

Models of Care Conference Report

June 5, 2006

Introduction

On June 5, 2006 the Florida Developmental Disabilities Council held a Models of Care Conference. This day long conference examined successful, comprehensive models of care for persons with developmental disabilities that have been implemented in other states. The models presented provided information from both systems delivery perspective and financial perspectives. Through the exploration of the successful integration of services into governmental systems of care, the participants will learn ways of integrating successful service delivery systems throughout the state.

Participants included local and state Medicaid policy makers, the Agency for Persons with Disabilities, the Agency for Health Care Administration and the healthcare community. Additionally, representatives from the medical industry, policy leaders, primary care providers and consumers were in attendance. The following is a list of results that participants wanted answered by this conference:

- What to talk to Legislators about as the new Medicaid policy is implemented;
- Successful models of managed care services;
- The benefits, issues and implications of Medicaid managed care; and
- Models of care that were successful and what barriers were identified.

Florida's Medicaid Reform

Roberta Kelley, Bureau Chief of Health Systems Development with the Agency for Health Care Administration, provided attendees with an overview of Florida's Medicaid Reform. The Florida Legislature in SB 838 passed Medicaid Reform on May 6, 2005. The waiver was approved by CMS on October 19, 2005 and approved by the Legislature on December 8, 2005. Roll-out begins in Duval and Broward counties and the phone lines will be opened to provide consumers with information on July 1, 2006.

Key elements of Medicaid Reform in Florida include:

- New options and choice that will include customized plans with services that vary by plan, enhanced benefits accounts that will provide additional benefits for individuals and an option to opt out. The latter option would mostly be utilized by people who are currently employed.
- Financing will be premium based. Premiums will be risk-adjusted to encourage enrollment of persons with disabilities and chronic conditions and to pay health plans to better meet individual needs.
- The delivery system will be a coordinated system of care where Health Management Organizations (HMO) are capitated and Provider Service Networks (PSN) are fee-for-service up to three years and then capitated. This allows PSNs to take a more active and larger role.

Key Elements that Medicaid Reform WILL NOT do:

- Change who receives Medicaid;
- Include Home and Community Based Services, however, that may change in the long term;
- Cut the Medicaid budget. Reform is intended to slow the rate of growth;
- Waive early and periodic screening diagnosis and treatment for children including immunizations;
- Limit medically necessary services to women or children;
- Limit medically necessary services for pregnant women;
- Permit reform health plans to charge higher cost sharing.

Medicaid Reform will increase recipient choice and empower recipients to participate in their health care by having options and selecting a plan. Reform will encourage benefits that better meet recipient needs and allow access to services not traditionally covered by Medicaid. Recipients will be rewarded for healthy behaviors and choices.

Beginning July 1, 2006 in Duval and Broward Counties, 200,000 persons will participate in Medicaid Reform. Temporary Aide to Needy Families (TANF) related groups, aged and disabled (not Medicare and Medicaid dual eligible), children with chronic conditions and persons with HIV/AIDS (capitated plans) will participate in reform. There are populations that may participate, but are not required, and include individuals with developmental disabilities, foster care children, and individuals receiving Medicare. There will be 16 plan options in Broward County and 8 plan options in Duval County.

Will there be requirements to serve individuals with developmental disabilities? The law requires the Agency for Health Care Administration (AHCA) to develop and recommend service delivery mechanisms within plans to provide services to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these people. AHCA anticipates that the standards will be available by Year 3 of reform operations.

How will the state determine if an individual has a developmental disability? The Agency for Health Care Administration worked with the Agency for Persons with Disabilities (APD) to identify individuals. Persons meeting the definition of Developmental Disabilities based on Chapter 393, F.S., are persons who are receiving home and community-based services or are identified on the Agency for Persons with Disabilities wait list, and persons receiving APD-funded services.

How will Medicaid Reform affect home and community-based services? Home and Community Based Services are not part of the reform. Individuals that are receiving these services will continue to receive the services that they receive today. The goal includes moving toward more integrated care. The timing of how this would best be accomplished has yet to be established.

What are customized benefits? Reform health plans will create benefits to meet recipient needs and will include all Federally-required benefits and will probably include some

services not currently covered by Medicaid. The benefit packages must have the same value as the current Medicaid benefit package. The benefits must meet Florida defined standards of sufficiency based on the health plan's target population and not just the 'average' member. The Agency for Health Care Administration is looking at historical utilization of services by the target population to use this as a baseline for what each plan will need to offer at minimum.

What are Enhanced Benefit Accounts? These accounts reward healthy behaviors and wellness activities such as dental exams and mammography. Funds will be deposited in an individual account and the individual will have control over how the funds will be used. Funds may be used for health care services that are not covered by Medicaid (over-the-counter medications). Most recipients will be able to access these funds for up to 3 years after losing Medicaid eligibility.

Ms. Kelley concluded her presentation by noting that the Choice Counseling Reform Helpline will go live on July 1, 2006 and materials will be sent on July 24, 2006 to those persons who must choose a plan. General reform information will be sent to those that 'may' choose and on September 1, 2006 voluntary enrollment into the Reform plans begins. Persons who are required but do not choose a plan, will be auto-assigned a Reform Health Plan beginning October 1, 2006.

Attendees had the following questions for Ms. Kelley:

- If there is a healthcare crisis after a person opts out can you opt back in?
ANSWER: Opt in is only available at specified times (during open-enrollment and on anniversary date).
- What is the cost to administer enhanced benefits accounts?
ANSWER: There is no additional cost. Administration of the benefit can be done under the current infrastructure.
- What is the ratio of people to Choice Counselors?
ANSWER: There are incentives to meet measures but there are safeguards in place. Affiliated Computer Services (ACS) manages Choice Counselors. Florida State University provided materials and training for Choice Counselors, who must pass a test before counseling. Face to face visits can be conducted if the consumer chooses this option instead of phone choice counseling.

