



Managed Care Principles:

*A strong, sustainable, and person-centered approach
to health and long term services and supports*

The Arc believes our current Medicaid system design for people with intellectual and developmental disabilities (I/DD) is not working. Any new system designs must start with the individual service recipient, assuring that quality supports and care are available to eligible individuals. The administrative structure must be designed to be highly efficient, cost effective and accountable.

Our membership is less concerned with *who* manages this system than *how* the system is managed. People first. Accountability. Strong community partnerships. An end to antiquated medical models. We believe any system design must take into account the following principles in order to be successful. These principles are steeped in the understanding that individuals with I/DD are valued members of their families and communities. They must have innovative, quality services and supports designed to enhance their health, community participation, and independence.

We will work with the Administration and Legislature to design a system that best meets these principles.

1. Self-direction

- An individual (and when needed with the assistance of his or her representative) decides what services best meet their needs, who delivers these services and at what intervals.
- A qualified service and health advocate is critical to assuring that individuals receive the right services at the right time across an integrated long term services and supports (LTSS), medical and behavioral health system.
- If efficiencies are discovered and agreed upon, the individual directs any new service implementation and shares in cost savings with state and provider entities.

2. Outcome-based reporting

- Process-based reporting is tedious, costly and ineffective, putting the emphasis on paper, not people. We must shift to self-directed outcomes steeped in individual life goals: Services funded by public dollars should be guided and monitored by a person-centered plan based upon outcomes established for and by the individual receiving services and others who know them best.
- Quality of life outcomes should be prioritized over outdated medical model indicators. In some instances, maintenance and habilitation are the outcomes.
- Outcome-based reporting models, such as CQL's Personal Outcome Measures, already exist and are widely implemented by many service provider organizations across the state.

3. Cost efficiencies cannot be achieved on the back of individuals with disabilities living in the community

- If the North Carolina Medicaid system is redesigned yet again, service maintenance of effort must be preserved for people already in the system, and people waiting for services must have a reasonable expectation of receiving services under this new plan.
- State run facilities are not funded the same way as community services and include an institutional bias. Any new system should include more equitable and transparent methods of funding in institutional and community settings.
- "Efficiency" must mean better services and improved delivery systems. It cannot be a pseudonym for cuts. Cost savings through improved service delivery should be reinvested in innovative services and waitlist reduction.

4. Accountability

- When structuring contracts with any entity implementing managed care, the state must build in actionable accountability measures and ongoing evaluation processes to ensure quality.
- No less than 85% of Medicaid dollars can be used on services and supports.
- Appeals processes must be independent of any entity implementing managed care.
- Training for providers working with individuals with I/DD and demonstrated expertise with this population, including person-centered materials and services, should be a requirement to receive a state contract.
- Advisory committees representing and comprised of individuals, families, and advocates should be funded outside of any entity implementing managed care.

5. Integrated care must not be based on a medical model

- Successful integrated care requires significant expertise in LTSS, person-centered approaches to individuals with I/DD, and partnership with skilled providers.
- Unlike medical interventions that seek to eradicate disease, individuals with disabilities are not sick and cannot be "fixed." The goal instead is maximum independence and dignity in community living.
- Statewide plans must include robust habilitative services and devices.
- Meaningful partnership with I/DD organizations, coalitions and thought leaders – beyond a token advisory role – is critical to ensuring success.

6. Sub-capitation and payment reform

- Payments to providers must become efficient and consistent. Payment systems based upon 15-minute increments are costly, antiquated, and illogical for long term services and supports.
- A sub-capitated model creates billing efficiency and service flexibility which leads to effective and innovative services.
- Subcapitation paired with person-centered outcome measures puts the focus on people successfully living in their communities – a stronger measure for effective use of state dollars than arbitrary increments of contact time.

7. Health promotion incentives for individuals with disabilities must be a part of any benefit plan offered by the system

- Individuals with disabilities, like all health care consumers, need access to healthy living programs, classes, and information designed with their needs in mind. Partnership with disability organizations and thought leaders can assure dissemination of quality, accessible products.
- Good health is the goal. It benefits both individuals with I/DD and entities implementing managed care: individuals with I/DD with reduced health co-morbidities require less emergent care, expensive interventions and supports.

