Making Healthcare Reform Work for People with Developmental Disabilities

A REPORT TO THE OHIO DEVELOPMENTAL DISABILITIES COUNCIL

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Acknowledgements:
The Ohio Colleges of Medicine Government Resource Center (GRC) is Ohio’s academic resource for health systems change.

Sponsored by the Council of Medical Deans of Ohio’s seven colleges of medicine, the GRC provides expertise to state and local government agencies concerning health issues, including professional medical expertise, quality improvement science, health services research, work force development, and administration of cost-containment programs.

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Executive Summary
The Patient Protection and Affordable Care Act (ACA) represents a significant stage in the advancement of healthcare reform. The ACA has important implications for persons with disabilities. The ACA included the following provisions designed to make it easier for people with disabilities to access health care services: 1) more options in obtaining private health insurance, 2) new Medicaid options for the financing and delivery of health care services for persons with disabilities, 3) a definition of Essential Health Benefits (EHB) that includes habilitation services as one of those benefits, 4) a range of payment reform options that could affect how people with disabilities obtain care, and 5) the development of new accessibility standards for provider practices related to medical equipment.

Many of these provisions remain under development. There is significant latitude for individual states in the design, implementation, and/or enforcement of these provisions. Therefore, there remains great opportunity for persons with disabilities and organizations representing these individuals to contribute to the development of Ohio’s ACA provisions to ensure the provisions best meet the needs of persons with disabilities.

Given the pace of reform and its implications for persons with disabilities, the Ohio Development Disabilities Council commissioned the Government Resource Center (GRC) to identify opportunities for disability-related input into Ohio’s ACA provisions. The GRC used a combination of a survey of individuals and their representatives, focus groups with individuals and their representatives and with representatives from organizations serving people with disabilities, and interviews with insurance industry representatives to identify existing issues with access to and delivery of healthcare services to persons with disabilities. This information served to create a foundation of information to discuss at a summit with more than 30 participants from all of these groups, as well as state policymakers.

The summit employed an idea-generating process called the World Café format. Moderators solicited discussion of issues and recommendations on three topics:

1. What can be done to improve the patient experience?
   a. What can be done to improve physical access?
   b. What can be done to improve interpersonal interactions with clinicians?
2. What can be done to help people make more informed choices between coverage options?
3. What should effective care coordination look like?

Summit participants developed recommendations in the following areas:

- The ability of individuals with DD and their representatives to make informed choices among coverage options on the exchange or between Medicaid managed care plans
- The ability of individuals to have better information on the accessibility of provider practices and experiences of providers in serving people with developmental disabilities (DD)
- The accessibility of provider practices
- The effectiveness of providers in serving patients with DD
The ability of individuals and their families new to the DD health care and support system to be effective navigators
- Inclusion of the DD perspective in the development of ACA program elements, including the basic benefit package, monitoring for plan discrimination, and payment reform initiatives
- Innovations to increase patient access to specialists and promote care coordination
- Evaluation of the effects of health reform on persons with disabilities

Examples of these recommendations include:

- Create a checklist of questions to answer for any health plan choice
- Train the certified patient navigators on health coverage issues and needs for people with disabilities or establish patient navigators specifically trained to assist persons with DD
- Explore the feasibility of a DD health home and examine how Ohio's mental health home initiative will work for persons with dual diagnosis
- Evaluate the feasibility of creating medical communities designed to provide easier access to an array of services with a team-based orientation for persons with disabilities
- Include a persons with disabilities component in efforts to evaluate the effects of health reform

Stakeholders gave broad support for implementing many of the recommendations. However, they realized that moving this important work forward requires effective leadership and resources. Finding these resources and creating the process and structure to move forward will ensure these recommendations are acted upon in a timely manner.
Background

The Patient Protection and Affordable Care Act (ACA) includes a multitude of provisions intended to make it easier for people with preexisting conditions, such as developmental disabilities (DD), to obtain affordable private health care coverage. The ACA also includes additional Medicaid reform options, such as integrating Medicare and Medicaid spending and health homes. In addition, the ACA supports efforts to change the health care delivery system and facilitate payment reform, such as promoting patient-centered medical homes and accountable care organizations (ACOs) provisions that will apply to people with developmental disabilities.

