Managed Care Options for People with Developmental Disabilities

People with disabilities with different kind of medical conditions and disability labels have similar functional needs; (i.e. mental retardation, brain injury, cerebral palsy, stroke, Alzheimers

Pilot(s) should test whether all persons with disabilities could be served in one community based delivery system;

Total ICF-MR system should be included, public and private;

Build on existing managed care systems;

Report should make recommendations to make current waiver system more alike than different so when pilot is implemented it can integrate into a more functional system;

Encourage cooperative relationship between aging/physical disability delivery system and the DD delivery system;

Pilot(s) should include adequate planning time and lots of self-advocate and family input;

Ongoing disability input by establishing advisory council;

Prioritize person-centered, person-directed community services;

Eventual elimination of the waiting lists;

Focus on individual and shared housing and focus on services not tied to housing; person should have key to front door and a lease;

Select urban areas that has shown some success in providing person-centered, person-directed services in cooperation with MRA;

Test Option 2 and 3 in two separate pilot areas;

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10 REASONS TO REFORM THE COMPLETE ICF-MR PROGRAM
(STATE INSTITUTIONS and PRIVATE ICF-MR's)

Though there is a critical need to continue reducing the over 50,000 people waiting list for the HCS and CLASS programs, the reality is the ICF-MR Program in Texas is structurally broken. Doing the same thing over and over again has resulted in the waiting list for services to INCREASE! The time to think out of the box and begin the process for long term reform is NOW! There are many reform models to consider but Michigan that has almost totally eliminated their ICF-MR facilities by using a 1915 (b) (c) waiver approach might be a model to seriously consider. Below are 10 general reasons to reform the ICF-MR Program.

1. The current system of ICF-MR Facilities does not offer individuals choice with respect to where they want to live and who they want to live with.

2. The current system of ICF-MR Facilities is extremely expensive.

3. The current system of ICF-MR Facilities have rigid bureaucratic rules.

4. The current system of ICF-MR Facilities is not person centered and does not allow for self-determination.

5. The current system of ICF-MR Facilities mandate the payment of a "package" of services and supports that families and people with disabilities don't want and don't need and thus does not allow for the most cost-efficient use of scarce Medicaid funding. This "bundling" of services means the state may pay for services that are not provided.

6. The current system of ICF-MR Facilities does not allow for providing supports in flexible, cost-efficient and person centered ways.

7. The current system of ICF-MR Facilities is a service dinosaur that is being phased out in most states because of maintenance and repair of aging facilities that will continue to increase the cost to the state and compete against service dollars for all people with disabilities regardless of age.

8. The current system of ICF-MR Facilities does not allow for creative affordable, accessible, integrated housing alternatives.

9. The current system of ICF-MR Facilities keeps people with developmental disabilities separated from their communities and families (including aging parents) who are often unable to visit regularly due to age, infirmity, travel distance and expense.

10. The current system of ICF-MR Facilities violates the substance and spirit of the Americans with Disabilities (ADA) and the U.S. Supreme Court decision in Olmstead which states people with disabilities should receive support services in the "most integrated setting".

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AHIP/ADAPT
Guiding Principles for Serving Individuals with Disabilities through Medicaid Health Plans
March 2007

America's Health Insurance Plans (AHIP) and ADAPT, a national disability rights organization, support the following guiding principles for serving individuals with disabilities through Medicaid health plans to promote availability of services that are responsive to these individuals' interests and concerns. We have worked in close consultation to create these guiding principles as a foundation for ongoing collaborative action.

1. Regional training: National, regional, state-based, and local training should be designed and conducted through collaboration of individuals with disabilities, health plans, States, and other stakeholders. These initiatives should focus on how the integration and delivery of acute and community long term services advance community integration principles such as:
   1) consumer directed services;
   2) person centered planning;
   3) accessible, affordable, integrated housing;
   4) voluntary service coordination;
   5) delivery of services in the most integrated setting;
   6) access to independent community-based service coordinators;
   7) service plan responsive to the unique needs of individual enrollees, including access to network and out of network specialists, if needed, who have experience in serving individuals with disabilities;
   8) delivery of services based on individual need as determined by functional assessment;
   9) livable wage/benefits for attendants; and
   10) comprehensive, continuous quality improvement programs.

2. Ongoing dialogue with stakeholders, including individuals with disabilities: In establishing and operating programs to provide services to individuals with disabilities through Medicaid health plans, States should ensure significant statewide and local ongoing public input in the development of Medicaid health plan contract requirements and program design including eligibility, rates, community integration principles, and program requirements. As part of this process health plans should facilitate ongoing, active participation by individuals with disabilities.

3. Community integration: State programs should include and adequately fund a requirement that Medicaid health plans provide covered individuals, regardless of age

or extent of disability or place of residence, with the option for services to be delivered in the most integrated setting, and that services be based on a functional assessment outlined in a person centered plan. To allow covered individuals to take advantage of this option, States should facilitate access to housing that meets the individual's needs. Access to community integration services should not be linked to specific types of housing.

4. Outreach and education: An aggressive strategy of outreach and education for populations with all disabilities regardless of age should be implemented to ensure that these individuals have the information they need to be knowledgeable about the programs and services available to them. These efforts should include use of community based organizations, whenever available, in the development and implementation of these outreach and education initiatives.

5. Community integration and consumer directed services: Medicaid managed care programs that serve individuals with disabilities should offer home and community-based services as an option for covered individuals regardless of age or extent of disability. There should be no institutional bias in the financial or functional eligibility criteria for the coverage of long term services and supports provided under State Medicaid managed care programs. Consumer directed services should be offered as a first delivery option for all covered individuals. To allow covered individuals to take advantage of this option, States should facilitate access to assistance with locating accessible, affordable, and integrated housing not linked to their other community support services.

6. Control of individual health maintenance activities: Covered individuals should have the option of developing, negotiating, and implementing plans to accept risk for and take control of their activities of daily living, instrumental activities of daily living, and health maintenance activities. Health maintenance activities should include but not be limited to: 1) medicine administration; 2) catheterization; 3) ventilator care including suctioning; 4) IV injections; 5) wound care; 6) tube feeding; 7) bowel care. To expand availability of such options, States should work with health plans and advocates, including those representing individuals with disabilities and nurses, to enact laws that amend nurse practice acts.

7. Access to medical equipment and assistive technology: Funding should be provided under State Medicaid managed care programs for coverage that allows individuals access to appropriate medically or functionally necessary durable medical equipment (DME) and assistive technology that would enhance independent functioning and promote independent living for covered individuals, including professional assessment of need and type of equipment, and set-up and training for users.