Medicaid Reform in Florida: Recommendations for Promoting Access and Quality in Medicaid Managed Care for Persons with Developmental Disabilities.

Mari-Lynn Drainoni, Ph.D., was present to share with conference attendee's information about the paper she co-authored with Michelle Johnson. The complete paper was provided to attendees in the meeting packet. Following are the highlights presented at the Models of Care Conference.

Dr. Drainoni addressed the fact that the project was executed because there were concerns that the current Medicaid Reform plan would not meet the needs of person with disabilities. The project methods included conducting meetings and calls with key players,

working with the Advisory Committee to guide and inform, performing an extensive literature review, using a national survey, and completing information-gathering about plans serving persons with disabilities.

According to information provided by Dr. Drainoni, in 2004 there were 44 million Medicaid beneficiaries nationally and 6.6 million people on supplemental security income (SSI). In Florida, there are about 2.2 million Medicaid beneficiaries and about 500,000 people receiving SSI benefits. It is estimated that 17% of the population account for 41% of Medicaid costs. Florida's Medicaid costs have been increasing about 13% annually since 1998. It is expected that 24% of Florida's budget will be spent on Medicaid in 2005. If this trend were to continue, by 2015 Medicaid would represent 59% of the state budget and equate to over \$50 billion.

The report showed that Florida, as in most states, the number of persons with developmental disabilities is unknown. The Agency for Persons with Disabilities serves approximately 40,000 people with developmental disabilities and there greater than 12,000 people on a waiting list, according to Drainoni's research. There are potentially up to 88,000 persons with developmental disabilities on Medicaid benefits or TANF not known to APD. These people will not be exempt from mandatory enrollment during the pilot phase of managed care.

When researching managed care programs, Dr. Drainoni found that participants programs received expanded access to primary care, care coordination, preventive health care and reduction of system inefficiencies. The threats were noted as limited access to specialty care, continued fragmentation, limits on community-based services, disincentives to enroll or attract costly individuals, and standard utilization management guidelines that were applied without modification.

The following standard services are typically covered in a Medicaid managed care plan: inpatient, emergency room, outpatient hospital, physician/clinic, pharmacy, labs, x-rays, durable medical equipment, home health care, emergency transportation, mental health/substance abuse and short-term rehabilitation (physical therapy, occupational therapy, and speech therapy). Some atypical services and benefits that a Medicaid managed care program can cover include: home modifications, non-emergency transportation, specialized mental health, long-term habilitation (physical therapy, occupational therapy and speech therapy), adaptive recreation (i.e. horse, dog or monkey), personal care, crisis alternatives, respite care, adaptive equipment (i.e. signing boards), nutritional supplements and day services.

Dr. Drainoni's research found that managed care can work for or against good care for persons with disabilities. Access problems with managed care plans can be a result of low Medicaid provider rates and capitation shifts risk from the state to the plan. When predicting rates for a smaller population, such as the developmentally disabled population, there is a greater probability that the actual cost and utilization will deviate from predicted values. To encourage plans to serve populations with higher costs, there should be

adjustments based on health measures. Risk adjustments can be based on diagnostic data, pharmacy data or service utilization.

Risk adjustments that are diagnosis-based take into account the heterogeneity among people with disabilities, there is more cost consistency by diagnoses and the level of severity. Dr. Drainoni indicates that this is a relatively good predictor of costs. International Classification of Disease (ICD) codes are required for all health encounters and they are relatively accurate, however, Drainoni notes that an ICD code is not a diagnosis. Large amounts of data are needed to calculate rates. There are three methods of diagnosis-based risk adjustment:

- Adjusted Clinical Groups – classify people into 1 of 93 mutually exclusive categories based on diagnoses on claims assigned during a specified time period. Then they are cluster them into 32 categories based on clinical similarity. The final categories are not clinical, but based on duration of the condition, severity and types of services that will be used. This type of classification with its mutually exclusive categories is not effective for multiple disorders. Diagnoses may not have the same duration and there are no separate clinical groups for children.
- Diagnostic Cost Groups – Originally developed for Medicare inpatient care, this method is used for Medicaid and other populations. Medical conditions are grouped into categories based on diagnosis codes and then assigned to one or more diagnostic clinical groups. Drainoni notes that this method does not account for severity of illness and some conditions for persons with disabilities may not be coded if the disability is not the reason for the medical encounter. There is no separate category for children.
- Chronic Illness and Disability Payment System – Used with the SSI population, this system defines 67 major categories by body system or condition and a person can be assigned to one or more categories. This method can take into account multiple diagnoses and the severity level for each diagnosis, according to Drainoni. Drawbacks to this system include that it is not as strong for mental health/substance abuse issues and a significant amount of data is needed to determine severity.

Pharmacy-Based Risk Adjustment. Dr. Drainoni recognizes the three common methods of using pharmacy claims data to determine capitation rates: Medicaid Rx, RxRisk and RxGroups. Using this type of data may not provide an accurate snapshot to set rates because many persons do not require medications for disabilities, medications can be used for a variety of different conditions, new medications are constantly being developed, studies show this method is not as good at predicting costs for people with disabilities and there are concerns about incentives if payments are linked to drug use. There is the consideration of episodic risk groups which combines diagnosis-based and pharmacy-based risk adjustment by grouping people into one of more than 119 medical condition categories. This method requires extensive data, is expensive and takes a lot of time.

Other risk-adjustment options that Dr. Drainoni recognized were Service Use-Based and Partial Risk-Adjustment. The former sets capitation rates based on past experience or

service utilization and this option is good for persons with a lot of Medicaid experience. However, with Partial Risk-Adjustment there is a single rate for Medicaid rating category with enhancement for high-cost diagnosis (i.e. AIDS, serious mental illness, end-stage renal disease). This method is used in Massachusetts and Drainoni views this method as ineffective because it is detrimental to specialty plans that enroll highest cost persons with multiple conditions.

