



Alliance for the Betterment of
Citizens with Disabilities

Empowering People: Providers Shaping Policies

Restoring Authority to the Individual

The Argument Against Incorporating the Delivery of Human Services to Individuals with Developmental Disabilities into the Formal Managed Care System

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Summary Implications

Medicaid Managed Care Organizations have achieved critical mass nationwide in the provision of health care services to the Medicaid population and have begun to take on more difficult populations with long term disabilities. There exists no evidence that Medicaid Managed Care Organizations have the capability to better supply the unique daily and lifelong supports and services required by people with developmental disabilities living full lives in the community. Medicaid Managed Care Organizations are not a panacea for all things Medicaid and could be a significant drawback for the provision of human services for individuals with developmental disabilities.¹

There are substantive issues that have caused failure in managed long-term care programs. Foremost is the fact that mainstream managed care plans have no experience in providing long term community supports and services to individuals with Intellectual and Developmental Disabilities. Their focus on reducing the cost of highly complex individuals prevents them from understanding what the true needs of people are. The only possibility of a plan succeeding would be if providers with substantial experience in dealing with this population are given the responsibility of managing their long-term care needs. This is a problematic issue because providers have remained in a fee for service reimbursement model stuck to providing rigid HCBS services. Providers could be in a capitated or global budget funding model. While positive in that this would allow them to provide individuals with the amount of support they actually need without having to worry about providing an amount of service that is economically beneficial it would also allow individuals to receive the services that are maximally beneficial to them and not the rigid level of support provided in residential and day programs. However, issues occur from experience with a capitated or global budget when funding is reduced; either the number of clients increases and the capitated ceiling remains the same or government reduces the capitated ceiling on the funds and does not reduce the number of individuals served.

¹ Health Management Associates Report for ANCOR, June 2018, "Current Landscape: Managed Long Terms Supports and Services for People with Intellectual and Developmental Disabilities."

Background Presentation

A Short-Term Transactional System

Most adults with intellectual and developmental disabilities in New Jersey are enrolled and receive their health care services through one of the Medicaid Managed Care Organizations (MMCO). The MMCOs contract with health care providers and medical facilities to provide care for members in exchange for a monthly capitated rate based on member category, paid for by the State. The rationale for moving to a managed care model was based on the assumption that the MMCOs would have better access to health care providers than Medicaid as well as a comprehensive package of preventative health strategies allowing for better healthcare outcomes. Despite improvements, people with disabilities have three times as many unmet healthcare needs when compared to those who do not.² MMCOs use the medical model of treatment which is disease centered and transactional, where the patient's role is passive and compliant. Plans are permitted to retain any portion of payment not expended for covered services for administration, marketing and profit.

An Ongoing Relational System

Adults with intellectual and developmental disabilities in New Jersey receive their HCBS human services such as employment, community supports and ADLs through approved community providers managed by the Division of Developmental Disabilities in the Department of Human Services and paid for by Medicaid.³ This Medicaid Fee for Service system utilizes many features of managed care including prior authorization, fixed rates, funding caps or tiers, utilization guidelines, individual service plans and care management. The system was designed to rebalance cost of individual services so that as a result each service would be purchased by the consumer at the identical cost. Agencies that served those with more challenges for less money under the old contract for services model would receive higher compensation while those legacy agencies who had higher contract for service model reimbursement would receive less money if serving those with less challenges and needs. As a result of efficiencies, provider agencies could use accumulated savings to proactively address items like planned capital expenses. Retained earnings remain within the individual agencies system for the benefit of that system and the individual. The conversion from the contract reimbursement system with various costs not related to the services performed to the Medicaid fee for service system with equal reimbursement for equivalent services and supports benefit the consumer by allowing them and their families to have flexibility in what services they can purchase; choice on who is to provide those services; and portability that allows families to move from one provider to another.

² Kelsall, Diane. 2016. "Doing the Right Thing for Our Patients with Disabilities." *Canadian Medical Association Journal*. Vol 188, no.14, p. 993-996.

³ Regrettably, rent, food and clothing are not reimbursed by Medicaid requiring additional resources be drawn from multiple sources both public and private

A Step Backward

Let us not overlook the legacy of suffering. One of the most historically pervasive ways of understanding people with developmental disabilities was through the medical model. For centuries, medicalization led to differentiation between the “fit” and “unfit.” Intellectual differences were diagnosed and treated, as though they were diseases to be cured. This forced individuals into the “sick role,” characterized as passive and powerless further leading to their stigmatization. After decades of advocacy and education, our community continues working daily to change the focus of society from the disability to the person. To move human services back to a system entrenched in the medical model would be a painful and harmful step in the wrong direction.

Conclusion

Any effort to move human services into the formal managed care system, as it is in health care, would shift additional funds from a system already having difficulty finding resources to an entity with no expertise in providing human services to individuals with developmental disabilities. The MMCOs have plenty of work to do, improving the health care delivery system for people with developmental disabilities without adding responsibilities for which they are unqualified. Whether paid for in a fee for service or global budget model, let the provision of services in the person-centered system of care stay with the mission-driven Division of Developmental Disabilities and their partner agencies in the community; people who have devoted their careers to restoring authority to the individual.