The Community Living/Service Coordination Task Force at its February 8th conference call, requested a description of the options being discussed for developmental disabilities waiver services within the managed care framework. Specifically, the options put before the task force were (1) the state DD agency (i.e., the Agency for Persons with Disabilities) being the managed care organization for the DD waiver services and (2) the current developmental disabilities providers could form provider services networks to provide waiver services under a managed care contract. A third issue relative to the managed care discussion has emerged for which input from the Community Living/Service Coordination Task Force and the Health Care Task Force is requested; the integration of State Plan Medicaid services and Home and Community Based Waiver services for individuals with developmental disabilities.

Currently, the position of the Council is it does not support moving the developmental disabilities waiver services into a private managed care system and, instead, believes that the iBudget operated by APD would provide the spending limits to contain and predict costs, similar to a managed care system. This current system for the DD waiver services already utilizes many features of managed care, such as prior service authorization, fixed rates, funding caps (tiers), utilization guidelines and individual service planning. The implementation of the iBudget will strengthen further the utilization control by providing individual spending limits to contain and predict costs. The iBudget will also offer more flexible spending so that individuals with developmental disabilities can use their allocated funding for services and supports they need the most.

Moving the developmental disabilities service system into a formal managed care system with a private for-profit HMO will shift additional funds from a system that has already experienced tremendous reductions and shift the management to an entity with little, if any, expertise in provision of long-term care for individuals with developmental disabilities. Given the limited funding currently available, there is grave concern that quality services could be provided given the profits that a for-profit private HMO would expect to make. APD’s current administrative cost are a low 5% of the total budget. In addition, the managed care systems for DD waiver services found in the research are operated by public or non-profit entities. There is also concern that the for-profit private HMOs that would operate Florida’s DD waiver system would not have the experience or expertise needed.
However, the council should be prepared to respond to the range of options being considered. When considering the issue of the DD waiver being operated within a managed care framework, there is actually a continuum of options with maintaining APD as the operating entity and implementing the ibudget to provide a type of managed care framework at one end of the continuum and contracting with a private HMO for provision of the DD waiver services on the opposite end of the continuum. In the middle are two options that provide a more formal managed care operation and financing mechanism but does not utilize a non-developmental disability entity. These two options are as follows:

- The Agency for Persons with Disabilities would be the managed care organization (MCO).
- The current developmental disabilities providers would form provider services networks to provide waiver services under a managed care contract.

Both of these options would provide for the formal establishment of a managed care structure while maintaining the decision making with an entity (or multiple entities) that has the expertise in long-term care for individuals with developmental disabilities. The ibudget could be retained and implemented as the determining document for individual budget allocations. While these options are not the desired structure for the developmental disabilities waiver system, it is believed that they would be less detrimental than contracting with a private for-profit HMO.

The concept of the state developmental disabilities agency becoming the managed care organization has been used by Arizona for its developmental disabilities waiver services. Below is a description of the Arizona system from Health Management Associates Stakeholder Review and Comment: Options for a Capitated or Non-capitated Pilot to Serve Persons with Intellectual and Developmental Disabilities, June 2010 (pages 10 and 11). Note, the option of APD being the managed care organization would not mean that the Arizona model would be implemented. Provision of information on the Arizona model is for background on the concept only.

“Arizona has implemented a fully capitated, comprehensive managed care program that encompasses all Medicaid services. The state agency serving individuals with Intellectual developmental disabilities (IDD) is, in effect, a managed care contractor responsible for delivering or arranging for the delivery of all Medicaid services for members with IDD (acute care services, behavioral health services, long-term care services – including institutional and HCBS services.) All Medicaid eligible individuals with IDD who are eligible for long-term
care services (at immediate risk of institutionalization) are enrolled into this program, called the Arizona Long-Term Care System (ALTCS). Acute care services are delivered by HMOs – the HMOs are at-risk for these services but there is a negotiated shared risk arrangement with the DD agency. Behavioral health services are delivered by the traditional behavioral health regional authorities. Long-term services are delivered by traditional providers under a fee-for-service arrangement. The state IDD agency is at-risk for covered services.”