Dr. Drainoni surveyed all state Medicaid and Developmental Disability agencies to examine the current landscape of managed care plans for persons with developmental disabilities, to identify mechanisms of distinguishing the developmentally disabled population from other SSI enrollees and to identify best practices and opportunities for Florida. Responses were received from 42 states. The project team found that the developmental disabilities programs knew little about managed care plans and Medicaid programs knew little about the developmentally disabled population.

When reviewing managed care, Drainoni found that 47 states have managed care programs for the TANF population and 39 states include some SSI enrollees. It was found that it is not uncommon for enrollment to be mandatory for TANF but voluntary for SSI. Only 2 states exclude persons with developmental disabilities while other states essentially exclude persons with developmental disabilities in that they do not allow people receiving home and community based services or other developmental disability waivers to enroll. At least one capitated plan that includes people with disabilities is offered in 32 states (22 mandatory, 12 voluntary and 2 have both geographic and/or population variation). There are 22 states with fee-for-service managed care programs that include people with disabilities (15 mandatory and 7 voluntary). In the 32 capitated plans, 18 states “carve in” behavioral health in their capitation payments to HMO and plans can keep behavioral health carved in or subcontract out to behavioral health managed care organizations. There are 14 states that “carve out” the behavioral health portion and the state contracts directly with behavioral health managed care organizations.

When identifying the populations for enrollment, Dr. Drainoni has concerns about many persons with developmental disabilities that are not known to the state, but will be affected by mandatory enrollment in a managed care program. At this time no state Medicaid agency has the mechanism to identify persons with developmental disabilities and the goal should be to determine how to distinguish persons with developmental disabilities from other SSI enrollees and within the TANF population. The state developmental disabilities agencies also do not have a mechanism in place to identify persons with developmental disabilities unless they are receiving state services or are on a waiting list. Dr. Drainoni recommends that a health assessment be completed prior to or at enrollment to identify the needs of participants.

Enrollment brokers are used in 21 states and typically have no particular knowledge about disabilities. Some states have incorporated special features to better support enrollment/choice counseling of persons with disabilities. They are:

- Home visits by enrollment staff;
- Contracting with disability agencies to conduct enrollment;

- Additional time to chose without auto assignment;
- Special “help lines” or ombudsmen for people with disabilities;
- Continuity of care forms at enrollment (Oregon);
- Complete health assessment prior to enrollment;
- Allow specialists or a team of physicians to serve as the primary care physician (Kentucky);
- Invite new providers to join the network;
- Training families and development disabilities program staff about managed care.

Most states have not moved to a full risk adjustment, according to Drainoni, and 17 states with full risk have single SSI and TANF rates for capitated programs. Some risk adjustment is used by 15 states and includes diagnosis-based, full diagnosis based or have special rates for special plans or particular diagnoses/disabilities. Most states with fee-for-service primary care case management programs there is no payment of case management fee for persons with disabilities. In states that pay a case management fee, typically it is small and paid per member per month to the primary care physician. A less common option that is used is enhanced Medicaid office visit payment per primary care physician visit by a person with a disability (i.e. \$10 per visit enhancement payment).

In reviewing disability-specific requirements by managed care contracts, Drainoni noted the following:

- Case management (18 states);
- Full screening/needs assessment before enrollment (17 states);
- Physical examination within 60-90 days of enrollment (16 states);
- Annual quality improvement activity (3 states);
- Develop/monitor clinical protocols for certain conditions (2 states);
- Hire ombudsman devoted to persons with disabilities (2 states);
- No change in care plan without home visit (1 state);
- Must indicate attempts to enroll physicians who traditionally treat population in provider network (1 state);
- Special needs unit focused on persons with disabilities (1 state);
- External monitoring of access to specialty care (1 state).

There were fewer requirements targeted specifically to persons with developmental disabilities. Most states require regular satisfaction surveys, however none require oversampling of people with disabilities, ask if a person has a disability or disability-specific questions. Specialized models for the developmentally disabled population have been identified. Three of the models are presented in this paper and the other models are discussed in the paper entitled “*Medicaid Reform in Florida: Recommendations for Promoting Access and Quality in Medicaid Managed Care for Persons with Developmental Disabilities.*”

Summary of Models Presented

Model 1 - iCare – Independent Care Health Plan, Wisconsin

Patricia Jerominski, President and CEO of Independent Care Health Plan of Milwaukee, WI offered congratulations to Florida for taking the issue of managed care for persons with developmental disabilities into consideration.

Ms. Jerominski explained that what makes iCare different is that they focus on quality, choice (understanding how a member makes a choice) and results. The plan always puts the member first. iCare is an insurer-coordinator of health care and human services for indigent adults, ages 18 years and older, with disabilities and special needs.

iCare provides services for adults who, because of their disabilities, are SSI eligible and covered by Medicaid or by Medicare and Medicaid. Currently, over 8,600 members in Milwaukee County are covered by iCare and 2,500 of these people are dual eligibles. iCare also serves long-term care and home and community-based service waiver clients and serves over 22,000 Wisconsin Department of Corrections clients. Nearly half of voluntary enrollees choose iCare, according to Jerominski.

Independent Care Health Plan became a licensed HMO in 2003 and is affiliated with the Milwaukee Center for Independence (50%) and Humana (50%). They officially opened their doors in 1994 when HCFA awarded them a 3-year research grant to research and develop a workable managed care model for people with disabilities. The goals of the grant were to improve the quality of care, increase consumer satisfaction, develop an adequate capitation payment and provide a savings to the state. In February 2005, iCare became mandatory for persons receiving Medicaid-only benefits. Persons who are dually eligible could choose whether or not they wanted to participate.

