DDPA

Developmental Disabilities Provider Association

Presentation to Arkansas Health Reform Task Force
September 16, 2015

With or Without Managed Care

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- Potential savings can be achieved in developmental disabilities programs only through hard political choices
- The following suggestions apply whether or not the state contracts with outside managed care organizations

ACS Comprehensive Waiver

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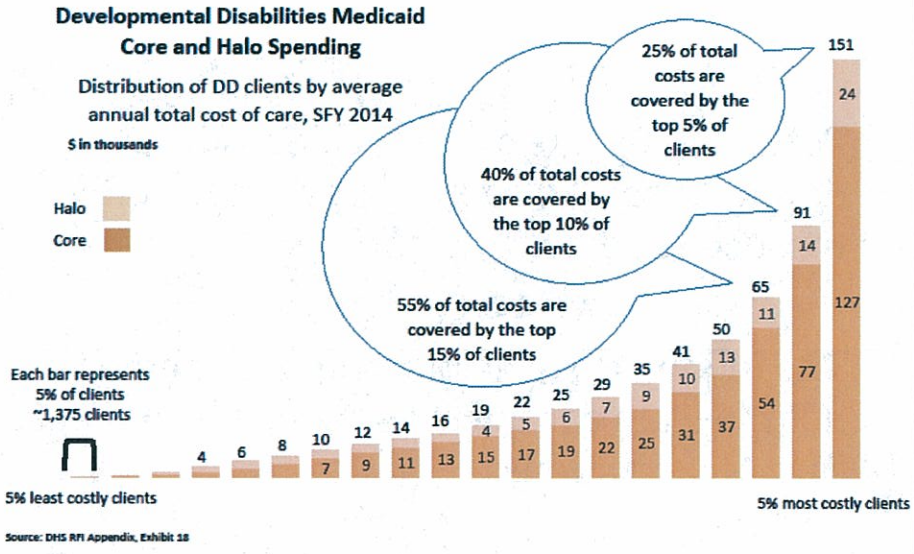
- $196 million
- 4,126 individuals
- 7.2% annual growth 2011-2014
- Waiver is heavily "managed" already
  - Independent third-party assesses applicants
  - DDS developing tiered rate system based on assessments
  - Enrollment capped
  - Service plans are prior approved by DDS



How to Bend Cost Curve in ACS Waiver

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- **Intensive care coordination for high need/high cost enrollees**
  - Patient-Centered Medical Home inadequate for DD enrollees
  - Today state pays DD providers same amount for "case management" for every DD waiver enrollee: $117 per member per month
  - Need to revamp case management -- re-allocate more resources to coordinate care for top 15% of enrollees through DD Health Home or similar model
  - Top 10% includes HDC clients. To effect significant change, need to address top 15%
  - Community-based providers much better situated than managed care organizations to achieve successful coordination due to frequent contact with enrollees, access to multiple services, local presence, DD expertise
  - MCOs cannot import care coordination – MCOs would have to subcontract with providers or hire away current provider staff to build care coordination network
  - State needs to invest in health information technology for DD services that is interoperable with medical providers, not delegate that to MCOs

How to Bend Cost Curve in ACS Waiver (cont.)

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- Match funding to assessed need
- Require care plans to reflect natural supports from family and friends
- Reconsider heavy reliance on 1:1 staffing
- Greater use of shared living arrangements
- Greater use of shared staffing for community integration activities
- Implement state-certified Host Homes
- Integrate care plans/prescriptions across all DD services

How to Bend Cost Curve in ACS waiver (cont.)

