will arise principally to the extent that the supply of various services is realigned. Professional practice rules are another constraint in this area.

In the case of therapeutic and behavioral services, it is especially difficult to identify levels of service that would be more appropriate than those which are currently employed. Few answers can be found in existing data. Utilization patterns vary widely from area to area and depend heavily on the supply of providers and payment policies. Insurance benefit data are of little help as they represent rather arbitrary limits; they should not be taken to represent appropriate care levels to be furnished under a managed care arrangement.

Few studies are rigorous enough to establish the effectiveness of different therapies for specific disabilities. Most are not able to separate the effects of one therapy from another, let alone from the effects of motivation and factors in the person's environment. It is also difficult to build the weight of evidence needed to establish appropriate levels of intensity by combining study results; available studies are too disparate in terms of method, the characteristics of the individuals served and the therapeutic approach used.

Therapeutic service patterns across the country have been heavily affected by the supply of therapists. Direct therapeutic services are utilized less in many rural states where therapists are in short supply than in many urban states where the supply is greater.

Depending on the level of expenditures and corresponding cost containment potential in this area, a special study of a random sample of the case records of moderate to heavy users might be undertaken whereby qualified professionals would attempt to discern the relationship between functional outcomes and duration of service. A less time consuming and costly approach would be to establish a focus group (subcommittee) of therapists, administrators and advocates in order to develop practice protocols and expectations.

Another common sense approach is awaiting the evaluation of the cost/effects of a utilization management program instituted as part of the demonstration or pilot managed care arrangement on a non-risk basis. The fact is, the experience base for setting actuarially sound rates for therapeutic services is lacking. Consistent with the principle of risk minimization (discussed in the *consumer-centered capitation section* of Chapter VIII), the accumulation of data based on pilot approaches is probably the most prudent alternative. Likewise, it would be prudent to avoid savings projections relating to the implementation of intensive care management alternatives for more challenging persons with developmental disabilities until further evidence of the efficacy of these approaches is available.

- **Service Substitution.** The first task in projecting these costs is to develop an understanding of alternative service and support arrangements that might be introduced or expanded under the managed care system. There are a variety of supported work and living models that have proven cost-effective for consumers. It

is important to examine these alternatives constructively but critically in order to make a realistic assessment of their potential for affecting system costs. Some alternatives can be employed more cost-effectively for certain resource-related groups than for others. The committee must bring its collective knowledge and experience to bear in projecting the extent to which consumers may choose these alternatives, the availability of direct service and support workers to staff such alternative arrangements, and political factors that may limit the managed care organization's ability to effect the substitution. The modeling committee also must estimate the extent and pace at which new providers will develop these alternatives and existing providers can convert to such service models. Competition is a powerful force for change. To the extent that competition is expected to be introduced as part of a managed care system, the pace of change will be more rapid.

Depending on the time and resources available to complete the feasibility study, the committee might project any one-time start-up and conversion costs (e.g., facility divestment; staff retraining; service start-up). All start-up/conversion costs that must be accommodated under the new managed care arrangement should be reflected. Start-up costs include administrative outlays, the costs of site occupancy and consumer transition costs. Pre-operational activities necessary to establish an agency or individual as a provider also fall into the category of administrative start-up costs. This may include staff hiring, program planning and budgeting, facility siting and development, the purchase of furnishings and legal activities (e.g., organizational and tax filings). The occupancy stage includes activities necessary to prepare for consumer admission, including staff training, licensing and certification, establishing working relationships with other community organizations, etc. Consumer transition costs cover any differences in provider revenues expected under full operation and during the build-up period.

In the case of public service agencies, there may be costs associated with employee terminations, including: (a) the costs of surplus staff during the phase-down or conversion of existing provider operations; (b) the costs of accrued vacation and sick leave; (c) the costs of any early retirement benefits; and, (d) the costs of unemployment compensation. In the case of facility-based service providers, there may be costs associated with the divestment from the facility. This includes any costs and losses associated with the sale or rental of the facility. There may also be revenue losses to providers with occupancy/participation-sensitive reimbursement rates or to providers whose rates cover facility-related depreciation and amortization costs.

In the case of large-scale provider conversions, there may be organizational development costs and the costs associated with staff retraining. States that have attempted and are attempting to support the conversion of traditional residential and day service agencies to providers of supported living and supported employment have found that there can be significant organizational development costs, because it involves changing the basic culture of the organization. It is the type of fundamental

change that cannot simply be directed from the outside or from above, but must be owned and accepted at all levels of the organization through persuasion and diffusion (by example). Some providers have undertaken the change process alone; others have used outside consultants to guide and support the organization through the transition period.

- **Consumer-Centered Capitation.** In assessing the effects of the rate payment schemes, it is necessary to project a new set of rates for each service and support or group thereof by reference to resource-related groups. These capitation rates should reflect the amounts that would be necessary to allow providers to furnish services at an acceptable level of quality. As explained in Chapter VIII, there are rates specific to each type of service and support as well as comprehensive rates designed to encompass all services and supports that an individual might need in conjunction with consumer managed care. The steps to follow in setting the service- and support-specific rates and comprehensive rates are described above. These same steps need to be followed during the feasibility study stage, but in a much less methodologically rigorous fashion. The rates developed for each of a limited number of resource-related groups then can be compared to current rates in order to estimate potential savings.

Estimates of the size of the risk pools (reserve funds) needed to accommodate the unforeseen needs of individuals funded on a capitated basis can be informed from the efforts of a number of states. These states have established funding pools to address the unexpected needs of consumers, funding for whom is restricted by established service rates, and to accommodate special needs for adaptive equipment, home modifications, assistive devices, intensive short-term therapies and start-up costs.

In the case of services and supports for which a flat fee or charge is made per unit of the practitioner's time (e.g., physical therapy, occupational therapy, speech-language, nursing services, and personal care), current rates are likely to reflect the market for these services. Any rate projected should be sufficient to attract and retain the needed supply of providers. It is an issue of supply and demand and, thus, will differ from state to state as well as from area to area within a state. Naturally, in those areas where practitioners are in ample supply and where the competition for their services is minimal, the rates can be lower than in areas where the reverse is true. As a rule, it is unlikely that the current rates for such services and supports will be any higher than they need be and, thus, the potential for cost savings is probably minimal.

As indicated earlier, typically reimbursement rates in many states vary widely; some providers are paid well above average and some well below for furnishing the same services to similar consumers. Consequently, in order to move to a system of capitated service rates, the high-paid providers often must be grandfathered in for a period of time to give them the opportunity to make an orderly transition to more

cost-effective operations. Such time lags should be reflected in projecting the savings associated with capitation schemes. In the case of comprehensive rates, there also should be a phase-in period allowed during which the capitated rates for most existing consumers can be expected to reflect their current rates of expenditure.

Step 4: Comparing the projected demand, utilization and costs of services and supports with and without managed care

The purpose of this step is to estimate the probable costs/savings associated with the managed care alternatives by calculating the difference between the costs as projected and baseline (current) costs.

The estimates of potential savings should be presented for a limited number of managed care alternatives (combinations of mechanisms). The comparative analysis can be valuable in pointing out cost-ineffective alternatives as well as cost-effective strategies.

What types of costs must be incurred to operate the managed care system?

The cost comparisons should be presented graphically with key sources and assumptions clearly stated. The analysis should span a five year period with separate estimates shown for each year as well as for the entire period.

Activity 5: Projecting the Increase or Decrease in Administrative Costs Associated with the Implementation of the Contemplated Managed Care Mechanisms

This activity involves projecting the administrative costs overall and those associated with each of the managed care schemes being considered. Then the probable costs/savings need to be estimated by taking the difference between the administrative costs as projected and current costs.

There are a set of irreducible system-level responsibilities that the state or county must undertake as the purchaser and overseer of any managed care program for people with developmental disabilities. These include policymaking and budgetary support, MCO contracting, and quality assurance/performance management. Additionally, public purchasers may retain, rather than delegate to an MCO or another entity, responsibilities for consumer and provider eligibility and enrollment, case management, and provider training. The Responsibilities generally assumed by MCOs are: provider contracting/subcontracting, quality improvement, and network management, by employing variations and combinations of the mechanisms described in Chapter VIII. Both the state and the MCO have information management responsibilities that must be carried out in support of their management and administrative functions.

Projecting the costs of these activities is again a modeling process. The costs may be modeled based on the current costs of comparable activities with common sense adjustments to reflect differences in workload. It is safe to say that there are comparable operations to be found for every activity, if not within present developmental disabilities organizations, then in other organizations; if not within the state, then elsewhere.

As with the costs of existing services and supports, one must be cautious in adopting current cost figures unless what they cover is well understood. This is particularly true where cost figures are available only in relative form as administrative rates (i.e., as a percentage of total costs or as a percentage of direct service and support costs). Administrative rates can be defined quite inclusively to encompass a broad range of administrative activities that might actually over-represent the costs of the particular administrative activity of interest, or quite exclusively to include a very narrow set of administrative activities that might under-represent the real costs.

The most efficacious approach, particularly at the feasibility stage, is to concentrate on identifying the configuration of personnel (employees or contract workers) directly responsible for the activity. Such personnel will account for most of the costs. However, even these direct personnel can be difficult to isolate in governmental organizations since often they are part of larger administrative units with responsibilities for functions other than those of concern. Relevance costs, therefore, frequently are buried in general administrative budgets.

The costs of personnel indirectly connected to the activity and other (non-personnel) costs (direct and indirect) generally can be assumed to represent no more than 20 percent to 30 percent of direct personnel costs (including fringe benefits). The lower percentage should be used in the case of public agency functions, assuming that up to 10 percent of these costs would be covered under existing budgets. The higher percent should be assumed in the case of private agencies.

Listed below are administrative activities involved in managed care. The scope of each of these activities is briefly discussed, and existing models that might shed light on the development of cost estimates are suggested.

- **Policymaking and budgeting.** One of the major tasks is the formulation of policies, evaluation of performance and securing the funds needed for the managed care organizations to operate in the interest of persons with developmental disabilities and the general public. The task should involve top level staff who are able to keep abreast of the state-of-the-art in supporting persons with disabilities, who are politically adept and who are able to “steer” the system. Today, state DD agency directors/commissioners, their deputies and assistants, perform these functions as well as other operational tasks, which under a managed care approach would be turned over to an MCO or third party administrator.

- **MCO contracting.** This task involves budgeting, contract negotiation and monitoring, and making payment for consumers served under the contract. The costs involved, adjusted to scale, should be similar to the costs of administering contracts with large providers in many states where the payment for services is on a prospective basis. The costs of administering MCO contracts with capitated payments should be somewhat less than the costs of administering contracts which involved cost-based payment arrangements.
- **Quality assurance and improvement.** A number of interrelated activities are involved in this task: developing strategic level performance indicator systems, quality assurance activities designed to assure basic health and safety, quality improvement efforts aimed at helping service and support providers to better serving consumers, and methods of strengthening the consumer's ability to gain system improvements. All but the first of these four sets of mechanisms exist in various forms today in many states. Costs may be estimated to the extent that the nature and scope of the envisioned mechanisms are known at this stage and are comparable to the existing mechanisms upon which the cost figures are based. The costs of the performance indicator systems are harder to predict. However, the marginal cost should be minimal as most indicators will be extracted from MCO/provider information systems, automated and manual.
- **Consumer and provider eligibility determination and enrollment.** These activities involve consumer assessment, eligibility determination, intake and referral. There are such operations in every state that can be referenced in building an estimate of the resources required. Individuals already receiving publicly-funded services may be grandfathered into the managed care system, in which case most of these individuals will already have been determined eligible and "enrolled" in services, thus the marginal cost of these activities should be modest.
- **Information Management.** The development and management of information will be a part of all of the other administrative functions listed here. It is important not to duplicate the other cost estimates. Managed care organizations must have: (a) a reasonably sophisticated automated general ledger cost accounting system; (b) a budgeting and expenditure monitoring system; (c) a statistical module; and, (d) still other modules depending on the scope of the managed care system and its responsibilities. The state or other payor must have information systems to process selected cost and performance data from the MCO(s), in order to evaluate their performance. The ball park costs of developing and operating such systems can be estimated by any one of the many vendors offering such packages (National Community Mental Healthcare Council, 1995). Ball park estimates for instituting and administering these systems also might be obtained from administrative service organizations that take over information management functions for a fee. It is important to keep in mind that current systems expend considerable amounts in some of these same areas. Hence, to one degree or another, implementing a managed care system will involve redirecting current outlays.

- **Managed Care Organizations.** The logical candidates for building MCO cost models, adjusted to scale, are the private, non-profit regional and area agencies in different states which are charged with administering service systems for people with developmental disabilities. Colorado and New Hampshire have such agencies for which detailed cost information is reported each year. Administrative expenditures should be expected to run no lower than 8 percent of total system costs. The costs could rise to as high as 12 percent of the total system costs if the agency is expected to manage the system through the utilization management and consumer-centered capitation schemes described in Chapter VIII. Administrative costs could rise even further if the MCO becomes actively involved in engineering the restructuring of the service network as part of an aggressive service substitution strategy. At the same time, it always is important to keep in mind that outlays for administrative expenses detract from the dollars available to pay for services and supports. Hence, estimated costs should be tested against the "what's needed, nothing more" standard.
- **Utilization Management.** Estimates of the costs of utilization management might draw upon the experience of the many utilization review programs in existence that are designed to weigh the appropriateness of long-term and short-term interventions. These include prior review, concurrent review and retrospective review schemes. Estimates might also draw upon the reported costs of applicable case management models. There have been a number of studies of case management caseloads and costs. For some types of utilization management, a state may need to increase its outlays (e.g., acquiring the expertise to conduct intensive care management). There may be off-sets, however (e.g., shifting from a uniform comprehensive model of case management to one regulated by a "value-added" approach).
- **Service Substitution.** Service substitution, as defined here, is aimed at restructuring the service system to create a more cost-effective service array. Smaller providers may need help and administrative supports that will enable them to form alliances with other organizations that lead to comprehensive service and support networks. Larger providers, may need organizational development assistance in converting to the provision of different services and supports. Providers may need special fiscal assistance to assist them in covering the costs of conversion (e.g., the costs of facility divestment, revenue losses associated with low occupancy and staff development during the transition period). Keep in mind that the costs of supportive living and employment often are hidden in the costs of facility-based residential and day programs. Providers, with and without state support, in Maryland, Oregon, Colorado, North Dakota and elsewhere have undertaken conversions from facility-based residential and vocational programs to supportive models. Their experiences can provide information upon which conversion cost estimates might be based.

- **Consumer-centered Capitation.** This task involves the development and administration of prospective consumer-assessment, budgeting, and allocation/payment systems. Estimates of such costs might take into account related experiences of Kansas, Ohio, Utah and other states. These systems provide information on the added costs of individual consumer assessment and rate determination. The individual capitation approach carries the added costs of appeals; the group capitation rates carry the added costs of risk management and fiscal management designed to keep the MCO solvent. These administrative costs may or may not compare favorably with the administrative costs associated with existing cost-based payment systems. It is worth pointing out, however, that current fee-for-service/payment rate negotiation models are very labor intensive.
- **Consumer managed care.** The administrative costs associated with consumer managed care principally lie in the expenses entailed in supporting the individualized planning and budgeting process, helping the consumer where necessary to negotiate with providers, and the intermediary costs of assuring that bills and taxes are paid and services accounted for. There are a rich variety of individualized planning and budgeting/resource development models upon which cost estimates might be based. These range from the individualized program planning approaches tied to the existing service system to the less formal, more wide-open futures planning approaches which are currently gaining favor -- i.e., from the more formal interdisciplinary team approaches to the more informal circles of support. There also are any number of service coordination models, ranging from those that serve a minimal information and referral role with caseload ratios of 1:100+ to those that provide more intensive service brokerage and development, with caseloads under 1:30. The costs of intermediary services will vary depending on the scope of services provided. There are a number of intermediary operations upon which estimates of the costs of these services might be based. There are the charges of payroll service companies. There is the personal agent/intermediary service model for persons with developmental disabilities served under Florida's home and community-based waiver program. There are dozens of consumer-directed personal care attendant programs for elderly and disabled persons with intermediaries assuming a number of different roles (Flanagan, 1994).

The feasibility study also must look at the capacity of various organizations to operate the managed care system.

Activity 6: Assessing the Capacities of Different Organizations to Assume Responsibilities Entailed Under a Managed Care System

The sixth step involves assessing the capacity of existing organizations to perform their assigned roles within a system of managed long term care for people with disabilities. Consideration should be given not only to the current capacity of organizational candidates, but their potential capacity.

Depending on the managed care approaches, jurisdictions under active consideration and the organizations active in the state, the assessment may be of organizations singly or in combination; organizations operating statewide or locally; and, organizations with system management capabilities, service provision capabilities or both. The assessment should address: (a) the capacities of public state and/or local agencies of government that could be involved in governing the managed care system; (b) the capacity of prospective managed care organizations to forge and oversee comprehensive network(s) of services and supports and to effect the managed care cost containment models under consideration (e.g., consumer managed care, utilization management, delivery system reconfiguration, and consumer-centered capitation); and, (c) the capacity of these and still other organizations to assist in carrying out these responsibilities and in other functions integral to managed systems of care (i.e., quality assurance and improvement, fiscal management, and information system management).

- **Managed Care System Governance.** State level agencies whose roles should be considered include the state Developmental Disabilities Authority, Developmental Disabilities Planning Councils, other state disability and program agencies, the state Medicaid Agency and other funding agencies in fulfilling the policy level responsibilities identified earlier. The capacities of each of these agencies to perform their assigned functions as part of a managed care approach need to be carefully assessed. This assessment should identify any state and/or federal legislative and regulatory provisions that would have to be changed in order for such agencies to assume their assigned responsibilities.

The assessment of the capacities of existing state and local agencies to govern the managed care system should examine leadership capabilities and knowledge of the field -- the extent to which agency officials know the industry and communities served. It also should address the proven and potential capacity of such agencies in the areas of quality assurance, performance monitoring, contract and fiscal management.

- **Forging and managing comprehensive service and support networks.** The assessment should gauge the capacity of prospective MCOs to coordinate and deliver the full range of services and supports to be accessed through the managed care system. The presumption under managed care is that consumers will be able to access all needed services and supports through the MCO.

Statewide MCOs cannot perform this core function. There must be area level agencies responsible and accountable for the development and management of service and support networks. Though they might not be identified formally as MCOs, many large providers and area administrative agencies presently operate in this manner. It is the capacity of such organizations that must be assessed during this stage of the feasibility study. In some states this function could be performed by existing areawide agencies; in others it might be effectively put in the hands of large provider agencies (as is the plan in Rhode Island).

In the case of those agencies not already managing comprehensive service and support networks, the critical question is: will they have the standing, administrative and managerial capabilities to establish such networks through mergers, alliances, partnerships, contracting, and development. An integral part of this assessment is an analysis of the comprehensiveness of the existing services and supports in each area, and the ability to network them. In some areas, sparse resources and independent providers will present difficult challenges. The assessment also should include an analysis of the extent to which the jurisdictions of interest have the capacity to support competition among providers or among provider networks (MCOs). In less populous areas, the demand may be insufficient to justify more than one MCO (service and support network), in which case the only possibilities for competition would be among providers which make up the network. In the health care field, attempts to generate competition among HMOs in areas too small to support more than one have led to HMOs cornering the market in these areas and effectively eliminating competitors, to the long-term disadvantage of both the payor and consumers.

- **Cost Containment.** The capacity of a system to achieve cost containment objectives is integral to the assessment of the extent to which the system will yield savings that can be reinvested. Along these lines, the following considerations need to be taken into account:
 - **Managed Care Organizations.** The assessment should consider the current and potential capacity of the prospective MCOs to administer the contemplated utilization management, service substitution, and consumer-centered capitation schemes which are contemplated. Maximum savings will be achieved only when the MCO has both the capacity and the mission to enforce managed care strategies.
 - **Utilization Management.** The performance of prospective and concurrent reviews require some expertise and clear procedures but as important, good standing with consumers and providers. In the absence of these ingredients, the review process can be more acrimonious and demanding than would otherwise be the case. Sound relationships with the care management mechanism is particularly important, as are the training and experience of the care managers and their knowledge of the formal service system and community. Any retrospective review procedure will require a data system capable of capturing and compiling service and support utilization data.
 - **Service Substitution.** The power of the MCOs to restructure the system can be established as part of the managed care system. The exercise of that power will depend on the MCO's leadership and its network management capacity (discussed under MCOs). It is the interest and experience of the agency

leadership in system reform that should be the focus of this part of the assessment.

- **Consumer-centered Capitation.** The consumer-group approach to consumer-centered capitation is the method applicable to MCOs. It is essential that an MCO have relatively sophisticated budgeting, expense reporting and control procedures. These are needed in order to keep expenditures within budget (the overall cap) while allowing providers the flexibility needed to respond to consumer demands. The assessment should consider not only the current system, but the potential capacity of the organization to support such a system.

In this aspect, the feasibility plan assesses both system "readiness" and capabilities of carrying out a managed care plan.

Activity 7: Preparing and Presenting the Results of the Feasibility Study

The seventh activity involves the preparation, presentation and distribution of the feasibility study results. The study report should summarize and synthesize the cost/savings projections and assessment of organizational capacities.

The results of the feasibility study need to be pulled together and presented to decisionmakers.

The presentation of the cost analyses and projections should be primarily graphic in format, with the base figures and assumptions clearly spelled out. Sensitivity analyses (i.e., identifying which factors do or do not affect the results) can be helpful to policymakers. This involves altering some of the key assumptions and corresponding service or administrative costs upon which the total cost projections are based in order to assess their fiscal significance. This type of analysis needs completed only for those assumptions where the degree of uncertainty is relatively high, as is the potential cost effects. For example, the effects of substituting supported living for ICFs/MR might alter the cost projections by as much as 20 percent, plus or minus, given the uncertainties concerning the interest and ability of current ICF/MR providers to move to alternative forms of living supports. This sensitivity analysis allows policymakers to understand better the power of particular assumptions to alter the cost picture.

The federal, state and local shares of the projected costs/savings should be shown. Where unmet demand is projected, state and local cost savings should be translated into projections of the number of additional persons who would/could be served. This is done by dividing the projected savings by the average projected cost per person across all resource groups or by resource-related group.

The analysis of organizational capacities should include capsule assessments of each of the key organizations or classes of organizations by managed care function as well

as a summary analysis in table form. The report may or may not include recommendations that follows from these findings.

It is important to keep in mind that the purpose of the report is to inform decisionmakers and policymakers concerning the implications of employing various managed care approaches. They will be less concerned about the details than with understanding the fiscal implications. The aim is to gain their concurrence and support for a particular approach so that the process can move to the next stage: constructing the managed care plan.

Conclusion

The managed care feasibility study is best understood as a first-cut assessment of the opportunity areas for employing managed care in a service delivery system. It helps participants to gain an understanding of the potential advantages of employing a managed care approach and in pinpointing likely strategies. While the study is not intended to be fully comprehensive or answer all of the questions concerning how managed care might affect a service system, it does force system planners to sharpen their thinking about each of the critical dimensions that will be entailed in operating such a system. Since the feasibility study is designed to cover a multi-year timeframe, it assists planners and policymakers to understand the timing of any savings which might be achieved. It also helps to avoid the pitfalls of having over promised the level of savings that might be realized.

Since the feasibility study will be based on guiding principles, it should establish the tone for future planning efforts. In addition, conducting a feasibility study is a way of obtaining the blessing of decisionmakers and policymakers about proceeding to the next stages.

CHAPTER X
MANAGED CARE PLAN

X. Managed Care Plan

The managed care plan is a concrete, detailed road map for designing the managed long-term support system. The managed care feasibility study identifies likely directions and opportunities. The plan, in contrast, describes the system specifications and how the various components of the system are to be put into place. As described here, the managed care plan also would include the development of an implementation strategy that describes the timelines and resources necessary to bring the new system on line. If the objective is to implement a managed care system in relatively short order (which should be avoided if possible), then the managed care plan itself must be far more detailed, since there will be fewer opportunities for revising the specifications.

The managed care plan contains the concrete, detailed specifications for how the managed long-term support would be structured and operate.

Whether the development of a managed care plan follows from the feasibility study depends on the state. Ideally, decisionmakers would use the results of the feasibility study to inform the development of the managed care plan. In other words, they would furnish system planners with the guidance needed to design the system. Our objective in this chapter is to describe the key components of such a plan and their scope. The exact contents of a plan, of course, will vary from jurisdiction to jurisdiction depending on the approaches taken.

The managed care plan has many dimensions. Its development is a complex undertaking that requires a substantial commitment of time and resources. The planning process should be operated through a project manager approach in order to ensure that all the various aspects are being addressed and ultimately dovetail.

Purpose and Scope

To start, the managed care planning process should be commissioned or blessed by the key state officials who made the decision to proceed with the planning. The charge to the responsible planning group should include:

- **A definition of the objectives and design principles for the managed care system that spells out the key objectives that the managed long term support system is intended to accomplish and not to accomplish for consumers and the general**

Topics Covered...

- ☒ **Purpose and scope**
- ☒ **State-level responsibilities**
- ☒ **Control system design and specification**
- ☒ **Quality Assurance and Improvement**
- ☒ **Information System Design/Specification**
- ☒ **Implementation Plan**
- ☒ **Budget**
- ☒ **Evaluation**

public. In other words, the central principles and goals under which the system would operate must be delineated **before** the planning process begins.

- **A definition of the scope of the managed care system which is envisioned should be spelled out in terms of the:**
 - **Jurisdictions and organizations to be involved.** Insofar as it is practically and politically possible, system planners should identify the organizations to be involved in the planning, development and implementation of the managed care system.
 - **Population.** The definition of the target group of the managed care initiative should be as clear as possible in order to inform the development of the managed care eligibility criteria.
 - **Services and supports.** Here it may be easier to identify those services and supports by type or provider agency that will **not** be covered.

The purpose and scope statement also should identify any expected or possible changes in scope that could result from the planning process. The plan should operationally define the state-level managed care responsibilities as well as the jurisdictions, populations and services and supports to be covered as part of the managed care system. The clearer these definitions, the fewer administrative and legal disputes there are likely to be. Obviously, some of these areas will have been addressed if a feasibility study has been conducted.

The managed care plan should include specifications for each of the cost containment mechanisms to be used as part of the managed care system. It also should include design specifications for the quality assurance and improvement mechanisms, and information systems. Because these two subsystems have not been discussed in earlier sections of the **Guidebook**, as have the other subsystems, they are discussed in more detail in this chapter. The plan should include an implementation timetable, a layout of organizational and individual responsibilities, and a budget.

State-Level Responsibilities

This section of the plan should specify the extent of the state's funding and payment responsibilities, including its responsibilities for covering expenditures exceeding any expenditure cap or in the case of MCO insolvency. It should spell out the state's system oversight responsibilities, including quality assurance and contract management.

This section of the plan (as with other sections) will be detailed and concrete. Particular attention must be paid to contract management, especially in the arena of oversight of the MCO(s) and spelling out their responsibilities in terms of reporting.

Mechanisms for resolving disputes between the state and the MCO(s) also must be included in the plan.

Control System Design/Specifications

This section of the plan will define the basic design of the managed care mechanisms to be instituted as part of the managed care system. The shorter the implementation period, the greater the detail that should be included in the plan concerning these subsystems. The development of such detailed specifications should not await the preparation of the implementation plan. Managed care systems will largely supplant current service delivery systems. Before that happens it is important to understand the implications of the changes which will occur, many of which will surface as the focus turns to specifics -- "the devil is in the details." The following discussion is organized around the various managed care models described in Chapter VIII, fully recognizing that most "real life" managed care systems will blend and combine these models.

A. Managed Care Organizations

This section should address such network management and administrative issues as:

- **MCO governance.** The plan should address whether the state intends to contract with a single MCO or multiple MCOs and the criteria to be used in selecting such organizations, the pros and cons of which are discussed later. The payor may decide to restrict its contracting to nonprofit entities, or to impose various governance stipulations, including the extent to which consumers/families must be represented on governing and/or advisory committees.
- **The powers and responsibilities of the managed care organization(s) to manage service and support networks.** The MCO may be restricted in its ability to offer services and supports to eligible consumers directly, via contract or subcontract. Expectations concerning the way in which the MCO will organize, manage and operate the provider network can include: (a) maintaining a sufficient supply of providers to ensure that consumers have ready access to needed services; (b) directing the MCO to contract with specified "essential providers" or with providers that meet specified standards; (c) directing the MCO to contract with all existing providers for some initial period; (d) MCO monitoring of provider agency performance; (e) the extent to which the MCO may limit the number of providers with which it contracts ("open" versus "closed" panel); and, (e) the extent to which an MCO may shift risk to network providers (in the form of its own payment policies).

D. Service Substitution

This section should address such issues as:

- How and to what extent free market (competition) and planned market approaches will be used to spur provider restructuring?
- The nature and extent of any short-term financial assistance to support MCO/provider restructuring.
- The nature and extent of any training and organizational development assistance to be offered providers/MCOs to facilitate restructuring.