Ms. Jerominski states that what makes iCare different is:

- Integrated and multi-disciplinary focus on behavior change and the recognition that behavioral health drives medical needs;
- The multi-level approach to care management to include a high impact team for members with severe conditions and a standard impact team for members whose care is less intensive and the development of an assessment tool that took into consideration functional parameters;
- Integration of social, medical and behavior aspects of care management for better outcomes;
- Maintaining close relationships with members and providers;
- Persistent care coordination follow-through.

In 2004 iCare started utilizing the Chronic Disability Payment System with individual severity adjustment. For the years 1994-1996 iCare reported financial losses and then they moved to a full risk program. In 2002 there was significant savings to the state of Wisconsin, in 2003 there was a loss, in 2004 they broke even and in 2005 there was a 2% margin of revenues over expenses.

What does mandatory mean in Wisconsin? According to Jerominski, the Medicaid client can choose an HMO in the first 60 days and stay in or opt out. During that time the HMO must pay for all previously ordered services. In Milwaukee County for SSI Managed Care

enrollment, iCare is the leader with 8,665 members followed by Managed Health/Centene with 3,095 members, United/AmeriChoice with 2,301 members, Abri with 1,166 members and Network Health Plan with 844 members.

Ms. Jerominski and her staff found that people choose iCare because they offer quality services. Member satisfaction is over 95% for the last six years and over 97% for the last two years. iCare provides member choice and flexibility. Members work closely with staff to access a variety of services and staff will meet a member at appointments if requested. iCare also offers members results. The behavioral health approach provides better outcomes for members. Of the 2,000 persons with developmental disabilities that are enrolled, 75% had an identifiable behavioral health condition.

According to iCare, characteristics of the membership include:

- 1 in 15 have a legal guardian;
- 1 in 15 have no permanent address;
- 2% are hard to contact;
- 13% have functional needs at the comprehensive level - at least 3 activities of daily living (ADL) or 2 ADLs and 1 instrumental activities of daily living (IADL);
- 26% have functional needs at the intermediate level (at least 1 ADL or 1 IADL for medication, money management or meal preparation);
- 37% identify no primary care physician at the time of enrollment;
- 53% are identified as needing mental health services at the time of enrollment;
- 62% require transportation services;
- 68% are assessed with having no formal dental care or relationship with a dental provider.

iCare spends a lot of time building relationships. Jerominski indicates that they receive referrals from the advocacy community and ongoing Advisory Committee, the community, and providers. With the latter, iCare helps manage more complex patients. Providers view iCare as a professional resource with accurate, trouble-free administrative process. Care coordinators used to maintain up to a 700 person caseload (BA degree level trained) and 200-250 person caseload for Registered Nurses. Now, care coordinators carry a 350 person case load. Upon enrollment members are placed in a high risk category with a care coordinator with a smaller case load and then members are moved to medium then low risk categories as the situation warrants.

The iCare model looks to create meaningful choices for members through an integrated continuum. A comprehensive, single funding source consolidates Medicare, Medicaid, Waiver, Block Grant and County funding.

Figure 1: Current funding sources and programs and the fragmentation that occurs. Similarly noting that many segments of the population have overlapping needs and must access services from multiple programs.