“Arizona’s Medicaid program operates under a unique, statewide managed care structure known as the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS arranges for provision of all Medicaid services using risk-based managed care contracts. Medicaid recipients who do not have long-term care needs, primarily low-income families and children, receive their managed care services from health plans that are competitively procured and include governmental (county) entities, private for-profit and not-for-profit health management organizations (HMOs). Individuals with IDD who do not have long-term care needs receive their Medicaid services from one of the health plans.

Medicaid recipients with long-term care needs receive all of their Medicaid services, including home and community based services (HCBS) and institutional services, under a managed care arrangement overseen by the Arizona Long-Term Care System (ALTCS), a part of Medicaid. ALTCS is “split” into two population groups: 1) aged persons and persons with physical disabilities; and 2) persons with IDD.

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

The remaining program contractor is the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES is a separate state agency from Medicaid and is the statutorily-authorized division within DES responsible for providing services to persons with IDD. DDD is required by state statute to contract with Arizona Medicaid (and vice-versa). DDD negotiates a managed care contract with AHCCCS. The contract specifies DDD’s responsibilities for Medicaid members with IDD who have long-term needs. DDD is responsible for delivering or arranging for delivery of all services included in the monthly capitation payment:
• Acute care services (hospital, physician, lab, x-ray, etc.) delivered by sub-capitated health plans;
• Behavioral health services provided through Regional Behavioral Health Agencies under the terms of an Interagency Agreement; and
• Long-term care services including HCBS for persons with IDD, provided fee-for-service by HCBS providers that serve individuals with IDD.”

The concept of traditional providers forming provider service networks to provide waiver services through a managed care contract has been used by Michigan for provision of behavioral health and IDD services. Below is a description of the Michigan system from Health Management Associates Stakeholder Review and Comment: Options for a Capitated or Non-capitated Pilot to Serve Persons with Intellectual and Developmental Disabilities June 2010 (pages 10 and 12 - 13). Note, the option of the current developmental disabilities providers forming provider services networks to provide waiver services to individuals with developmental disabilities would not mean that the Michigan model would be implemented. Provision of information on the Michigan model is for background on the concept only.

“Michigan, using a Prepaid Inpatient Health Plan (PIHP) approach, contracts with the traditional public providers of behavioral health and IDD services, known as the county-sponsored Community Mental Health Service Program (CMHSPs), for the delivery of all behavioral health and long term care services. These include HCBS waiver services for individuals with IDD. This program is called the Managed Specialty Services and Supports Program (MSSSP). The CMHSP (or a collaboration of CMHSPs) act as PIHPs to deliver services and are at risk for the covered services. Acute care services are not included in this arrangement.”

“Michigan implemented a managed long-term care program, the Michigan Managed Specialty Services and Supports Program (MSSSP), in 1998. The program operates under the authority of two Medicaid waivers: a Section 1915(b) and a Section 1915 (c) waiver.

The MSSSP is delivered by Prepaid Inpatient Health Plans (PIHPs). The PIHPs are a single Community Mental Health Services Program (CMHSP) or a collaborative of numerous CMHSPs (in more rural areas of the state). The CMHSPs are the traditional county-based organizations serving persons with mental illness, substance abuse or IDD. The PIHPs are selected through a competitive procurement, but the procurement is only opened to non-
CMHSP providers if the CMHSP in a service area is unable to enter into a contract with the state. To date this has not occurred.

