Containing Medicaid Costs: Moving Toward Medicaid Managed Care
Today’s webinar will cover:

- Overview: Medicaid managed care & state trends.
- Successful examples of expanding managed care to "new" populations
- Q & A
Presenters

- **Neva Kaye**
  Managing Director of Health Systems Performance,
  National Academy for State Health Policy

- **Allan I. Bergman**
  President and Chief Executive Officer,
  High Impact Mission-Based Consulting & Training

**Moderator:**
  **Raul Burciaga**
  Director, New Mexico Legislative Council Service
Medicaid Managed Care: Trends and Transformations

Containing Medicaid Costs: Moving Toward Managed Care
April 20, 2012

Neva Kaye
Managing Director for Health System Performance
National Academy for State Health Policy
nkaye@nashp.org
Primary Sources of Data

• Original research and literature review (www.nashp.org)

• Seven point-in-time surveys of state Medicaid managed care policies
  – CMS: 2010 data
Widespread Use and Proven Savings
47 States and DC Used Managed Care in 2010

Uses Managed Care
47 States and DC Used MCOs in 2010

- 5 Use only comprehensive MCOs
- 12 Use only limited MCOs
- 30 Use both

[Map showing the distribution of MCO usage by state]
Distribution of Medicaid Managed Care Enrollment: 2010

- Medicaid: 39 million
- Comp MCO: 26.7 million
- PIHP: 9.3 million
- PAHP: 11.4 million
- PCCM: 8.2 million
- Other: 1.1 million
The Lewin Group Analyzed 24 Studies

- Savings from 0.5%-20% over fee-for-service
- Indications of potential significant savings through enrolling SSI populations
- Indications savings comes from inpatient hospital
- Evidence of increased access
- Study produced in 2004, updated in 2009
- Study conducted for America’s Health Insurance Plans (AHIP)

http://www.ahip.org/content/default.aspx?docid=27090
Savings reported by selected states

• 10.7% in Wisconsin in 2002; also reports MCOs outperform fee-for-service on quality measures

• 7% in Arizona from 1983-1993

• 4.2% in Ohio in 2006
On the Horizon
Continued Expansion

• **Drivers**
  – Unsustainable cost growth in Medicaid
  – Relentless pressure on state budgets
  – Many more Medicaid beneficiaries in 2014
  – Federal Opportunities

• **Medicaid managed care to expand into:**
  – Moving from voluntary to mandatory enrollment
  – More comprehensive set of services
  – New areas of the state
  – New populations
Innovations

• Multiple states: Programs to integrate care for Medicare/Medicaid eligibles

• Colorado: Regional Care Collaborative Organizations

• Missouri: Health Homes for SPMI under section 2703 of the ACA

• New Mexico: single BHO for all state agencies: Medicaid, Child Welfare, Juvenile Justice…..

• Wisconsin: Specialized MCO for children with extensive mental health needs at risk of incarceration
Success Factors

• Clear goals for the program

• Sufficient resources to build and oversee a strong program

• Sufficient time for the program to produce results
Welcome to the Complex World of “Managed Care”, Capitation & its permutations: Is It The "Magic Bullet" for Medicaid Cost Containment?

NCSL Webinar
April 20, 2012
Allan I. Bergman
Managed Care

“States’ proposals can only be described as a stampede”

- CMS reports managed care now reaches all populations across the states
- Within 24 months trend shows most state plan amendments abandoning fee for service as a meaningful part of Medicaid.

Individuals with **Disabilities** are a very heterogeneous and diverse population

### No “one size fits all”
- ADHD
- Alcoholism
- Autism
- Bipolar disorder
- Blindness/vision impaired
- Cerebral palsy
- Cystic fibrosis
- Deaf/hearing impaired
- Depression
- Down syndrome
- Epilepsy

### Individuals within “labels”
- HIV/AIDS
- Intellectual disabilities
- Multiple sclerosis
- Muscular dystrophy
- Parkinson’s disease
- Schizophrenia
- Spina bifida
- Spinal cord injury
- Stroke
- Substance abuse
- Traumatic brain injury
## Prevalence of Behavioral Health Comorbidities among Medicaid-Only Beneficiaries with Disabilities

### Chronic Condition Only
- Hypertension; 31.4%
- Diabetes; 32.1%
- Coronary Heart Disease; 26.3%
- Congestive Heart Failure; 30.1%
- Asthma and/or COPD; 23.8%