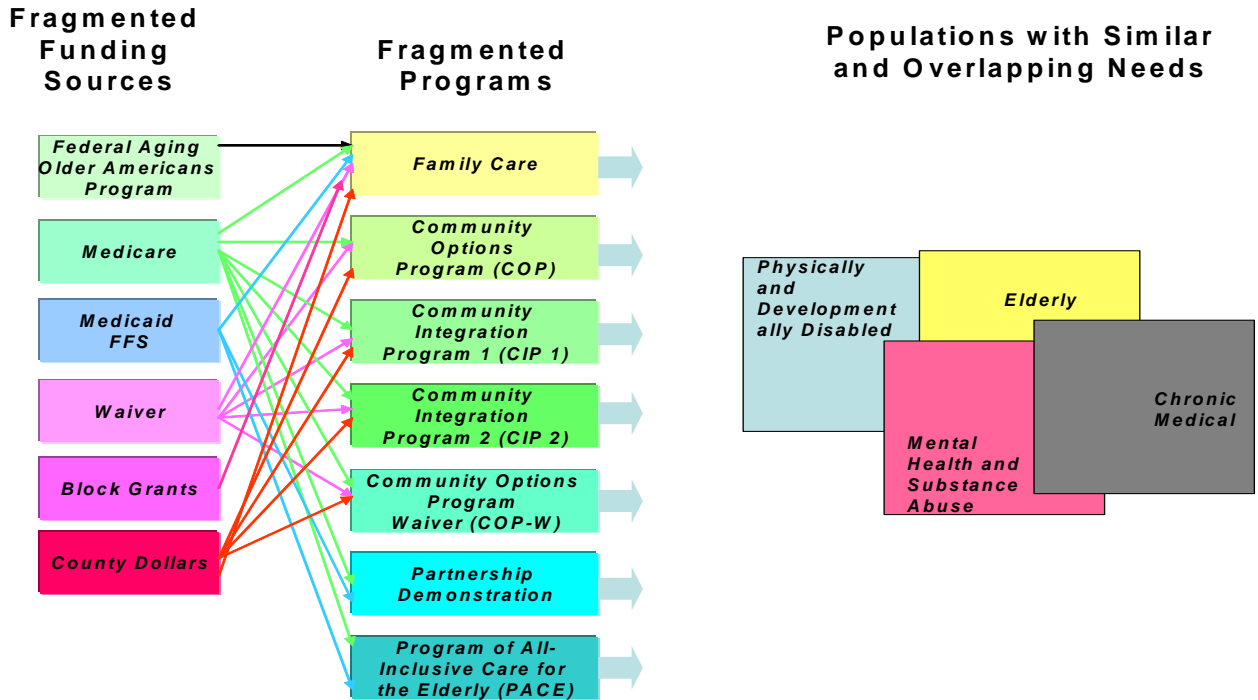
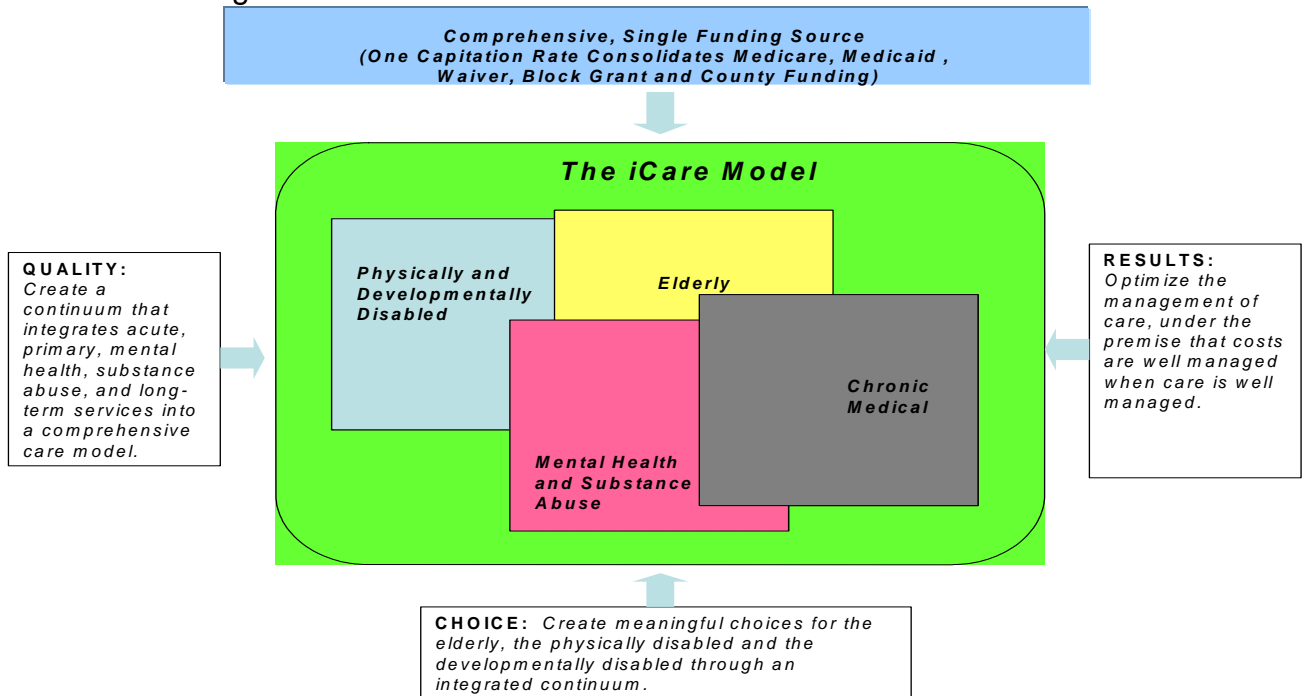


Figure 2: The iCare Model is comprehensive with a single funding source. This model provides clients with an integrated continuum of care that optimizes the management of care costs and creates choices for clients.



Ms. Jerominski goes on to address that the iCare model is one about life cycle planning and management. Members and staff making the right choices to maintain independence and support program efficiency while moving members from an entitlement mindset to a planning mindset. In that, clients have choices that impact them and making the correct choices can balance out health status, independence and satisfaction during the entire life cycle.

The principles of the iCare model are:

- Improve outcomes through a care continuum of primary and preventive health care, acute and chronic medical care, psycho-social support services, home and community based long term care and support and institutional long term care;
- Build an integrated continuum model together;
- Importance of consumer choice and input.

Model 2 – Community Medical Alliance, Massachusetts

Mari-Lynn Drainoni, Ph.D. with the Boston University of Public Health began by giving a history of the Community Medical Alliance (CMA). The program was the first fully capitated managed care plan in the United States developed specifically to serve people with disabilities. CMA had its origins in the 1970s where a group serving frail elders and adults with severe physical disabilities pioneered the use of Nurse Practitioner/Medical Doctor (NP/MD) teams. In 1982, this became a clinical model to people with severe physical disabilities moving from institutional care to independent living. The NP/MD team provided primary care and care management to people with severe physical disabilities in their homes and coordinated/authorized all care. A clinician was available for routine care and consultation 24-hours a day and Massachusetts Medicaid paid for the primary care on a standard Medicaid fee-for-services basis with enhanced fees for home care and case management. In 1992 CMA received a special contract and began receiving capitation. They formed a second NP/MD group and began providing services to persons with late-stage AIDS.

For adults on Medicaid that met clinical criteria and lived within clinical groups' service region, Community Medical Alliance became the option for mandatory managed care. Populations included were recipients dually eligible for Medicare and Medicaid, and Medicare fee-for-service consumers with care coordination by CMA staff. Primary/routine care was often provided in a home setting by a Nurse Practitioner for the following reasons:

- Easier and more efficient for patients to receive care at home;
- Addressed prevention/routine care issues in community setting rather than inpatient or Emergency Room setting;
- Community based care reduced costs and allowed people to stay at home rather than be institutionalized;
- Nurse Practitioners were found to be more cost-effective than physicians for routine care and provided 24-hour on-call services as well as assisting with scheduling of appointments, transportation, referrals and evaluating service plans;

- The savings from capitation were used to provide alternative services that were not typically covered (i.e. support services, home modification);

Dr. Drainoni described CMA as a full-service managed care organization that included claims payment, utilization management, provider network, contracting and member services. The model was added in 1996 for the population of adults with developmental disabilities, living in the service area and not Medicare/Medicaid dually eligible. This was done in cooperation with the Department of Mental Retardation. There was an additional focus of the developmental disabilities program in that nurse practitioners offered staff training at developmental disabilities residential programs. CMA also developed a specialized mental health/substance abuse program for populations. Drainoni notes the following key components of the program to include:

- Provider network experienced with specific disability groups. The network was fully accessible and they were willing to provide care in the home;
- First disability-specific crisis team;
- Mental health/addictions specialists for each program to co-manage complex cases with nurse practitioners, provide home based evaluation and short-term treatment;
- Savings on inpatient and crisis care allowed for the addition of new behavioral health services within capitation that included: professionally led support groups, substance abuse step-down and transitional substance abuse housing.