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- Flexibility to shift services/hours within the plan of care as needed
- Reduce daily documentation burden – focus on outcomes, not process
- Stop "provider shopping" that leads to plan inflation
- Consider North Carolina policy on appropriate use of family as paid caregivers
  - Third party screening of relatives who apply to be paid caregivers
  - Family member must be qualified to provide level of care needed
  - Use of family should not compromise independence of individual
  - No payment for types of services that family provides for non-disabled family members
  - No payment to family members beyond 40 hrs absent extraordinary circumstances

How to Address the Waiver Waiting List

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- About 2,800 individuals on DD waiver waiting list
- Consider separate "supports waiver" with limited benefits
- Used in over 18 other states
- Would not have to give up spot on waiting list for comprehensive DD waiver
- Set max plan amount lower than the average comprehensive DD waiver plan (typically 20% to 50% lower in other states)
- No 24/7 care
- Require or encourage shared staffing
- Provide support for, not replacement of, family caregivers
- Income based co-pay
- No "provider shopping"
- Evaluate sustainability over time -- consider removing cap and draw down additional fed match for attendant care across DD/LTSS/BH

Employment

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- Arkansas near bottom nationally in percentage of persons with DD who are employed in integrated community settings
- Today Arkansas has only about 100 persons receiving integrated employment through the waiver and less than 100 through Ark Rehab Services
- Why? ➡ Reimbursement too low.

How to Increase Employment

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- Create 1915(i) for long term employment support, which caps income eligibility at 150% FPL
- Permit 1:3 instead of 1:1 staff-to-client ratio
- For those who do not require staff assistance long term, typically that means savings to the state of approx 15 hrs/wk in waiver or DDTCS services
- Revise DDS/ARS to more effectively integrate funding streams for employment
- Incentivize providers to meet outcomes-based criteria

Day Habilitation Programs

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- $255 million plus $15 million for DDTCS transportation
- 25,377 individuals
- Two day programs:
  - Developmental Day Treatment Clinic Services (DDTCS) –nonprofit
  - Child Health Management Services (CHMS) – predominantly for-profit
- 4.5% annual growth 2011-2014
  - 3% annual growth in DDTCS adult services 2011-2014
  - 1% annual growth in DDTCS children's services 2011-2014
  - 9.8% annual growth in CHMS 2011-2014
- Both offer day habilitation + speech, physical, and occupational therapies
- DDTCS includes adults and children. CHMS is children only.
- Although CHMS was conceived as more intensive medical model, over time the programs have become more alike than different
- Greatest day habilitation expenditure is on children (80%)

How to Reform DD Children's Day Programs

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- "Moratorium" on new programs (already existed for DDTCS; CHMS added in 2013 session)
- Universal screening (by qualified professionals)
- Clinical evaluations with approved testing instruments
- Clearly defined eligibility standards
- Require annual re-evaluations of eligibility for day habilitation
- Implement therapy dosing standards to match frequency and duration with level of need
- Track screening and evaluations to prevent "provider shopping"
- Retrospective reviews for day habilitation comparable to those in place for occupational, physical and speech therapies

DD Rebalancing & Community Integration

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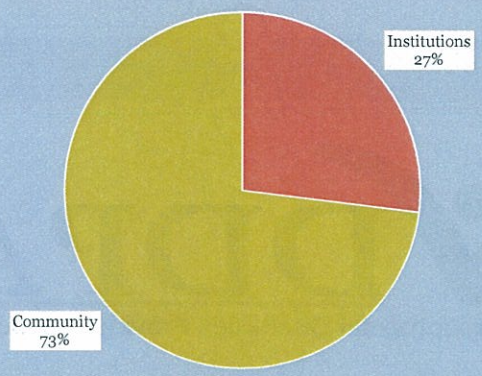
2014 Expenditures



Is Managed Care a Good Fit for DD?

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- DD ≠ LTSS in Arkansas
- LTSS budget is 78% institution and 22% community
- DD budget is 27% institution and 73% community
- Clients in HDCs will have high-dollar plans even in community
- Only significant rebalancing left to achieve in DD will require significant participation of HDCs – which only the legislature can determine, not MCOs
- Direct caregivers, not MCOs, best positioned to coordinate care in the community
- MCOs promising rebalancing and greater care coordination – neither are within their control in DD area

Thank you!

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