### Chronic Condition & MI &/or drug/alcohol disorder
- Hypertension; 69.6%
- Diabetes; 67.9%
- Coronary Heart Disease; 73.7%
- Congestive Heart Failure; 69.9%
- Asthma and/or COPD; 76.2%

Kronick, Bella, & Gilmer, 2009
### Age Adjusted Prevalence Rates for Chronic Health Conditions, MEPS 2006

<table>
<thead>
<tr>
<th>No Disability</th>
<th>Cognitive Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Arthritis</td>
</tr>
<tr>
<td>9.7%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>Asthma</td>
</tr>
<tr>
<td>7.6%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>5.1%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes</td>
</tr>
<tr>
<td>3.7%</td>
<td>18.0%</td>
</tr>
<tr>
<td>High B.P.</td>
<td>High B.P.</td>
</tr>
<tr>
<td>16.1%</td>
<td>27.5%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>16.7%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Stroke</td>
<td>Stroke</td>
</tr>
<tr>
<td>0.7%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>
Summary Guidance on Medicaid Managed Health Care for Individuals with Disabilities

“The potential for savings lies in more appropriate patterns of care over time, especially reduced hospital use, which may result from better prescription drug management and advanced clinical management and care coordination for people with disabilities.”

Kaiser Commission & the Uninsured, February 2012
People with Disabilities and Medicaid Managed Care
Managed/Integrated/Coordinated Care for/with **Individuals** with Disabilities
How States Should Proceed: Slowly

- Stakeholder input is essential from the beginning
- Recognize the potential gains and risks for individual with disabilities
- FFS rates so low in many states; they cannot be basis for capitation
- Phase in voluntary enrollment for several years before considering mandatory
Steps for States to Consider, cont.

1. Design mandatory provider network; capacity, access, outreach
2. Design Care Coordination; consider using Medicaid Health Home with 90/10 FMAP for 2 yrs.
3. Design beneficiary protections; consider third party appeal; recognize low health literacy
4. Develop detailed contract specifications with resources for state oversight
Purpose of Medicaid, Title XIX of the Social Security Act:
The Foundation for LTSS

- “…(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care.”

42 U.S.C. Sec. 1396
Projecting the Numbers in Wisconsin

- 2011 spent $1.5 billion on community LTS&S for 43,500 people
- An additional 16,000 people could be enrolled in these programs within 2 years
- This 36.8% increase in enrollment could drive program costs to $2.1 billion
- By 2035, Wisconsin's over 65 population will double and the over 85 group will triple
- What are the numbers in other states???

Beth Wroblewski @ ANCOR October, 2011
Medicaid Long-Term Care Users Accounted for Nearly Half of Medicaid Spending

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure. SOURCE: KCMU and Urban Institute estimates based on MSIS and CMS-64 2007 data.
Distribution of Medicaid Elderly by Long-Term Care Use

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure. SOURCE: KCMU and Urban Institute estimates based on MSIS and CMS-64 2007 data.
Distribution of Medicaid Individuals with Disabilities by Long-Term Care Use

<table>
<thead>
<tr>
<th>Enrollees</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>84%</td>
<td>42%</td>
</tr>
<tr>
<td>13%</td>
<td>35%</td>
</tr>
<tr>
<td>3%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Total = 8.8 million

Total = $127.3 billion

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure. SOURCE: KCMU and Urban Institute estimates based on MSIS and CMS-64 2007 data.
Distribution of Medicaid Dual Eligibles by Long-Term Care Use

- **Enrollees**
  - 72%
  - 14%
  - 14%

- **Expenditures**
  - 14%: Individuals Who Used No LTC Services
  - 31%: Individuals Who Used Community-Based Services
  - 55%: Individuals Who Used Institutional Services

Total = 8.9 million
Total = $109.5 billion

NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure. SOURCE: KCMU and Urban Institute estimates based on MSIS and CMS-64 2007 data.
Dual Eligibles as a Percent of Medicare and Medicaid Enrollment and Spending, 2006/2007

NOTES: FFS is fee-for-service. Estimates for Medicare include non-institutionalized and institutionalized beneficiaries, excluding Medicare Advantage enrollees. SOURCE: Medicare spending and enrollment estimates from Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006; Medicaid spending and enrollment estimates from Urban Institute analysis of data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.
The “Dual Eligible Market”

“Dual patients are seen as a potential $300 Billion opportunity for Managed Care firms.”