The financing for CMA was based on enhanced capitation rates for its severe physical disabilities (SPD) and AIDS populations. Massachusetts does not have full risk adjustment, and CMA worked with the state on risk sharing. For late-stage AIDS the capitation rate was \$4,000 and for SPD the rate was about \$2,000. Drainoni points out that as CMA managed care came in under or at the cap, the state would decrease rates and it became difficult to manage. Capitation rates varied based on the enrollees' diagnosis and health status. The capitation rate was determined through a comprehensive clinical assessment prior to enrollment. While the capitation rate was sufficient for some enrollees, it was not sufficient for all (i.e. persons with co-morbidities or severe mental health or behavior disorders). CMA attracted patients who were the most ill and disabled (adverse selection) and the lack of risk adjustment did not allow compensation for this. Because of the clinical criteria and home-based model, the program remained small and not available state-wide. At its peak, CMA did not exceed 500 members and nurse practitioner caseloads were 30-50 clients. However, Dr. Drainoni explained that because CMA included all of the functions and positions of an HMO, plus additional supports and positions designed to enhance the quality of life for persons with disabilities, the administrative costs were high (26-30%).

CMA changed its structure in 1999 due in part to financial pressures. They were integrated into a larger Medicaid HMO, Neighborhood Health Plan (NHP). With a statewide membership of almost 100,000 Medicaid enrollees and 8,000 SSI enrollees, NHP allowed CMA to maintain the clinical programs but saw no need for two sets of infrastructure and administrative support. CMA, no longer a freestanding HMO, integrated into NHP. NHP provides administrative functions as the HMO of record and receives capitation payment. Medicaid beneficiaries can select NHP as one of the HMO options

and if the individual meets clinical criteria they will be enrolled in one of the CMA programs within NHP. Currently there are multiple systems of care and a continuum of care management models within NHP. Additionally, specialized programs have been developed for medically fragile foster children and youth with serious emotional disorders.

Dr. Drainoni states the following keys to the success of CMA:

- Clinically-based capitation rates;
- Flexible use of capitation to provide services based in the home and community and discourage inpatient and emergency room care;
- The role of the nurse practitioner in providing a comprehensive initial assessment at enrollment and to be the first to respond to new medical problems by providing frequent home visits;
- Care coordination/utilization management that was clinically driven and linked;
- Specialized provider networks with expertise in disability populations and willing to work within the CMA model;
- Providers trained on expectations with language in the contract and regular meetings with the provider network;
- Members encouraged to use or transition to network providers by including the right providers in networks;
- Enhanced benefits and services.

Model 3 – Developmental Disabilities Health Alliance, New Jersey

Renee Mailloux, Director of Program Development with the Developmental Disabilities Health Alliance (DDHA)/Centene in New Jersey, addressed issues related to the implementation of a managed care model serving persons with development disabilities.

Beginning in 1994, the DDHA began the process for ensuring advocacy and consumer input into the drafting of HMO contracts. The final contract was finished in 2000. The provision of services, according to Ms. Mailloux's presentation, was developed on a "carve-out" or "carve-in" basis. The following were "carved-out":

- Mental health (partial care or partial hospitalization programs);
- Pharmacy;
- Home Health (i.e. home health aides, personal care attendants and/or skilled nursing services) remained fee-for-service;
- Rehabilitation (occupational therapy, physical therapy and speech/language therapy);
- Transportation.

When considering how to develop the contracts, it was noted that there were specialists in nearby cities (Philadelphia/New York) that consumers were accessing but found these specialists were not in the network. In order to ensure the continuity of care with health care providers, access to out-of-state providers would be preferred.

Under the DDHA plan contracts, specialists could serve as the primary care provider. Disability specific quality management programs were required as was compliance with

Americans with the Disabilities Act (ADA) accessibility and communication standards. ADA compliance did not happen with every office. Ms. Mailloux notes that one of the most important provisions in the contract was the use of risk adjustment in setting the capitation rates. Also under the contracts, there was an effort to maintain linkages with state and community organizations by participating on the community advisory board. The creation of a Managed Care Ombudsperson was suggested, but was not activated. Instead of complaints being received by an Ombudsperson, they were forwarded to the local Medicaid Access Center.

According to Mailloux, there were specific requirements for the provision of care coordination and case management services. Each HMO was to have a case manager and create linkages on behalf of their clients. Case managers maintained a client list of up to 75 clients who had the highest levels of needs. Case managers would maintain up to 300 clients who had lower levels of needs. The goals of case management are as follows:

- Complex Needs Assessment that would include: medical status and history, functional status, physical well-being, mental health status, history of tobacco/alcohol/drug use or exposure, identification of social supports, determination of willingness and capacity of family to provide informal support, condition and proximity to services in relation to current housing and transportation and the need for medical supplies and/or durable medical equipment. This assessment is to be completed within 10 days of enrollment.
- The development of an Individual Health Care Plan. The plan specifies short and long-term goals, identifies medical service needs, relevant social and support services and provides an ongoing accurate record of the individual's clinical history.
- Coordination of care between case management and utilization management.
- Quality management that will look at quality measurement (structure, process, outcomes and satisfaction), as well as, continuous quality improvement.
- Identify clinical pathways and practice guidelines to reduce variation, improve quality and utilize specific disease/condition management models.
- System integration through the use of interagency agreements, system integration and population health.