E. Consumer-centered Capitation

This section should address such issues as:

- Whether or not to develop either a consumer-centered capitation system or consumer-mix capitation system as the basis for payments/allocations to MCOs?
- The process, organizations and individuals to be involved in the development of the capitation rates.
- Criteria/instruments to be used in arriving at capitation rates.
- Amount of funds to be held in reserve (outside of the cap) to meet the extraordinary needs of challenging individuals and for unexpected, unbudgeted needs of persons under the cap, including the extent to which an MCO will be required to establish internal reserves and whether the state will operate a "stop-loss" or "reinsurance" mechanism.
- The process and criteria to be used in deciding on the use of reserve funds, including the conditions under which excess reserves would be released in order to serve persons who are on the waiting list.

F. Observations

Each of the five principal managed care models will require a state to address somewhat different topics in developing control mechanisms and specifications. Certainly, additional questions could be added to those listed above. When models are mixed (as they undoubtedly will be), it will be important to ensure that these control mechanisms work in tandem as well as possible.

Quality Assurance and Improvement

The quality assurance and improvement mechanisms under which the system operates will have to be determined and steps taken to develop of any new mechanisms that will be required. There are many requirements and options to consider.

Basic quality assurance mechanisms must be a part of any QA system. These include state licensing and certification mechanisms or private accreditation systems that are recognized and deemed by the state to assure the competency of service and support providers and to protect consumer health and safety. They also include grievance and complaint procedures, and a system for reporting and reviewing incidents involving abuse, neglect and rights violations (including connections to protective services systems). These fundamental quality assurance mechanisms are needed to assure consumer health, well-being and safety, irrespective of the care management system in operation.

The expectation under a managed care system is that the MCOs and service provider will be freed of past regulatory attempts to extend licensing/certification reviews well beyond health and safety issues into the programmatic arena. Federal (ICF/MR) and many state regulations are sweeping in scope and prescriptive in nature to the point where they frequently override reason, rob front-line workers of their ability to use good judgment in carrying out their jobs, and create unnecessarily impediments to constructive interactions between the consumer and provider. Ideally, any managed care system would focus on outcomes as their chief regulatory tool.

Coincident with the move to separate policy-level from operational responsibilities under managed care has been the emergent interest in outcome indicators to inform the policymaking process. Outcome indicators offer an important perspective, albeit a somewhat simplified and incomplete one, of the cost-effectiveness of the existing system of services and supports. Work is afoot at the federal and state levels to define performance indicators that reflect consumer satisfaction, choice (independence), life quality, and economic self-sufficiency (Human Services Research Institute, 1995).

There are two critical drawbacks with most of the performance indices developed thus far to monitor provider performance in the developmental disabilities field. Most of these measures are highly subjective in nature and thus hard to employ as accountability mechanisms applicable to service providers and provider networks. Most involve labor intensive survey and review methods. Such methods may not be economically feasible to apply to all consumers, though they might be applied to a sample of consumers.

Other indicators sure to find a place in the managed care environment will be those concerning access, MCO/provider solvency, critical incidents, and staff adequacy. Some of these indicators have been defined in the managed health arena, although

adaptations will be required in order to apply them to developmental disabilities service systems. It is also likely that the relative costs of providing residential living and day services and supports across MCOs, areas and states to different resource-related groups will be used as indicators of system "efficiency."

There should be avenues for consumers and members of their families to communicate to the state, the MCO and service providers their preferences and ideas for improving the administrative practices and services, for reporting their satisfaction, and for receiving timely responses to MCO-related problems. Consumer/family involvement is important if the managed care system is to function in a truly customer-driven manner. Consumer involvement and accountability mechanisms increasingly are being seen as the ultimate and most practicable approach to assuring that managed care operations are working in the consumers' interests.

There is widespread agreement among management and organizational thinkers that successful organizations are those that are consumer-driven, where every employee is either serving customers directly or actively supporting those that do (Albrecht, 1992). Customers provide particularly meaningful information on their expectations and helpful feedback on the interpersonal, qualitative aspects of service. Customer input can be obtained by conducting consumer surveys, creating focus groups or other activities to obtain formal and systematic customer feedback. While consumer surveys are the most common means of obtaining information from consumers, there are important limitations to the nature and reliability of the information that can be obtained from many persons with developmental disabilities (Bradley, Ashbaugh et al, 1984).

Another key feature of the plan is the establishment of an appeal process which allows customers to seek redress, most commonly for denials of service. The payor will need to specify how consumer appeals/grievances will be addressed, including the right to appeal to a party not controlled by the MCO. The MCO model delegates major system responsibilities to a single organization. Consumer appeals/grievance mechanisms are a vital "check and balance" when such delegation occurs. It also is important to provide an avenue for consumers to obtain timely responses to problems that require immediate attention (e.g., consumer hot lines and consumer telecommunications networks (Ashbaugh, 1995).

Another key aspect of the quality assurance/improvement equation is allowing consumers to choose among MCOs or providers, thereby giving them the bottom-line leverage required to gain services and supports responsive to their needs and preferences. As discussed previously, Rhode Island's approach is designed very much on the basis that promoting competition among service agencies will serve as a powerful force in fostering quality improvement.

At the MCO and provider levels there must be an abiding interest in continuous quality improvement. The typical signs that such a commitment exists include: (a) an organizational culture and set of management practices that clearly evidence a

customer-first orientation; (b) a top management commitment to continuous quality improvement; (c) respect for employees and the contributions they can make; and (d) employee education and training. These elements are widely recognized among management experts as characteristic of successful service organizations. They have surfaced in recognition of the fact that the externally driven, minimal quality assurance mechanisms that rely principally on sets of rules and post-hoc inspections have little effect on provider performance day-to-day and that the commitment to quality improvement must emanate from within the front-line organizations.

The state can do little more than require an MCO to implement a continuous quality improvement approach. The extent to which it is implemented and makes a positive contribution will depend heavily on the agency's leadership. Leadership training may be needed. Existing agencies have had to comply with externally imposed quality assurance measures for so long, that they have a hard time assuming ownership and devising quality improvement approaches that make sense to them. They still tend to see quality improvement as something that must be done to please the state.

Information System Design/Specifications

There is no doubt that long term managed care will impose greater demands on providers and particularly MCOs in terms of the tracking and reporting of service, cost and quality/outcome data. With capitation covering all services delivered by providers in a network and with the relationships, operational and financial, among the providers becoming more complex, the communication of information among providers within the network and to the state (payor) becomes critical.

Managed care is information-driven. **In the minds of many experts, managed care makes automation a necessity not a luxury.** Certainly, many national software developers are convinced; they have been making significant revisions in their software to accommodate managed care requirements for a number of years¹. Many of these organizations now have applications for managing systems of services and supports for people with disabilities.

However, automating or, as is more often the case, replacing current automated systems should not be the first order of business. First the control systems outlined above must be designed so that the new information demands are understood. In some areas (e.g., cost accounting) this can be done much more rapidly than in others (e.g., performance/outcome monitoring where the state-of-the-art is more primitive).

¹ The National Community Mental Healthcare Council issues a periodic "Directory and Resource Guide on Software Applications for Behavioral Health", (301) 984-6200.

The core modules in any MCO information system include:

- General ledger cost accounting that allows for the tracking of expenditures and identifying the costs of services and supports (including those provided directly and via contract), by organization and site. This system enables the MCO to cost services and supports accurately and, thus, establish rates of payment for members, and agree to capitated payments so as not to lose money.
- Budgeting and expenditure monitoring enables the MCO to track expenditures and compare them to its budget in a real-time environment. This is particularly critical when capitation is employed, since the receipt of capitated payments and actual outlays for services may not be in synchronization.
- Statistical systems that allow for the compilation and reporting of quantitative measures of fiscal status, cost-related performance, and quality indicators.
- Fund accounting will be required where there are separate funding sources to be accounted for and reported.
- Other modules might be needed to support particular types of managed care mechanisms (e.g., billings/claims payment and service utilization/review).

Software vendors promote comprehensive MIS systems that include many other modules. The question is whether such modules would be nice to have or are really essential. When it comes to automation, the investment is considerable -- less so the software cost than the operational and training costs involved in its installation. Two years should be considered the minimum time required to install the software systems integral to managed care. The more modules, the more difficult this will be. Hence, caution and careful planning are vital.

A suitable statistical module is the only core module unlikely to be found in existing packages. Many of the statistical modules in behavioral health and health care systems do not make sense in the case of long term service and support systems for people with developmental disabilities. A recent report entitled *Performance Indicators for a Consumer-Oriented Mental Health Report Card: Literature Review and Analysis*, provides some useful insights into the state-of-the-art in performance indices in the mental health arena (Mulkern, Leff, Green and Newman, 1995). As indicated earlier, the statistics and data needed simply have not been settled on at this point. There is no need to rush into the automation of this module. The difficult and important part lie in the design not the automation. Data-based performance measures will surface, and modules will be developed which allow them to be captured and reported.

Basic state information requirements and MCO information system specifications should be defined beginning with the managed care plan, continuing as part of its implementation and ending in MCO contracts or agreements. It is in the state's interest,

the consumer's interest and the MCO's interest to have established as early on as possible the parameters within which MCO information systems eventually will have to operate. Most providers and many MCOs will have their own systems already in place. The aim is not to impose a uniform system statewide. However, it is essential and reasonable with today's technology to require MCOs to have the core modules and any optional modules needed to institute the managed care mechanisms which are planned, to be able to report and eventually transfer electronically key indicators of performance to payors and consumers, and to do so with appropriate confidentiality safeguards.

The state should establish guidelines for auditing and reporting expenditures and performance data. The use of sampling, periodic surveys and other economic approaches to the generation of cost and performance data should be encouraged. The state should be prepared to build on to and not duplicate any useable management information systems that already are in place.

Implementation Plan

The implementation plan lays out the organizational responsibilities and the timetable for system articulation, development and implementation. The implementation plan should cover the entire demonstration period, but need to include details on only the first three to six months, with provisions for periodically updating it thereafter. The implementation plan should use "critical path" techniques to ensure that key components of the system will be completed on time, particularly where the completion of one component is necessary before work can begin on the next. Plan implementation must be designed to unfold in the proper sequence.

Budget

The budget for putting the managed long-term support system into place must set forth the resources available and required, by funding source. The budget periods should correspond to the budget periods of the organizations underwriting the planning and implementation effort. The budget will detail the dollars/resources required to pay for the development of system components (e.g., including contracting with consultants, information system design, and so forth). The budget also should identify how current agency resources will be redeployed in support of the design/implementation of the system.

Evaluation

Before a managed long-term support system is launched, it is vital to define a strategy for evaluating it vis-a-vis its central goals and guiding principles. In other words, the question must be asked: how will we know whether we have accomplished what we set out to do? No system design is likely to be perfect. All parties must expect that some aspects of the design will not work well in practice however well concerned

they may have seemed when the system was being planned. Making a commitment to evaluate (and continually re-evaluate) the system is critical. Managed long-term support systems must be expected to evolve (just as managed health care systems have). Including an evaluation strategy in the plan is a commitment to continually assess performance with the aim of securing the information needed in order to modify the system and improve its performance in relation to system goals and objectives.

A variety of capitated, case managed care arrangements have been evaluated over the past decade relative to traditional fee-for-service arrangements in terms of their effects on service utilization, costs and care quality. The results have been mixed; the demonstrations and related evaluations usually have been less than comprehensive. The vast majority of demonstrations have encompassed only a portion of eligible population groups and covered services and have not addressed at all the special, longer term needs of non-elderly persons with disabilities. Many of these evaluations were poorly designed and, hence, yielded results that are neither reliable or generalizable. Even many of the better evaluations have been able to draw conclusions only with regard to service utilization patterns and costs and not with regard to quality. This has prompted the U.S. General Accounting Office and the Office of Technology Assessment to recommend in recent reports a greater focus on health care appropriateness and effectiveness in future managed care evaluations.

The Evaluation Center @ HSRI, established under a grant from the National Institute of Mental Health, has established network evaluators in most of the states now engaged in mental health managed care. The purpose of the network is to facilitate collaboration in order to improve managed care evaluations. The network, *Eval10*, can be a source of guidance to state officials in undertaking the design of evaluation plans. To enter the network, call 617-876-0426 and ask for The Evaluation Center. There is no charge.

The evaluation specifications defined in the managed care plan should encompass quality outcomes as well as utilization and cost outcomes. This **Guidebook** is replete with important questions that need to be answered as we proceed down the managed care road. All parties participating in the system design effort should be invited to participate in the development of an evaluation strategy to ensure that it is capable of answering important questions regarding system performance.

Conclusion

The managed care plan defines the system in concrete terms. By its very nature, it is multi-dimensional. Developing a workable plan is a challenging undertaking because it requires planners to spell out how the system would function in considerable detail. There is no doubt that developing a well-crafted plan will require intensity and commitment; nearly all of the questions that the plan is intended to answer cannot be "left until later" or allowed to dangle.

Our discussion of the content of the plan merely illustrates the dimensions and considerations that will need to be addressed during its construction. Since the development of a plan demands intensity, it must be sanctioned and supported by key decisionmakers. Plan construction also will demand well-honed project management skills in order for the plan to be completed within reasonable time horizons.

APPENDIX A

**MANAGED CARE AND PEOPLE
WITH DISABILITIES**

Appendix A

Note: This position statement was developed by the Health Care Task Force of the Consortium for Citizens with Disabilities. It was submitted on May 24, 1995 by the Consortium to the House Ways and Means Health Subcommittee.

Managed Care and People with Disabilities

The 49 million people with disabilities in this country include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses which impair their ability to function. People with disabilities are disproportionately represented among the underinsured and uninsured in America's private health insurance system.

A sound managed care plan can offer several advantages to people with disabilities: well-coordinated care or case management, comprehensive services, the convenience of "one-stop shopping" which minimizes physical and other obstacles to obtaining care, and an emphasis on primary and preventive care. Unfortunately, these potential positive impacts of managed care are usually undermined by the economic incentives in managed care and capitated health plans. Many of these incentives run counter to the interests of all beneficiaries, particularly people with disabilities and chronic health conditions. People with disabilities often have extensive, special, and complex health care needs and are often underserved in these types of plans.

Managed care plans would significantly decrease their costs over time if appropriate services were delivered to people with disabilities and chronic conditions in a timely manner. The provision of appropriate rehabilitative therapies, services, and devices today can substantially reduce secondary, expensive conditions tomorrow. The provision of home and community-based services, including personal assistance services, can greatly save expenditures on institutionally-based inpatient and long-term care. All health plans, particularly managed care plans, should consider their enrollee's long-term health status, and seek to maximize their function and independence through primary and preventive care, appropriate rehabilitative therapies and services, and assistive devices and technologies. More often than not, managed care plans simply do not do this.

As managed care is increasingly offered by both the private and public health care systems, it is imperative that consumer and provider safeguards are established and offered under Medicare, Medicaid, and private managed care plans.

Problems with Managed Care

Gatekeeper Independence/Choice of Providers

Most managed care plans use "gatekeepers" to manage individuals' care. While in theory a gatekeeper provides coordination of care, in reality a gatekeeper can create many problems for people requiring frequent or specialized health care services. Due to financial disincentives, gatekeepers may delay access to critical services which people may need immediately. Gatekeepers may also be reluctant to refer patients to specialists because of utilization limits imposed by managed care plans, despite gatekeepers' unfamiliarity with the health care needs of people with specific conditions or disabilities or the medical needs of the chronically ill.

People with disabilities often require specialists with whom the managed care plan may not have a contractual relationship. Another common problem is that of insufficient numbers of specialists in the panels of managed care plans, leading to long waits for appointments.

Many managed care plans assign enrollees to physicians and do not allow subscribers to choose their own physician who may be familiar with their medical history and health care needs. In addition, most plans do not allow specialists to serve as a gatekeeper. However, many people with disabilities, because of their complex requirements, often need a specialist to meet their primary care needs and to determine if additional specialized services are needed. Children with disabilities often need the option of pediatric specialists as the primary physician or as part of a multi-disciplinary team. In some managed care plans, children with disabilities may be limited to adult specialists who may not be familiar with the special needs of children.

Inadequate Benefits

A comprehensive benefit package is critical for people with disabilities, but all too often managed care and other private insurance benefit packages are based on an acute care model. For example:

- Managed care plans typically cover only 60 days of rehabilitation and sometimes provide no rehabilitation services at all.
- Managed care plans rarely cover home and community-based health care services, such as home nursing and personal assistance services, which often prevent multiple re-admissions to acute care settings.
- Managed care plans often have annual or lifetime caps for certain conditions or treatments (usually mental health and substance abuse).

- Enrollees are often denied benefits based on narrow definitions of "medical necessity" because these definitions are based on the health care needs of the "average" person. For example, managed care plans often refuse to authorize physical therapy for people with chronic conditions because such therapy would "maintain" rather than "improve" function.
- Many plans refuse coverage of durable medical equipment, orthotics and prosthetics (orthopedic braces and artificial limbs), and certain therapies, such as respiratory and recreation therapy, which are important to maintain function and prevent secondary complication.
- Definitions of durable medical equipment and prosthetics/orthotics are often restrictive. This is a particular problem for individuals requiring customized medical equipment, such as specialized wheelchairs and seating systems, and most types of orthotics and prosthetics, which require specialized expertise and custom fitting and fabrication to the unique needs of each patient.
- Drug formularies or other restrictive lists of covered pharmaceuticals are commonly used by managed care plans. For some people with disabilities and chronic conditions, particularly people with rare disorders, effective drug therapies may not be available in managed care plans.

Access to Centers of Specialized Treatment

Some people with disabilities require highly specialized providers who may not participate in a managed care plan's network. Furthermore, continuity of providers is critical to people with special health care needs who require specialized care over time. Some people with chronic conditions, including individuals with mental illness, sustain great harm when forced to disrupt existing relationships with providers.

Many people with severe or rare conditions can often only receive appropriate care at highly specialized centers which may be affiliated with schools of medicine or teaching hospitals, or may be free-standing centers with specialized treatment expertise. Examples of these conditions include certain neurological and rare disorders, intractable pain, and a number of orthopedic impairments requiring specialized assistive technology. Many managed care plans will not cover care received at these centers.

Incentives to Underserve

Many managed care plans, particularly capitated plans, have built in incentives to underserve patients which can place persons with disabilities at significant risk. They may --

- pay nonsalaried physicians according to the number of patients served, which leads to insufficient time and attention being paid to individual patients;

- provide bonuses or penalties to providers based on their adherence to utilization limits determined by the managed care plan;
- place individual physicians at financial risk for caring for patients by requiring physicians to assume the cost of out-of-plan specialty care.

Recommendations

Managed Care Safeguards for Consumers and Providers

To address these significant problems with health care delivery through managed care, Medicare, Medicaid, and private health insurance reforms should include safeguards for consumers and providers from certain managed care practices. Managed care plans continue to gain market power with few federal or state guidelines do the provision of quality care, particularly for people with disabilities and those with specialized or complex health needs. Managed care plans should at least be required to meet certain standards to maintain access, quality and accountability to enrollees. Without these protections, managed care plans can be devastating to the health status and ability to function of people with disabilities and chronic health conditions.

CCD strongly encourages the 104th Congress to include the following provisions in any proposals to reform both the public and private health insurance systems. These provisions have wide support in the consumer and provider communities.

- **Consumer and Provider Due Process Protections**

CCD strongly supports the inclusion of due process protections in Medicare, Medicaid, and private health insurance reform legislation so that consumers and providers are on a level playing field when interacting with powerful managed care companies. These protections will ensure appropriate decision-making and selection procedures for providers, and in so doing, will protect consumers in their choices and access to health and mental health professionals and other providers.

- **Quality Assurance Provisions in Managed Care Plans**

The need for appropriate quality assurance measures is particularly important for people with disabilities and chronic conditions in managed care settings. As enrollment in managed care health plans continue to increase, consumers must be informed about the nature of managed care health delivery and their rights within these plans. Consumer needs must be routinely and systematically considered and consumers must play a central role in decision-making within the managed care entity. In fact, consumer involvement is critical at all levels of health care system governance. CCD strongly supports an emphasis within public and private health plans on consumer choice, consumer involvement in the governance of the plan, consumer rights, consumer satisfaction. We believe that this emphasis on the role of

the consumer is directly related to assuring the actual quality of health and health-related services provided under managed care plans.

- **Point-of-Service Options**

Managed care plans should provide a point-of-service option to their enrollees in order to allow persons with specified health care needs to obtain care from out-of-network providers, assume they opt to pay the extra premium and copayments necessary. This provision retains the ability of closed panel HMOs to contain costs but also allows enrollees the flexibility to opt out of the network if they pay a little more for this option.

- **Specialists as Gatekeepers**

Enrollees in network plans who require ongoing, specialized health services should be able to choose a specialist to act as their gatekeeper and to manage their condition. Relevant physicians and non-physicians should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated. For instance, a person with spinal cord injury should be able to access a qualified physiotherapist as a gatekeeper who would provide primary care at the primary care reimbursement rate and specialty care at the specialty rate. Similarly, a person with multiple sclerosis should be able to choose a neurologist as a gatekeeper who has authority to refer to non-physician providers of specialty care in order to manage a chronic condition over time.

- **Health Plan Arrangements with Providers**

All health plans should enter into agreements and other arrangements to create an appropriate mix, number, and distribution of qualified health professionals in order to adequately provide the plan's benefit coverage.

- **Access to Specialized Treatment Centers**

Managed care plans should ensure access to academic and other specialized health centers. CCD recognizes that much specialized health expertise is provided in centers that are not academically affiliated. Provisions should be made in legislation addressing health care issues to provide people with disabilities and chronic illnesses requiring specialized care access to a variety of centers of specialized treatment expertise.

- **Utilization Management Protocols and Financial Incentive Plans**

Utilization review should be performed by qualified personnel with knowledge in the specific medical area in which the coverage decision is being made. Physician incentive plans can be extremely harmful to enrollees who require significant and/or ongoing health services due to the incentives to underserve inherent in these arrangements. In fact, all incentives to underserve managed care enrollees, financial or otherwise, should be prohibited.

Any legislation addressing the public or private health care system should include all of these important provisions.

APPENDIX B
THE OREGON HEALTH PLAN

Appendix B: The Oregon Health Plan

Since the late 1980s, Oregon has been engaged in a comprehensive, multi-year effort to reform the State's health care system. The goals of this initiative are to: (a) achieve universal coverage; (b) ensure that all Oregonians have access to a basic set of health care services; and, (c) rein in the costs of health care. Oregon's efforts encompass insurance reform, employer health care coverage mandates, and Medicaid expansion/reform. Central to the Oregon reform agenda is a strong emphasis on managed health care delivery approaches. The unique and most controversial feature of the Oregon Health Plan (OHP) has been the reordering of the State's Medicaid program to "ration" health care services based on an evaluation of the benefits and efficacy of various types of medical interventions.

In 1994, Oregon began implementing a Medicaid "superwaiver" that broadened eligibility to include low-income households which previously could not qualify for Medicaid benefits. In January, 1995, individuals with disabilities began transitioning to managed health care plans under this "superwaiver". Throughout this process, the State Office of Developmental Disability Services and various advocacy organizations have been intensively involved in ensuring that people with developmental disabilities receive high quality health care under OHP.

Background

Oregon's health care reform initiative began in the late 1980s. It was sparked by many of the same themes that fueled the national health care reform agenda: curbing runaway spending on health care services, addressing the needs of the growing number of uninsured individuals, and countering discriminatory health insurance practices. Oregon outlined its own comprehensive approach to health care reform in order to achieve universal coverage, system reform, and contain the rapid growth in health care costs. Key features of the State's plan

In a Nutshell....

- ☑ The Oregon Health Plan (OHP) is one element in a multi-pronged State initiative to reform the health care delivery system.
- ☑ In January, 1995, OHP began enrolling individuals with disabilities into managed care.
- ☑ Oregon has elected to carve out most Medicaid-funded long-term supports and services from OHP in favor of delivering such services/supports through the State's existing program networks.
- ☑ The Office of Developmental Disability Services has been an active participant in ensuring that OHP is responsive to the needs of people with developmental disabilities and its implementation does not disrupt the provision of long-term supports to them.

included: (a) insurance reform; (b) a mandate (as yet unimplemented) that employers provide health care coverage to employees; (c) the creation of a high-risk pool to provide coverage to individuals unable to obtain health insurance elsewhere; (d) specification of a basic health care benefits package available to all Oregonians; and, (e) an expansion/restructuring of the State's Medicaid program in order to extend health care coverage to low-income, uninsured individuals and families.

While the State's Medicaid expansion has gained the most notoriety due to some of its controversial features, it is important to keep in mind that Oregon's "superwaiver" is but one component of a broader-based health care reform initiative. The State already has established a high-risk insurance pool. A central component of Oregon's health care reform initiative -- the mandate that employers offer health insurance to all their employees -- has been suspended in the absence of Congress enactment of legislation that would allow Oregon (and other states interested in charting their own course in health care reform) to obtain an exemption from certain provisions of the federal Employee Retirement Income Security Act (ERISA). Absent such an exemption, Oregon cannot impose a comprehensive employer mandate. In addition, the continued expansion of Medicaid services to more low-income individuals and families faces an uncertain future due to concerns regarding the restricted dollars that Oregon would receive under the Congressional Republican plan to restructure the Medicaid program.

The Oregon Superwaiver

A key feature of Oregon's health care reform strategy is the extension of Medicaid eligibility to a broader range of low-income households. In order to secure this expansion, in 1991 State officials prepared and submitted to HCFA a Section 1115 "superwaiver" request that was entitled the Oregon Health Plan (OHP). The essential features of this plan included:

- The extension of Medicaid eligibility to low-income individuals and households who lacked health insurance but are not eligible for Medicaid. Oregon proposed to extend Medicaid coverage to all such individuals with incomes below 100 percent of federal poverty guidelines;
- The conversion of this expanded Medicaid program from a fee-for-service to a managed care system in order to contain costs; and,
- A prioritization process that relied on an evaluation of the efficacy of medical services and procedures as the basis for deciding the benefits that would be available to OHP enrollees.

This prioritization process was the most controversial feature of Oregon's plan. During an 18-month public process, the full range of health care services were prioritized according to their benefit to the entire population. This evaluation resulted in a list of medical procedures that were ranked according to their effectiveness and appropriateness, taking

into consideration public social health values. Oregon then "drew a line" and included in its OHP standard benefit package the 597 "priority" medical procedures it would offer eligible individuals as standard benefits under the plan. This process (described in more detail later) aligned the plan's coverages with the resources available to extend Medicaid eligibility to all individuals with incomes below the poverty level. Under State legislation, this priority benefit list is to be updated every two years. Excluded from the list are most Medicaid-reimbursable long-term supports and services (see discussion below).

Oregon's strategy has been to offer OHP enrollees an affordable, efficacious package of health care benefits that can be sustained within the financial resources available to implement the program. However, it is important to keep in mind that the conversion of Medicaid service delivery to managed care is another equally important element in achieving the overall cost savings needed to enable the State to extend Title XIX eligibility to additional low income, uninsured individuals and families. By employing a managed care approach, Oregon expected to achieve significant savings due to lower utilization of high-cost emergency room services and reductions in public assistance caseloads. In order to implement OHP, Oregon also increased state general fund matching appropriations for Medicaid and earmarked the proceeds of a 10-cent per pack cigarette tax to underwrite the cost of expanded coverage. During its 1995 session, the Legislature earmarked \$665 million in State dollars to continue the program and extended the cigarette tax but tightened eligibility standards and imposed a monthly premium (ranging from \$5 to \$26/month depending on income) for non-Medicaid eligible recipients.

When originally submitted to HCFA, Oregon's Section 1115 waiver/ demonstration request sparked considerable controversy. Various advocates charged that the State's prioritization scheme discriminated against individuals with disabilities. In August, 1992, the Bush Administration rejected the plan based on a finding that it violated provisions of the Americans with Disabilities Act. Oregon officials revised the plan to correct these defects. In 1993, the Clinton Administration gave Oregon the green light to implement OHP.

OHP is being implemented in two phases. Phase I began in February, 1994. During this phase, existing Medicaid recipients and newly-eligible individuals/ households with incomes below 100 percent of federal poverty guidelines were enrolled in the plan. Exempted from Phase I enrollment were populations commonly referred to as "blind, aged, disabled and children in foster care." During Phase II -- which began January 1, 1995 -- these populations also were enrolled in OHP. During Phase I, these individuals continued to receive Medicaid services through traditional fee-for-service mechanisms. In addition, during Phase II expanded mental health and chemical dependency services were to become available in 20 participating counties.

In September, 1995, 400,000 Oregonians were enrolled in OHP (270,000 individuals eligible for Medicaid under previous criteria, plus 130,000 low-income individuals who became eligible under OHP's expanded income eligibility criteria). Phase II resulted in the enrollment of an additional 67,000 individuals. Approximately one-third

of Oregon's 450,000 uninsured individuals have incomes under 100 percent of the federal poverty guidelines and, hence, are potentially eligible to participate in OHP.

The implementation of OHP also has contributed to a significant decline in State public assistance roles. A mid-1980s study revealed that one in five Oregon families returned to public assistance in order to obtain Medicaid health care coverage. Since the implementation of OHP, it is estimated that one in seven families that dropped out of public assistance programs did so due to the availability of ongoing health care via OHP.