Wall Street Journal
Market Watch
April 9, 2012
Integrated Care for Dual Eligible Individuals
States Providing Letters of Intent (not binding) to work on Financing Models to Align Services to Dual Beneficiaries

- AL.
- IN.
- MT.
- TN.
- AZ.
- IA.
- NV.
- TX.
- CA.
- KS.
- NM.
- VT.
- CO.
- KY
- NY
- VA.
- CT.
- ME.
- NC.
- WA.
- DE.
- MD.
- OH.
- WI.
- FL.
- MA.
- OR.
- HI.
- MI.
- PA.
- D.C.
- ID.
- MN.
- R.I.
- IL.
- MO.
- SC

October 2011
Why Integrate Medicare & Medicaid?

- **Good reasons:**
  - Improve health outcomes leading to reduced costs
  - Align incentives to avoid cost-shifting between programs that disrupts care

- **Bad reasons:**
  - Generate short-term savings by limiting care
  - Expand private managed care for its own sake
Individuals who are "dually eligible" are not all the same

- **Length of Service**
  - Elderly – 18-24 months
  - IDD - up to 60 or 70 years

- **Focus**
  - Elderly - End of Life Care
  - IDD - “Getting a Life”

- **Family Care Giving**
  - Elderly - Involved near the end of life
  - IDD - Begins at birth and endures through a life time

- **"Care" Issues**
  - Elderly- medical needs primary
  - IDD – integration in the community primary

- **Primary Services**
  - Elderly – medical and personal assistance
  - IDD – habilitation, training, employment, independent living

NASDDDS
National Association of State Directors of Developmental Disabilities Services

ALLAN I. BERGMAN  High Impact  Mission-based Consulting and Training
Program of All-Inclusive Care for the Elderly: PACE

- Individuals must be over 55 years of age; mean age is 78
- Individuals must be dually eligible for Medicare and Medicaid; voluntary
- Individuals must be eligible for nursing home level of care
- 82 programs in 29 states; some states exploring major expansion
- Is capitation and integrated care; not an MCO
Integrated Medicaid “Managed Care” plans for various populations:

Medical, Institutional & HCBS fully covered

- AZ—All but DD-mandatory
- FL—Frail elders-voluntary
- HI—All but DD-voluntary
- MA—Frail elders-voluntary
- MN—Frail elders-voluntary
- All NPOs
- NM—All but DD-mandatory
- 2 national commercial MCO
- TN—Frail elders & adults with phys. dis.-mandatory
- WA—1 county—Frail elders & adults with Phys Dis-vol

Not full coverage

- NY—Mostly frail elders-voluntary-limited medical
- TX—Frail elders and younger adults with physical and mental disabilities—mandatory—State Medicaid pays institution after 120 days and in-patient hospital
- WI—All-voluntary-mostly NPOs—all medical is State Medicaid FFS
### 11 States have no Institutions for individuals with DD

<table>
<thead>
<tr>
<th>Closure Date</th>
<th>State</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>New Hampshire</td>
<td>1,315,000</td>
</tr>
<tr>
<td>1991</td>
<td>District of Columbia</td>
<td>582,000</td>
</tr>
<tr>
<td>1993</td>
<td>Vermont</td>
<td>624,000</td>
</tr>
<tr>
<td>1994</td>
<td>Rhode Island</td>
<td>1,068,000</td>
</tr>
<tr>
<td>1996</td>
<td>Maine</td>
<td>1,322,000</td>
</tr>
<tr>
<td>1997</td>
<td>Alaska</td>
<td>670,000</td>
</tr>
<tr>
<td>1997</td>
<td>New Mexico</td>
<td>1,955,000</td>
</tr>
<tr>
<td>1998</td>
<td>West Virginia</td>
<td>1,818,000</td>
</tr>
<tr>
<td>1999</td>
<td>Hawaii</td>
<td>1,285,000</td>
</tr>
<tr>
<td>2009</td>
<td>Oregon</td>
<td>3,641,000</td>
</tr>
<tr>
<td>2010</td>
<td>Michigan</td>
<td>10,079,985</td>
</tr>
<tr>
<td>2011</td>
<td>Alabama</td>
<td>4,779,736</td>
</tr>
</tbody>
</table>
## Biggest Opportunities