The DDHA/Centene Model of Primary Care/Care Management provides care management, primary care and specialty care for mental health and seizure management. Currently, there are 6 offices statewide and 90% of DDHA participants are within one hour's driving distance of any office. The offices are staffed by Nurse Practitioners and Physician Consultants with three offices also staffed with a Care Manager. At this time there are 3,000 primary care patients in the program and 1,500 specialty care clients (mental health and/or seizure management). Accessibility is important to the DDHA/Centene Model and they state that 98% of new patients are seen within two weeks, the average waiting room time is 6.4 minutes, the offices are physically accessible, there are office accommodations (scales, tables, etc.) available as needed and there is 24/7 availability.

Ms. Mailloux concluded by presenting the 2005 program assessments. Staff quality received a 95% approval rating and 98% of participants agreed or strongly agreed that

they were pleased with treatment. For comfort and privacy, 97% participants rated DDHA/Centene as good or excellent. Health status, according to 92% of participants, improved during the past year and emergency room utilization was reduced by approximately 20%. The DDHA/Centene model is scalable and able to be replicated in that it does not depend on governmental support. The major barrier to this model is the lack of start-up capital.

Discussion

The panel discussion was facilitated by Robert Frank, Ph.D. Conference attendees began the discussion questioning why there are so many case managers. The panel noted that there are so many case managers because it is the nature of what was developed by merging and simplifying services. Umbrella agencies need to merge social work with health to simplify the delivery system. The recommendation is to have one case manager in charge of meeting and collecting all of the information from multiple sources and look at a health care rather than medical management model. Roberta Kelley, AHCA, responded by saying that AHCA is looking at how to best coordinate services under reform.

The paper, *Medicaid Reform in Florida: Recommendations for Promoting Access and Quality in Medicaid Managed Care for Persons with Developmental Disabilities*, does not show savings for other states. What is Florida going to do to show cost savings? Ms. Kelley responded by saying that the program will be budget neutral. To measure the success of the pilot the legislature will compare pilot counties to other counties and the University of Florida received a contract to do an evaluation of the pilot. The goal is to reduce the future growth in Medicaid spending.

Renee Mailloux stated that with the implementation of the managed care program, access to medical care has improved. The developmentally disabled population often encounters technology advances first and therefore there is additional expense. The interest should be in changing patterns of how care is provided and not change how dollars are allocated.

What about a home and community based services waiver for the developmentally disabled? There should be support coordinators – care coordinators need to be mandated to attend care coordinator meetings as part of the contract. Ms. Kelley indicated that the contracts expect quality of life measures (need to have 6 with 2 being mental health). Access to preventive care for persons with developmental disabilities including dental, dermatology, neurology, and gynecology is very important. Providers will be required to administer patient satisfaction surveys and measures. AHCA is looking for input regarding provider requirements under reform.

Accessibility, with reform, will be measured by more than physical health. Access to specialty care and waiting times for appointments, recreation and social supports are all important components of a quality and inclusive managed care program. Community outreach to determine non-traditional Medicaid supports and alternative provider treatments allowing providers to be more creative should be implemented. Patricia Jerominski stated that when Wisconsin moved to capitation, the state's performance in

serving persons with diabetes and mental health increased. Disease management was not as successful in the developmentally disabled population. The population that iCare was serving had a high number of individuals that were obese and smokers. Trying to change these behaviors was unsuccessful; however the pneumonia/flu vaccine prevention strategies and the mammography program were very successful.

Process of intake and complete assessment has an impact on financials. iCare now includes intake as part of the contract and has been doing it for 12 years. This is significant in getting outcomes and developing an adequate capitation rate. The intake and assessment will help to identify what kind of the disability the client may have and what the patient status is from their own view and what changes will they be willing to make.

In an ideal world we would have 15 years to plan legislative funding less compels the need. We do not have a lot of time to work with the Medicaid state plan. Controls are not slowing the growth and there is an understanding that legislation will include home and community based services waiver program.

There is a need to understand how to train family members and developmentally disabled staff and self advocates on what is managed care, how does it work and what does it mean. The first step is how to best serve persons with disabilities. To do this the provider community, families, and persons with disabilities have to be at the table to advocate for needs and to fully understand how changes will affect their access to quality care.

Questions About Florida Medicaid Managed Care Implementation

Below is a list of questions for AHCA to consider in developing Medicaid reform for the developmentally disabled population.

1. Developing and implementing a risk adjustment system is very costly and time consuming. Is the plan to begin with a pharmacy-based mechanism and then move to a diagnosis-based method when HMO encounter data become available cost-effective, particularly given the preference for diagnosis-based risk adjustment?
2. How will Medicaid Rx account for some very severe disabilities and needs in people with disabilities that are not reflected in pharmacy data? Will there be data in addition to pharmacy claims will reflect the health care utilization and costs of persons with developmental disabilities and other long-term, more "stable" disabilities that may not require extensive medications.
3. Can alternatives be considered? Studies show diagnosis-based methods are much better than pharmacy-based methods at predicting costs, especially for people with disabilities. Would it be better to wait until claims data become available from the pilot programs, to use Medipass claims, or to pay fee-for-service for a period of time?

4. The idea of separate medical and home and community based services will not work for very long. Consider the pilots, if someone loses therapies at age 22 or 23 how can one continue without diluting what is medically necessary? There are different guidelines regarding patient centered care. Can AHCA require that if HMO denies long-term PT/OT – is there a way to require service is continued while under appeal?

Recommendations for Implementing a Successful Model of Care for Florida's Medicaid Reform.

The recommendations for implementing a successful model of care for Florida are listed below and were presented by Dr. Drainoni based on findings from the report, *Medicaid Reform in Florida: Recommendations for Promoting Access and Quality in Medicaid Managed Care for Persons with Developmental Disabilities*.