Managed Care Models

OHP encompasses several approaches to health services delivery. Pre-paid Health Plans (PHPs) include full-risk, capitated plans such as Health Maintenance Organizations (HMOs) and partial-risk Physician Care Organizations (PCOs). PCOs are not at risk for the costs of hospitalization but coordinate and provide or contract for all other health care services. Oregon officials regard PHP as the health care service delivery model of choice; Medicaid recipients are encouraged to enroll in a PHP wherever they are available. However, OHP also provides for the use of the Primary Care Case Manager (PCCM) model. Under this model, a primary care practitioner (e.g., a physician, nurse practitioner or physician assistant) coordinates and authorize health care services for OHP enrollees.

As with managed care initiatives in other states, Oregon officials anticipate that through the use of pre-paid and other managed care models it will be possible to promote more appropriate and less costly health care services for enrollees. Since the implementation of OHP, expensive emergency room utilization has dropped by 4.5 percent. Hospital "charity care" has fallen by 9.8 percent.

Target Group/Enrollment Criteria

As discussed above, one of the central aims of OHP is to provide health care coverage for low-income Oregonians while restricting the services that are covered under the plan. OHP limits the scope of covered benefits rather than restricting eligibility. OHP's Administrator points out that "what we've done before is ration [health care] by who we give access to the system". OHP enables individuals and households with incomes below the federal poverty guidelines to receive the same benefits as persons who could qualify for Medicaid under previous eligibility criteria. Oregon's choice was to include all low income households under OHP (regardless of whether they qualified under federal Medicaid eligibility rules) while "rationing" the health care dollar by limiting covered conditions and employing managed care. As noted above, while Phase I excluded the enrollment of "aged, blind, disabled and foster children"; these individuals are being enrolled during Phase II. OHP does not cover individuals eligible for Medicare only but does cover dual entitlees (e.g., those eligible for both Medicare and Medicaid).

Covered Services

Determining the scope of benefits available under OHP has been the most controversial and difficult part of implementing the plan. Oregon's prioritization process was based on the principle that only services with proven effectiveness for health conditions that are unlikely to improve on their own would be covered. Beginning in September, 1989, an 11-member Health Services Commission was charged with developing a public process that would result in a prioritized list of medical procedures. Over the next eighteen months, the Commission reviewed outcome and clinical data and conducted public hearings and surveys.

The result was a list of 745 "condition/treatment pairs". These pairs were ranked first by ability to prevent death; then, if tied, by cost; and, finally, by the Commission's judgment. Twelve criteria reflecting Oregon's social values were considered by the Commission in reviewing the list.

This prioritized list serves as the basis for the OHP Standard Benefit Package, which:

- continues coverage of virtually all services that previously were covered under the State's Medicaid program;
- covers all major diseases contracted by children;
- covers all major diseases experienced by women;
- exceeds previous Medicaid coverage in some areas, such as unlimited medically necessary hospitalization, dental services for adults, hospice care, prescription drugs, most transplants, mammograms, physical and occupational therapies, and diagnostic and screening services for adults; and,
- assures coverage for all physician visits needed to diagnose a condition.

Even though OHP coverages included several improvements in the services offered through Oregon's Medicaid program, the condition/treatment pairs list and Standard Benefit Package were hotly contested by disability advocacy groups which contended that the Commission's initial recommendations were influenced unduly by considerations revolving around the health care needs of children and adults without disabilities. The disability community was concerned that conditions resulting in disabilities would rank lower than those which do not. The Commission addressed this concern by developing a series of dysfunction lines which considered the symptom being treated rather than focusing on the condition causing the disability.

OHP was implemented by excluding approximately the bottom quartile of condition/treatment pairs in the prioritized listing. This "rationing" step is a critical

element in achieving the State's goal of limiting OHP's scope of benefits to the most efficacious services that the State can afford to furnish to its low income citizens.

Many services that are particularly important to people with disabilities are covered under OHP and, consequently, are the responsibility of publicly-subsidized health plans. These include: dental care, durable medical equipment and supplies (including wheelchairs, respirators, assistive communication devices, and so forth), private duty nursing, physical and occupational therapy, and speech therapy. In many respects, OHP coverage of these services is broader than those previously available under Oregon's Medicaid program. A key difference, however, is that these "specialized services" must be authorized and provided or arranged for through the managed health plan with which the individual is enrolled. Each plan varies in how it obtains these services.

With some exceptions, most Medicaid-reimbursable long-term supports and services (frequently referred to as "social services" in the Oregon plan) have been carved out of OHP's defined scope of benefits. Home and community-based services waiver services are excluded as is nursing facility care. However, nursing home residents will be enrolled in managed care organizations, which will be responsible for providing them with pharmacy and other health services.

Interaction of Managed Care and Long-term Care

As noted above, most long-term care services are not included in OHP's scope of benefits. These services will continue to be provided as they have been in the past, rather than managed or authorized by MCOs. The principal exceptions lie in mental health and chemical dependency services which are being shifted to managed care in 1996. In addition, OHP explicitly addresses the way in which case management and personal care services are to be furnished.

Case Management

In OHP, Oregon officials clearly distinguish between *medical* case management and *agency (social services)* case management. By clarifying the roles and responsibilities of the case managers, Oregon has sought to avoid the care coordination problems that might arise between primary medical care case managers and specialized services care coordinators. State officials have explicitly defined case management roles and responsibilities in order to prevent duplication and confusion.

In particular, various State program offices (Senior and Disabled Services; Children's Services; Developmental Disability Services; Alcohol and Drug Abuse Programs; and Mental Health Services) currently operate specialized community case management systems that coordinate the specialized services and supports that each program office oversees. These case management systems have been qualified to receive Medicaid funding through the Section 1915(g) targeted case management coverage

option. For example, nearly 12,000 individuals with developmental disabilities receive case management services through Oregon counties.

In designing OHP, one of the decisions that State officials faced was whether to continue these existing case management networks or, instead, consolidate all case management activities under the MCOs or the PCCMs. The State opted to maintain specialized case management systems and their role in arranging for and coordinating specialized long term supports and services for the respective disability target populations. In reaching this decision, State officials recognized that the basis and responsibilities of such systems are quite different from the roles played by medical case managers. Moreover, consolidation would have proven to be quite disruptive. Thus under OHP, for example, county developmental disabilities case managers continue to be responsible for arranging for HCB waiver and other specialized services and supports that fall under the jurisdiction of the State's Office of Developmental Disability Services.

However, Oregon officials also recognized that inclusion of vulnerable populations in OHP would pose unique service coordination challenges. To ensure that MCOs were responsive to the needs of individuals and persons with disabilities, *Exceptional Needs Care Coordination* (ENCC) was established as a mandatory service that each pre-paid health plan must offer (on the following page are OHP's description and specifications for this service). In particular, an MCO must designate either a nurse or social worker to assist the medical case manager in working with plan enrollees who have special needs. The Exceptional Needs Care Coordinator is responsible for coordinating complex medical care for these individuals. In addition, these case managers are charged with linking such individuals to needed long-term services and supports through referrals to social service agency case managers.

The requirement that each health plan offer ENCC stems from the fact that "people with disabilities and seniors often have special health care needs requiring several different doctors and/or a lot of coordination of health care services". An individual (or the person's doctor, case manager, family member or another advocate) may request ENCC. In concrete terms, an ENCC "might help someone who has physical disabilities to schedule therapy services and to coordinate them with the company that supplies the individual's wheelchair and with the staff of his or her residential program". ENCC "is designed to be a single point of contact for problems and questions within the plans and to assist those who cannot 'navigate' the system on their own".

Mental Health Services

In January, 1995, Oregon began covering mental health services under OHP. Following the issuance of an RFP, the State Mental Health and Developmental Disability Services Division has contracted with four managed care plans, four community mental health programs, and two other organizations to provide mental health services to OHP recipients in 20 counties. Some 25 percent of OHP enrollees will be eligible to receive "medically necessary" mental health services -- i.e., services deemed necessary to address

Exceptional Needs Care Coordination

Senate Bill 5530, which authorized Phase II of the Oregon Health Plan, provided special safeguards for eligible persons who are age 65 or older or who have disabilities. One of these safeguards is medical case management. The statute requires that such case managers be trained in and exhibit skills in communication with and sensitivity to the health care needs of people who are elderly and those with disabilities. The overall role of these case managers is to assist patients served by the managed care organization with the coordination of the patient's health care services at the reasonable request of the patient, a physician, or other medical personnel serving the patient.

During planning for the implementation of Phase II, this safeguard was termed Exceptional Needs Care Coordination (ENCC), rather than case management. This term more closely describes the purpose of the service to be provided and distinguishes it from medical case management provided by managed care plans as well as from social service case management provided by various agencies of the Department of Human Resources.

ENCC services include the following components:

- A system for early identification of those members in the plan who have disabilities or have intense or complex medical needs.
- Assistance to individual members to ensure necessary access to providers and medical services provided in a timeframe consistent with the members' medical needs.
- Coordination with medical providers to ensure consideration is given to the unique needs of such patients in treatment planning.
- Coordination and communication with community support and social service systems, as necessary, to link their services to the delivery of medical care for those patients.
- Representation of the unique needs of persons who are age 65 or older or have disabilities in the internal quality assurance processes and dispute resolution system of managed health care plans.
- Identification of barriers to necessary medical care for persons with intense or complex needs. Assistance in removing their barriers.
- Thorough documentation of unique needs of those members and of care coordination activities performed to meet those needs.
- Communication with the Oregon Health Plan ombudsman services in resolution of concerns about access to, quality of, or limitations on care being provided through the health plan.

Each managed care plan is to make ENCC services available during normal office hours, Monday through Friday, at a minimum. In addition, health plans are required to provide an initial response to the member by the next working day following the request. This initial response may not be a final resolution to the problem, but rather will confirm to the member that ENCC services are addressing the situation.

The ENCC staff is to serve an important role as the visible and accessible point of contact within a managed care plan for members, agency case managers, medical providers, long term care providers, and others with a bona fide interest in the health care of a member who is elderly or disabled. The single entry/easy access system of problem-solving will offer a measure of convenience to all parties and should reduce or eliminate situations where a member or representative has to make multiple calls to various offices within a managed care plan.

Finally, it is important to recognize that ENCC services are not designed to compete with medical providers or other case managers. Instead, ENCC staff will assist eligible members to access other needed services and to guide them through the world of managed medical care. As such, this service provides members who are elderly or disabled with an added resource to complement the provision of all other services.

treatable mental health problems. Covered services include therapies as well as medication management.

Oregon elected to phase in the coverage of mental health services under OHP due to legislative concerns regarding the costs of such services and how well they could be provided in a managed care setting. Ultimately, State officials would like to incorporate mental health services as a mandatory benefit that all MCOs must offer. The MCOs directly furnish these services or contract with mental health professionals/agencies. However, according to Oregon's Medicaid Director, "there's a lot of anxiety, especially on the part of [the nonprofit and public agencies that provide services to the chronically mentally ill]. They say managed care plans don't know how to take care of this population." If the outcome of the initial coverage of mental health services proves satisfactory, then mental health coverage will be extended to all OHP enrollees by July, 1996. Also, effective January, 1995, chemical dependency services were brought completely under OHP.

Personal Care

Personal care services are excluded from the benefits that MCOs must furnish or manage. The delivery of personal care has remained within the existing provider network. Personal care is not "diagnosis driven", according to Oregon's health reform plan. Management of Medicaid-funded personal care remains under the purview of the various disability program offices where it is frequently coordinated with the delivery of other long-term services and supports. Because personal care is a core, ongoing service for many elderly and disabled individuals, leaving personal care outside of OHP permits better coordination of supports and avoids disruptions in established service patterns.

Role of the Office of Developmental Disability Services in Managed Care

Early in Oregon's health care reform initiative, the Office of Developmental Disability Services (ODDS) decided that it would play an active role in the development of OHP. ODDS assigned a staff person to give "total attention" to the design of OHP and monitor its potential implications for people with developmental disabilities. This attention has yielded important dividends by assuring that persons with developmental disabilities will continue to receive a full range of medical and social supports without disruption. The ODDS staff were instrumental in helping define case management roles. ODDS also advocated for carving out personal care from the OHP scope of benefits to ensure the continuity of long term services and supports to people with disabilities.

In tandem with ODDS, the Oregon Developmental Disabilities Council and the Oregon Advocacy Center are sponsoring training for case managers as well as health care professionals (including physicians) and specialized developmental disabilities services providers to assist them in gaining a better understanding of OHP and its ramifications. ODDS officials have recognized that the staff of MCOs also need to be equipped with

more in-depth information concerning people with developmental disabilities and how the long-term supports system for this population operates. Moreover, case managers and long-term support providers need to have a better understanding of the steps necessary to assist individuals with lifelong disabilities in gaining access to health services under OHP. ODDS has detailed State facility staff to assist MCOs in assessing and planning services for persons with developmental disabilities. The Developmental Disabilities Council and the Advocacy Center also have collaborated in the preparation of materials to assist people with disabilities and their families in understanding OHP and making sound decisions concerning the selection of a health plan.

ODDS played an important role in assuring that individuals with disabilities were not negatively affected by the prioritization process that was used in establishing the OHP Standard Benefits Package. ODDS officials also successfully advocated for the use of five additional functional status "diagnoses" in order to assure that persons with disabilities receive needed treatments.

ODDS officials point out that, without their intensive involvement and review of OHP, people with developmental disabilities may have lost important benefits or experienced serious disruptions in services due to the shift of such services from the social services system to the managed health care system. They also note that managed care providers are not experienced in authorizing such services as durable medical equipment or supplies. Active ODDS involvement has enhanced the prospects that the needs of persons with developmental disabilities who have specialized health care and related needs will have those needs appropriately addressed as OHP moves towards full implementation.

Quality Assurance

In addition to routine provider monitoring and well-defined enrollee grievance procedures, OHP provides for an extensive evaluation of the affects of managed health care on "vulnerable populations". While the evaluation's central focus will be on the interaction of expanded program eligibility/benefits and controlling costs through prioritization and managed care, there also will be a critical examination of the quality of care that enrollees with chronic disabilities receive. In particular, the evaluation will examine:

- How effectively are the health care needs of vulnerable populations being met through managed care?
- Do enrollees experience better health?
- Are appropriate referrals being made to specialists?
- Does managed care result in improved coordination of care between primary and specialized services providers?

This evaluation will use data collection, medical records review, consumer and provider surveys to gather the information needed to answer these questions.

ODDS officials are well aware that serving persons with developmental disabilities may be a new undertaking for many MCOs. By offering assistance and training as well as by participating in monitoring reviews of health providers, Agency officials will be active participants in assuring the quality of care received by persons with disabilities.

Ombudsman Services

Ombudsman services are available for OHP clients who are age 65 or older or have disabilities. The Ombudsman serves as the client's advocate whenever the client, the client's representative, a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Ombudsman services are located in the Managed Health Care Unit of the Oregon Medical Assistance Program. PHPs, PCCMs, and agency field staff are directed to inform eligible clients of the availability of Ombudsman services and the manner in which these services may be accessed.

Specifically, the Ombudsman:

- Receives and responds to individual health care-related complaints from managed health care participants; researches facts surrounding the complaint; communicates with interested parties (the client, the client's representative, family members, case managers, PHPs and medical providers, as necessary); attempts to mediate complaints or resolve problems before use of more formal due process procedures.
- Refers complaints to PHPs for resolution when appropriate; refers cases to other agencies or ombudsman offices when the expressed concern does not involve access to, quality of or limitations on the care rendered by medical plans or providers; advises clients of rights and procedures for accessing formal due process functions when necessary; refers cases of abuse, neglect or exploitation of vulnerable people to appropriate investigative agencies.
- Tracks complaints received; documents actions taken and disposition of complaints; identifies patterns of complaints and prepares summary reports of major or repetitive problem areas; identifies barriers to covered medical care for persons with intense or complex needs.
- Coordinates with PHP exceptional needs care coordinators, agency case managers, client advocacy groups, and other ombudsman offices to ensure continuity in complaint resolution; reviews client satisfaction surveys, quality assurance studies, PHP complaint processes, and proceedings of fair hearings to identify common areas of grievances or quality of care concerns. Recommends to DHR policymakers modifications to rules, standards, or practice affecting clients' rights or ability to access quality care.

Safeguards

Oregon officials recognized that the "move to managed care can disadvantage individuals with cognitive limitations who might not understand the 'rules' (access to emergency rooms, grievance procedures, pre-authorization process, etc.) of managed care". The requirement that each plan offer ENCC is one means of addressing this problem. The continuing role of agency case managers offers another safeguard for many individuals with disabilities. Each managed health care plan is required to have its own complaint resolution process. Elderly individuals and people with disabilities also have guaranteed access to ombudsman services to help resolve problems with managed care plans (see accompanying description of the ombudsman's role). The plan's grievance system is open to surrogate decisionmakers. In addition, OHP operates under a sixteen-point consumer bill of rights that spells out the plan's responsibilities to individuals (see accompanying description). In addition, the plan has a process for exempting individuals from assignment to a managed care plan under certain circumstances.¹ Finally, people with disabilities may not be discharged from the plan solely as a result of disability.

OHP Consumer Rights

- Right to access a Primary Care Provider
- Right to preventive services
- Right to services to diagnose a member's condition
- Right to urgent care
- Right to emergency care
- Right to have written information on how to access emergency care
- Right to make complaints
- Right to request a hearing
- Right to specialty care, if needed
- Right to a medical record and to have access to a medical record
- Right to receive services which meet generally accepted standards of service
- Right to information about medical or dental services
- Right to make an informed decision about proposed medical or dental services
- Right to say, in advance, how they want to be treated
- Right to medically appropriate services covered under the Oregon Health Plan
- Right to Confidentiality

¹ Individuals are enrolled in health care plans by "choice counselors". Counselors seek to match individuals with plans, based on the person's medical needs and choice of primary care practitioner. An individual may be exempted from plan enrollment under certain conditions. People who are exempted from enrollment can be linked with a Primary Care Case Manager (PCCM) who provides or arranges for needed services on a fee-for-service basis. In some instances, an individual is exempted from both plan enrollment and from being assigned a PCCM. Exemptions may be granted for a variety of reasons, including: (a) the person's needs are so specialized that they only can be met by a practitioner who does not participate in a plan or is unwilling to enroll as a PCCM; and, (b) the person's usual practitioner is not a member of a plan and chooses not to enroll as a PCCM and the counselor determines that "changing practitioners is likely to result in harm to the client's physical or psychological well-being" due to a breakdown in continuity of care. OHP also contain provisions for delaying the enrollment of individuals who are involved in a treatment plan that needs to be carried to completion by a non-participating physician.

Conclusion

In January, 1995, people with developmental disabilities in Oregon began receiving their health care through managed care providers. Intensive involvement by ODDS has meant that OHP is likely to be more responsive to the needs of these individuals with developmental disabilities. There will be better coordination of medical services and long-term supports. ODDS' decision to assign a full-time staff person to participate in the development and implementation of OHP should pay handsome dividends over the next few years.

Many states have shied away from enrolling people with disabilities in managed care programs. Oregon's decision to include such individuals in OHP, therefore, sets the State apart. The decision reflects the view that people with disabilities will fare better if they are included in the system with appropriate safeguards rather than left to fend for themselves in obtaining health care through a "fee-for-service" system where an increasing number of health care providers are refusing to participate in the Medicaid program. As OHP unfolds, it will provide important information regarding the quality of care received by people with disabilities under a managed care framework and the extent to which the steps taken by the State to ensure access and responsiveness are effective.

Sources and Resources

For more information concerning the interaction between ODDS and OHP, please contact:

Tina Kitchin, M.D., F.A.A.P.
Mental Health and Developmental Disabilities Services Division
Oregon Department of Human Resources
2575 Bittern Street
Salem, Oregon 97310
503/945-9795

To Your Health: Choosing the Health Care That is Right for You is a publication that was prepared by the Oregon Advocacy Center and the Oregon Developmental Disabilities Council. The purpose of this publication is to assist individuals with disabilities and seniors (as well as their families, friends, caregivers, case managers and advocates) in selecting a health care plan. It provides an excellent overview of OHP and its various features in clear and understandable terms. ***To Your Health*** concludes with a checklist to assist individuals in evaluating various health plans. FMI: Janna Starr, Health Policy Analyst, Oregon Advocacy Center, 620 SW 5th Avenue, 5th Floor, Portland, OR 97204 (503/243-2081).

APPENDIX C
PENNSYLVANIA -- HEALTH CHOICES

Appendix C: Pennsylvania

-- Health Choices

In Pennsylvania, officials of the Office of Mental Retardation (OMR) recognized that the managed care "train was on the tracks". As a result, they have taken a variety of proactive measures that are aimed at: (a) ensuring that managed care organizations (MCOs) have the capacity to meet the health care needs of people with developmental disabilities; (b) working with individuals, families, advocates, and service providers to ensure a smooth transition to managed care; and, (c) assessing the impact of managed care on individuals who receive publicly-funded mental retardation services.

Background

Pennsylvania began applying managed care principles to the delivery of Medicaid-funded health care services as one step in a more ambitious health care reform plan authored in the Casey Administration. Governor Casey's proposed Pennsylvania Health Security Act laid out a far-reaching health care reform strategy, designed to ensure all Pennsylvanians access to affordable health care, while attempting to control costs. Medicaid managed care programs, both those proposed and already being implemented, are components of this overall health care reform initiative. While it is uncertain whether comprehensive health care reform will be enacted in the near future due to the recent changes in political leadership, Pennsylvania already has embarked on managed care for Medicaid recipients.

The first HMO enrollments of Medicaid recipients in Pennsylvania occurred in the early 1970s. Although most HMOs showed little interest in serving the Medicaid population, these initial experiments proved cost-effective and set the stage for the exploration of other managed care options. A task force convened in 1983 recommended the expanded use of HMOs. As a result, the Department of Public Welfare (DPW) requested a Section 1915(b) "freedom of

In a Nutshell....

- ☑ Under HealthChoices, all Medicaid recipients (including people with developmental disabilities) in the six-county Philadelphia metropolitan area will be served through MCOs.
- ☑ The PA Office of Mental Retardation (OMR) secured the inclusion of key principles for effectively meeting the health care needs of people with developmental disabilities in the bid requirements to identify and select MCOs to serve Medicaid recipients.
- ☑ OMR has taken a number of steps aimed at ensuring an effective and smooth transition to managed care for individuals with mental retardation.
- ☑ MCO performance in serving individuals with developmental disabilities will be assessed through a special satisfaction survey.

choice" waiver in order to establish HealthPASS, a Health Insuring Organization (HIO) that coordinates and arranges for medical services through contracts with service providers. Care coordination is a key component of HealthPASS. By 1986, Pennsylvania had enrolled 96,000 individuals in HealthPASS in areas to the south and west of Philadelphia.

By 1993, Pennsylvania had enrolled 150,000 Medicaid recipients in other managed care organizations (MCOs) in addition to the 79,000 individuals who continued to receive medical services and case management through HealthPASS. These initiatives resulted in roughly 20 percent of all Medicaid recipients, statewide, being enrolled in a managed care plan, or roughly one-third more than the nationwide average.

Much like other states, Pennsylvania has experienced rising health care costs for Medicaid recipients. At present, health care for low-income individuals accounts for 20 percent of the Commonwealth's budget and Medicaid expenditures have more than doubled over the past four years.

In October, 1993, DPW submitted another Section 1915(b) freedom of choice waiver to HCFA requesting approval to substantially expand the use of managed care for Medicaid recipients. The aim of this managed care expansion -- entitled *HealthChoices* -- is to push the enrollment of Medicaid recipients in managed care plans up to 650,000 in the six-county Philadelphia metropolitan area. The key goals of HealthChoices are to:

- improve access to quality health care for Medicaid recipients;
- step up the provision of preventive health care services; and
- achieve better cost control by reducing unnecessary service utilization, particularly emergency room services.

Under HealthChoices, voluntary enrollment of Medicaid recipients in MCOs is being replaced by mandatory enrollment. All Medicaid recipients (including SSI recipients and individuals who receive Medicaid-reimbursable community long-term supports and services) will be required to enroll in an MCO in order to obtain health care services.

Managed Care Models in Pennsylvania

Pennsylvania currently uses two approaches to managed care: the Health Maintenance Organization (HMO) and the Health Insuring Organization (HIO). The HMOs provide primary medical care services for a fixed, prepaid capitated fee. HMOs are certified by the Department of Public Welfare and the Insurance Commissioner. HIOs are organizations that assume the underwriting risk of arranging health care services for recipients in exchange for a prepaid, capitated rate; but, unlike HMOs, HIOs do not provide direct care. Instead, HIOs act as fiscal intermediaries that assure access to all services, typically through subcontracts with health care providers. HIOs are selected through a competitive bidding process using Request for Proposals (RFPs) issued by the Department of Public Welfare.

Target Group/Enrollment Criteria

Enrollment in managed care organizations encompasses most Medicaid recipients, including individuals with developmental disabilities. Pennsylvania has excluded individuals who reside in ICFs/MR or nursing facilities from enrollment, but not persons served via Medicaid home and community-based (HCB) waiver programs.

Enrollment in managed care has been voluntary for Medicaid recipients. With the expansion of managed care via HealthChoices, enrollment in managed care becomes mandatory for Medicaid recipients living in the six-county area. Individuals can select from available MCOs. If an individual fails to choose a health care provider, he or she is assigned to the "default" contractor for that region. Individuals have the choice of at least two plans in each region and in some areas may select from as many as four plans. Whether an individual is assigned to a plan or chooses a plan, each participant has the right to change plans at any time.

Covered Services

Both the HMOs and HIOs are responsible for covering the full range of primary health care services furnished under Pennsylvania Medicaid's fee-for-service program. Coverage of mental health and alcohol treatment services through MCOs will be phased in. Other Medicaid-funded services, such as targeted case management services for people with mental retardation and HCB waiver services (for all waiver target populations except persons with AIDS) are not included within the scope HMO or HIO benefits. In other words, institutional services and community long term supports as well as specialized case management services for people with mental retardation have been "carved out" of the State's managed health care plan.

Interaction of Managed Care and Long-Term Care

Pennsylvania has elected to exclude long-term institutional services and community supports for persons with developmental disabilities from the scope of managed care benefits (although mental health and alcohol treatment services are included in the managed care coverage). Targeted case management is not included in the managed care benefit, but medical care coordination is a mandatory covered benefit that MCOs must furnish.

Since many people in the community would be transitioning from a "fee-for-service" to a managed care system, Pennsylvania officials decided early in the process to recognize the need to plan for and conduct training in order to integrate persons with developmental disabilities into MCOs. As a consequence, OMR officials developed a protocol that covers key issues which MCOs must address in serving persons with developmental disabilities. This protocol was included in the Requests for Proposals issued by DPW to secure MCOs for the HealthChoices initiative. Entitled ***Mandatory***

Managed Care RFP Considerations for People with Mental Retardation, this protocol provides an excellent brief guide to the critical issues that should be addressed when serving persons with developmental disabilities through managed care organizations.

The protocol points out that the primary issue is consumer choice. It affirms the right of persons with developmental disabilities to have access to the same range of services and choice of providers as other enrollees. The protocol stipulates that *"contracts for segregated primary or specialty care only for persons with mental retardation will not be considered fair and equal access to health care services"*.

In addition to choice, the protocol describes seven specific factors that DPW will weigh with respect to health care services for people with developmental disabilities when reviewing MCO proposals:

- 1. Compliance with governmental regulations:*** Contractors must demonstrate their awareness of existing state and federal regulations regarding the delivery of health care services to persons with mental retardation to assure cooperative working relationships with State and local offices of mental retardation and other services providers.
- 2. Quality Assurance:*** The organizations should establish internal quality assurance processes that include persons with mental retardation, family members and advocates. This requirement is intended to heighten awareness of the needs of persons with mental retardation in order to prevent service exclusions or denials. In addition, clinical review teams are to include individuals who are specifically knowledgeable about the health care needs of individuals with mental retardation.
- 3. Identification of a Point Person:*** Each managed care organization is to designate a "point person" who will be available to explain the managed care plan and its benefits to individuals with mental retardation, their advocates, family members and other service providers. This individual should be knowledgeable not only about the managed care plan but also about the state/local MR/MH service delivery system as well as other support and service systems used by persons with mental retardation.
- 4. Training Availability:*** The managed care organization must demonstrate that it has the capacity to secure training for its primary and specialty care providers concerning the health care needs of persons with mental retardation.
- 5. Fair Marketing Practices Assurance:*** The MCO must provide an assurance in its RFP response that it prohibits discrimination against enrollment of persons with mental retardation or recruitment practices that could result in segregated health care.
- 6. Appropriate Reimbursement to Clinicians:*** The MCO should ensure that clinicians are appropriately reimbursed when additional time is needed to serve

persons with mental retardation. Additionally, clinicians are to be reimbursed when they are asked to attend planning sessions on behalf of such an individual. This requirement recognizes that individuals with mental retardation may require additional time or services from the clinician in order to receive quality health care.

7. **Full Range of Service Availability:** Finally, the protocol requires MCOs to assure that specialized services outside of the managed care network, such as dental care under anesthesia, nursing services, home health, adaptive medical equipment, and the use of specialty services, are available to people with mental retardation and other developmental disabilities.

This protocol offers an excellent framework for assuring at the outset of a managed care initiative that MCOs have the capacity to serve persons with development disabilities. The areas addressed in the protocol also can serve as the basis for assessing provider performance and assuring quality of care.