The PIHPs receive capitated per member per month payments for Medicaid behavioral health, substance abuse and long-term care services including HCBS waiver services. The HCBS waiver services are only available to individuals with IDD. Since 2010, the PIHPs have received two managed care payments each month for the Medicaid covered services:

- One payment is based on all Medicaid eligibles within the PIHP region and covers mental health, developmental disability and substance abuse state plan services including targeted case management and special children’s Medicaid services as well as additional services funded from savings (that are similar to the HCBS waiver services but available to all members).
- The second payment is based on the subset of Medicaid eligibles that are also enrolled in the Habilitation Supports Waiver (persons with IDD at the ICF/MR level of care) and covers the cost of these services.”

Other developmental disabilities organizations, such as the ARC/Florida and the Florida Association of Rehabilitative Facilities (FARF), also do not support a private HMO operating the DD waiver system. However, FARF has introduced a concept that blends the approach of APD being the MCO with the developmental disabilities providers forming provider services networks, if the Legislature moves the DD waiver system into managed care. FARF’s position paper is attached.

**It is therefore recommended that the Council be prepared to recognize that the options of -- the Agency for Persons with Disabilities (or the developmental disabilities state agency if reorganized) operating as the managed care organization, the existing developmental disabilities providers forming provider services networks, or a combination of these two options -- would be less detrimental than a private HMO, if the Legislature decides to move the developmental disabilities service system into a formal managed care system.**

The third issue relative to the managed care discussion is the integration of state plan Medicaid service and HCBS for individuals with developmental disabilities. Currently, under Florida Medicaid Reform, services are delivered primarily through HMOs or PSNs that have been approved to operate as a Medicaid Reform health plan in the designated pilot counties.
Enrollment is mandatory for several types of Medicaid beneficiaries. Individuals with developmental disabilities are currently a voluntary population (i.e., they should not be assigned mandatorily and can opt out of the health plan at anytime.) In addition, Florida Statute (s. 409.91211 (3)(cc) F.S.) requires that a managed health plan to sufficiently meet the medical, developmental and emotional needs of individuals with developmental disabilities be developed. The Council, under the Health Care Task Force, currently has a contract in place to develop the minimum specifications for such a managed health care plan.

There has been discussion about the benefits of delivering the state plan Medicaid services and the HCBS waiver services as an integrated system. In this context “integrated system” means the administration of services under one umbrella entity. State plan Medicaid services would require a different set of providers (with possibly some exceptions) than the developmental disabilities waiver services. Some stakeholders in interviews for the Health Care Task Force contract pointed out “that “health care” for persons with developmental disabilities is significantly impacted by the requirements of day-to-day community living. Therefore, residential services, supported housing, homemaker services, etc. are key services that address the health and well-being of the individual. The specialty plans for managed care services for persons with developmental disabilities must be founded on the principles of community living and overall health personal choices. The philosophy of the health plan must be based upon quality long-term care (habilitative) services and not just the traditional medical model.

Whether the state plan Medicaid services are operated as a separate specialty health care plan or integrated with the DD Waiver system, the specifications being developed would hopefully provide the minimum requirements for the delivery of service. At a minimum, some level of coordination is important and would improve the system of care for persons with disabilities. Close alignment of state plan and waiver services could result in cost savings, particularly the services related to the day-to-day service provision such as therapy for children, home health care, and community behavioral health. Integration of these systems is an approach to be worked towards, not for implementation at this time. If these systems are to be integrated, the inclusion of individuals with developmental disabilities into the Medicaid Reform health plans needs to remain voluntary. More specifically, individuals with developmental disabilities must not become a mandatory population for enrolling in the Medicaid Reform health plans, even if as a specialty plan using the specifications being developed through the Health Care Task Force project. It is important that private HMOs not begin to offer Medicaid Reform health plans to individuals with developmental disabilities now because it would be very difficult to shift to an integrated approach in later years.
It is recommended that the Council’s position on managed care include keeping the state plan Medicaid services voluntary and that the Council be prepared to advocate for integrating the state plan Medicaid services and the developmental disabilities waiver services under one umbrella entity, if the Legislature decides to move the developmental disabilities service system into a formal managed care system.