8. Managed care networks must not require provider exclusivity

- North Carolina has a strong network of existing, local providers who deliver quality, life-enhancing supports for individuals with I/DD.
- If there are multiple entities implementing managed care across the state, it makes good sense for providers to offer quality long term services and supports in each plan.

9. Transition to a new system must be seamless

- Assurance must be given, with systems in place, to people with disabilities and their families that current provider relationships will not be disrupted.
- Similarly, providers must have assurances that payments for services will not be disrupted by the plan.
- The dramatic effects of poorly planned transition throughout the current LME/MCO conversion were felt by individuals and families, as well as providers, across the state. With these lessons learned, coupled with partnership and feedback from individuals, families and providers, the state can avoid a similar outcome.

10. Statewide IT and payment systems must be a part of any system design

- It's inefficient and illogical to require providers to enroll data and claims into multiple systems in North Carolina. Let's extend the concept of statewide services and supports to our IT infrastructure as well.

11. Reduce the waitlist

- Under any new system, individuals and families who are currently waiting for services must have a reasonable expectation of getting their needs met based on state-issued guidance and timelines.
- Costly emergent care due to lack of services and supports is bad for individuals, families and North Carolina.
- Cost savings achieved through efficiency should be reinvested in individuals and families waiting for services.

ADDENDUM:
Damage from the Elimination of Case Management

The elimination of independent case management and the lack of establishing a compatible service has created undue burden for providers, families and individuals with developmental and intellectual disabilities. Some of the barriers created by the elimination of this service are:

1. The loss of an independent advocate and support professional to guide the family and individuals through an often complex service system.
2. The loss of an independent developer of the person's plan.
3. There is also a loss of coordination of medical services and treatment. This coordination is critical as the state develops a health care system that address the needs of the whole person.
4. The loss of expertise in understanding and providing access to on the ground natural supports for the individual being served under the LME/MCO system. For a significant portion of our community on the list of unmet needs, the loss of a case manager means the inability to be linked into the current delivery system.

Any new system design for the state of North Carolina needs to address the creation of an independent professional to act as a liaison between the families and the LME/MCO systems care coordinators.

I would like to extend my sincere appreciation to the members of this committee for opening the discussion to the public on Medicaid Reform and the reorganization of the Department of Medical Assistance. The Arc of North Carolina is both an advocacy organization and a provider organization and my comments today reflect the input of staff, our board, our membership, and over 60 years of experience in serving the intellectual and developmental disabilities community.

The Arc believes our current Medicaid system for people with intellectual and developmental disabilities (I/DD) is not effective. Any new system designs must be highly efficient and cost effective, but most of all accountable to the individuals receiving those services.

The system of delivery of services for the I/DD population has been in continual change for several years and is very fragile. We urge caution on any additional changes and we respectfully request that any future plan for North Carolina includes meaningful stakeholder input, is rolled out carefully with time for fine tuning, and it must respect the needs of the individual. To this end there must be an allowance for Self-direction. To be effective, the system must be based on outcomes which focus on life goals and reflect the whole person. Short term cost efficiencies often lead to greater long term expenses, and cannot be achieved on the backs of individuals with disabilities living in the community. And, any new system must be created to address the growing waitlist for the I/DD population. No family should have to wait over seven years to receive needed services. In addition we must increase funding and support to the NCStart system, because our crisis system for people with I/DD is overburdened and underfunded.

We believe that the current provider system is unduly burdened by repetitive reporting and audits. The provider payment system needs to be cleared of needless red tape. And subjective criteria to measure progress for people with I/DD needs to be avoided.

People don't trust the system because it is inconsistent. Rates across the state must be balanced and predictable and the supports package more standardized allowing for mobility between networks.

There must be accountability measures, with an appeals processes that is independent of the implementing agency. The system of integrated care cannot be based on a medical or curative model. And there must be choice of network and providers in the plan for both behavioral health services and for physical health services.

Any new system must include independent case management. The damage from the elimination of independent case management and the lack of a comparable service for providers, families and individuals with I/DD must be addressed.

In conclusion, The Arc of North Carolina is ready to assist and work with the legislature to address the real needs of our state. We understand the need for fiscal responsibility, for sustainability, and in creating a system that addresses the needs of the individual in a comprehensive manner. Any system design must take into account that individuals with I/DD are valued members of their families and communities. And that they deserve innovative, quality services and supports.

We look forward to participating in this collaborative process.