The Office of Mental Retardation's Role in Managed Care

OMR has been an active participant in the managed care development process from the beginning. OMR officials recognized that the State's decision to embrace managed care as a universal approach to the delivery of Medicaid-reimbursable health care services would affect persons with developmental disabilities. As a result, they decided to direct their efforts toward ensuring that the transition of affected individuals in the greater Philadelphia area to managed care providers was carried out as smoothly and beneficially as possible.

OMR's particular concerns included whether Medicaid targeted case management services would fall within the scope of benefits that MCOs are mandated to furnish (and, thereby, disrupt the long-established delivery of case management services through the State's network of county mental health/mental retardation authorities) and how the case management of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services would interact with other services (including early intervention) for children with mental retardation.

To deal with these and other issues that might affect individuals who receive long term supports funded through OMR, the Office formed its own, separate work group on managed care, with representatives from consumers, providers and state staff. This work group was co-chaired by the director of a Philadelphia agency that provides health services for persons with mental retardation and other developmental disabilities. This individual's knowledge of health care, managed care and disabilities proved enormously valuable to the work group.

The work group was charged with keeping abreast of developments and bringing potential issues to the group for discussion. This internal work group enabled OMR officials to bring to the larger Department of Public Welfare work group on managed care

a united, well-reasoned approach to serving persons with mental retardation. Since OMR officials had developed a clear idea of how the new managed care initiative should mesh with existing community service systems, they were able to obtain early agreements to exclude case management services for persons with mental retardation from the scope of services that MCOs would furnish. In other words, county mental retardation authorities would continue to play their long-standing role as the single-point-of-entry and authorizing agent for specialized mental retardation services. With this decision in hand, OMR officials could focus their attention on access to health care, quality assurance, training and system coordination.

OMR also has been very proactive in providing managed care training to consumers, their family members and providers. A ***Training and Information Dissemination Plan for Philadelphia County: Transition to Managed Care*** has been developed. Training on managed care for people with developmental disabilities is being provided to case managers, county and State regional office staff and administrators, residential and vocational service providers, early intervention provider agency staff, parents and family members, consumers and managed care providers. These training sessions have been tailored to the specific audience. OMR has sponsored family forums, newsletters, special sessions for medical personnel as well as separate sessions for adult and child services workers. The training uses a "train the trainer" approach in order to achieve the widest possible dissemination of information. Again, OMR has been willing to dedicate resources to making sure the concerns of persons with mental retardation are known and addressed within a managed health care context.

One of the focal points of this training is cultivating effective communication between specialized service providers (e.g., residential services agencies) and the MCO. For example, OMR-funded provider agencies are being taught to keep improved health records so that the health care provider is better able to diagnose and monitor an individual's health status.

OMR's training and other efforts are strongly focused on forging effective alliances between the responsible MCO on the one hand and families and service provider agencies on the other. A key component in this alliance building is the specially designated ***point persons*** on the staff of the MCOs.

Quality Assurance

While managed care contracts typically include quality assurance measures such as utilization review, medical chart reviews, and internal grievance procedures, Pennsylvania has taken the additional step of specifically designing a consumer health care satisfaction questionnaire for persons with mental retardation. The ***Survey of Access and Satisfaction with Medical Services Provided to Individuals with Mental Retardation*** is designed to gauge consumer satisfaction with managed health care as it is implemented over the next four years. In order to establish a benchmark, the first survey is being administered to individuals who receive health care through the traditional fee-for-service delivery model.

Subsequent surveys will be conducted of individuals who are receiving health care services through MCOs. OMR officials are seeking to determine if there have been positive or negative changes in access to and the quality of health care received by persons with mental retardation as a result of enrolling in managed care programs. This survey will help Commonwealth officials and the MCOs to assess the need for changes or improvements in the system as well.

Conclusion

In Pennsylvania, early involvement and the investment of staff resources in managed care have helped to assure that persons with mental retardation receive appropriate access to services and high quality health care with minimum disruption in services during the transition process. At the outset of the HealthChoices initiative, OMR was "at the table" with well-reasoned RFP stipulations that laid out the capabilities that prospective MCOs should have to demonstrate their capacity to meet the health care needs of people with mental retardation.

OMR also has reached out to consumers and advocates in order to involve them in the planning and decisionmaking process regarding managed care. The Office has devoted considerable energy to working with affected individuals and service providers in the six-county, metropolitan Philadelphia area, in order to equip them with the information they need to interact effectively with MCOs. This high level of OMR involvement in the design and implementation of managed care in the greater Philadelphia area greatly enhances the probability that persons with mental retardation will receive high quality health care.

APPENDIX D

MANAGED CARE: ISSUES THAT MUST BE ADDRESSED

Appendix D

MANAGED CARE: ISSUES THAT MUST BE ADDRESSED

Tina Kitchin, M.D., F.A.A.P.¹

For very good reasons, many states are beginning to provide medical services through managed care. The potential benefits include the following:

- Cost containment;
- Guaranteed access to primary care;
- Preventive care;
- Incentive to keep people healthy;
- Early detection and treatment of disease and illness;
- Less duplication of labs and x-rays;
- More oversight into doctors' offices; and,
- Coordination of care.

Despite all the potential benefits, there are many issues and critical dynamics that must be addressed and resolved in order for the population with developmental disabilities to be safely served in managed care. Although each issue has potentially multiple different solutions, this paper will not attempt to delineate any. Instead, it will attempt to surface some of the issues and provide a brief framework. Only by inclusion of all stakeholders can each state develop the system that will maximize the benefits for all populations.

I. Conflicts

As medical services for Medicaid-eligibles are shifted from fee-for-service to managed care, the following inherent conflicts must be resolved in order to serve the needs of these individuals:

- **Cost Shifting.** Especially during times of limited resources, both the medical system and the social service system look to each other to fund needed services. In the transition to managed care, the state delegates the responsibility (and, therefore loses direct control) to managed care organizations of which "medical services" should be provided to an individual at a given time.

¹ Tina Kitchin works with the Mental Health and Developmental Disabilities Services Division, Oregon Department of Human Resources. She has been deeply involved in the design and implementation of the Oregon Health Plan, focusing particularly on issues related to the transition of people with disabilities to managed health care.

- **Social versus Medical.** In order to keep people independent and in their community, to protect public health and to save other state funds, the state has paid for some services and equipment (incontinence devices, gloves, shower equipment, dietary supplements, etc.) with "medical dollars". Traditional medical systems and managed care often have not thought of these services as "medically necessary". Yet, payment for them meets important state goals.
- **Long Term Care versus Acute Care.** The traditional medical system has focused on (and funded) acute care, not long-term care. The border between them is fuzzy and open to cost-shifting. Therapy services for rehabilitation is paid for in the medical system, not as habilitation. Managed care and Medicare have an "extended hospital benefit" whose site is frequently a nursing home. This has implications for PAS [preadmission screening], long term utilization, and coordinated discharge planning. If a managed care organization does not have responsibility for nursing home care, but does for home health and other home supports, there is a potential tendency to shift individuals into institutions.
- **Psychiatric and Other Mental Health Services versus Traditional Health Services.** Mental health and traditional health services each impact on the need for the other. If a person's physical health needs are not met, the person is usually more severely impacted by his/her mental illness, with the opposite equally true. In addition, mental health services traditionally use some traditional health services (e.g., non-psychiatric medications such as Tegretol and blood tests to monitor levels and side effects). In most medical situations, traditional medical providers (e.g., family practitioners) treat some mental health illnesses (e.g., depression). Yet, the move to managed care rarely includes mental health. The relationship between these two systems needs careful planning.

II. In and Out of Managed Care

As a state decide which services should be accessed and funded through managed care, some services are inherently obvious (doctor's visits, acute hospitalization); but other services need to be thoughtfully decided (targeted case management, personal care, in-home paid attendants, etc.). The decision should include the following considerations:

- Does the service control access to other non-medical services (e.g., vocational services)?
- Will loss of direct control of the service result in expensive demand for other related services (e.g., increase in the need for ICF/MR beds because of insufficient case management support in the community)? Can that risk be managed in a different manner?

- Is the financial risk so great that one managed care organization cannot manage it without appropriate safeguards (e.g., ventilator dependent individuals)?
- Does the entity serve a function so important to state interests that direct control should not be lost (e.g., public health and infectious disease control)? Are there sufficient safeguards in place to protect that function?

III. Safeguards

The move to managed care can disadvantage individuals with cognitive limitations who might not understand "the rules" (access to emergency rooms, grievance procedures, pre-authorization process, etc.) of managed care. In addition, payment by capitation sets up potential fiscal incentives to deny treatment. Oregon has looked at several important safeguards, including the following:

- **Education.** People need to understand the system of managed care and ways in which they may optimally benefit from it. In addition the plan and medical providers frequently need education about these populations.
- **Target Case Management.** This service should be kept out of the managed care plan, thus allowing case managers to advocate for individuals within the medical care system.
- **Exceptional Needs Care Coordination.** This is a new service provided by the managed care plans for people who are elderly or disabled (with add-on additional capitation rate of up to \$6.00 per month per person). It is designed to be a single point of contact for problems and questions within the health plans and to assist those who cannot "navigate" the system on their own.
- **Ombudsman.** Two state-level people are employed to help these populations advocate for themselves and help mediate conflicts.
- **Quality Assurance System Changes.** Both the state and managed care plans are required to monitor issues important to these populations (e.g., consumer satisfaction with medical equipment; referral rates to therapists).
- **Grievance systems** should be open to surrogate decisionmakers.
- **Discharge** from the plan should be prohibited if it is triggered by the person's disability.

IV. Medicare/Medicaid Dually-Eligible Individuals

Medicare carries its own set of complexities, including the following:

- The Medicare system contains its own set of rules and regulations that might not be compatible with Medicaid.
- Managed care entities frequently have separate plans, including separate provider panels, for Medicare and Medicaid recipients.
- Enrollment in Medicaid plans occurs at the state level; enrollment for Medicare takes place at the federal level. This results in time delays for Medicare enrollment and difficulties with billing when an enrollee is dually-eligible.
- Medicare does not allow enrollment in a managed care plan for individuals who have end-stage renal failure or are in a Medicare hospice program. If unresolved, this can result in significant adverse selection for those Medicaid managed care plans which do not have Medicare HMOs.
- All materials going to Medicare-eligible individuals must be federally approved. This can result in significant time delays for all materials.
- Surrogate decisionmakers who may choose a managed care plan are limited by Medicare and often different than those usually accepted by Medicaid (e.g., no provision for power-of-attorney or next-of-kin).
- Medicare does not allow individuals to be "locked-in" a managed care plan. In addition, the individual is not obligated to inform the state of a change in his or her plan. This can result in significant amounts of "catch-up" paperwork.
- The basic overall challenge is to develop an approach in which Medicare and Medicaid compliment each other and confusion is minimized for the members and providers.

V. Other Issues for This Population

- **Informed Consent.** Managed care plans bring with them a bureaucracy and lawyers who tend to be uncomfortable without legally-established surrogate decisionmakers.
- **Choice Makers.** Someone must choose a plan which can be a complicated process. This can involve conflicts of interest (individual choice versus the perceived need of a residential provider to have a single pharmacy).

- **Transitional Issues.** There needs to be a system to arrange the transfer of medical services, supplies and equipment from the old fee-for-service suppliers to the new managed care suppliers without a break in service and without requiring physician approval of each service.
- **Continuity of Care.** A system must be devised to allow individuals to remain with their doctors -- despite a doctor's "appearing full" to the managed care plans.

APPENDIX E

**THE ARIZONA LONG TERM
CARE SYSTEM (ALTCS)**

Appendix E: The Arizona Long Term Care System (ALTCS)

Until 1982, Arizona was the only state that did not participate in the Medicaid program. In that year, the State secured the Reagan Administration's approval to operate a Section 1115 demonstration program through which it would obtain Medicaid funding to furnish a limited range of health care services to public assistance and other low-income individuals. The State's program uses a managed care approach in overseeing the costs and utilization of health services.

Until 1993, Arizona was the only state that had been able to secure federal approval of a large scale Medicaid research and demonstration project. The Arizona Health Care Cost Containment System (AHCCCS) has operated on a demonstration basis for thirteen years through successive federal renewals of the demonstration. Over the years, AHCCCS has changed in various ways, including progressively adding coverages of more types of services.

In 1987-88, the State submitted to HCFA a proposal to add long-term care services to its demonstration project. HCFA approved this addition in 1988; this addendum to AHCCCS went into effect in early 1989. Prior to this addition, long-term care services for people with developmental disabilities were funded through a combination of State dollars, Social Services Block Grant funds and other non-Medicaid sources. Arizona did not participate in the ICF/MR program; nor did it operate a home and community-based waiver program. In the case of elderly/physically handicapped individuals, long-term care services were primarily paid for by local governments, with some state assistance. As it did with health care services, Arizona decided to chart its own unique course in adding long-term care coverage to its program, electing to propose a uniquely tailored demonstration authority rather than covering institutional services as a state plan option or electing to offer community services under an HCB waiver program.

The Arizona Long Term Care System (ALTCS; the long-term care component of the State's 1115 demonstration waiver) presently serves about 18,000 individuals, including 7,000 persons with developmental disabilities. ALTCS is divided into two components. One addresses the service needs of low-income individuals with physical disabilities and elderly persons. Counties are required to provide matching payments for this program. The second component targets long-term care services for people with developmental disabilities; matching funds for this component are provided solely by the State. While the physical disabilities/elderly component operates through the counties or capitated plans (where counties elect not to manage the program directly), the developmental disabilities component is managed by the Arizona Department of Economic Security (DES).

ALTCS (regardless of population group) has two key features. The first is a "tightly defined pre-admission screening (PAS) process to ensure that only individuals who are determined to need the necessary levels of care will receive these services". The PAS process is managed by ALTCS [an administrative unit of AHCCCS], where the screening is conducted either by a registered nurse or an ALTCS social worker, in consultation with a doctor "to determine the best method of treatment for the individual's well-being". When ALTCS was proposed, the State contended that its PAS process would prove to be more rigorous in identifying individuals in need of institutional or HCB services than instruments which other states have used. The second key feature of ALTCS is a capitated payment system. Since payments are capitated, incentives are created to furnish "less costly HCBS substitutes for more expensive institutional care". In a related vein, acute and long-term care dollars are bundled.

In the case of services for people with developmental disabilities, ALTCS capitated payments are made to the Department of Economic Security, which serves as the system's MCO. DES is at risk if the costs of services exceed the capitation; it must obtain additional dollars from the State Legislature to cover any cost overruns. In turn, DES manages these dollars by: (a) operating a "gatekeeper"/primary care case management model (through the regional office of its Division of Developmental Disabilities); and, (b) managing the provider agency rate setting/reimbursement/contracting process. The provider payment/contract management process includes the use of competitive bidding, selective contracting, and various payment rate schedules to control and standardize provider charges. There is no cap on the number of people with developmental disabilities who can be served through ALTCS/DD. Individuals who meet PAS screening criteria are eligible to receive services. The PAS mechanism is expected to control overall utilization by screening potential eligible individuals based on their need for institutional services.¹

In 1995, roughly 7,400 individuals will be served through ALTCS/DD. Only about 300 of these individuals are served in ICFs/MR (including State-operated facilities). The remainder receive HCB services, at an estimated cost of \$125.9 million. The HCB services that may be offered to ALTCS/DD participants include: (a) case management; (b) personal living skills; (c) respite; (d) orientation/mobility; (e) personal care; (f) home health nurse; (g) home health aide; (h) rehabilitative instruction; (i) occupational, physical and speech therapy; (j) adaptive aids; (k) day treatment; (l) transportation; (m) attendant care; (n) respiratory therapy; (o) environmental modifications; and, (p) supported employment (newly added in 1995). Relative to the State's population, the number of individuals with developmental disabilities participating in ALTCS/DD is high compared to other states. In the most recent extension of the Section 1115 demonstration, HCFA approved the State's proposal to tighten its PAS criteria for individuals with developmental disabilities. This proposal was based on the view that the existing PAS instrument is not sufficiently stringent.² Current recipients who are adversely affected by

¹ In contrast, HCFA has imposed a cap on the number of individuals with disabilities and elderly persons who may receive HCB services. The current cap is 40 percent of the total number of AHCCCS-eligible recipients who are disabled or elderly.

this change will be placed in a "transitional" program which has a more restricted list of benefits and a lower capitation rate. In the future, only individuals who qualify based on the revised PAS criteria will be eligible to participate in ALTCS/DD.

The Arizona ALTCS/DD program probably is described best as a gatekeeper system that stresses front-end eligibility determination as a caseload control device, with case managers prior authorizing services to control utilization. The provider/service delivery structure that the State has in place parallels systems in other states. Rate setting and contracting approaches are similar to those employed elsewhere; service capacity is subject to tight controls. Overall system funding is subject to annual legislative appropriations. DES performs the MCO role; however, its "risk management" approach is not substantially different from the budget control mechanisms that are used in other states to avoid appropriation overruns. Eligibility for ALTCS/DD services is regulated by a "need for institutionalization" test, as it is in other states with respect to Medicaid HCB waiver/institutional services.

The DD system's participation in ALTCS enables it to receive Medicaid dollars on a single-stream basis. The State was able to avoid some of the complications that other states encountered during the 1980s in launching and expanding Medicaid HCB waiver programs, particularly with regard to the "cold bed rule" that HCFA employed to regulate the number of individuals participating in a state's waiver program. However, with the elimination of that rule in 1994, this advantage disappeared.

Arizona's developmental disabilities service system has a very low rate of ICF/MR utilization and relatively few large, public facility beds. This fact is sometimes cited as evidence that the ALTCS/DD program has enabled the State to manage its system more cost-effectively than other states. But, historically, Arizona has had a low rate of public-facility bed utilization. The ability to access Medicaid dollars via a demonstration waiver program undoubtedly helped the State to continue its emphasis on community-based services and adopt a relatively unified approach to the delivery of such services.

² In particular, the instrument was designed around activities of daily living (ADL) needs, rather than the applicant's need for DD services.

APPENDIX F

**TENNCARE MR
SERVICES PROPOSAL**

Appendix F: TENNCARE MR Services Proposal

In April, 1995, Tennessee officials submitted a first-cut, proposed amendment to the State's Section 1115 TENNCARE "superwaiver" to incorporate into the State's Medicaid managed care system long-term services and supports for people with mental retardation. State officials proposed that this amendment take effect January 1, 1996. However, in August, 1995, the State withdrew this proposal at HCFA's request in order to allow the Agency to focus its attention on a concurrent proposal to restructure mental health services under TENNCARE. Even though the proposal's future prospects are uncertain (particularly in light of pending Congressional legislation to restructure the Medicaid program), it is worth profiling as an example of how managed care might be applied in mental retardation/developmental disabilities systems.

In 1993, HCFA approved Tennessee's Section 1115 demonstration program to convert Medicaid-reimbursable acute care services to a managed care model and expand eligibility to other low income individuals who lack private health insurance. The resulting "TENNCARE" program was implemented January 1, 1994. Under TENNCARE, Medicaid recipients are required to obtain their health care services through a network of 12 managed care organizations (MCOs) across the State. TENNCARE's initial scope explicitly excluded long-term care services (including ICF/MR and HCB waiver services for people with mental retardation as well as nursing facility services). Such services have remained outside the TENNCARE system and operate under standard Medicaid rules.

Tennessee's proposal to fold long-term care services for people with mental retardation into TENNCARE was designed with three goals in mind:

- "Develop a system which ensures that all consumers with mental retardation and/or developmental disabilities have access to a full range of home and community based services which might successfully reduce or prevent institutionalization.
- "Strengthen the home and community based infrastructure to attract and maintain a wider array of providers.
- "Move toward the use of a managed care approach under which home and community based and long term care services ... will be implemented under a fully capitated system of funding."

The proposal outlined an overall approach to achieving these goals that contained several different elements:

- **System Organization.** The State's TENNCARE Bureau would contract with an existing MCO or a "newly created specialized managed care organization" which would be responsible for ensuring that services required by eligible individuals are provided. This MCO would contract with existing HCB waiver and ICF/MR providers, manage the provider network, and set payment rates. It would be paid on a capitated basis by TENNCARE.

Concurrently, an "independent system of service coordination entities" would be put in place. These entities would be responsible for determining the "functional eligibility" of individuals to receive services and assessing the "levels of support needed by each consumer in the system". Service coordinators would develop an Individual Support Plan (ISP) for each eligible individual. The MCO would be charged with implementing this support plan through its provider network.

The Tennessee Department of Mental Health and Mental Retardation (TDMHMR) would be responsible for promulgating provider standards, monitoring the quality of services furnished by the MCO, handling abuse and neglect investigations, contracting for and monitoring the quality of service coordination services, and assisting in processing consumer appeals. MR/DD services would remain distinct from other services offered through TENNCARE (that is, they would be provided under a special "carve out" arrangement rather than included in the scope of benefits that the State's primary care MCOs are responsible for furnishing).

- **Eligibility.** Persons eligible to receive services would include "all individuals who have a diagnosis of mental retardation [1983 AAMR definition] ... and who are currently receiving services either through state-funded programs, the existing Section 1915 home and community based waivers or in public or private ICF/MRs." The total number of individuals served under the program would be capped based on available funds. Individuals with mental retardation who are wait-listed for services would be phased into the program over the life of the waiver to the extent that savings are achieved. Individuals with developmental disabilities other than mental retardation would be served, but only if sufficient savings have been achieved to clear the waiting list of people with mental retardation. Financial eligibility would be determined by using the 300 percent of SSI special income standard.
- **Services Offered.** The following services would be covered under the plan: (a) public ICFs/MR (i.e., Tennessee's four State-operated developmental centers); (b) residential habilitation in group home settings (including small ICFs/MR); (c) supported living (including personal support and community inclusion services); (d) family-based residential living (foster care model); (e) day habilitation; (f) vocational training; (g) supported employment (without regard to whether an individual has prior history of institutionalization); (h) specialized daytime services for elderly individuals; (i) specialized daytime services for individuals who are medically fragile and are "homebound"; (j) personal care; (k) crisis intervention; (l) nursing; (m) specialized equipment and supplies; (n) environmental modifications;

(o) transportation; and, (p) respite care. This mix would have wrapped around all of the current ICF/MR and Medicaid HCB waiver services presently offered in Tennessee.

- **Provider Network.** The proposal would grandfather into the MCO network all existing MR service system providers for the first year the demonstration. Thereafter, "it is recognized that after the waiver is implemented the provider network may change". The MCO would be required to ensure that "a sufficient number of providers will be maintained" in order to furnish services required by individuals. The MCO would have sole responsibility for contracting with providers and negotiating payment rates.
- **Service Coordination.** The proposal stated that the "linchpin of the proposed service delivery system under this waiver amendment is the development and implementation of a private, statewide, service coordination (case management) system". "Service coordination" was defined in the proposed amendment as a "process by which eligible persons and their individual service coordinators work together to find access to supports indicated by the Individual Support Plan This effort ... can help make the TENNCARE support delivery system more cost-effective because individuals will use only the supports he or she needs, as opposed to having to accept a full menu of services common to many programs in a slot-funded system". Service coordination would be available to all eligible individuals and decentralized on a regional basis. Service coordinators would be certified and periodically recertified. Either a single or multiple entities would furnish service coordination. Service coordination providers "must be free of conflicts of interest with other service providers and MCOs in the TENNCARE system". Service coordination would be reimbursed on a capitated/per enrollee basis. This system would be phased in during the first year of operation.

Service coordinators would have the following responsibilities: (a) information and referral; (b) portal of entry/eligibility determination; (c) assessment; (d) individual support plan (ISP) development; (e) working with the MCO concerning the implementation of the ISP; (f) furnishing ongoing support coordination; (g) monitoring the provision of services; (h) advocacy; and, (i) periodic plan review.

Should "the MCO disagree with the ISP that has been developed by the service coordination entity", the proposal stipulates that "the MCO and the service coordination entity should first attempt to resolve the differences through discussion. If the parties are unable to mutually agree upon a satisfactory solution or if the time required to reach the solution would, in the opinion of the service coordination entity, place the member at immediate risk, then the ISP is to be implemented. The parties will then agree upon an independent party to resolve the dispute".

- **System Financing.** Payments to the MCO would be composed of the following:
 - *A monthly administrative fee for each enrolled consumer.* This fee would compensate the MCO for provider network development, payment rate negotiations, and monitoring of provider and service quality.
 - *Service capitation.* A "monthly clustered rate will be paid to the MCO for each consumer with mental retardation enrolled and will be based on the category of service and/or level of care in which the individual is enrolled as determined by the service coordination assessment." The material submitted to HCFA in April did not contain details concerning the methodology that would be used in constructing these clustered rates.
 - *Profit Taking.* The MCO would be allowed to retain a profit of no more than 5 percent of expenditures. Profits above this level would be diverted to extending services to people with mental retardation who are on the waiting list or, potentially, to individuals with developmental disabilities other than mental retardation.
 - *Deinstitutionalization Incentive Payment.* If the MCO were able to accelerate the community placement of State developmental center residents, it would receive an additional 5 percent payment on top of the monthly clustered rate for services provided to these individuals. This incentive payment would not be figured into the calculation of the MCO's profit.
- **Quality Assurance and Monitoring.** The proposal contained a number of quality assurance/consumer protection features. These included:
 - *A Consumer Review Board* would be established which, along with TDMHMR and the TENNCARE Bureau, would monitor and oversee the implementation and ongoing operation of the program. This thirteen-member board would be composed principally of consumers and/or family members. The proposed amendment noted that the "primary responsibilities of the Board will be to study the effectiveness of the program based on consumer satisfaction evaluations and to ensure that there is an appropriate use of resources across the service system".
 - TENNCARE would contract with TDMHMR to provide quality assurance monitoring, including consumer satisfaction surveys, "system analysis, contract compliance, and outcome measurement of the [MCO, service providers, and the service coordination system]". TDMHMR would conduct a variety of activities in conjunction with this monitoring.
- **Spending.** In order for HCFA to approve a Section 1115 project, a state must demonstrate that the costs of its proposal would not exceed the costs that otherwise

would be incurred under regular Medicaid requirements. This proposal's point of comparison was estimated ICF/MR outlays plus spending levels already approved under the State's home and community-based waiver programs for people with mental retardation. Currently unmatched state general revenue dollars would be included in the program in order to capture additional federal Medicaid dollars within this cap.

During 1996, total outlays under this proposal were projected at \$273 million. About 6,800 individuals would make up the first group of enrollees, with an estimated service cost capitation of \$38,255/enrollee. MCO administrative costs were estimated at \$3.9 million, while service coordination costs were pegged at \$9.2 million (approximately \$1,360/enrollee).

- **Waivers Requested.** The proposal requested that HCFA approve the following waivers:
 - **Eligibility.** The State asked for a waiver of Section 1902(a)(10)(A)(ii)(VI) of the Social Security Act, so that it could furnish home and community-based services to individuals regardless of whether they meet ICF/MR level of care criteria.
 - **Expanded Services.** The State requested various waivers to permit the services that would be offered under the proposal to be furnished as "medical assistance" without reference to the special authority contained in Section 1915(c) of the Social Security Act (the home and community-based waiver statute).
 - **Freedom of Choice.** A waiver of Section 1902(a)(23) of the Act was requested so that the State could require enrolled individuals to receive services through the MCO. A related waiver would have restricted the number of individuals who may be placed in State developmental centers in accordance with outstanding court orders which obligate the State to reduce the census of such facilities.
 - **Utilization and Quality of Care Review.** Since Tennessee expects to phase out the use of ICFs/MR, it requested waivers of Sections 1902(a)(26), 1902(a)(30), 1902(a)(31) and 1903(g) in order to permit the State to substitute "alternative utilization review and quality of care requirements" for such facilities.
 - **Deeming.** The State also requested a waiver in order to disregard the deeming of parental income to children so that they would be eligible to receive services through the program.
 - **Supported Employment.** Finally, the State requested a waiver to enable prevocational, supported employment, and educational services to be furnished to participants without regard to whether they were previously institutionalized.

Discussion. While the proposal submitted by Tennessee was not fully developed, there are several observations which can be made regarding the State's approach:

- The State opted for an exclusive MCO arrangement similar in many ways to the approach which some states have used in implementing managed mental health services. Since service coordination would be conducted independently, the proposed MCO takes on some of the characteristics of a **Third Party Administrator** arrangement by being responsible for the delivery but not the determination of necessary services. In other words, the MCO would not have "care coordination" responsibilities.
- However, the MCO would bear risk (rather than solely acting as an agent for delivering services). Since the MCO would be at-risk but not perform front-end utilization management, its primary risk management tool would lie in managing the supplier network through payment negotiations and, potentially, shifting some of the risk to that network. In addition, while the MCO was portrayed in the proposal as the "implementor" of the ISP, the proposal also provided that the MCO could dispute the services contained in the ISP. Here again, the MCO would not function solely in an "implementor" role. The proposal would resolve conflicts between the MCO and the support coordination entity through mediation in order to ensure that economic interests would not override programmatic objectives. The proposal, however, did not specify the criteria to be used in mediating such disputes. The construction of the proposal dictated that the MCO, as opposed to the service coordination entity, bear risk. Since the MCO would be administering 97 percent of the system's total dollars and have the authority to set payments and manage the supplier network, service coordination entities could not be placed at risk.
- The proposal calls for making capitated payments to the MCO in the form of "clustered monthly rates" based on enrollee characteristics. This is a form of "risk adjusted" capitation. When the proposal was submitted, however, the methodology for establishing these rates had not been worked out. Service coordination entities would be responsible for conducting assessments and evaluations that would result in individuals being categorized by cluster group. While these rates would form the basis of capitated payments to the MCO, they were not portrayed as limitations on the amount of services that a particular individual might receive. Given the legion of problems associated with case mix or tiered payment rates in developmental disabilities services, it was unclear whether Tennessee could develop cluster rates that have predictive validity in estimating enrollee resource utilization patterns.
- The proposal fully wrapped around Tennessee's mental retardation service system, including its state-operated developmental centers. Tennessee no longer would offer ICF/MR services but instead operate its developmental centers under alternative standards while shifting privately-operated ICFs/MR to generic residential service standards. The ICF/MR-related waivers requested by Tennessee were unprecedented. The State's proposal was complicated by federal Department

of Justice investigations and suits against the State under the Civil Rights of Institutionalized Persons Act.