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Texas</td>
<td>4,899</td>
</tr>
<tr>
<td>2</td>
<td>New Jersey</td>
<td>2,703</td>
</tr>
<tr>
<td>4</td>
<td>Illinois</td>
<td>2,308</td>
</tr>
<tr>
<td>3</td>
<td>California</td>
<td>2,194</td>
</tr>
<tr>
<td>5</td>
<td>North Carolina</td>
<td>1,638</td>
</tr>
<tr>
<td>6</td>
<td>New York</td>
<td>1,492</td>
</tr>
<tr>
<td>7</td>
<td>Ohio</td>
<td>1,423</td>
</tr>
<tr>
<td>8</td>
<td>Mississippi</td>
<td>1,371</td>
</tr>
<tr>
<td>9</td>
<td>Pennsylvania</td>
<td>1,253</td>
</tr>
<tr>
<td>10</td>
<td>Virginia</td>
<td>1,184</td>
</tr>
</tbody>
</table>

Thinking for the Long Term

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Cost per Person</th>
<th>20 yrs. Cost</th>
<th>30 yrs. Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICF/MR Institution</td>
<td>$128,275</td>
<td>$2,565,600</td>
<td>$3,848,250</td>
</tr>
<tr>
<td>HCBS 24hr staffed Residential</td>
<td>$70,133</td>
<td>$1,402,660</td>
<td>$2,103,990</td>
</tr>
<tr>
<td>Shared Living (Adult Foster Care)</td>
<td>$44,122</td>
<td>$882,440</td>
<td>$1,323,660</td>
</tr>
<tr>
<td>Supports in Own or Family Home</td>
<td>$25,072</td>
<td>$502,440</td>
<td>$752,160</td>
</tr>
</tbody>
</table>
MICHIGAN

State Institutions <1%
Nursing Facilities 1%
Other 16+ 3%
Other 7-15 8%
<6 Persons 25,018
Group Homes, Foster Care & Apartments 5,252
Supported Living 19,766
Total 28,233

Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2011.
https://www.cu.edu/ColemanInstitute/stateofthestates/
SUPPORTED LIVING PRINCIPLES

✓ CHOICE
  • Where to live, with whom and which lifestyle

✓ OWNERSHIP BY OTHER THAN THE SERVICE PROVIDER
  • Individual owns or rents;
  • Family owns or holds lease;
  • Housing cooperative owns

✓ INDIVIDUAL SUPPORT
  • Focus on individual’s changing needs over time;
  • Individualized support plan or support contract

## Thinking for the Long Term

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>1 yr. Cost</th>
<th>3 yrs. Cost</th>
<th>10 yrs. Cost</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered Work / Day Habilitation</td>
<td>$15,000</td>
<td>$45,000</td>
<td>$150,000</td>
<td>No money Segregation Dependence</td>
</tr>
<tr>
<td>Employment Services</td>
<td>$20,000 ($20,000 yr. 1 $20,000 yr. 2 $10,000 yr. 3)</td>
<td>$50,000 ($50,000 1-3 yrs. $25,000 3-10 yrs.)</td>
<td>$75,000</td>
<td>Makes money Pays Taxes Meets People Sense of Independence and Accomplishment</td>
</tr>
</tbody>
</table>

Estimated figures – use your own figures and do the math
NUMBER OF SUPPORTED EMPLOYMENT WORKERS IN WASHINGTON STATE 1986-2009

SUPPORTED EMPLOYMENT WORKERS WERE 62 % OF TOTAL DAY WORK PARTICIPANTS IN 2009

Vast State Disparities In Supported Employment Programs

- Percentage of individuals in supportive or competitive employment goes from:
  - Washington: 72%
  - Connecticut: 59%
  - Michigan: 55%
  - Delaware: 49%
  - Oklahoma: 48%
  - S. Carolina: 40%
  - Vermont: 39%
  - Maryland: 36%
  - New Mexico: 35%
  - Nebraska & Mass: 33%

- to:
  - Arkansas: 2%
  - Missouri: 4%
  - Alabama: 7%
  - Arizona: 8%
  - N. Dakota: 8%
  - Hawaii & Oregon: 9%
  - West Virginia: 10%
  - Montana: 10%
  - D.C.: 11%
  - California: 13%
  - NJ., MN., ID.: 14%

Obviously state government is a significant policy maker

UCP Case For Inclusion, 2011
Managed Care in I/DD LTSS Services

- Arizona
- Michigan
- Vermont
- Wisconsin
- Texas Star Plus
- North Carolina – Piedmont expanding
- New York*
- California*

- Kentucky
- New Hampshire*
- Kansas*
- Illinois - Integrated Care Pilot phase 3
- New Jersey*
- Virginia*
- 15 states dual eligible demonstrations