All of the ACA’s provisions, along with coverage, payment, and delivery system changes that were taking place independent of the ACA, portend to create challenges and possibilities for people with developmental disabilities. The effects of these changes are not predetermined. People with developmental disabilities, and the organizations and agencies working to promote their interests, have an opportunity to influence the implementation of health reform provisions to make sure that the interests of people with developmental disabilities are incorporated into new policy.

The Ohio Developmental Disabilities Council, recognizing the significance of the ACA and other health reform changes, commissioned this report to achieve two goals. First, articulate the challenges and opportunities facing persons with development disabilities during this period of significant health reform implementation. Second, identify action steps that can incorporate the interests of people with developmental disabilities into these implementation activities.

Methods

This project employed multiple research strategies to achieve these ends. These strategies included:

1. an online survey about the health care experience of persons with developmental disabilities with providers and with health plans;
2. a focus group with representatives of agencies serving people with developmental disabilities;
3. two focus groups with individuals who had completed the survey of individuals with DD;
4. individual interviews with representatives of the Medicaid managed care plans that will be participating in Ohio’s Medicare-Medicaid dual integration project; and
5. a summit involving individuals or their representatives, health plans, organizations serving people with development disabilities, and state level agency staff.

Each of these strategies provided information that was useful to the discussions that occurred at the summit. However, because the people who answered the surveys were not randomly drawn, information obtained does not necessarily represent the developmental disability population in Ohio as a whole.

Survey of Individuals with DD

The research team developed a survey in order to understand the health care access experience of individuals with disabilities. The survey served as the recruitment invitation to participate in the focus groups. The online survey used a convenience sample of people who chose to respond.

The respondents were either an individual with developmental disabilities, his/her parent or guardian, or someone else able to speak on behalf of the individual. Of the 96 surveys started, 68 (71%) were completed by
parents, 18 (19%) by the individual, while 10 were done by grandparents, siblings, other relatives, or non-family guardians (10%).

Individuals or their representatives received a link to the survey from organizations serving people with developmental disabilities. They completed the survey through Survey Monkey®. A script at the beginning of the survey informed respondents that they were providing consent by deciding to complete the survey. While 96 individuals started the survey, only 70 completed the entire survey (73%). However, 78 individuals completed the access to services section and 74 completed the health plan section. The survey instrument can be found in Appendix A.

**Focus Groups**
The Ohio Developmental Disabilities Council and the GRC recruited participants for three focus groups. The first focus group included seven individuals from organizations that serve people with disabilities. The organizations represented included:

- Easter Seals of Central Ohio
- Ohio Center for Autism and Low Incidence (OCALI)
- Ohio Statewide Independent Living Council
- Bureau of Children with Medical Handicaps (BCMH) Family Council
- The Paralyzed Veterans of America, Buckeye Chapter (BPVA)

The other two focus groups were with individuals and/or the legal guardians of individuals with developmental disabilities. One session was held in Columbus and the other session took place in Akron. The participants were identified from people who completed the survey and indicated an interest in participating in a focus group. The Columbus session had six participants, five of whom were parents of a child or children with developmental disabilities and one who was a person with a developmental disability. The Akron session had five participants who care for a child with a disability. For most of the participants, the child was an adult. Appendix B contains the focus group script including the questions participants were asked. Participants were asked to provide written consent before participating in the focus group.

**The Health Plan Interviews**
Representatives from Aetna, Buckeye Health Plan, CareSource, Molina, and United Health Plan were interviewed by phone or on an individual basis. The purpose of these meetings was to solicit the perspective of health plans regarding meeting the needs of persons with developmental disabilities. The interviews revolved around a set of questions sent to each health plan participant prior to the meeting. The interview questions were developed based on the literature but also drew heavily on the feedback received from individuals, parents, and advocates in the focus groups and survey responses. The health plan interview questions are included in Appendix C.