- Under the demonstration, Tennessee would operate its program under an enrollment cap. Such enrollment caps, of course, are a common feature of Section 1915(c) home and community-based services waivers. Tennessee operates its TENNCARE managed health care program under such a cap, however that cap is structured so that the State only has the discretion (which it has employed) to stop the enrollment of individuals who otherwise would not be eligible for Medicaid. At least under present federal policies, it is uncertain that a state could regulate long-term care services in a similar fashion.
- The proposal would have given the Tennessee Department of Mental Health and Mental Retardation several roles in the arena of quality assurance/quality enhancement. However, the Department would have had a considerably reduced role in terms of direct management of the State's mental retardation community services network.
- The proposal provided for the creation of a consumer board with system oversight responsibilities. This clearly was an effort to introduce checks and balances into the proposed system.

While the Tennessee proposal had not been fleshed out before it was withdrawn, it nonetheless illustrates one approach to applying a managed care approach to a mental retardation/developmental disabilities service system.

APPENDIX G

**WEST VIRGINIA'S PROPOSED
BEHAVIORAL HEALTH SYSTEM**

Appendix G: WEST VIRGINIA'S PROPOSED BEHAVIORAL HEALTH SYSTEM

In March, 1995, West Virginia officials submitted a Section 1915(b)(4) "freedom of choice" waiver request to HCFA. In this request, State officials ask for authority to replace categorical Medicaid funding of various mental health and developmental disabilities services with a unified managed care system. A single statewide MCO would be established, the proposal explained, which would receive capitated payments in exchange for furnishing "behavioral health" services to all eligible Medicaid recipients. While other states have gained HCFA's approval to operate their mental health systems under this type of arrangement, this is the first instance in which a state has proposed wrapping mental health and developmental disabilities services together under a unified managed care approach.

West Virginia's proposal requests waivers of: (a) comparability (in order to exclude nursing facility residents and certain other categories of Medicaid recipients from its program); (b) freedom of choice (in order to require all recipients to obtain the services to be offered through the managed care program only through the single, designated MCO; and, (c) a waiver of Section 1905(a) of the Act (in order to permit the state to furnish "non-traditional" services to recipients). The State did not request a waiver of statewideness.

Except for the relatively small number of Medicaid recipients who would be excluded from the plan, all other Title XIX-eligible West Virginians would be required to enroll with the single MCO in order to obtain covered mental health and developmental disabilities services.

The State would select a single MCO through an RFP process. The State's proposal calls for implementing this program in January, 1996. Since at this writing (October, 1995), the proposal had not received HCFA's approval, the proposed timetable for implementation is uncertain. In addition, proposed Congressional changes in the Medicaid program cast further uncertainty on the fate of this proposal.

As set forth in the State's proposal, the selected MCO would be responsible for coordinating a "comprehensive benefit package" that would lead to establishing a "seamless and uniform behavioral care delivery system" that "has greater flexibility to meet client needs" and, thus, achieve "improved outcomes" and "more efficient use of resources". The benefits package that would be available under the program would include:

- Assessments (screening, assessment, and testing)
- Crisis services (crisis intervention, crisis support, and crisis stabilization)
- Case management
- Rehabilitation/habilitation (individual, family, group, physical, speech, and occupational therapy, behavior management, and supported employment services)
- Supportive services (in-home respite, out-of-home respite, and personal care)
- Residential long-term care for persons with developmental disabilities
- Inpatient services
- Transportation

The proposal indicates that these services would employ "care criteria and utilization standards" jointly developed by the contractor and State officials, following the selection of the MCO. The "care criteria will outline appropriate intervention strategies for persons with particular diagnoses and clinical profiles. Utilization standards will indicate for each clinical population the level and intensity of service that is appropriate".

The MCO would be expected to establish a network of behavioral health providers and would be required to offer contracts to existing providers during the first year of the plan's operation. After the first year of operation, however, the MCO would have a freer hand in managing the supplier network, subject to requirements concerning geographic access. Recipients would be able to choose a specific provider from among those that join the MCO's network. The MCO would be expected to operate a 24-hour hotline to address the needs of individuals in crisis and also would be responsible for conducting outreach and consumer education programs.

In addition, the MCO would be required to operate a "systematic, comprehensive, continuous" quality management program that includes: (a) outcome measurement; (b) "data-based decision making"; (c) following "clinical guidelines based on best practices research"; (d) consumer satisfaction measures; and, (e) measurable quality improvement goals. In addition, the State would contract with an "external quality review organization", which would conduct an independent assessment of the quality of services furnished by the MCO to enrollees as well as the MCO's performance.

In order to be approved by HCFA, this type of waiver request must be found to be cost effective (i.e., the program "will reduce costs or slow the rate of increase of costs and maximize outputs or outcomes per unit of cost"). Generally, in order to demonstrate cost effectiveness, a state prepares estimates of the costs of furnishing services in the absence of the waiver (this is termed the "upper limit") and compares these estimates with the payments it would make under the waiver. In capitated approaches, a state generally proposes to set its capitated payments at some percentage below the cost per recipient that it would incur if it were to continue a fee-for-service payment methodology.

In its proposal, West Virginia estimates that it would expend \$584.9 million for behavioral health services in the absence of the waiver during the two-year period

commencing on January 1, 1996. [N.B., These waivers may be approved for a period of only two years but may be renewed an indefinite number of times if performance is satisfactory.] With the waiver in effect, the State estimates that total spending would drop to \$574.6 million (including the additional administrative costs that would be incurred), or about 1.3 percent less than under current arrangements.

The West Virginia "behavioral health"/Medicaid spending base upon which these calculations are made includes: (a) clinic services; (b) ICF/MR services; (c) inpatient psychiatric services; (d) mental health rehabilitation services; (e) the State's HCB waiver program for people with developmental disabilities; and, (f) physician/psychologist services. Under the State's proposal, these dollars would be bundled together and converted to a discounted capitation payment that would be made to the MCO. Capitation payment levels would be established for each of four Medicaid recipient groups: (a) aged/disabled; (b) disabled; (c) AFDC; and, (d) non-AFDC eligible children. For example, State officials estimate that a payment of \$265.40/month would be made for each of the 86,000 Medicaid recipients with disabilities who would be enrolled in the MCO. In contrast, a monthly payment of \$5.88 would be made for the 400,000+ AFDC recipients who are expected to enroll. These amounts are based on present patterns of behavioral health services utilization among the specified eligibility groups.

With respect to developmental disabilities services, the plan is expected to result in a 10 percent reduction in the utilization of ICF/MR services, which would free up dollars for less costly community services and supports. With regard to mental health services, savings are expected to be achieved through the reduced use of inpatient hospital settings and more effective contracting methods for clinic and rehabilitation services.

APPENDIX H

**GEORGIA'S BEHAVIORAL
HEALTH PLAN**

Appendix H: GEORGIA'S BEHAVIORAL HEALTH PLAN

In August, 1995, Georgia officials submitted to HCFA an interwoven package of waiver requests aimed at clearing the way for the State to employ managed care approaches in the delivery of mental health, substance abuse, and mental retardation services. The package was composed of a Section 1115 demonstration waiver request that would alter the delivery of mental health/substance abuse services and a Section 1915(b) freedom-of-choice waiver request that would apply to Medicaid-reimbursable mental retardation services furnished through the State's home and community-based waiver program. Georgia also concurrently submitted an amendment to its HCB waiver program for persons with mental retardation that would expand the scope of the program, modify its service coverages and make various changes in program operations. This package of waiver requests is designed to promote a more integrated, decentralized system of services in Georgia.

Background/Overall Directions

In 1993, the Georgia Legislature approved a measure (H.B. 100) that was aimed at fostering a new approach to the delivery of mental health, mental retardation and substance abuse (MH/MR/SA) services. The "concept behind the legislation is to fund people, not programs, and to provide incentives for communities to develop the most effective and efficient service delivery systems that will be responsive to the needs of the local population". In particular, H.B. 100 provided for the creation of a network of Regional Boards that would plan for, manage and oversee the delivery of MH/MR/SA services at the substate level. This Regional Board system was viewed as a long overdue replacement of the State's patchwork of public and private agencies and programs. Under the legislation, all dollars (including Medicaid funds) earmarked for MH/MR/SA services were to be allocated to the Regional Boards in order to establish a decentralized, locally-directed system of services across the three population groups. Nineteen Regional Boards were created as a result of H.B. 100.

The waiver requests submitted to HCFA would funnel both Medicaid and other state dollars to the Regional Boards so that they can develop "fully integrated" local behavioral health service systems. The broad aims of these waiver requests are to: (a) put the Regional Boards in a position to coordinate all public dollars earmarked for MH/MR/SA services; (b) promote the development of comprehensive and more community-oriented behavioral health services; (c) strengthen consumer choice by offering an increased range of services furnished through more providers in more locations; (d) increase access to long-term supports for all three target populations;

(e) replace categorical programs with single stream funding; and, (f) improve quality while containing the growth in the costs of behavioral health services.

In order to accomplish these aims, dollars for mental health and substance abuse services would be channeled to Regional Boards via capitated payments. In turn, the Boards would contract with one of two or more Third Party Administrators (TPAs), managed care organizations designed to assist the boards in developing and managing local service systems, including contracting with service providers. This arrangement would be accomplished through the Section 1115 demonstration waiver request that Georgia has submitted. For the time being, however, mental retardation services would not be included in this capitated payment system. Instead, they would continue to be furnished on a fee-for-service basis, although, at some point, State officials expect to transition mental retardation services to a capitated approach. The State proposed to strengthen the role of the Regional Boards in the management of mental retardation services through the submission of the Section 1915(b) freedom-of-choice waiver request to HCFA.

The Section 1115 Waiver Request

The State's Section 1115 demonstration waiver request encompasses mental health and substance abuse services. Through various waivers of federal law, Medicaid dollars that purchase mental health and substance abuse services would be channeled to the Regional Boards in the form of capitated payments. The State has requested these waivers in order to gain permission to use Medicaid dollars not only to pay for such services on behalf of traditional Medicaid eligibility groups but eventually to expand the eligible population to other populations on a recipient cost-participation basis. This element of the proposal led to Georgia officials to opt in favor of a Section 1115 waiver request rather than the types of Section 1915(b)(4) waiver requests that other states have used to place mental health and substance abuse services under a managed care system.

As proposed by the State, individuals would enter the local behavioral health service system through any contracted provider. Based on an assessment conducted by the provider, the individual would be assigned to one of three service tiers. "Tier I" services would be available to all individuals and would include screening and evaluation, crisis intervention and referral services. "Tier II" services would include acute care mental health/substance abuse services that resemble services offered by private insurance plans (inpatient and outpatient services, subject to length-of-stay and/or visit limitations). "Tier III" services would be targeted for individuals who are determined to be "Most In Need" (MIN). Such individuals require intensive interventions and long-term supports. Each person who meets MIN criteria would be assigned a Regional Board-contracted service coordinator who would be responsible for developing a plan of care on the individual's behalf. This plan of care would encompass the full range of acute and long-term care services needed by the person.

Each Regional Board would contract with a TPA to assist it in managing the local service system. Through a Request for Proposal (RFP) process, State officials would contract with two or more TPAs in order to give Regional Boards a choice among private firms to carry out TPA functions. The Board and the TPA would share various system management functions, including: (a) provider network development (each Regional Board would specify provider recruitment/selection criteria with the TPA performing the actual recruitment and contracting, subject to Regional Board approval); (b) payments (each Board would develop payment rate criteria but the TPA would conduct the actual rate negotiations with providers); (c) TPAs would be responsible for prior authorization of services, utilization management, collecting data and paying claims (again, subject to Regional Board concurrence); and, (d) Regional Boards would be responsible for quality assurance activities and resolving consumer grievances/complaints. This approach is designed to ensure that Regional Boards maintain policy control over mental health and substance abuse services while shifting system administration to a TPA.

As noted above, Medicaid dollars for mental health and substance abuse services would be paid to the Regional Boards on a capitated basis. The amount received by each Board would depend on the total number of eligible individuals who reside in its catchment area (e.g., capitation would be in the form of fixed payments per eligible individual rather than fixed payments per person actually utilizing MH/SA services). As long as costs remained within a 10 percent corridor above or below the amount of the capitation, risk would be shared equally between the Regional Board and the TPA. Outside this corridor, the Regional Board would assume 90 percent of the risk.

Georgia's proposal called for implementing this approach to delivering MH/SA services during 1996. Initially, state-only, non-Medicaid funds would not be folded into capitation payments to the Regional Boards, but would continue to be distributed through the present "grant-in-aid" funding system. Eventually, however, it is expected that state-only dollars also would be capitated to create a unified, single-stream funding approach.

The MR Section 1915(b) Waiver

Services for people with mental retardation are excluded from the capitated funding methodology that would be used for mental health/substance abuse services. Instead, Georgia is requesting that HCFA approve a Section 1915(b)(4) freedom-of-choice "program" waiver request in order to permit the management of mental retardation services to be consolidated under the Regional Board network. Via this waiver, Medicaid dollars for MR services would be channeled to the Regional Boards, which would become "single portal" entities for authorizing the delivery of such services. Initially, Regional Boards would not be at risk and payments would continue to be made on a fee-for-service basis. However, in future years, the State would transition both Medicaid and state grant-in-aid dollars for mental retardation services to a capitated, at-risk basis. The State's proposal notes that it would be premature to capitate the mental

retardation system. Instead, the plan is to collect additional data that would permit a capitated system to be implemented at some future date.

This Section 1915(b)(4) waiver program would span the following Medicaid-reimbursable services: ICF/MR, HCB waiver, and "clinic option" Medicaid state plan services for individuals with mental retardation. Eligible individuals would access these services through providers in a fashion similar to mental health/substance abuse services. Again, Regional Boards would employ a TPA to assist in local service system administration and management, including provider network management. However, since a "fee-for-service" framework would be maintained and the Section 1915(b)(4) request would not subject the Regional Board and/or TPA to risk sharing.

The essential thrust of this proposal is to permit Regional Boards to consolidate the administration of Medicaid-funded mental retardation services at the local level. By superimposing a Section 1915(b)(4) freedom of choice waiver on top of the existing HCB waiver program for persons with mental retardation, the State would be taking its first step toward decentralized program management but stop short of the larger step of placing Medicaid-reimbursable mental retardation long-term care services under a full blown managed care program.

It is worth pointing out that this waiver request does not propose any change to an individual's freedom of choice between HCB waiver and ICF/MR services. Persons who meet ICF/MR level of care criteria would still be offered this choice. In addition, HCB waiver services still would be subject to limits in terms of the maximum number of individuals served.

The HCB Waiver Amendment

Concurrently, Georgia also submitted a request to HCFA to amend its Section 1915(c) HCB waiver program for people with mental retardation. Generally, this request continues the State's existing array of services but provides for the following changes:

- Greater flexibility in the mix of "diverted" and "deinstitutionalized" waiver participants;
- The distribution of waiver "slots" to the Regional Boards based on average total costs, rather than distributing service specific slots;
- Having QMRPs perform level of care determination;
- Determining diagnostic/functional eligibility through assessments conducted by providers under contract with the Regional Boards;
- Increasing the cap on the number of program participants from the current limit of 1609 to 2109; and,

- Offering supported employment services to all participants regardless of whether or not they were previously institutionalized.

This amendment would take effect upon approval and, thus, potentially in advance of HCFA action on the Section 1915(b)(4) waiver request. If the Section 1915(b)(4) waiver were to be approved, its provisions would apply to the services offered under the State's HCB waiver program.

All three waiver requests were submitted concurrently to HCFA in order to give the Agency a clearer picture of how Georgia officials intend to restructure its entire MH/MR/SA service delivery system.

APPENDIX I

**RHODE ISLAND'S
CHOICES PROPOSAL**

Appendix I: RHODE ISLAND'S CHOICES PROPOSAL

In March, 1994, Rhode Island officials submitted to the Health Care Financing Administration (HCFA) a five-year research and demonstration proposal that would "test the applicability of a capitated managed care model for acute and long term care services for people with developmental disabilities." Entitled CHOICES (Citizenship, Health, Opportunities, Interdependence, Choices, Environments, Supports), this Section 1115 waiver program would combine current Medicaid and other State funding streams into a "single, coherent system" in order to promote more streamlined and cost efficient service delivery as well as spur the "transition of [Rhode Island's] current delivery system from one which is provider driven to one that is more consumer driven."

State officials originally proposed that this demonstration commence on July 1, 1994 and continue through June 30, 1999. However, as of October, 1995, the proposal was still being negotiated between the State and HCFA. Pending Congressional changes in the Medicaid program could clear the way for Rhode Island to proceed with the implementation of CHOICES without securing HCFA's approval of its Section 1115 waiver request.

Background

Over the past fifteen years, Rhode Island has forged a comprehensive community-based developmental disabilities service system. In FY 1993-94, 3,470 adults with mental retardation and developmental disabilities were expected to receive specialized services and supports underwritten through a combination of Medicaid and state-only dollars. About 1,600 of these individuals were being served in community residences (including 80 small, community-based ICFs/MR) and family living arrangements. Services were provided in programs operated directly by the State's Division of Developmental Disabilities (DDD) and by a network of private agencies. Publicly-operated services accounted for roughly 25 percent of all spending.

In March, 1994, Ladd Center, the State's only large public facility for individuals with developmental disabilities was closed, hence enabling Rhode Island to join New Hampshire and Vermont in offering only community-centered services. Over the past few years, the State has had virtually no waiting list for daytime or in-home support services for adults. Furthermore, only about 60 individuals were awaiting an appropriate out-of-home placement at the time the CHOICES proposal was submitted. Most of these individuals were receiving in-home supports. Consequently, there has been relatively little unmet demand for services and supports in Rhode Island.

In FY 1993-94, Rhode Island's expenditures for specialized adult developmental disabilities services totaled approximately \$154.3 million, of which roughly \$117 million was earmarked for community living arrangements. In addition, State officials estimated that Medicaid acute health care outlays on behalf of adults receiving specialized developmental disabilities services would total \$18.7 million (about \$5,000 per individual). Federal Medicaid expenditures accounted for \$90 million, or 52 percent, of the estimated \$173 million in total spending for specialized and acute care services furnished to adults with developmental disabilities. State general revenue dollars accounted for an additional \$76.7 million, or 44.3 percent of total outlays, with client funds making up the remaining \$6.4 million or 3.7 percent. In 1992, Rhode Island ranked third nationwide in total fiscal effort (i.e., spending for specialized MR/DD services divided by state personal income).¹

Medicaid financing has played a very significant role in Rhode Island's strategy to pay for specialized services and other community supports. The existing Medicaid funding streams used by the State include: (a) ICF/MR services; (b) home and community-based waiver services (the State ranks 4th, nationwide, in terms of the number of waiver participants relative to its population); (c) Community Supported Living Arrangements (CSLA) services under the provisions of Section 1930 of the Social Security Act; and, (d) rehabilitative services covered under the State's Title XIX plan (which are used principally to pay for daytime services). In combination, federal Medicaid and associated state matching dollars pay for over 90 percent of all specialized MR/DD services in Rhode Island.

CHOICES: Basis and Overview

Although Rhode Island has one of the most well-funded developmental disabilities service systems nationwide, it "has been essentially a traditional provider operated and regionalist system of sheltered workshops, group homes, and other support services." Moreover, "new people entering the system have had to fit into available openings within programs, which offered limited opportunities for choice of provider as well as service design." As a consequence, the State's service system has been "program driven", due in significant part to Rhode Island's heavy reliance on Medicaid categorical funding streams.

The CHOICES proposal is the outgrowth of "a significant fundamental shift in [Rhode Island's] thinking of how people with developmental disabilities are defined from 'consumers with a categorical disability' to 'people with individualized needs'." CHOICES is intended to assist the State in transitioning from a program-driven to a more consumer-driven service system. CHOICES also is aimed at achieving a "more streamlined and cost efficient service delivery system that will result in greater consumer satisfaction." During its 1993 session, the Rhode Island Legislature enacted a measure to encourage the use of managed care approaches. The State obtained HCFA's approval to implement a Medicaid managed health care program, entitled "RIte Care." CHOICES would introduce managed care strategies into the developmental disabilities service

¹ National Mental Retardation/Developmental Disabilities Expenditure Base Project, University of Illinois at Chicago, University Affiliated Program, 1993.

system. In many respects, the strategies Rhode Island has proposed depart from conventional managed care approaches.

State officials designed the CHOICES program to accomplish four central objectives:

- "Utilize existing resources more efficiently and simplify the system. Currently, there are several Title XIX funding streams, some of which fund similar, overlapping or alternative services but each of which has its own variation on eligibility requirements and its own set of procedures. We will reorganize this into a more efficient system.
- "Contain costs. By applying principles of managed care and by capitating costs, we expect to control costs at manageable levels without sacrificing service quality or availability.
- "Continue our commitment to a community-based service system. We believe that normal growth and development occurs in natural settings rather than in institutions. Therefore, CHOICES will fund the supports necessary for people to live and be in the community without references to institutional care as an alternative.
- "Reinforce our commitment to consumer participation, decision-making and choice whenever possible. We will emphasize consumer participation and strive to create a system that is consumer driven to the degree possible while still containing costs."

With these objectives in mind, the Rhode Island CHOICES waiver proposal would institute the following changes:

- State-federal Medicaid dollars, as well as state-only funds, that pay for both long-term and acute care health services for adults with mental retardation and other developmental disabilities would be combined to pay for a "single, coherent system of community-based residential, daytime, and community support services." Single stream funding would introduce "a more rational approach to program eligibility, funding, and cost control."
- Under this single stream approach, present categorical program requirements would be dropped in favor of a unified, cross-cutting set of consumer-centered service and outcome standards.
- Similarly, eligibility requirements would be standardized. Existing differences in eligibility for ICF/MR or HCB waiver services and other Medicaid state plan services would be eliminated in favor of adopting uniform financial eligibility criteria that would not be referenced against the need for institutional care.
- Present program-based funding mechanisms would be replaced by assigning individual capitated dollar amounts to eligible individuals. In turn, consumers would be empowered to use these dollars flexibly to obtain services and supports identified in their Personal Support

Plans (PSP) from qualified providers. State-operated programs would compete with services and supports offered through private agencies.

- In addition, capitation/managed care principles would be employed in obtaining basic health care services for individuals who are eligible for MR/DD services, either by purchasing such services from managed health care plans that are participating in Rhode Island's RItE Care program or through other arrangements.
- Also, various other changes would be made in order to reinforce "quality, accountability, efficiency and consumer satisfaction."

Each of these features of the CHOICES proposal is discussed in further detail below.

In short, Rhode Island's proposal lays out a five-year plan for reconfiguring state and federal Medicaid funding along substantially new lines. Program funding would be replaced by assigning individuals a capitated dollar allowance that they could use in purchasing the services and supports they need from the provider agency or practitioner of their choice. In submitting the CHOICES proposal to HCFA, State officials pointed out:

"Rhode Island is clearly in a unique position compared to other states to successfully implement a managed care waiver. First, being the smallest state in the country not only provides a manageable size for a demonstration but gives us the opportunity to personally know virtually all of the people within our system. Because Rhode Island already has a fully developed service delivery capacity with no waiting lists, it can test alternative models for efficient service delivery without the associated risk of a 'woodwork' or unknown population and/or the rapid increase in service capacity. Presently, we are expending a considerable amount of dollars on people to meet their needs, and we have provided some type of service to all people who are known to us. We do not have a waiting list for people to get into the system. We believe we have the capacity to restructure our management system to be more efficient, which will serve as a good model for the rest of the country as the national health care debate unfolds."

The CHOICES proposal was endorsed by a wide range of State organizations, including the Rhode Island Conference of Executive Directors of Arcs, the Rhode Island Developmental Disabilities Council, United Cerebral Palsy of Rhode Island, and other provider organizations.

Demonstration Waiver Proposal

CHOICES was submitted to HCFA as a Section 1115 research and demonstration proposal. Rhode Island requested seven waivers of federal Title XIX statutory requirements, including:

- **Comparability.** A waiver of Section 1902(a)(10)(A) was requested in order to permit the State to limit the availability of services and supports that would be available to CHOICES

participants to individuals with mental retardation, developmental disabilities, or a traumatic brain injury. In the absence of such a waiver, Rhode Island would be required to offer these services and supports to all Medicaid recipients.

- **Income Limitations.** The State requested a waiver of Section 1903(f) of the Social Security Act in order to allow it to employ a "special income standard" in determining the Medicaid financial eligibility of CHOICES participants. Rhode Island planned to use the same standard it presently employs in determining financial eligibility for institutional and HCB waiver services (e.g., 300 percent of the SSI individual need standard). Without this waiver, individuals who have not been determined to need institutional services would have had to meet less generous Medicaid categorical eligibility requirements. This waiver enables financial eligibility to be determined without reference to the need for institutional services.
- **Freedom of Choice.** Under Section 1902(a)(23) of the Social Security Act, a state cannot restrict Medicaid recipients from receiving services from any qualified vendor. Rhode Island requested a waiver of this provision in order to implement its single-payor, managed care approach, and also to limit the provision of health care services to qualified managed health care plans.
- **Uniformity.** In addition, Rhode Island requested a waiver of Section 1902(a)(1) of the Act, which requires that the state plan be in effect for all services and all eligible recipients in all political subdivisions of the state. While the CHOICES demonstration would be in effect statewide, services would be available only to the eligible target population.
- **Contract Flexibility.** State officials also asked for a waiver of Section 1902(a)(13) of the Act and various regulatory requirements concerning payments to providers and prepaid health plans in order to "obtain maximum flexibility in arranging reimbursement agreements with providers and to allow use of functional level based capitation."
- **Inspection of Care and Utilization Control.** Since the State intends to eliminate ICF/MR services, it requested a waiver of inspection of care and utilization control requirements contained in Sections 1902(a)(26) and 1902(a)(31) of the Act.
- **Cost-Sharing.** Finally, the State plans to impose cost-sharing requirements on CHOICES participants. Each individual would be expected to contribute a flat minimum of \$25/month. In addition, individuals with income over and above SSI or SSDI assistance levels would be required to contribute \$1 out of every \$4 received monthly after the first \$2,000 in earnings. In order to implement this cost-sharing plan, the State is requesting a waiver of the provisions of Section 1902(f) of the Act, which proscribes cost-sharing requirements for Medicaid-reimbursable services.

These waivers would enable Rhode Island to target services and supports to people with developmental disabilities through the CHOICES demonstration by using uniform financial eligibility criteria that are not tied to a person's "need for institutional services."

Target Population/Eligibility

Under CHOICES, Rhode Island would make services and supports available to individuals with mental retardation or related conditions and other developmental disabilities who are 18 years of age or older, including all current recipients of Medicaid-reimbursable services as well as future applicants. Financial eligibility would be determined through the application of a special income standard of 300 percent of the SSI standard of assistance for an individual.

In addition to individuals presently receiving Medicaid-reimbursable specialized developmental disabilities services, eligibility also would be extended to four additional groups:

- **Individuals with Traumatic Brain Injury.** During the first two years that the CHOICES demonstration is in operation, State officials propose to offer long-term community living supports to up to 50 individuals with traumatic brain injury who are "inappropriately institutionalized or living in the community with inadequate support."
- **Supported Employment Participants.** Some 500 individuals in Rhode Island receive supported employment services funded with state-only dollars. These individuals would participate in CHOICES and supported employment services would be a covered service for all CHOICES participants.
- **DD Program Participants.** Since 1987, Rhode Island has operated a special program for individuals with developmental disabilities who are not mentally retarded. Roughly 40 individuals are being served in this program with state-only dollars. These individuals would participate in CHOICES and be eligible for the full array of services and supports offered under the program.
- **Special Education Graduates.** Finally, the proposal provides for serving an additional 125 young people with developmental disabilities who will be graduating from special education programs.

Taking these additional populations into account, the State estimated that 3,610 would participate in the demonstration during FY 1994-95 and that this number would grow to 4,050 by FY 1998-99. The number of individuals who would be served in CHOICES was estimated to be only 2-3 percent higher than under existing programs.