* Under development
Wisconsin Family Care

- Being phased-in (since 1999) as the foundation of Long-Term Care Reform, replacing State/County LTC System
- Capitated, managed long-term support and health care management program
- Serves adults with developmental disabilities, adults with physical disabilities, and frail elders (*no children and no BH*)
- Built upon:
  - Aging and Disability Resource Centers (ADRCs)
  - Managed Care Organizations (CMOs)
Wisconsin Family Care and Partnership Program

Number of Members Enrolled as of September 30th of Each Year

# of Members

- 30,000
- 25,000
- 20,000
- 15,000
- 10,000
- 5,000
- 0


Family Care

Partnership

ALLAN I. BERGMAN  High Impact  Mission-based Consulting and Training
Wisconsin Long Term Support RESPECT Values

- Relationships
- Empowerment to make choices
- Services to meet individual needs
- Physical and mental health services
- Enhancement and maintenance of a person’s value
- Community and family participation
- Tools for independence
Family Care Lessons to date:

- Most members meeting desired outcomes;
- Overall, per person Medicaid costs (LTC & acute) are decreasing compared to previous system;
- Nursing home and ICF-MR usage decreasing;
- Rapid expansion over past 3 years has led to growing pains;
- Concerns over provider rate cutting
- Independent Ombudsperson program is an important systems component
Design Overview

- CMS required alternative to Family Care
  - Began 7/1/2008
- Comprehensive, creative Self Directsed Supports waiver
- State-Administered with two primary contracts
  - IRIS Independent Consultant Agency
  - Fiscal Services Agency
<table>
<thead>
<tr>
<th>IRIS Services List</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adaptive Aids</td>
</tr>
<tr>
<td>• Adult Day Care</td>
</tr>
<tr>
<td>• Adult Family Home</td>
</tr>
<tr>
<td>• Certified Residential Care Apartment Complex</td>
</tr>
<tr>
<td>• Communication Aids/Interpreter Services</td>
</tr>
<tr>
<td>• Community-Based Residential Facility (CBRF/Group Home)</td>
</tr>
<tr>
<td>• Consumer Education and Training</td>
</tr>
<tr>
<td>• Counseling and Therapeutic Resources</td>
</tr>
<tr>
<td>• <strong>Customized Goods and Services</strong></td>
</tr>
<tr>
<td>• Daily Living Skills Training</td>
</tr>
<tr>
<td>• Day Services</td>
</tr>
<tr>
<td>• Home Delivered Meals</td>
</tr>
<tr>
<td>• Home Modifications</td>
</tr>
<tr>
<td>• Housing Counseling</td>
</tr>
<tr>
<td>• Personal Emergency Response Services</td>
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<tr>
<td>• Prevocational services</td>
</tr>
<tr>
<td>• Relocation Services</td>
</tr>
<tr>
<td>• Respite</td>
</tr>
<tr>
<td>• Support broker</td>
</tr>
<tr>
<td>• Skilled Nursing Services</td>
</tr>
<tr>
<td>• Specialized Medical Equipment and Supplies</td>
</tr>
<tr>
<td>• Supported Employment</td>
</tr>
<tr>
<td>• Supportive Home Care</td>
</tr>
<tr>
<td>• Transportation</td>
</tr>
<tr>
<td>• Vocational Futures Planning</td>
</tr>
<tr>
<td>• <strong>Self-Directed Personal Care</strong></td>
</tr>
</tbody>
</table>
Selected Cost Effectiveness and Fiscal Sustainability Strategies in Wisconsin

- Strengthen Consumer-Directed-Care
- Focus on people living "independently" as long as possible; assure health and safety
- Support the family and community for youth in transition
- Ensure utilization of informal and less intensive supports whenever possible
- Assure employment in PCPs
- Focus on youth in transition

Beth Wroblewski, WI. Dept. Health Services, October 2011
Historical Events

Created as State Mental Health Agency in 1983
Purpose: Close Plymouth State, DD Institutions and Nursing Homes
Plymouth Center closed 1986, Southgate 1991, all in 2010
Transfer: State Agency to Wayne County CMH as Non-Profit 1991
Robert W Johnson Self-Determination 400 Individual Budgets 2001
Now 1400 directly control budget all other PC Plans have budgets
Became Wayne CMH MCPN in 2002 providing Managed Care
Only MCPN that also Provides Support Coordination
RFP Awarded from Oakland County CMHA in 2004
Currently serve over 4000 with DD, MI/DD and Seniors
Medicare Home Health and Advantage Programs now in place
Proven lower unit costs, fewer per home, integration in Health Care
Jim Dehem, CEO
# Financial Indicators Wayne County

