Talking points on DHHS's proposal

- **Approve of plan to maintain and condense LME/MCOs as long as a plan for community input and advocacy remains in place.**
  - There should be benchmarks for integration of LME/MCOs.
  - Statewide standardization for consumers and providers.
  - Recommend no additional major changes for 1 year so MCO's have time to implement changes and evaluate impact.
  - CAP C should not become an MCO responsibility in the near future (too many major changes increase the chances of failure).
  - MCO's should be able to use Innovations waiver funds saved to serve others on the wait list.

- **Support the concept of integrated care with the understanding it will take time to determine new service definitions, assignment of responsibilities, and reimbursement protocols.**
  - In integrated care, adequate medical insurance is a benefit to limiting emergency care and crisis intervention. Many citizens served by the MCO's would benefit from Medicaid expansion.
  - System of Care for adults should be developed. This could include a new array of services to support adults in non-institutional settings but which afford in home in reach to maximize benefit of outpatient services.
  - Create service goals that allow people with IDD to address social integration goals in the presence of peers rather than isolation with one-on-one services.
  - Flexibility being added to existing service definitions or through additional billing codes will be critical to achieving the community integration desired by persons with I/DD. Community Based service definitions need to be expanded to match tomorrow's system to provide the expected array of services in future community based infrastructures. In addition to services based on the interests, career goals, and life goals of the individual, the I/DD service definitions need to have a service rate structure to allow billing models for community groups and skill building groups. Provisions and flexibility need to be built into the service definition for co-occurring disorders for persons with an I/DD diagnosis and a mental health diagnosis.
  - Reward success. Measure success via outcomes and patient satisfaction, and incentivize success for providers and LME/MCOs by allowing possible monetary bonuses or additional waiver slots.

- **Agree that the Registry (wait list) must be addressed.**
  - Agree that an additional waiver is needed but disagree on a capitation of $20,000. While this amount is adequate for some youth as adults it would leave them with a huge deficit if they were in need of a group home and day service. A second waiver with a limit of $50,000 would provide the support actually needed instead of just bringing the registry down.
  - Supports Intensity Scale matrix needs to take the region into consideration.
  - Plan for an increase in the registry. The numbers of people with autism spectrum disorder has dramatically increased and people with disabilities are living longer.

    - Families should be introduced to the Innovations program through their experiences with the Children's Developmental Agency and the IEP process in elementary in school.

- **Agree the crisis services continuum needs to improve.**
    - A well developed portal for crisis.
    - More individualized crisis plan.

- **Agree that social as well as physical integration into the community are needed.**
    - Community supports will need to be developed or enhanced.
    - An increase in housing options other than group homes needs to be expanded for people with I/DD.
    - Individuals should have access to the most effective drugs that allow them to be productive citizens in their communities.

Note: IDD, SA, and MH Medicaid expenses account for only 20% of costs.