Services and Supports to be Offered

In its CHOICES program, Rhode Island would eliminate service categories tied to existing Medicaid-reimbursement streams in favor of offering participants "an individualized, integrated complement of natural, generic and specialized services, programs and assistance designed to support the individual in community environments, and to enhance (and maintain) the individual's health, adaptive capacity, community

experience and opportunities for growth and development in these settings." In addition to case management, CHOICES participants would be able to obtain services and supports in four general categories:

- **Supported Living** for persons who live in their own or their family's home. These supports would include: (a) homemaker/home health aide; (b) respite; (c) personal care; (d) training habilitation and support services; (e) 24-hour emergency assistance; (f) transportation; (g) home modifications; (h) assistive technology and adaptive equipment; and, (i) "other services to provide supports at home and in the community, because of disability." The range of these supports more or less parallels those available to individuals under the State's present CSLA program.
- **Alternative Living Arrangements (ALAs)** are "supervised settings for persons who have insufficient natural supports or who require specialized assistance ... beyond the capability of supported living." In ALAs, "supervision, assistance, and habilitation are provided by and are under the oversight of a certified service provider." Such services may be furnished in "houses, apartments, condominiums, duplexes, or in special care homes or with a family." The ALA site may be owned or controlled by the State, a private agency, or the individual. Funding for ALA services would vary depending on intensity of the supervision/ interventions that an individual requires. Receipt of ALA services would be contingent upon a finding of "medical necessity" by the Division of Developmental Disabilities (DDD). This medical necessity determination would hinge on a person's need for supports over and above those that would be made available in supported living settings.
- **Daytime Services** are defined as "regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve as therapeutic vehicles to maintain or increase adaptive capabilities, independence, or integration and participation in the community." Such services would include: (a) vocational assessment and career development; (b) supported employment, job training, or competitive employment; (c) work activities, "which may include volunteer activities or paid work activities and are for the purpose of achieving therapeutic goals"; (d) adult development and habilitation services; (e) retirement related activities "designed to maintain presence and participation in the community and to maintain or enhance capabilities and skills appropriate to the lifestyle of an older person who has chosen retirement"; and, (f) transportation.
- **Medical Services**, furnished through a health maintenance organization or another approved health care plan, which encompasses the "full range of health services, including a primary care physician, hospitalization, catastrophic health care, and dental services."

The above services would be eligible for state-federal Medicaid reimbursement under the CHOICES demonstration. Excluded would be living expenses or other supports not set forth in the proposal.

Determination of Individual Payments

A central feature of CHOICES is giving each participant control over a fixed amount of resources which may be used to obtain services and supports. A capitated amount would be assigned to each person rather than paid directly to a managed care organization or a vendor agency. This approach is intended to empower consumers, spark market competition among providers, and create incentives for maximizing the use of natural and other community supports. Thus, a key element of CHOICES is the determination of the individualized capitation amount.

As originally submitted to HCFA, CHOICES would have employed a multi-dimensional assessment process to determine the level of assistance into which each participant fell for purposes of assigning the maximum capitation amount that would be assigned to an individual. The assessment was to include: (a) an evaluation of adaptive behavior [N.B., Rhode Island officials expected to employ a modified version of the new American Association for Mental Retardation classification and description system.]; (b) a behavioral assessment; (c) physical/health/etiology considerations; and, (d) environment (including physical environment, "the presence, absence and quality of natural support systems, quality and number of personal relationships, degree of integration and participation in the environment, and range of opportunities for meaningful choices available to the individual"). State officials characterized the assessment process as "a cooperative effort in which the consumer (or appropriate guardian, family member, or other legitimate advocate) participates fully, by expressing their views of the presenting problem and of the relative personal importance of the different areas assessed." Final decisions regarding capitation levels or placement were to be made by the DDD staff based upon need and available resources.

Based on the assessment, each individual was to be assigned to a "level of assistance." This determination was to be based on "collective professional judgment based on evaluative material in the multi-dimensional assessment tool. The level of assessment would be a statement of the applicant's need for support. The applicant's current environment, relationships or support systems would be considered as well." State officials expected to define seven levels of assistance, ranging from intermittent through limited, extensive, and "pervasive."

HCFA officials questioned the feasibility of developing "a reliable and valid assessment of individual need that can be satisfactorily linked to individual 'capitated' services cost rates." As a result, Rhode Island officials decided to substitute a different approach to capitation. In lieu assessment-driven tiers, State officials decided to:

"... to develop a capitation protocol based primarily on a comprehensive analysis of similarly situated individuals. We have decided to alter the approach predicated upon the seven levels of assistance Instead the State proposes to develop a protocol based upon the actual resource use (service experiences, utilization, and expenditures) for all persons presently enrolled in the Rhode Island DDD long term care service system. Our predicate is

that among the approximately 3,500 individuals who are currently receiving services, the full range of possible service arrangements, and, therefore, service costs, already exists.

"In brief, the State proposes to array each of the current individual service arrangements along a continuum of possible service arrangements and costs. A scale will be developed to allow measurement of individual characteristics in such areas as level of disability (e.g., mildly disabled or significantly retarded), need for assistance (e.g., homeless or living with family), availability of natural supports (e.g., no family or very involved family), and additional disabilities (e.g., sensory impairments, mobility impairments, or communication disorder). Once all of the existing program participants have been characterized and assigned an annual cost based on actual experience, the same protocol will be employed for new individuals coming into the service system. New individuals will be 'paired' with similarly situated individuals already in the system. This analysis should result in an approximate capitation level for each new applicant which should assure a sense of fairness or equity because the capitation will be similar for similarly situated individuals and should result in an appropriate capitation level since the final determination will be based upon a professional judgment of the analytic outcomes.

"This entire protocol will eventually be automated, and the initial instrument, still to be developed, will undoubtedly undergo refining and improvement over the course of the waiver period. Developing the capitation process is one of the most complex aspects of the proposal. The State understands the need to develop a reliable and viable capitation process. A failure to do so would result in potential inequity and inappropriate service provision, both of which are rampant in the present system of multiple Medicaid funding streams.

"The statistical methodology for development of capitation in CHOICES based on resource use is similar to case mix methods employed in other states for institutional reimbursement systems such as RUGS, DRGs, or other patient based reimbursement designs. Under CHOICES, all expenses for long term care will be included in the case mix analysis".

In essence, Rhode Island officials discarded their initial plan to employ tiered capitation payments in favor of developing a more complex scheme that would generate individualized capitation amounts based on an array of factors that are reflective of current resource consumption patterns in the existing service population. Initial capitation amounts for individuals already receiving services would be based on current outlays on their behalf.

HCFA also asked how capitated payments would be affected by changes in the assistance that an individual might require. Rhode Island officials responded by pointing out that two percent of available funds would be withheld to cover the cost of emergency situations. In particular,

"additional supports will only be available in the event of a manifest change in circumstances such as loss of a place to live, loss of caretaker (e.g., death of a parent), major health

deterioration (e.g., new seizure activity, significant emotional upset, or heart attack) or other significant life event. The State will respond to these emergency situations during the year and will then build the extra cost into the following year's capitation. Similarly, if someone obtains additional support or requires fewer supports, then that person's annual capitation rate will be reduced during the annual planning session for the following year."

This two percent reserve would serve as a safety valve in the event that the original capitation amount provided to be insufficient due to major changes in an individual's needs or circumstances.

Capitation/Vouchers/Personal Support Plans

Once a capitation amount is set, "a person or agency authorized by the consumer or the consumer him/herself, prepares a Personal Support Plan" (PSP). This plan would delineate the specific services and supports to be provided, their frequency, from whom they would be received, and their overall costs. Eligible individuals would exercise control over the selection of provider agencies. The PSP would integrate information concerning paid services, consumer income and living expenses. The PSP would be reviewed by DDD officials. This review would include confirming that plan costs fall within the capitated payment amount and that the plan is responsive to the problems and issues identified through individual assessments.

The PSP may be managed by a provider agency selected by the consumer or by the consumer with, as desired, technical assistance from DDD and/or peer groups organized to furnish such assistance. State officials point out that "if the person elects to manage the plan ..., the consumer has full control of service and support design. This includes hiring, firing and choosing support persons, selecting locations and activities and all other aspects of managing the plan." Consumers managing their own plans would be required to use an approved fiscal intermediary agency to "bill Medicaid, make disbursements to service providers, and maintain payroll, tax and other appropriate records." This approach amounts to a voucher system. However, direct cash payments would not be made to consumers.

CHOICES is designed to support direct consumer management of the PSP. Individuals can elect to have an agency manage the PSP. CHOICES, however, places agencies in the position of having to compete in order to do so. Agencies that take on this responsibility would be held at risk.

Managed Health Care Services

CHOICES originally envisioned setting up a specialized managed primary health care plan for participants. This plan also would have served employees of service provider agencies. By creating this relatively large pool of individuals, State officials believed that savings could be achieved in obtaining health care services for all enrollees. Rhode Island officials are exploring the feasibility of creating such an alternative health care plan.

HCFA, however, questioned the feasibility of creating such a plan, particularly in light of the relatively limited number of potential enrollees. The alternative to such a plan would be to expand the State's RItE Care program to serve CHOICES participants.

Quality Assurance/Enhancement

The CHOICES proposal outlined a variety of monitoring and evaluation processes to ensure the quality and appropriateness of the services furnished to participants. These processes would include: (a) licensing of community agencies; (b) human rights promotion; (c) conducting investigations of alleged cases of abuse, neglect, and/or mistreatment; (d) critical incident reporting; and, (e) implementing strategies for identifying consumer and family satisfaction with supports received as well as individual outcomes of services. CHOICES builds upon the State's existing, well-defined systems for ensuring the health, safety, and well-being of its citizens with developmental disabilities.

In conjunction with CHOICES, DDD would expand its Office of Quality Assurance by hiring 10-12 additional staff, some of whom would be consumers, family members and staff from private community agencies. In addition, the DDD staff would conduct regularly scheduled follow up and monitoring visits to participants. This monitoring and follow-up would vary depending on each participant's level of assistance.

Program Administration & Management

The CHOICES demonstration would be jointly administered by Rhode Island's Department of Human Services (the single state Medicaid agency) and DDD. DHS would: (a) determine financial and categorical eligibility for Medicaid; (b) administer and process payment claims; (c) set payment rates with the advice and assistance of DDD; and, (d), carry out various other responsibilities.

DDD would "develop, maintain, and oversee a long [term] community care support system and [the] managed medical care system." DDD would "recruit, develop, license or certify, monitor and oversee providers of community support services." It also would manage provider contracts as well as furnish technical assistance and clinical consultation to program participants. DDD social workers would conduct case management/service coordination activities, including intake and helping participants navigate enrollment procedures and other processes. In order to carry out its responsibilities, DDD plans to shift workers from the now-closed Ladd Center, expand its central office infrastructure, and, as noted above, add to its quality assurance monitoring staff.

Cost Effectiveness

Rhode Island officials estimated in the CHOICES proposal that the proposed demonstration project would result in savings of \$97 million in state-federal outlays over

the five year period of the demonstration. These savings were expected to stem from the implementation of capitated service allowances and cost efficiencies arising from giving consumers greater flexibility in obtaining needed services and supports as well as promoting greater competition among service providers. Since CHOICES would be phased in over the five-year period, cost savings were expected to grow during the later stages of the project as a greater number of existing consumers are converted to the new approach. In FY 1994-95 (Year 1 of the original proposal), cost savings were estimated at 1.6 percent (\$3.1 million) of the state-federal dollars that would be expended in the absence of the demonstration program. By FY 1998-1999, cost savings were expected to reach 12.7 percent (\$43.9 million).

Research Questions

In line with the requirements of Section 1115 research and demonstration waivers, State officials outlined a wide range of research questions that are to be examined during the course of the demonstration. These questions spanned four areas: (a) service costs; (b) service quality; (c) service networking; and, (d) consumer choices. In the area of service costs, for example, State officials would assess the effects that replacing ICF/MR regulations with alternative standards would have on program costs. Regarding consumer choices, researchers plan to look at strategies that appear to assist consumers in making more of their own decisions and taking greater control of their lives.

Negotiations with HCFA

Even though HCFA officials greeted the CHOICES proposal with considerable enthusiasm, some eighteen months after submission Rhode Island has not obtained HCFA's approval. In October, 1995, State officials were in the process of submitting new materials to HCFA to address various concerns that the Agency had voiced. While some of these issues concerned technical questions, it was apparent that the central premise of the State's proposal -- consumer control over resources -- was proving difficult for HCFA to fit within the conventional vendor-oriented framework of the Medicaid program. With major changes in store for the Medicaid program, it is unclear whether Rhode Island will continue to pursue approval for the Section 1115 demonstration project or simply attempt to implement choices on its own once the pending statutory changes are enacted into law.

APPENDIX J

THE COLORADO BLUEPRINT

Appendix J: THE COLORADO BLUEPRINT

Key stakeholders in Colorado are taking an in-depth look at how the State's service system for people with developmental disabilities might be restructured to permit the system to cope with tightening dollars yet also meet the needs of individuals who are waiting for services and still honoring individual choices and preferences. The State's *Proposed Blueprint for Change* is the jumping off point for a system-wide dialogue concerning the reforms and restructuring that will be necessary. One of the central features of the *Blueprint* is shifting the state's service system to a managed care approach.

Colorado's developmental disabilities service system has evolved steadily toward increased emphasis on personalized, community-centered supports. Relatively few individuals are served in the State's two large public residential treatment facilities. Large private sector ICFs/MR have closed or are in the process of shutting down their operations. The State is continuing to expand supported living opportunities and has long been a leader in assisting people to hold integrated jobs in the community. Colorado has a well-defined family support program. Community services and supports are delivered through a network of non-profit "community centered boards" (CCBs) that coordinate, furnish or arrange for services.

The State is facing some critical challenges. The *Blueprint* describes these challenges as follows:

- **The system is unlikely to see a significant influx of new dollars for the foreseeable future.** State dollars already are tight. Congress is expected to cap the rate of growth in Medicaid spending. Medicaid dollars compose two-thirds of the State's financing of community services. Funding growth will flatten considerably. A large premium will be placed on cost containment.
- **Unless there is system change, the waiting list for community services is likely to grow longer.** In recent years, despite continued growth in systemwide resources, the number of individuals waiting for services has continued to grow in Colorado. With flat funding on the horizon, fundamental changes will be needed to prevent this situation from worsening.
- **Decentralization, deregulation and government downsizing already have affected the state's DD service delivery system and will have more pronounced effects in the future.** These factors will continue to affect Colorado's DD service system. The system will need to adjust to this new funding environment.

These challenges necessitate a top-to-bottom examination of the ways in which the State's DD service system might be re-engineered.

The first product of this process is the *Proposed Blueprint for Change*. The *Blueprint* outlines the following path toward reconfiguring the State's system:

- **The elimination of categorical funding of services and supports in favor of making block grant allocations of state and federal Medicaid dollars to the CCBs.** CCBs would be required to serve a minimum number of individuals in order to receive their full block grant allocation. Single-stream block grant funding is regarded as the key to promoting maximum flexibility in meeting the needs of individuals with lifelong disabilities at the community level. If such flexibility leads to lower costs, savings could be reinvested to meet the needs of individuals on the waiting list for services.
- **Two distinct block grants would be made to each CCB.** The **Supported Living Block** would provide dollars for individuals who need personal assistance, employment and/or habilitative services, environmental engineering supports, family support or professional services such as physical therapy. The **Supervised Living Block** would provide funding for persons who need a more intensive mix of supports, including significant supervision. CCBs would be able to use the dollars in these blocks flexibly. Splitting the funding in this fashion recognizes differences among localities in the composition of the population being served. The benefits CCBs would furnish to individuals would correspond to those offered in the current system. However, both CCBs and individuals/families would have greater flexibility in customizing supports to meet the needs "which are the most critical for each person". This flexibility has been the "cornerstone of success of newer service models such as Community Supported Living Arrangements ... and Family Support Services Program" Block grant dollars would flow to CCBs in the form of capitated payments.
- **CCBs would become managed care organizations.** This means that the CCBs would be responsible for local management of the block grant dollars within parameters established by the State. Instead of following a rigid, State-defined payment schedule, CCBs would be able to negotiate payments directly with local providers. In addition, CCBs would have the latitude to offer individuals and families vouchers for services and supports. As managed care organizations, CCBs also would have front line responsibilities for performing utilization review (i.e., assessing the efficacy of services and supports) as well as conducting outcome surveys aimed at improving performance. The *Blueprint's* drafters were keenly aware of the potential for managed care to be superimposed on the State's service system. By proposing that CCBs become managed care organizations, the *Blueprint* acknowledges the need for restructuring the system but along lines that will keep decisionmaking in the hands of local communities and agencies.

- **The services and supports that individuals receive still would be identified through an individual planning process.** However, since overall dollars will be limited, all parties will need to become more adept at "assessing needs for individual supports versus assessing needs for packages of services, and to be frugal in determining necessities versus what would be nice to have". Here again, the State's experience with the CSLA program as well as family supports illustrates that planning teams can stretch "limited dollars in very creative and practical ways in order to meet the needs of individuals".
- The *Blueprint* outlines a four-pronged strategy for ensuring system accountability. This strategy includes utilization review, outcome surveys, audits, and contract negotiations. This strategy would be implemented with a combination of State review of CCB operations coupled with affirmative requirements regarding activities that CCBs would have to carry out as managed care organizations.

The *Blueprint* proposes that Colorado's DD service delivery system be transformed from one where dollars flow categorically in the form of "slots" and "service packages" to a single-stream approach that features substantial individual and local flexibility in pulling together the most cost-effective support strategies possible under a global funding limit. CCBs would serve as managed care organizations. As such they would be placed at risk. "Profits" would be earmarked for waiting list reductions.

Colorado officials are quick to point out that the *Blueprint* is simply a starting point for re-engineering the State's service system. Copies of the proposal have been widely distributed; the Office of Developmental Disabilities Services has provided a variety of opportunities for all affected parties to obtain more information regarding the proposal or make their views known. A series of public forums were held to gather direct public input concerning the proposal. A wide variety of issues and questions have been identified that will need to be resolved in order to flesh out the proposal. Some of these issues include the degree to which individual CCBs will be exposed to financial risk under a managed care arrangement and the types of protections that must be established to ensure that individuals and families are fairly treated. Based on this input and further refinements in the original *Blueprint*, a final proposal will be prepared and forwarded to the Colorado Legislature for consideration during its 1996 session.

The *Blueprint* is a thoughtful examination of the issues that will confront developmental disabilities systems as a result of both state and federal policy changes in the wake of federal deficit reduction initiatives. It takes an informed look at how managed care concepts might be used to enable a system to restructure itself in a fashion that seeks to balance the interests of individuals and families against the harsh realities of flat funding. In order to obtain a copy of the **Proposed Blueprint**, please write the Office of Developmental Disabilities Services, Colorado Department of Human Services, 3824 W. Princeton Avenue, Denver, CO 80236.

Appendix K

Presentation by Dennis Harkins

To:

1995 Wisconsin Supported Employment Conference (September 19, 1995)

This morning SB 246 was introduced in the State Senate, with full support of the Governor, the Wisconsin Counties Association, and the leadership of both parties in the Senate and the Assembly. This bill would repeal Chapter 51.437 of our Wisconsin Statutes, which, as you know is the legislation which authorizes and requires Wisconsin counties to provide services to people with developmental disabilities.

SB 246 will replace our county system with a statewide system of managed care for all community and institutional services for people with developmental disabilities. It will take the current \$500 million being spent on these services, and subtract \$30 million in county funding which counties will be able to use to provide property tax relief. Effective January 1, 1997, the Department of Health and Family Services will contract with one or more Managed Care Organizations (MCOs) to provide services to the 26,000 Wisconsin citizens with developmental disabilities now receiving community services, the 4,000 individuals now living in institutions, and the 6,000 people on waiting lists.

The initial contract will be for five years. It will mandate a number of service outcomes, including a 5% increase in individuals served each year. This will eliminate our waiting lists by the end of the year 2000. The MCO(s) chosen will receive a 2% increase in funding each year, considerably less than the anticipated rate of increase for our current institutional and community system.

How do we expect to achieve such dramatic results over this period of time? For the past nine months, we have been working with ComCare, a managed care consulting group based in Minneapolis to quietly but systematically analyze how we provide developmental disabilities services in Wisconsin. I will briefly summarize their overall conclusions, as well as their specific findings regarding vocational services.

To cut to the essence of several hundred pages of analyses and recommendations, their basic conclusion is Wisconsin's developmental disabilities services system is a complicated mess which virtually no one understands; is administered by a highly regulated and inefficient federal state, county and provider bureaucracy; and, wastes an

enormous amount of funding by serving people in settings they don't need and in ways that make little economic sense. They are convinced there will be no shortage of MCOs which will be capable of serving more people for less money than we are currently spending, with significantly better outcomes. The major cost efficiencies are expected to occur through eliminating unnecessary layers of bureaucracy; drastically reducing Wisconsin's long standing dependence on costly institutional care; and revising or replacing contracts with local providers, many of which have continued for more than 20 years with little regard for service outcomes or cost-effectiveness.

Looking at community employment and other daytime services, the word which best characterizes ComCare's analysis of our current system is "appalling". They found relatively little correlation between the abilities of a person and whether that person spent his or her day in a congregate daytime facility for people with disabilities; in makework, subminimum wage employment; or in a real job with real pay. The more significant correlations were simply the county in which the person lived, and the beliefs and competencies of the agency providing services.

ComCare found many examples in which supported employment was effective in helping people find and maintain jobs; however, overall it described supported employment as "... a program which has become simply another part of the self-perpetuating vocational rehabilitation industry, only occasionally achieving cost-effective outcomes". ComCare found numerous examples of job coaches in a long-term 1:1 relationship with a person receiving subminimum wage. Not infrequently, they noticed job coaches reading books or newspapers for much of the time they were paid to be supporting the individual on the job.

ComCare found agencies receiving \$15-25 per hour to provide 1:1 job coaching for individuals who were getting paid a fraction of that amount. They found a contractual relationship between counties and providers which typically discouraged success. For many agencies, the reward for effectively transitioning from job coaching to natural supports is simply a reduction in funding. Thus, ComCare was not surprised to find people receiving long term supported employment who had relatively few needs for support.

Most disheartening, at a time when unemployment in Wisconsin is at an all-time low, when entry level positions are expanding in virtually every part of the state, when large and small employers are crying for help, ComCare found on a statewide basis supported employment has had no significant impact on the unemployment rate of people with developmental disabilities.

Let me talk briefly about how the proposed new system will work. The organization or organizations which receive the contract to manage Wisconsin's developmental disabilities services system beginning in 1997 will be required to stay within a prescribed amount of funding and meet specific performance outcomes in a number of service areas. For example, the recommendations for supported employment are:

1. To freeze funding at the 1996 level;
2. With that amount of funding maintain at least the level of employment of all individuals being supported in jobs in 1996; and,
3. Decrease the current 75% unemployment rate of people with developmental disabilities by 15% in 1997 and by an additional 10% in each of the subsequent years of the contract.

ComCare is confident these outcomes can be achieved.

What does this mean for supported employment agencies in Wisconsin? I believe it means agencies have about 15 months to eliminate mediocrity, waste and activities which violate the basic test of common sense. I believe it means agencies must passionately and obsessively focus *on getting people jobs*, not on providing something we call supported employment. I believe it means we use conferences like this, the supported employment network, and other training events we can create to truly become experts in getting people jobs, and skillfully supporting people on those jobs with as little and as inconspicuous support as each individual needs.

The organization which will begin managing our system in 1997 will not be asking you what you can do; they will be asking the employers in your part of the state what you have done. What will employers you work with tell them about the value of the workers you have found for them, about the value of the support you provide to them? What will you tell the organization about the cost of your services, what you will provide for that cost, the number of people for whom you will find jobs and support for that cost?

Okay, by now, many of you have decided that I have spent at least one day too many in the bureaucracy, and have figured out that there is no SB 246; there is, *at the moment anyway*, no attempt to repeal Chapter 51.437; there is no ComCare looking over your shoulder from Minneapolis. For those of you who have not reached that conclusion, I apologize for any problems I may have caused in the digestion of your lunch. Let me suggest, however, that while ComCare is fictional, their analysis of our overall system, of our vocational services and of supported employment is not.

We have now entered the most exciting and threatening period in the brief history of community services to people with developmental disabilities. You need only read the newspapers, watch TV, or listen to the conversation at you local barber shop or hair styling salon to know that the public and its elected representatives have no interest in increasing funding for human services in the foreseeable future. That's the bad news.

The good news is that the public is right. Government does spend tax dollars in an unacceptably wasteful manner, and everyone in this room knows that. In developmental disabilities services, much of that waste is tied to regulations and practices *we know we can change*. We can no longer spend \$300 a day on institutional services for someone who can live a better life in the community at half that cost. We can no longer afford to

buy support which can be better provided by friends, neighbors and co-workers. We can no longer tolerate rules and regulations and contracting procedures which increase the cost of services without adding *anything* to the quality of people's lives.

In the not too distant future, I am convinced that an organization like ComCare will be looking over your shoulder. What will they see? Will they see an agency which knows how to get jobs for people with disabilities? Will they see agency staff creatively adapting jobs to minimize the impact of people's disabilities, build upon people's capacities and interests, and connect people to their coworkers? Will they see employers asking how they can hire people with disabilities because they have heard from other employers that you can help them obtain good workers?

Each of us in this room, all of us together have the responsibility to make sure those questions are answered with an enthusiastic "Yes!" We believe that people with severe cognitive disabilities are valuable and productive workers when given the opportunity and support. We must be equally confident in our *own* capacity to learn to be more valuable and productive workers, whether our work is to help people find jobs, support people to do those jobs, or create the policies and administer the funding in a way which *increases* rather than limits the number of people we can serve.

I will leave you now (this is the one statement I made this afternoon which I though would get applause) and return to my ivory tower in Madison. I have tried in this short time to share my thoughts, and share concerns I have heard expressed throughout our state about how we are doing our work. If I have offended you with the manner in which I have conveyed these concerns, I sincerely apologize. My intent has been to communicate a *sense of urgency* about the need for us to transform the system, before someone else does it for us ... someone who may not share our respect for the capacities and potential of people with developmental disabilities.

At this moment, we are all doing the best we know how. What I am asking of you, and what I am asking of myself, is simply that we learn together as rapidly as possible over the next few hours, weeks, and months how to do even better. We owe that to the people we are serving.

APPENDIX L

**NASDDDS POLICY STATEMENT
ON MANAGED CARE**

Appendix L

National Association of State Directors of Developmental Disabilities Services

Policy Statement:

MANAGED CARE AND LONG TERM SUPPORTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

State developmental disabilities service systems are facing major challenges. In most states, there are long waiting lists for services. In all probability, the availability of federal Medicaid funding to purchase long term supports for people with developmental disabilities will decline significantly over the next few years. Moreover, competing budgetary demands will make it increasingly difficult for states to sustain reasonable growth rates in developmental disabilities funding. These challenges demand a thorough reassessment of every opportunity for improving systemwide productivity.

A growing number of states are evaluating the potential utility of adapting managed care approaches for improving the cost-effectiveness and efficacy of long-term supports for people with developmental disabilities. The central question posed by these initiatives is: **can managed care enhance the capacity of states to meet the overarching goal of ensuring that all individuals with developmental disabilities obtain the supports they need to live inclusive lives in their communities?**

Over the past decade, states have taken many steps to improve the quality and cost-effectiveness of publicly-funded developmental disabilities services. Costly segregated public institutions have been downsized and, in dozens of instances, closed. States have aggressively expanded their Medicaid home and community-based waiver programs while deemphasizing the development of costly intermediate care facilities for persons with mental retardation and related conditions (ICFs/MR). They also have been very active in sponsoring innovative family support, supported living and supported employment programs that more effectively meet the needs of their customers and make better use of scarce public dollars. Furthermore, more attention has been focused on quality improvement. Much has been accomplished; but, more remains to be done.

Today, state developmental disabilities services systems are extensively managed. They operate under fixed budget ceilings and are accountable to multiple entities. These systems are complex and highly dynamic. They are based on decentralized service networks that succeed by tapping into a vast pool of community resources and supports.

Managed care for people with developmental disabilities has evolved into a distinctly different arena of health care. As the pros and cons of employing managed care techniques in developmental disabilities services are weighed, it is vitally important to keep in mind that the central question is not whether to substitute managed care for current systemwide management strategies but rather which managed care technologies will improve the quality and effectiveness of existing systems while affirming the values upon which those systems are based and the essential need to keep them intimately tied to communities.

Better system management is an essential step toward assisting people with developmental disabilities to be active, valued members of their communities. In examining the role that managed care might play in this process, it is critical that we not lose sight of the fact that our basic goal is to support -- not control -- people with disabilities and their families.