<table>
<thead>
<tr>
<th>(in 000’s)</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dollars</strong></td>
<td><strong>PMPM</strong></td>
<td><strong>Dollars</strong></td>
<td><strong>PMPM</strong></td>
<td><strong>Dollars</strong></td>
<td><strong>PMPM</strong></td>
<td><strong>Dollars</strong></td>
<td><strong>PMPM</strong></td>
</tr>
<tr>
<td>Net Revenues</td>
<td>$117,017</td>
<td>$118,720</td>
<td>$123,760</td>
<td>$119,695</td>
<td>$121,872</td>
<td>$118,414</td>
<td>$117,760</td>
</tr>
<tr>
<td>Member Months</td>
<td>30,614</td>
<td>27,928</td>
<td>30,120</td>
<td>30,299</td>
<td>32,295</td>
<td>34,492</td>
<td>36,964</td>
</tr>
<tr>
<td>PMPM Revenues</td>
<td>$3,822</td>
<td>$4,251</td>
<td>$4,109</td>
<td>$3,950</td>
<td>$3,774</td>
<td>$3,433</td>
<td>$3,186</td>
</tr>
<tr>
<td>Consumer Cost</td>
<td>$109,284</td>
<td>$111,726</td>
<td>$114,610</td>
<td>$116,162</td>
<td>$120,273</td>
<td>$111,794</td>
<td>$112,704</td>
</tr>
<tr>
<td>Consumer Cost % to Revenue</td>
<td>93.40%</td>
<td>94.10%</td>
<td>92.60%</td>
<td>97.00%</td>
<td>$98.70%</td>
<td>94.40%</td>
<td>95.70%</td>
</tr>
<tr>
<td>Total Administrative</td>
<td>$6,709</td>
<td>$6,591</td>
<td>$5,486</td>
<td>$4,716</td>
<td>$5,087</td>
<td>$4,742</td>
<td>$4,195</td>
</tr>
<tr>
<td>Percent to Revenue</td>
<td>5.70%</td>
<td>5.60%</td>
<td>4.40%</td>
<td>3.90%</td>
<td>4.20%</td>
<td>4.00%</td>
<td>3.60%</td>
</tr>
</tbody>
</table>
Total number of Individuals with Self-Determination and Individual Budgets in Wayne County
Number of People Living in Licensed vs. Own Home

<table>
<thead>
<tr>
<th>Year</th>
<th>Licensed</th>
<th>Own Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>652</td>
<td>580</td>
</tr>
<tr>
<td>2003</td>
<td>667</td>
<td>688</td>
</tr>
<tr>
<td>2004</td>
<td>722</td>
<td>972</td>
</tr>
<tr>
<td>2005</td>
<td>925</td>
<td>925</td>
</tr>
<tr>
<td>2006</td>
<td>880</td>
<td>845</td>
</tr>
<tr>
<td>2007</td>
<td>884</td>
<td>817</td>
</tr>
<tr>
<td>2008</td>
<td>1000</td>
<td>1105</td>
</tr>
<tr>
<td>2009</td>
<td>1153</td>
<td>1105</td>
</tr>
<tr>
<td>Mar-11</td>
<td>1300</td>
<td>580</td>
</tr>
</tbody>
</table>

**Note:** The number of people living in licensed homes shows a steady increase from 2002 to Mar-11, while the number of people living in own homes decreases over the same period.
Number of locations by household size varying from 1 to 6 persons

- 1 person: 218 locations
- 2 persons: 185 locations
- 3 persons: 141 locations
- 4 persons: 84 locations
- 5 persons: 45 locations
- 6 persons: 24 locations
Policy Recommendations for States

I. Stakeholder engagement and ongoing involvement

II. Clearly articulated vision and mission

III. Core values and guiding principles

IV. Assessment and rate setting methodology; transparent

V. Performance measures and metrics
Policy Recommendations for States, cont.

VI. Types of waiver(s) being used and other Medicaid policies

VII. State responsibility and regulations

VIII. Financial risk between the state and the MCOs

IX. Requirements for the MCO

X. Health Information Technology and Electronic Health Records
ADA INTEGRATION MANDATE

“"A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”

28CFR section 35.130(D)
For Additional Information, contact

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Questions?

Type your question in the "Q&A" box on the lower right corner of your screen.
Contact Information

The webinar archive and power points will be available online next week.

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