1. A significant amount of time has been invested in reform and it is in everyone's best interest to do everything necessary to make it work. Although the current plan is for pilot programs in two counties with voluntary enrollment of persons with developmental disabilities during the pilot phase, the expectation is that persons with developmental disabilities will be required to enroll in managed care after one year, with statewide mandatory enrollment over five years. Prior to setting a schedule and calling for mandatory enrollment, it is recommended a full evaluation of the experience of persons with developmental disabilities and other people with disabilities in the pilots be completed.
2. The diverse spectrum of persons within the SSI population makes it critical to clearly define the managed care target population. It is much easier to build programs for specific subgroups. But, if the entire Medicaid & SSI populations are targeted, it is important to include multiple models of managed care and allow different types of entities to serve managed care organization.
3. Much will come down to financing and the capitation rate. Capitation can only be used flexibly and creatively if the rate is adequate to meet members' needs. Risk adjustment can provide sufficient rates and limit problems with adverse selection. People with disabilities are likely to choose specialty plans; for these plans the most effective way to survive is to obtain a rate that allows them to meet the needs of their members.
4. All risk adjustment is challenging for persons with developmental disabilities, as developmental disability encompasses a range of diagnoses, with variation in co-morbidities and severity. This is also the case for other long-term and "stable" disabilities that require habilitative services to maintain function. The importance of being able to account for the presence of multiple disabilities and conditions and severity in the risk adjustment system is crucial. It will be important to not only work with actuarial firms, but to confer with administrators from different types of

managed care programs that have enrolled people with disabilities, both general plans and specialty plans, to understand their experience.

5. Although AHCA has developed a mechanism to identify persons with developmental disabilities receiving APD services or on the waiting list to exempt them from mandatory managed care enrollment during the pilot phase, national data estimates make it extremely likely that there are many more persons with developmental disabilities in Florida receiving Medicaid but not visible to APD. These persons need to be identified and exempted from mandatory enrollment. A mechanism, such as a screening tool, needed to allow all persons with developmental disabilities to be identified and excluded from mandatory enrollment needs to be established before any enrollment begins.
6. AHCA has indicated that managed care organizations will be expected to meet a minimum set of requirements before they can enroll people with disabilities. The enrollment process will work much more smoothly if AHCA identifies plans that are “certified” to enroll people with disabilities and their types of disability expertise. This is especially important for individuals with very severe disabilities or multiple of disabilities. Additionally, all plans may not be able to meet the needs of persons with all types of disabilities.
7. The HMO Request for Proposals and contracts will need to specify requirements for plans considered “certified” to enroll people with disabilities. Specific areas plans may need to address in responding to AHCA might include how plans identify providers with disability expertise in enrollment materials; specifying the role of a disability advocate or ombudsman within the plan; identifying specific benefit enhancements available; and indicating plan requirements for care coordination, disability training, accessibility, new member assessments, and quality improvement initiatives.
8. The enrollment broker contract should include expectations for strategies to ensure smooth enrollment of persons with disabilities into managed care, such as training enrollment staff to work with persons with disabilities or subcontracting with an organization serving persons with disabilities. Other important expectations are flexible enrollment options, such as home visits and training family members and developmental disabilities program staff on managed care and how to assist consumers to navigate managed care systems.
9. To make managed care viable for persons with disabilities, consumers and family members must be actively involved in its design and implementation. A task force of stakeholders can serve in an advisory capacity and given an active role to partner with AHCA in managed care program development. It is particularly important that stakeholders participate in review of the standards that will be required for plans serving persons with developmental disabilities.

10. In addition to indicating in the Medicaid contract that managed care plans must have policies for transition planning upon enrollment and out-of-network care, AHCA needs to indicate the minimum parameters for these policies. The contract must also indicate that out-of-network care should remain an ongoing option if there are not providers within the managed care network who have expertise and experience serving persons with developmental disabilities, including those with severe disabilities and multiple disabilities.
11. Managed care plans should be encouraged to coordinate care for dual eligibles. Plans without Medicare risk contracts should be encouraged to learn Medicare billing and other administrative procedures that are more easily done by a health plan and will lessen the burdens for members, thereby encouraging them to remain in managed care.
12. An important aspect of choice is to allow persons with disabilities to select providers who can best meet their needs, including allowing specialists to serve as primary care physician's (PCP) if the provider is willing to coordinate the member's care
13. Managed care plans may need to be educated about the complexity of persons with developmental disabilities. The PCP should be contractually required to serve as the "medical home" for persons with disabilities. In addition to coordinating medical care, this requires a strong connection to the services that support persons with disabilities in their homes and communities.

Conclusion

Medicaid reform is not positioned to cut services to populations that need them, according to the Agency for Health Care Administration. Reform will increase recipient choice and empower recipients to actively participate in their healthcare. Florida's Medicaid costs have been increasing annually, and Reform will help to curb the growth of spending.

Managed care can work for or against good care for persons with disabilities. Working towards identifying persons with disabilities to ensure that access to diverse and needed services is vital. This can be done through the education of policy makers, advocates, service organizations, families and the persons with disabilities about the needs of the population. Education about how to access care and make decisions about plan choice will be an important part of ensuring quality care and quality of life.

Attendees rated the conference as good to excellent. Overall the conference was well received, viewed as very informative, well organized, and beneficial. By and large the speakers were very knowledgeable and responsive to the questions of attendees. Responses included that the event was a good mix of information and that bringing together AHCA with representatives from successful managed care models was very helpful. If the event is held again, one attendee suggested that more experts be brought to the event to speak to professionals/consumers and provide a longer discussion opportunity with each of the representatives.

Feedback also included a response, “(this session) created more questions for me – but that is a good thing.” One satisfaction survey requested that additional information and more analysis of the current developmentally disabled system in relation to managed care principles already in use. Additionally, future studies could be focused on assessment tools to determine clinical diagnostic groups and rate setting methods for risk adjustment. Attendees noted that they are interested in seeing this conference replicated and holding annual follow-up sessions as managed care is integrated into the Florida Medicaid program.