NASDDDS supports a thorough assessment of potential ways in which managed care approaches might be used to better meet the needs of people with developmental disabilities and their families. Some features of managed health care have potential for improving the cost-effectiveness of community developmental disabilities services. These features include utilization management of high cost services and interventions, better approaches to substituting flexible community supports for more rigid, traditional service models, re-engineering provider agency contracting and reimbursement policies in order to foster greater efficiency and improved service quality, and better use of data systems in support coordination, management and monitoring. Managed care may assist us in discovering new approaches to tackling long-standing system management issues. By applying lessons learned in other health and social services arenas, states may be able to increase the productivity of their developmental disabilities service systems. **And, better managed systems are critical if the states are to successfully meet the challenges they face.**

However, the translation of managed care approaches to long-term developmental disabilities support systems is largely uncharted territory and, hence, extreme caution is warranted. There is no evidence that managed care models which have evolved in the health care field can be adapted successfully to the financing and delivery of long-term supports to people with developmental disabilities without significant modifications. Moreover, there are very fundamental, critical differences between furnishing health care and long term supports. Health care touches one aspect of an individual's life; long-term supports affect many different facets of community living for people with developmental disabilities. **Furthermore, the conversion of long term supports systems to managed care can have enormous and irreversible implications for the individuals and their families who rely on these systems for essential services and supports.**

NASDDDS believes, therefore, that any attempt to apply managed care models to long-term supports for people with developmental disabilities must proceed cautiously and in strict accordance with the following principles:

- **Assisting people with developmental disabilities to lead full and productive everyday lives in their communities must remain the central, defining aim of a state's service system.** Public supports are a means toward an important end: assisting people with developmental disabilities to achieve full citizenship as active and valued members of their communities. This aim can be accomplished best by constantly striving to offer flexible, high quality, personalized supports that honor individual choice and promote interdependence with others in the community. NASDDDS opposes managed care approaches that would undermine this essential principle.
- **All key stakeholders, including individuals with developmental disabilities, family members, support agencies, advocates, and others, must be enlisted in designing, implementing and overseeing the operation of a managed care system.** Demanding active, open and continuous consultation with all affected parties will ensure that the resulting system resolutely keeps the best interests of individuals and families in mind. All parties must be confident that changing over to managed care will promote better outcomes for people with developmental disabilities. NASDDDS opposes the development of a managed care system in isolation from the community of stakeholders who will be directly affected by its implementation.
- **The implementation of managed care approaches must safeguard the quality of services and supports available to people with developmental disabilities.** Any managed care approach must ensure that people with developmental disabilities will be safe and secure while receiving efficacious services and supports that enhance their ability to lead productive, fulfilling lives in the community. Individuals with developmental disabilities are especially vulnerable to exploitation and neglect. Consequently, the service system must contain reliable safeguards that include active, independent monitoring of service provision, coupled with the authority to intervene when individuals are placed at risk. People with developmental disabilities and their families should play a central role in monitoring managed care organizations as well as the agencies responsible for furnishing services. In addition, individuals and families should be fully informed about the performance of managed care entities and service providers.
- **Managed care should expand – not diminish – opportunities for people with developmental disabilities and their families to choose services and supports that will improve the quality of their lives.** Service systems must respect and honor individual preferences. Persons with disabilities and their families must have real choices in selecting the supports and support providers that offer them the best opportunities to enjoy meaningful lives in the community. Embracing self-determination and promoting real choices are vital if service systems are to help individuals and families realize valued outcomes. We also know that, when families and individuals have choices that enable supports to be tailored to their distinct needs, costs usually are lower and supports are more effective. Choice should be

limited only where it is demonstrated that services are not promoting practical outcomes that improve an individual's quality of life or where it is clear that there are other accessible and more cost-effective support strategies available which would achieve the desired results.

- **Managed care strategies should encourage innovation in supporting people with developmental disabilities.** Such strategies should include improving access to and utilization of generally available services, forging creative partnerships within and across service systems, making better use of natural and community supports, and examining other opportunities to accomplish essential system functions more economically.
- **Managed care strategies must provide for the effective coordination of specialized developmental disabilities services with other systems upon which people with developmental disabilities rely.** Such coordination is especially critical in interactions with the health care system. Many of the supports that certain individuals require necessitate the involvement of health care professionals. Care must be taken to ensure that both service systems operate in tandem in the best interests of the person. But, health care professionals should not be assigned responsibility for overseeing the provision of long term supports.
- **Managed care approaches must be premised on reprogramming any resulting savings to the provision of services and supports for individuals who are on service waiting lists.** With nearly all states facing large waiting lists and the continuing influx of new applicants for services, managed care strategies must be designed to translate any cost savings that are achieved into services to additional individuals, including segments of the DD population currently excluded from services.
- **The criteria used in authorizing services and supports under a managed care system must be spelled out prior to implementation.** Individuals and families should play a central role in developing such criteria. The resulting criteria should be understandable, defensible and aimed at achieving critical outcomes for people with developmental disabilities and their families. Such criteria should not undermine basic eligibility standards.
- **Appeal and grievance rights/procedures must be specified in advance.** These rights and procedures must provide for the timely resolution of complaints and offer assurances that individuals will not be placed in jeopardy while disputes are being resolved. Grievances that cannot be resolved through timely, direct negotiations between the disputing parties should be referred for independent mediation/arbitration.
- **Managed care organizations as well as provider agencies through which services are delivered should not be permitted to profit at the expense of people with developmental disabilities.** Based on experiences in the broader health care arena, NASDDDS has serious concerns regarding managed care strategies that rely on inappropriate financial incentives which may lead managed care organizations to curtail or deny necessary services and supports in order to contain costs. Fiscal incentives and disincentives should be used only in ways that cannot place the safety and welfare of individuals at increased risk.

- **The impact of managed care arrangements on existing community support agencies must be scrutinized carefully.** Over the past twenty years, states have painstakingly fostered the development of community support networks. These networks play a vital role in meeting the needs of people with developmental disabilities and their families by enlisting community support. One objective of any managed care strategy should be to identify possible ways in which these support networks can be expanded and improved in order to ensure that people with developmental disabilities and their families have access to a wide range of services and supports.
- **A managed care system must be structured in a manner that decentralizes decisionmaking and promotes innovation.** NASDDDS is concerned that conventional managed care approaches may narrow, rather than broaden, the choices available to consumers and their families and stifle the search for creative solutions to the unique support needs of each individual. The foundation of a service delivery system that promotes such values is a strong commitment to decentralized decisionmaking and the empowerment of local communities to make individuals with developmental disabilities an integral part of community life.
- **Responsibility and accountability for overseeing the performance of a managed care system must be clearly fixed with, and vigorously exercised by, a designated agency within the executive branch of state government.** Managed care should not be viewed as a means by which state policymakers divest themselves of their legal and constitutional responsibilities to ensure that recipients of publicly-funded services and supports as well as the general taxpaying public receive optimal benefits from the dollars invested. When private sector managed care organizations are employed to deliver services, policymakers must ensure that there is vigorous and reliable public agency oversight of their operations.

NASDDDS is committed to helping states find more cost-effective ways of furnishing long term services and supports for people with developmental disabilities. Experiences with managed care in the general health care sector potentially could provide states with new tools to improve the cost-effectiveness and efficacy of services and supports for people with developmental disabilities. **In the final analysis, however, the overriding criteria that should be used in determining the value of introducing managed care approaches to developmental disabilities services is: will the restructured system result in better outcomes for people with developmental disabilities and their families than the present system?**

July, 1995

APPENDIX M

PATHWAYS TO COMMUNITY: A COLORADO COMMUNITY CENTERED BOARD MODEL ON MANAGED CARE

Appendix M

PATHWAYS TO COMMUNITY: A COLORADO COMMUNITY CENTERED BOARD MODEL OF MANAGED CARE¹

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August 14, 1995**

Challenges and Opportunities

Managed Care for people with developmental disabilities in Colorado can be seen as a frightening time to retrench and fortify defenses or as a once in a lifetime opportunity to make long overdue changes. With funding already considered scarce and hundreds of people now on waiting lists for services, the notion of managed care funding capitation coupled with a "service to all" mandate seems nearly impossible. Meanwhile, a growing number of parents, advocates, and people with disabilities themselves are now demanding equal access to the real jobs, homes, and relationships available to every other American citizen. As a result, special "places for them" thinking must be replaced with supports that ensure the opportunity for everyone's presence and participation in the working and social fabric of our community. The challenge is to meet these demands with fewer resources. The Resource Exchange² believes that Managed Care presents a long overdue opportunity to answer this challenge.

¹ We appreciate Stephen Hall's willingness to permit us to include this paper in the **Guidebook**. By way of background, in Colorado, Community Centered Boards (CCBs) are non-profit agencies created under state law. They are charged with serving as the "single-point of entry" into the State's developmental disabilities service system. CCBs authorize, provide and arrange for services. They serve designated catchment areas.

² The Resource Exchange is one of twenty Community Centered Boards serving persons with developmental disabilities across the State of Colorado. In particular, the Exchange serves persons with developmental disabilities in El Paso, Park, and Teller Counties. The views expressed in this paper are those of The Resource Exchange Board and Executive Director.

Managed Care Already

Many people believe that Colorado's Community Centered Board (CCB) system is already an excellent model of managed care. For example, The Resource Exchange solidified its operation as a true Managed Care Organization (MCO) on July 1, 1995 when the final remaining direct service component, Pioneer Industrial Enterprises, became autonomous. By bringing this last vestige of providing direct service to an end, The Resource Exchange achieved its goal of fully concentrating on the leadership necessary to ensure that providers deliver the highest quality services possible, meet all regulatory requirements, and stay within the given funding constraints.

Indeed, Colorado's local citizen-led Community Centered Board system ensures the effective and efficient use of the taxpayer dollar. For more than thirty years, local CCBs have been the single point of entry for families and persons with disabilities throughout their communities. These citizen boards make certain that people with developmental disabilities receive the services they cannot live without at the lowest possible cost. Through well-developed resource coordination, persons with disabilities and their families are carefully matched with service and support providers. Similar to medical managed care systems, the current developmental disabilities managed care system operates within funding limits while meeting expected outcomes.

Maybe Not Managed Care

Although the contention that The Resource Exchange is already an excellent example of a Community Centered Board/Managed Care Organization (CCB/MCO) is a good one, there are seemingly unchangeable funding streams, categorical funding mandates, and a dominant "program orientation" in the services provided that suggests otherwise. The current Developmental Disabilities Services' "slot-funding" mechanism is the antithesis of Managed Care. Not surprisingly, long waiting lists for those without a "slot", and overfunding of those people with slots, are the result. In some circumstances, persons with slots are overfunded as the positive effects of the providers' work mitigates the effects of the person's disability. Community Centered Boards and providers are effectively stopped from shifting resources to others with greater needs or to others on the waiting lists who don't have a funded slot. This is not managed care.

Another attribute of the current system is inflexible, pre-designated funding streams. These governmental funding streams often dictate how services should happen without consideration for real measurable outcomes or whether they should be occurring at all. Advances in community employment methodologies and community living arrangements are challenging archaic funding mechanisms that help keep some people outside of society's mainstream. Funding streams were developed when sheltered workshop employment, large group homes that were not very much like homes, and separate transportation systems were the only options. As providers seek community employment alternatives to sheltered settings, real homes instead of "mini-institutions", and other side-by-side relationships between people with disabilities and other citizens,

they are continually thwarted by these funding mechanisms. There never seems to be enough funds for Supported Employment, Community Participation, and Community Supported Living Arrangements. For example, a group home provider may believe that a three bedroom apartment, a person living with a friend, or a two bedroom apartment would be a better alternative to a six-bed group home. Funding always seems to support four-bedroom and larger placements or even institutionalization instead of regular homes. Another example is the funding mechanism for Supported Employment. Although Colorado ranks third in the nation in getting persons with disabilities employment and an El Paso County provider operates one of the most successful community employment services in the nation, the current supported employment funding mechanism provides inadequate funds to get people with more significant disabilities real employment. Medicaid and most Developmental Disabilities Services funding mechanisms were designed well before the Education for All Handicapped Children's Act (1975), The Rehabilitation Act of 1973, The Rehabilitation Act Amendments of 1986 and 1992, and The Americans with Disabilities Act (1992). In short, providers are often forced to deliver services with less than the Twenty-First Century technologies due to funding streams rooted in mid-century methodologies.

In concert with slot funding and rigid categorical constraints is the tendency toward funding programs instead of supports. Instead of getting the job done with needed funding and moving on to the next person, "program thinking" relies on treating people as a never-changing group that needs continuous intensive services in a program setting forever. As wage, utilities, and rent costs all increase, so do program costs. "Economy of scale" arguments that make little sense in most circumstances seem to be the only remedy as more people are packed into smaller places with fewer competent staff to address a person's individual needs. When this doesn't occur, it is often due to heroic efforts by the CCB and providers who must work against the system in order to get the supports that people really need. Too often, only those with the less significant disabilities -- "those most like us" -- get real jobs, ordinary homes, and a real life in their community. This program orientation, where everyone gets a restrung version of the same tune, due to funding constraints, is not compatible with managed care.

The Components of Managed Care

Funding capitation with future funding increases based on general demographic data, population increases, or disability incidence data are key components of Managed Care. Managed Care is also cost control, usually in the form of block funding. Block funding is accomplished in a manner that protects people with developmental disabilities. Funds for their benefit are never turned over to a government social service bureaucracy, medical care corporations, or other entities that combine funds designated to serve people with disabilities with other funds for persons with different needs. With block funding, the local CCB/MCO and service providers have the flexibility to use funds in an effective and efficient manner. The third component of Managed Care is the outcome orientation that replaces the process model. Managed Care is about results. Instead of dictating to the providers how dollars should be spent, when they should be spent, and mandating details

for every process along the way, Managed Care focuses on real outcomes. The final component of the CCB/MCO is full service to everyone in need. The assumption is that everyone will receive the services and supports they need within designated block funding constraints. Individual funding caps or other means of cost control that may harm those who require extraordinary services and supports to live is not a part of Managed Care for persons with developmental disabilities.

Managed Care for the Pikes Peak Region

Colorado has been a national leader in moving people with disabilities from the program/services orientation to a community/supports orientation. It was once thought that people with disabilities needed a program in a building in order to stay in their home communities. Adult day programs, sheltered workshops, and various group living programs were seen as the only alternatives to state-operated institutions. In recent years -- and even earlier in Colorado -- there has been a distinct shift from this program/services orientation to community/supports methodology.

While services are about programs and places that deal with personal deficiencies through prescriptive planning, a supports orientation builds on each person's strengths in the context of real community settings. The services orientation is about intake, evaluation, determining deficiencies, prescription programming, endless objectives, adjustment, and further evaluation. The supports orientation hinges on outreach, personal futures planning, and support management. Day centers, group homes, sheltered workshops, other sheltered employment settings, field trips, and other activities where a lot of people with disabilities are in the same rooms at the same time used to be what had been commonly termed "the service delivery system". The supports system, which began in the early 1980's, is about supported employment, other forms of real employment, community supported living arrangements, community participation, and other innovations that enhance the person's interdependence with ordinary citizens. Managed Care for the Pikes Peak Region is about building on the already existing and current movement from services to increasing options based on supports (see Services to Supports on the next page).

From Paid to Natural Supports

While it is true that Colorado Community Centered Boards have been unquestioned leaders in cost-effective community employment and real community living for persons with developmental disabilities, most supports have been "paid supports" instead of "natural supports". The supports orientation offers the opportunity to build community competence and ordinary citizen participation in the life of the person with disabilities to the extent that paid human service personnel are needed much less often. Rather than providing paid support in a direct manner or by hiring "friends", "community connectors", or other paid citizens, non-paid supports requires human service personnel to build bridges to the community through ordinary citizens.

SERVICES TO SUPPORTS

Employment Options

Institution Based Workshops	Community Based Workshops	Mobile Work Crews	Facility Paid Enclaves	Employer Paid Enclaves	Individual Placement w/ Support
Services					Supports

Day Services / Supports Options

Day Activity Center	Group Outings	Small Group Outings	1:1 Trips	Intensive Community Participation	Community Participation
Services					Supports

Residential Living Options

State Institutions	Large Private & Public Community Institutions	Multi-Bed Group Homes	Small Group Homes	Room-mate Homes	1:1 Supported Homes	Individual Options
Services						Supports

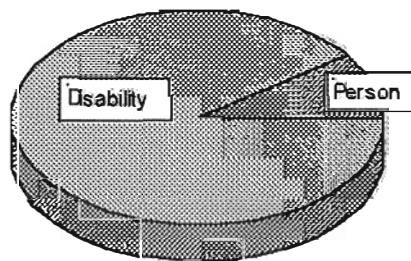
Transportation Options

Special Fixed Route Service to Service	Special Multi Route Services and Supports	Special Community Routes	Individual Demand Response	Public Demand Response	Public/Private Transportation
Services					Supports

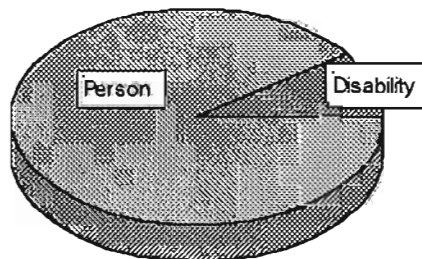
The natural supports paradigm may require very intensive initial paid supports in order to move to non-paid supports. In the natural supports paradigm, human service workers say to themselves in nearly every situation, "How can I build supports in this situation with ordinary citizens so that paid human service personnel will rarely, if ever, be needed again?"

PAID SUPPORTS	⇒	NATURAL SUPPORTS
Employment Training Specialist	⇒	Co-Worker with Consultation
Paid Community Provider	⇒	Non-Paid Citizen Relationship
Paid Community Supported Living Specialist	⇒	Neighbor
Facilitated	⇒	Unpaid

Natural supports are supports developed through reciprocal relationships between a person with a disability and other ordinary citizens. Natural support methodologies concentrate on the interactions of citizens with disabilities and other members of society. Instead of concentrating on deficiencies within the person with disabilities as if "disability" belongs solely to this person, disability is viewed as a social construct that occurs when the person interacts with their society in out-of-the-ordinary ways. The role of the human service professional in a natural supports orientation is to facilitate and interpret interactions in a manner that reduces or eliminates the definition of the person as "disabled". For example, a person with disabilities is often perceived like this:



When they should be seen like this:



The natural supports orientation is about moving from a "disabled person" reality to a "person with a disability reality". Natural supports cost less and exist throughout our communities. At first glance, the promise of lower cost supports to persons with disabilities seems easy enough. The natural supports orientation promises to get people with disabilities alongside ordinary coworkers, into ordinary houses and neighborhoods, and regular places in the communities. This orientation may assume that all we need are ordinary citizens to solve all our funding and support problems. But, our society has a history that is not so easy to reverse.

The Legacy of Human Services

The historic, century-long, congregation and segregation of citizens with significant disabilities from other citizens has created a "you're on your own" and "if there's a problem call somebody" way of thinking about citizens with disabilities. Massive human warehousing of people with disabilities on hundred-acre campuses throughout our nation has created a persistent "isn't there places for these people" way of thinking. Although the community services movement of the 1950's and 60's, the mainstreaming movement of the 70's, and the more recent inclusive movements all stand in dramatic contrast to institutionalization, still the idea that persons with disabilities are someone else's problem -- those of professionals or "the parents who had them" -- still persists.

This "don't worry we'll take care of them" theme had led to increased costs within the community that, while far less than institutional costs of the past, are still growing. One way to contain these costs is to put more people with disabilities into smaller rooms while paying those who oversee their well-being the lowest possible wages. Another way is to develop a managed care system based on the pragmatic transition of funding from a services systems to supports that are fostered through competent professionals. We need professionals who know how to build interdependent relationships between ordinary citizens, the community, and people with disabilities.

Managed Care in the Supports Paradigm

Managed Care is an opportunity to do business differently, improve services and supports to persons with disabilities, and contain both current and future costs. Managed Care does not have to result in families and Colorado's citizens with disabilities being sold off to the lowest bidder. Managed Care in the Supports Paradigm is an opportunity to finally get the needed funding flexibility from both the state and the federal government so that locally controlled, non-government, citizen-led Community Centered Boards/Managed Care Organizations (CCB/MCO) can maximize needed supports to persons with disabilities in the most economical manner possible.

These are the key principles of the Colorado Community Centered Board/
Managed Care Organization (CCB/MCO) Plan:

1. Colorado's Community Centered Board's system has delivered a single point of entry, one-stop shopping, managed care model of service delivery to men, women, and children with disabilities for over three decades. The current Community Centered Board system has put Colorado in the forefront of superior services at the lowest possible cost.
2. People with developmental disabilities should lead full, productive lives in the manner afforded those citizens of Colorado who do not have disabilities. Supported Employment, Supported Living, and Community Participation methodologies that all engage ordinary citizens in the habilitation process have delivered superior, cost-effective outcomes when compared to past congregate care methodologies.
3. A pragmatic shift from a service delivery or program orientation to a supports paradigm that fosters non-paid relationships and interdependence between persons with disabilities and ordinary citizens is essential. Rather than being seen as "service providers", professionals are seen as "bridge builders" who remedy the historic isolation of persons with disabilities from men, women, and children who do not have disabilities.
4. Innovation and creativity have resulted in persons with developmental disabilities having opportunities and lives that are far superior to many other segments of our society, including people who are poor and individuals with other types of disabling conditions. This creativity has led to "cost reversal" successes such as supported employment that now benefit many other citizens. Innovation and creativity should be encouraged in every possible manner.
5. An outcome orientation will replace the current process or program orientation. Real jobs, real homes, real relationships, real community definitions of life quality will replace the process orientation which rewards "progress" within a given program.
6. Provider efficiencies resulting from the services-to-supports paradigm shift will be used to expand opportunities to others with disabilities who the individual provider serves. Simply stated, providers who deliver superior outcomes in a cost-effective manner will be rewarded with stable and increased funding to serve additional persons with disabilities. No one will profit at the expense of people with disabilities.
7. A Preferred Provider Network will be established to ensure that the historic continuity of care and peace of mind provided to citizens with disabilities and their families will be maintained.
8. A capitated, set monthly fee will be paid to each provider of services in exchange for the provider's agreement to provide the supports necessary for persons with

disabilities to become an integral part of the working, living, and recreational life of their community. There will be no fees for a specific service.

9. Intake, referral, resource coordination, other forms of case management, quality assurance, cost utilization review, and outcome monitoring will continue to be the responsibility of the Community Centered Board/Managed Care Organization (CCB/MCO).
10. No additional fees, sliding fee scales, user fees, or other customer payment mechanisms may be used to provide or enhance supports. As taxpayers themselves, families and persons with disabilities already are paying on an income tax graduated scale for needed supports.
11. Services currently received will be maintained with the understanding that shifting in a pragmatic manner to supports in ordinary places of employment and regular homes will be necessary. Resources saved through provider efficiencies will be used to solve the problem of waiting lists. Everyone in need of supports will receive those supports necessary to ensure both presence and participation in their community.
12. Slot funding, program funding, specific service funding, restricted funding, fee-for-service funding, and other mechanisms that limit provider activity to a pre-specified process would be replaced by block funding for specific outcomes across a range of day, evening, living, and community participation-related needs.
13. There will be a powerful bias towards an informed customer orientation, replacing typical "professional/client" relationships with "customer/professional" partnerships. In short, people will get what they want and be informed about possible options.
14. One of the required components of this CCB/MCO would be the extensive redesign and ongoing supports system review by customers and providers to ensure progressive and creative supports for persons with disabilities to become an integral part of their communities.

Summary

This Community Centered Board Model of Managed Care is about local citizen control of services and supports for citizens with developmental disabilities who live in El Paso, Park, and Teller Counties. Managed Care is seen as an opportunity to replace antiquated funding mechanisms with flexible funding tied to real outcomes. This is a historic opportunity to shift from programs rooted in mid-century ideologies to supports founded on the interdependence of our communities. Due to history, there is much work to be done by professionals who know how to build working, living, and real relationships between persons with developmental disabilities and other citizens. Some believe that

Managed Care is a way to infuse human services with a long overdue "natural marketplace" ideology. "Market forces", "survival of the fittest competition", "natural market corrections", and other similar statements promote "a natural way" to control costs. Often missed in this market panacea is the horrific effect multi-state corporations with political buying power can have on local citizen-controlled human services delivery. A mega-government agency approach can be equally harmful. These "open season" approaches have led to exploding costs and out-of-state corporate monopolies in a few states. "Big brother" approaches will not work in our state that prides itself on local citizen control of local citizen affairs.

Citizen-led Community Centered Boards, like The Resource Exchange, have been a national model for superior, cost-effective services. These Boards, composed of community leaders, offer the benefits of both outcome-based management and close-to-the-customer reality. This Community Centered Board Model of Managed Care should be considered as a historic opportunity to fuse the citizen-led independence of Community Centered Boards with the promises of controlled costs and real outcomes of Managed Care.

APPENDIX N

MOVING TO A SYSTEM OF SUPPORT: USING SUPPORT BROKERAGE

Appendix N

Moving to a system of support: Using support brokerage

Michael W. Smull & Gary Smith

A cursory review of current conference themes and agendas gives the impression that achieving a system of support is inevitable and around the corner. Words like choice and inclusion fall glibly from the tongues of managers. However, changes in practice have fallen far behind changes in rhetoric. During recent visits with agencies that say they are providing supported living, we have found managers whose language is impeccable but whose practices are still firmly grounded in program model services. While managers talk support with a convincing fluency and naturalness, when you talk to the people being supported and the staff doing the work you discover a better program, not supported living.

Real supported living requires that we learn how people want to live and then support them in the lives that they want (within the constraints of available resources and any issues of health or safety). It requires efforts that help people be supported by their communities and have opportunities to contribute to their communities. Real supported living requires that people with disabilities and the people providing the direct supports be empowered. It requires that agencies move from tidy organizational structures where people with disabilities "fit" into program vacancies to a fluid structure that changes with the desires of the individuals supported. It requires that control be shared rather than flowing from the top of a hierarchical arrangement.

The programs being represented as supported living typically fall short in several of these areas. They begin with a superficial understanding of choice. They do not focus on continuously learning how people want to live. They do not challenge themselves to help people get the lives they want. They encourage people to settle for what is readily available. Power is seen as a finite commodity. Sharing power with people with disabilities and the direct support staff is perceived as diminishing the power available to managers and directors.

Why have these clearly intelligent managers engaged in this elaborate self deception? They appear to be quite sincere; they appear to believe that they have made the necessary changes. Why are they "talking the talk without walking the walk"? In *The Challenge of Organizational Change, How Companies Experience It and Leaders Guide It*, the authors note that all change involves loss, that "... almost any action that

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disturbs the status quo or represents a threat to an individual's habitual way of doing things is likely to provoke defensive, and often counter productive, behaviors -- behaviors learned early in life" (Kanter, Stein, & Jick, p. 374). The loss that managers fear is their perceived power, perceived control, and sense of predictability.

This suggests that systems change is not going to arise just from promulgating new supported living rules or new ways to fund supported living. New "top down" rules results in a few real supported living providers and many agencies that achieve paper compliance but are only providing "sort of supported living" (sometimes known by its oxymoron, the supported living program). Agencies need a more powerful motivation for change and external assessment to insure that each person is supported as they wish to live. Where there are new "top down" rules they tend to focus on new processes, not new outcomes, while the new ways to distribute dollars typically fund agencies rather than individuals.

Other "top down" efforts designed to change the system are not likely to be any more successful. Kanter, *et al.* suggest that you need a combination of "bold strokes" and "long marches" to change current practice and the underlying culture of an organization. "Bold stokes are those dramatic changes that can occur in a short period of time while the long march refers to the myriad of small actions necessary to change belief." Because "...behaviors reflect beliefs: If you want to change someone's behavior, you must first change their underlying beliefs" (Kanter, Stein, & Jick, pg. 444).

It is clear that changing beliefs takes extended periods of time and requires that there are incentives for change. Getting real change started and providing real incentives for continuing change is the challenge for system managers. A "bold stroke" that would result in dramatic and immediate change is the creation of local "support brokerage" entities that would:

- ♦ empower people with disabilities to have real control over their lives;
- ♦ support the best use of limited public funding; and,
- ♦ move control (and decision making) as close to the people with disabilities as possible.

These are also characteristics that independent case management was to have. Yet, as several state directors of DD systems have noted, independent case management has not made the difference that they had hoped it would make. The effects that they had looked for were substantial improvement in the lives of individuals and changes in the system of services. They had anticipated that independent case management would move the system from being "provider driven" to "person driven", that the desires and needs of each individual would determine the nature of the supports provided. Instead they have found that the greatest determinant of quality of life has been the quality of the service provider. The presence of agencies that believe in (and practice) supporting each individual has been more important than the presence of case managers. While a number

Kanter, R.M., Stein, B.A., Jick, T.D. (Free Press, NY – 1992).

of systems report that the presence of case managers has positively influenced the system, it has not caused the dramatic changes hoped for.

Why did independent case management not live up to expectations? The reasons for independent case management's "underachievement" are complex and vary from location to location. However, anecdotal reports suggest that the following apply in most areas. Independent case management has:

- ♦ had responsibility without authority;
- ♦ lacked the tools (e.g., person centered planning) needed;
- ♦ been independent only in name;
- ♦ been co-opted as just another compliance check;
- ♦ drowned in excessive paper requirements; and,
- ♦ had too many people for each case manager to support.

How would support brokerage be different? How could it avoid becoming another change in name without a change in practice? While there is nothing that can be done in design that cannot be undone in implementation, support brokerage can be designed to reflect the lessons that have been learned from case management. The first of these is independence. Support brokerage entities should be independent of any entity that provides services or has multiple responsibilities. Beyond the typical requirement that residential or day providers cannot provide support brokerage, county (or state) based systems, such as services boards, should not be the providers of support brokerage either.

In outline, support brokerage entities should be locally based private, not-for-profit corporations which would:

- ♦ be responsible for planning and funding services to all people with developmental disabilities within its catchment area;
- ♦ have boards of directors where:
 - people with disabilities (who are receiving services or are waiting for services) are a majority, with representation from both groups;
 - parents or other family members of those receiving services and those eligible for services are the second largest group; and
 - people appointed by state and local authorities are present but represent the smallest group.
- ♦ have an active mission statement which requires that people be supported in the lives that they want and that they be assisted in being a part of their communities;
- ♦ be required to -

- have "bottoms-up" rules which state that the primary goal is to support people with disabilities (not agencies) and where accountability is defined in terms of meeting the goals of the individual;
- assure that support brokers have competencies in -
 - ✓ learning how people want to live
 - ✓ recruiting community resources
 - ✓ supporting people in the lives that they have chosen
- demonstrate that each support broker knows the significant issues of every person with whom she or he does brokerage;
- support people in their choices (within the limits of available funding and the constraints of assuring reasonable health and safety), including the choice to "fire" their support broker; and
- have access to the resources necessary to assist agencies in changing from offering programs to supporting individuals.

Support brokers focus on assisting people with disabilities when they are:

- ♦ entering the system for the first time;
- ♦ in crisis;
- ♦ just unhappy with the life they are being supported in and;
- ♦ renegotiating plan implementation.

Individual support brokers spend the time necessary to learn how each person wants to live and develop an outline of what will be necessary to support that person. The support broker works with the person to arrange and negotiate the costs of the supports. While the supports are being developed and implemented the support broker maintains intense involvement. As the individuals and the support brokers are satisfied with the implementation of the supports, the degree of the support broker's involvement decreases. Unless there is an indication of dissatisfaction or inadequate supports, the support broker's involvement is reduced to periodic monitoring, at a frequency determined by the desires and needs of the individual. The minimum frequency for contact would be twice a year.

How extensively each support broker would be involved with each person would depend on the desires and issues of the person. In some instances people want simple things, like an environmental modification or a single service such as respite. What these people want is only enough assistance to get what they want and not a flood of paper or a parade of officials. Other people need significant assistance in determining how they want to live, how they can get the supports, and on-going efforts to make sure that they are happy and safe. The degree of support that most people need will vary widely over their lives. We need a system that provides people who need assistance in negotiating services with the support they need while it empowers people who know what they want (and where to get it) to do their own negotiating.

Helping people achieve their desired lives will require changes in agency and system activities, practices, and rules. The changes needed can be classified as:

- ♦ those that only require local effort - "just do it" changes;
- ♦ those that require technical assistance to be successful; and
- ♦ those that require permission - a change in the practices or rules of those who fund and regulate.

Successful support brokerage will require that these change efforts be incorporated in a feedback process that identifies best practice, secures the technical assistance required, and gets changes in system rules on the agenda of the system managers. This requires that, while the brokerage agencies are local, there is a communication network where information is shared and distilled. Requiring and maintaining the network would be one of the responsibilities of those who fund and regulate.

The support brokerage structure and governance is designed to achieve a positive local balance within the competing pressures on the disability system. There is the pressure to simply buy people their lifestyles because it is easier than recruiting community resources. There is the confusion between helping people work to achieve a dream and funding their fantasies. There is the need to support people while they live at home to reduce the stress on families and to nurture community so that it is developed from a natural base. There is the need to help people leave home when they want rather than when their waiting list number comes up. There are pressures from agencies to receive a level of funding sufficient to pay their staff a decent wage. There is the reluctance of many agencies to leave the program model that they are comfortable with. There is the need for technical assistance to help agencies successfully change.

A positive balance between all of the competing pressures starts with the governing body. Good support brokerage will require an active, knowledgeable, and involved board of directors. Training is essential. All board members need training in their responsibilities and in what they should expect from the staff. Those members who have disabilities should have access to the training and support needed for them to fully meet their responsibilities. Systems that include coaching and mentoring should be considered. By having people with disabilities and their families in a strong majority position on the board, there should be an ongoing focus on the lives of the people who are receiving services. By including on the board people with disabilities and family members who are waiting for services, there is an incentive to use community resources rather than public funds so that money is available to support those who are waiting for assistance.

Giving the brokerage agency the responsibility for conforming to standards, while simultaneously giving individuals with disabilities control over how their money is spent, should create incentives to maintain a balance between other competing interests. Rather than set a fixed ratio of support brokers to the number of people supported (e.g., 1 to 30), there is a requirement that support brokers know the significant issues of every person that they do brokerage with and that they see each person at least twice a year. If less is spent on support brokerage, then more is available to buy services/supports. However, if too little is spent on support brokers, then the quality of the brokerage and the assurance of

quality and safety in the lives of those supported is diminished. Where that balance is struck will depend on local issues such as the quality of the agencies that provide supports, how well these agencies know the people they are supporting, and the demographics of those eligible (i.e., how many people are entering the systems and how their needs change over time).

From the perspective of the service providing agencies, support brokerage will introduce market forces that were previously absent. The broker will be saying: "this is how this individual wants to live" and asking how the agency can provide the support and at what cost. Where a satisfactory agreement can be reached, the person with the disability will receive supports from that agency. Although costs would be negotiated individually, they would be audited against everyone receiving support from that agency. This would provide the agency with the flexibility to move resources around to meet rapidly shifting support needs. The costs would then be "rebased" annually. Where someone was not happy with the supports received, they could move and the level of funding most recently negotiated would move with them. If an agency says that it is unable to accommodate the individual reduction in funding because it reduces the support for a house by one person, then all of the people living in that house should have their supports reexamined.

The effects on agencies will depend on local circumstances. In rural areas, where there is only one provider, change will be slow. In areas where there are multiple providers change should be more rapid. In all areas, however, the emphasis needs to be on supporting agencies in making change. Confrontation and people leaving agencies may be required but it should not be where things start. The development of additional community capacity will be essential in many areas. The development of new agencies will require a partnership between the brokerage agency and state, regional, or county authorities. Brokerage agencies may need additional funds and additional expertise to be successful in new agency development.

Support brokerage is not the answer. But, it is one of the possible answers. It will likely work where there is leadership that: understands the difference between providing support and providing programs; insures the presence of the ongoing resources necessary for meaningful training of board members; enforces all of the standards outlined; and absorbs the "political heat" when the brokerage agency starts doing its job. However, without something like support brokerage, we are likely to see the paradigm shift change our language without changing the lives of people with disabilities.

APPENDIX O

A PROTOTYPE EXAMPLE: CONSUMER/SYSTEM MANAGED CARE

Appendix O

A Prototype Example: Consumer/System Managed Care

In Chapter VIII, we describe various managed care models. In this Appendix, we will sketch out a managed care prototype that we developed in order to illustrate how the various managed care models might be blended together. The prototype shows how various managed care strategies might be employed to achieve certain specified system goals. The prototype is solely intended to be illustrative; it is not meant to describe the optional approach to fashioning a developmental disabilities managed care system.

We have labeled this prototype "consumer/system managed care". It blends together consumer managed care features with a system managed care approach that includes utilization management techniques. We outline strategies for risk management and describe roles that would be played by the state MR/DD authority and MCOs. Like any prototype, this one is constructed in relatively simple terms. We acknowledge that it leaves many questions unanswered (sometimes purposefully). Hopefully, the reader will find the prototype useful in understanding how managed care strategies and models may be employed.

The explication of the prototype begins with a discussion of the goals and principles under which the managed care system would operate. It then turns to describing the overall framework, the "consumer managed care" sector, the "system managed care" sector, and special considerations concerning state agency and MCO responsibilities.

System Goals and Guiding Principles

As discussed in Chapters VI and IX, a managed care system must be crafted with key goals and principles in mind. The goals/principles that undergird the prototype are:

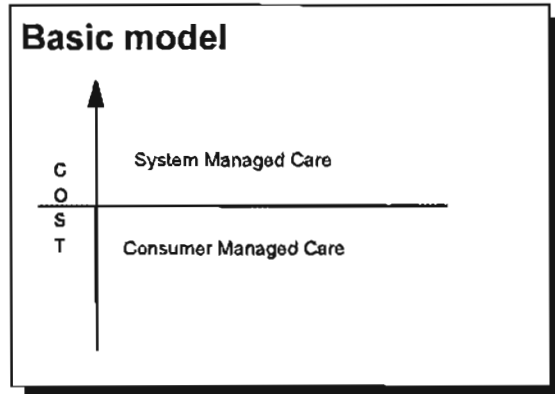
- The system must be designed to ensure cost containment and include incentives to promote improved systemwide productivity;
- Individuals and families should exercise choices concerning the services and supports provided as well as the selection of providers of such services/supports;
- The service system should be decentralized in order to maintain ties with the community;
- Managed care strategies should focus on reducing the use of high cost services;
- Systems savings should be captured to reduce waiting lists or make investments in improving system capabilities and quality;

- Service system administration should be streamlined as much as possible to reduce costs;
- Where appropriate, key system functions should be privatized; and,
- Crisis response services must be readily available.

The prototype is designed to achieve these goals.

Basic Model

The prototype employs a consumer managed care model as its foundation. It introduces more systematic managed care strategies as the costs of supporting an individual increase. In other words, as costs increase, the level of system involvement in managing supports will be intensified. The prototype is structured in this fashion for two reasons:



- In developmental disabilities systems, typically a relatively small proportion of consumers account for a disproportionate share of total outlays. Consequently, it makes sense to focus support management activities on this population.
- For the remainder of the population, the consumer managed care model are likely to serve the goal of containing costs best while still enabling consumers and families to exercise basic lifestyle choices. Attempting to closely manage supports for this population is likely to be very costly and have relatively few pay-offs. However, in instances where members of this group might require the provision of relatively costly clinical interventions, such interventions will be managed by the MCO.

The prototype, then, is structured in a manner that applies system support management attention to individuals whose overall support costs are relatively high and universally to all high cost interventions.

The principal line of demarcation between the two sectors will be cost-based. In practice, the dividing line probably will be those individuals who require intensive, 24-hour, round-the-clock supports. Again, in most systems, these individuals consume substantially more resources than their numbers would indicate.

The Consumer Managed Care Sector

In the consumer managed care sector, individuals/families will have a budget with which to work -- a fixed allotment of spending authority. Individuals/families will be able to use these budgets to pay for services and supports that they deem most relevant and

vital. These services and supports will be identified in a personalized support plan. The support plan will serve as the authorization document for the MCO to pay for service/support billings submitted by service agencies. The MCO will serve as a fiscal intermediary (or contract with another organization to play this role). Cash payments will not be made to individuals/families except when such payments are necessary in order to secure a particular support and reimbursement of individual/family outlays would prove to be a hardship.

Individuals/families may employ their fixed budgets to purchase supports for community living, work and community inclusion supports. Allowable and unallowable uses of these dollars will be pre-defined; unanticipated uses will be subject to MCO review and approval. Generally, allowable uses will include personal assistance, employment-related supports, respite, and facilitating the individual's participation in community activities. Assigning fixed budgets to individuals/families is expected to have two results:

- Individuals/families will seek to maximize the value of the funds made available to them by using these dollars to purchase high priority supports; and,
- Individuals/families will have incentives to use available public dollars to complement other natural supports or take advantage of no/low cost community supports.

In broad brush, these premises are quite similar to those which undergird many family support programs.

Individuals/families may obtain services/supports from MCO network providers (e.g., those providers with which the MCO has an ongoing contractual relationship) or from providers who are outside the network, subject to basic health/safety assurances. Individuals will be able to freely select providers; providers must compete for their business. Individuals/families could elect to do business with a single provider or employ several providers. The MCO will publish a list of its network providers and their capabilities along with information concerning prices and performance (compiled from consumer satisfaction surveys).

Individuals/families may elect to seek the assistance of a support broker/personal agent to assist them in developing a support strategy and obtaining desired services/supports. The support broker/personal agent would be reimbursed by the MCO under a fixed fee schedule. The MCO will maintain a list of individuals who may provide these services; individuals/families can select from among these individuals or request that another individual play this role. If an "out-of-network" individual is proposed, the individual must agree to the MCO's contractual requirements regarding payments and incident reporting. Individuals/families who want the support broker/personal agent play a more extensive role in managing supports than provided for by the MCO fee-schedule may use a portion of their budgeted funds to pay for these additional services.

In recognition that unforeseen events might arise that require additional resources, the MCO will maintain a risk dollar pool that individuals/families can access to meet such needs. This risk pool will be funded by discounting the consumer-centered capitation payments that will form the basis of individual/family budgets. Dollars will be dispensed from this pool under criteria established by the MCO; such criteria will be explained to individuals/families and support brokers/personal agents. The aim of creating this risk pool is to mitigate the individual/family risk that accompanies the consumer managed care model. If the dollars assigned to this pool are not needed, they will be reallocated by the MCO to reduce waiting lists.

In this area of the prototype, the principal cost containment tool is the fixed budget. System productivity is expected to increase as a result of: (a) individuals/families prioritizing the ways in which the budgeted funds assigned to them are used; (b) providing positive incentives for the use of natural/community supports; and, (c) creating a competitive marketplace environment among provider agencies. Individuals/families will bear risk; at the same time, risk will be mitigated by the creation of a set-aside risk pool. By definition, the majority of consumers/families will be assigned to this sector (i.e., the system managed care sector is reserved for the minority of "high-user" individuals). This sector will be the "primary care" sector of the system.

The System Managed Care Sector

The system managed care sector targets individuals with high support needs as well as the utilization of high cost clinical services/interventions and certain other specialized, low-incidence services (e.g., home modifications and assistive technology). Individuals who are served in this sector will be assigned to "support managers" who possess expertise in support technologies and are skilled in coordinating services/supports. Their roles and responsibilities will be most akin to those assumed by "care managers" in specialty health plans. Support managers will have low caseloads and be expected to be very proactive in the management of services and supports for this population.

The services and supports needed by such individuals will be spelled out in support plans. The support planning process will be person-centered, enlisting the active participation of the individual, his or her family, and others who are important in his or her life. The support manager will call on other professionals to participate in this process, based on the value of their expertise in addressing critical issues. System involvement in support planning will be more intensive; services and supports will be subject to frequent recurrent review to examine efficacy and appropriateness. There will be emphasis on service substitution strategies as part of an ongoing effort to reduce costs.

Provider agency options will be more limited in this sector. The MCO will build a provider network based on demonstrated competency and negotiated prices. The MCO may subcapitate to network providers in order create additional cost containment incentives. In some cases, the MCO may enter into exclusive service contracts with

designated providers which meet MCO specifications and can reduce their costs by virtue of having a minimum volume of services. Individuals and families will be permitted to select from among network providers; as a general matter, however, they will not be permitted to go outside the network.

Certain types of services/supports will be managed by the MCO for both individuals who are in the consumer managed care sector and those in the "system managed care" sector. These services/supports will include therapeutic services, which will be subject to prior authorization and recurrent review under established care criteria/protocols. The MCO will limit the providers of such services, seeking, where possible, to establish a limited network of providers with demonstrated competencies who also are willing to negotiate below market rate discounts in exchange for a guaranteed volume of services. MCO personnel will employ efficacy-based utilization management strategies to contain the costs of these services.

In addition, certain low-incidence services will be managed by the MCO. Such services include housing modifications and assistive technology. Since such services are low-incidence (and frequently high cost), their expected costs are removed from the consumer-centered capitation amounts that are calculated to establish the budget authorizations in the consumer managed care sector. The expected costs in the system managed care are similarly removed and pooled. Utilization of these low-incidence services will be regulated by prior authorization. In the case of assistive technology, the MCO will contract with the state's assistive technology center to evaluate the need for such services, determine the most appropriate technology to be applied and obtain the needed services. Such contracting procedures will enable the MCO to avoid having to develop in-house expertise concerning assistive technology and takes advantage of the network that the assistive technology center already has established.

Internally, the MCO will establish a proportionately higher risk reserve in the system managed sector than in the consumer sector. Since the individuals served in this sector, by definition, have more complex needs, the risk associated with serving them is higher. As is the case in the consumer managed care sector, dollars allocated to this risk reserve that are not needed will be redirected to reducing waiting lists.

MCO management will regulate the dollar cost of the support packages being developed by support managers more tightly, including the imposition of internal budget ceilings which may be breached only when approved by senior staff. The MCO will implement a real-time budget authorization/expenditure management system to keep abreast of outlays and authorizations vis-a-vis capitated payments. The MCO will track outlays for individuals longitudinally to determine whether costs are stable or declining. The MCO will work with its network providers to develop and implement quality improvement strategies designed to hold down costs while achieving key outcomes.

Because of the nature of the MCOs that will be employed (see next section), the state will establish a stop-loss reserve that will underwrite the excess costs of serving

individuals in this sector. This stop-loss feature will kick in when the costs of services exceed a predetermined threshold (e.g., two-three times the consumer-centered capitated payment amount). The intent of this stop-loss reserve is to prevent any single MCO from being placed at extraordinary risk as a result of serving challenging individuals.

MCOs

This system will be organized around locally-based, mission-driven non-profit MCOs. The number and size of these MCOs will be based on natural geopolitical catchment areas balanced against economy-of-scale considerations. These MCOs will be governed by board of directors consisting predominantly of consumers/family members.

These locally-based MCOs will be responsible for:

- Intake/screening/assessment of potential enrollees;
- Developing/contracting with network providers;
- Monitoring provider agency performance;
- Employing/contracting with a network of support brokers and managers;
- Financial management, including receipt of state capitation payments and management of local risk reserves;
- Operating the local grievance/dispute resolution system;
- Networking with other public and private human services agencies at the local level; and,
- Receipt of any local tax dollars that are earmarked for developmental disabilities services.

In the prototype, the MCO will not furnish direct services (except as might be needed in order to start-up a new service or capability). Instead, the MCO will focus solely on achieving improved cost efficiency throughout the system.

The MCO will be exclusive to its designated catchment area. In order to maintain and encourage ties to local communities and community resources, multiple MCOs are an absolute necessity. This means they will be smaller than might be indicated if the sole considerations were administrative efficiency and the ability to bear risk. In the prototype, there is a conscious trade-off between administrative efficiency and maintaining close community ties as a result of the expected (albeit frequently intangible) value of such ties. Including a state stop-loss reserve (see above) in the equation recognizes that small MCOs inherently are more exposed to risk than larger entities. Also, in many states, local governments/taxpayers contribute dollars to the operation of the developmental disabilities system. By keeping the MCO localized, access to these dollars is more likely to be maintained. Consumer governance of the MCO is mandated under the prototype in order to promote a mission-driven framework for the organization's performance.

State Structure

In the prototype, the state MR/DD authority will be responsible for:

- Establishing overall system policies;
- Managing available dollars, including establishing capitated payment amounts and managing the statewide stop-loss reserve;
- Monitoring and evaluating local MCO performance;
- Arranging for systemwide performance evaluations;
- Contracting with an Administrative Services Organization to make payments to certain providers and operate an information system;
- Contracting with an organization to conduct quality assurance reviews, including licensure surveys required by state law;
- Arranging for the disposition of disputes between consumers and MCOs that can not be resolved locally;
- Working with other state human services agencies with statutory responsibilities that affect services and supports for people with developmental disabilities (e.g., the income assistance agency, the health services agency and the state housing authority); and
- Contracting for systemwide service capabilities, including a crisis intervention network.

In the prototype, the state MR/DD authority will not be responsible for contracting with or developing provider agencies; nor will it set provider rates or monitor provider agency performance. It will structure itself around the "steer not row" paradigm. Its central aims will be to disperse dollars to local MCOs in an even-handed fashion, evaluate the performance of local MCOs, and evaluate overall system performance. Many of the authority's responsibilities will be contracted out so that it can focus its attention on performance.

In terms of an information system, the state authority will be most interested in compiling information necessary to operate a successful capitation rate determination process, spot significant variances in utilization, and compile information that will enable it to evaluate MCO and systemwide performance, including establishing performance norms that can be used in identifying under-performing MCOs. This system will be designed so that local MCOs will simply up-load needed information from locally-maintained systems. The state authority may contract with a vendor to develop a system that will serve the needs of local MCOs.

The prototype has the state contracting with a statewide crisis intervention network. This network will be staffed by a cadre of highly qualified staff who can be dispatched to assist service providers in meeting the needs of individuals in crisis. There are three rationales for the state contracting with this network:

- First, crises, by definition, are unpredictable and, hence, a major source of risk (in the form of high dollar outlays to stabilize a situation). Completely exposing small MCOs to this risk would threaten their viability. Establishing a statewide network (along with the stop-loss reserve) is a way to mitigate a source of risk that a local MCO cannot predict or manage.
- Second, it is potentially more economical to establish a statewide (or, in some cases, regionalized) network. Highly skilled personnel are in short supply. Individual MCOs may encounter problems in developing their own networks.
- Finally, it is difficult to finance a crisis intervention capacity on a fee-for-service, incident-based payment methodology. The network has ongoing costs but under a fee-for-service payment method would face an uncertain revenue stream that would require it to charge relatively high prices due to unpredictable utilization patterns. Pulling dollars out of the total budget to finance such a network underwrites its ongoing costs and avoids disincentives to using the network due to high fee-for-service charges.

The way the prototype handles crisis intervention illustrates some of the reasons why certain dollars should be carved out of capitated payments and dispersed centrally. It also illustrates a form of proactive risk mitigation. It is worth pointing out that the prototype, through the combination of a stop-loss reserve and the network, does not fully relieve the MCO of risk. The network is designed to help providers resolve crises quickly and thereby hold down costs. The MCO still will have risk exposure. Similarly, the stop-loss still results in MCOs being at risk for extraordinary outlays up to the stop-loss threshold.

Capitation

The prototype will use group-based capitation that is tied to assessment information and modified to reflect a consumer's living situation. This means that capitation payments will be multi-tiered (e.g., "risk adjusted") and further adjusted based on whether an individual resides with his/her family or has another living arrangement. This tiered capitation methodology will apply to all individuals presently receiving services. The amount of the capitation will be based on "modeled" resource consumption patterns.

The prototype does not employ "individual capitation" (see Chapter VIII). Individual capitation could be used, although methodologically it is more complicated, which necessarily means that MCOs will have to be more directly involved in decisionmaking regarding individual support strategies at all levels. In the consumer managed care sector, group capitation exchanges flexibility for precision (which may be difficult to achieve in any case). In the system managed care sector, group capitation necessarily places a high premium on the MCO's managing care across the full spectrum of individuals.

In the consumer managed care sector, the amount of budget authority with which each individual/family has to work will be directly tied to the capitation amount that the MCO receives. As discussed earlier, these amounts will be discounted to fund a risk reserve in this sector. This more or less parallels the methodology being employed in the Monadnock Developmental Services Self-Determination project. Capitation payments associated with individuals being served in the "system managed care" sector will be managed by the MCO. MCOs also will receive capitation payments for clinical and low-incidence services to meet the needs of individuals in either sector. Again, the MCO will establish its own internal control mechanisms to regulate this sector, including establishing internal risk reserves.

System Financing

In the prototype, the state MR/DD authority will establish an "all funds" pool. All state and federal dollars that are earmarked for services to the target population will be included in this pool, including, as appropriate and feasible, generic services dollars (such as personal care and therapeutic services) that might be under the management of the state medical assistance agency where such dollars are tied directly to supporting persons with developmental disabilities. Adopting a total funds approach -- rather than leaving dollars/services outside the pool -- is intended to prevent cost-shifting.

The State authority will set aside a portion of this pool dollars to fund system management activities, the stop-loss reserve, and the crisis management network. The amounts of these set-asides will be specified in the managed care plan. All other dollars will flow into the capitation pool.

These capitated payments will be transferred to the local MCOs based on the number of actual enrollees. The local MCO then will apportion such dollars among the consumer and system managed care sectors, taking set-asides for its risk pools, support brokerage/management costs, and other administrative costs. Administrative costs will be subject to state-established ceilings.

Unexpended funds not needed to support local risk reserves (once solvency requirements have been met) can be released by the MCO to serve additional individuals or make other system investments, subject to the approval of the MCO board.

Observations Concerning Risk

In the prototype, there are many types of risk. It is useful to discuss the various types of risk from the standpoint of risk management and potential outcomes.

- **Consumer Risk.** In the consumer managed sector, individuals bear risk to the extent that: (a) their budgeted funds are not well-managed; (b) the capitation amounts upon which their budgets are based is inadequate; or, (c) unforeseen circumstances arise and there are insufficient funds in the budget to meet the

additional costs. The local risk reserve is intended to deal with the third problem. The second problem can be dealt only at a systems level by evaluating and continually testing the capitation methodology. Individuals/families are on the hot seat with respect to the first problem. In some instances, they may wish to avail themselves of support brokers/personal agents to avoid this problem. Realistically, some level of screening of support plans by the MCO may be required to ensure that they are based on practical scenarios (e.g., basic supports can be provided over the entire budget period).

- **Provider Risk.** In the prototype, service providers bear risk. In the consumer managed care sector, this risk arises due to the expectation that individuals/families will shop for services and supports in the marketplace. A competitive framework means that provider agencies are at risk. Providers that are part of the MCO's service network also are at risk since the MCO will have a vested interest in contracting only with high performing/low cost providers. In some cases, it might be in the interest of the MCO to subcapitate to providers in order to share risk.
- **MCO Risk.** The MCO is at risk principally in the system managed care sector. By its very nature, the consumer managed care sector is a relatively low-risk sector as a result of the use of fixed consumer budgets. The system managed care sector involves supporting individuals with high costs and sometimes unpredictable needs. The MCO will need to manage its risk by tightly monitoring service authorizations and actual outlays. The use of support managers is another way in which the MCO can manage risk by tightly overseeing and monitoring the services being furnished to individuals in this sector. The statewide stop-loss reserve and the crisis intervention network are designed to mitigate this risk. As observed earlier, neither of these tools completely eliminates risk. Consequently, there remain incentives for the MCO to hold down costs.
- **State Risk.** As with any payor-based managed care plan, the prototype leaves the state with relatively low risk, a good deal of which it can regulate through the policies and threshold it establishes for accessing the statewide stop-loss reserve (i.e., the higher the threshold, the more pressure and risk is transferred to local MCOs). The State's principal risk is the systemic risk that the system will not function effectively in meeting its objectives.

Problem Areas

At the outset, we mentioned that the prototype is designed to illustrate how a managed long term support system might be constructed to achieve certain systemic goals, but we also admitted that it avoided dealing with certain questions. If this prototype were to serve as the basis for designing a managed long term support system, then the following (sometimes thorny) issues would need to be addressed:

- Superimposing an "objective" capitation system on top of an already existing service system is virtually certain to result in major discrepancies between the old and the new approaches to distributing funds. This problem arises because in current service systems dollars are distributed based on program categories and slots rather than on the basis of assessed need. To the extent that capitated payments that would flow to a particular MCO deviate substantially from current resources distribution patterns, immediate problems arise because local service systems would not be able to adjust quickly enough. Consequently, implementing an approach like the one envisioned in the prototype would need to be accompanied by strategies to mitigate short-term adverse impacts and enable local systems to adjust to the new funding rules.
- Next, obviously the prototype assumes that a competitive marketplace exists or would soon emerge. For the reasons discussed in Chapter VIII, this assumption may hold true only in the long-term and in areas that are able to support multiple suppliers. This means that the introduction of competition is not likely to have immediate salutary effects. At the same time, unleashing competitive forces ultimately will evoke a marketplace response (often in rural areas as well as urban areas).
- In the systems managed care arena, the prototype assumes a utilization management technology that probably is more sophisticated than current data systems can support. Here again, any gains from tight utilization management are likely to be secured over the long-term, and then only to the extent that data is available to support the development of more concrete practice protocols.
- By basing the prototype on exclusive local MCOs, it becomes more important to have in place the means to regulate and evaluate MCO performance. Exclusive arrangements are always difficult to manage. Consumer governance features are built in as an attempt to make the MCOs self-regulating based on their mission. Still, relying on exclusive arrangements can pose both managerial and political problems for the state authority.
- The prototype obviously is simpler to construct as long as the vast majority of dollars and consumers are participating in community services. Where a large public facility sector exists, additional complications arise. Intuitively, this sector should be folded into the managed care system and its use regulated by the local MCOs. If it is not, then opportunities for cost shifting arise. Local MCOs can be placed in a position of managing this sector by shifting public facility dollars to their control and requiring them to purchase services from the public facility for individuals who originated from the MCO catchment area. This model has been used in some mental health systems. The central problem that arises in using this model is its effects on public facility operations, chiefly the need to finance various fixed costs. This problem is not insoluble. Still, at a practical level, it is important that the issues be recognized and addressed.

RESOURCES & REFERENCES

The advent of managed care has spawned a rapidly growing industry that produced costly books and newsletters and conducts frequently very expensive seminars on the topic. The problem, of course, is that this industry is nearly totally devoted to the topic of managed physical/mental health care. As a consequence, one can spend a large amount of money in the pursuit of information concerning the application of managed care to long term support systems only to discover that such outlays fail to yield a commensurate gain in knowledge. Hence, *caveat emptor* applies.

The preceding observations do not mean that it is not useful to at least sample the literature of managed physical/mental health care. It is a rich literature that can supply valuable insights into this topic area as long as one is aware that it is a literature geared to endeavors other than long-term supports for people with developmental disabilities. A useful approach is to ask two questions: Can this managed care concept be applied in developmental disabilities? If so, how would it need to be adapted?

Our bibliography contains a listing of materials that helped inform us as we prepared this **Guidebook**. Some of the materials are directly relevant to the topic; others are general in nature. We also offer the observation that numerous Internet sites have popped up concerning managed care. Some are maintained by consulting firms, others by publishers, and still others by interest groups. Any standard Internet search engine will yield a listing of these sites.

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