**The Summit**
The final phase of engagement consisted of bringing a group of individuals together to engage in discussion and dialogue. More than 30 people attended the summit. Attendees represented a mix of individuals with developmental disabilities or their representatives, insurers, advocates, and policymakers, including staff from the Ohio Department of Developmental Disabilities, the Ohio Department of Health, and Ohio Medicaid.
The summit employed a World Café style process to generate dialogue. The summit began with an overview of findings from the survey, focus groups, and interviews. This summary information was used to set the stage for the discussion sessions. The summit included three rounds of discussions, with participants changing tables after each session. There were five tables, each with at least one person with a disability and one insurance representative. The questions for these three sessions concerned the patient experience, how to help individuals make informed choices about coverage, and care coordination.

**Context**

The ACA contains numerous provisions with important effects for persons with disabilities. These provisions include:

- Reforms to the private insurance marketplace
- Reforms to Medicaid
- Support for payment reform innovations
- Creation of provider medical equipment standards for better serving patients with disabilities

**Private Insurance Reforms**

The primary focus of the ACA is to increase the number of people with affordable private health care coverage. The ACA also includes a goal to provide a broader range of services than many health policies cover today. Several of these provisions are of special importance to persons with disabilities. These provisions include:

- Elimination of insurance underwriting practices that affect the ability of people with disabilities to obtain insurance coverage at all or at affordable rates
- Elimination of annual and lifetime maximums
- Prohibition of health plan discrimination based on various factors including present or predicted disability and degree of medical dependency
- Reduction in rating bands that should reduce the premium costs for people with preexisting health conditions
- Creation of health insurance exchanges that allow individuals who do not have access to employer-based coverage and are either locked out of or priced out of meaningful health benefit options on the individual market to purchase a broader set of health benefits at an affordable premium
- Premium assistance subsidies and cost sharing subsidies for individuals with lower incomes that may make accessing private coverage versus Medicaid an option for persons with disabilities
- Inclusion of habilitation services as part of the essential benefit package

The implementation of these provisions is dependent on the creation of a series of federal rules with enforcement of many of these provisions taking place at the state level. These rules have been under development for the past two years, and their final development and implementation remains open for further refinement. The state review process also remains under development.

The rules around two of the ACA provisions exemplify the ongoing challenge for making the provisions work well for persons with disabilities. One provision defines the criteria for discriminatory behavior by health plans. The final rule on Essential Health Benefits (EHB) states that “an insurer does not provide EHB if its
benefit design, or the implementation of benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition. But as Rosenbaum and Teitelbaum (2013) commented on the final rule, “the final discrimination rule does not offer specific applications of this broad prohibition, leaving individuals with DD, insurers, and insurance regulators without any guidance as to what the Department of Health and Human Services (HHS) considers discrimination in benefit design or its implementation” (Rosenbaum & Teitelbaum, 2013).

The second provision concerns the definition of habilitation services. The ACA requires plans to include habilitation services as part of the essential health benefit package. The National Association of Insurance Commissioners defines habilitative services as, “health care services that help a person keep, learn, or improve skills and functioning for daily living.” Implementation of this provision makes state law the primary source of regulatory policy. As evidenced by a state insurance bulletin from Wisconsin, where state standards do not exist, the states defer to the EHB rule (Wisconsin Office of the Commissioner of Insurance, 2013). This final EHB rule gives broad deference to the health plans to define their level of habilitative services coverage. According to Sara Rosenbaum, the final rule even allows health plans to substitute greater rehabilitative services for adults in favor of lesser habilitative services for children (Rosenbaum, 2013).

Another important area of activity will be the operation of the health insurance exchange. This exchange will serve as the primary vehicle through which uninsured Ohioans access health coverage, whether private or public. In Ohio, the federal government will establish Ohio’s health insurance exchange. Even so, there are several regulatory functions left to the Ohio Department of Insurance. In addition, to assist individuals in making informed choices among their health insurance exchange plan options the ACA supports the creation of navigators. The ability for navigators to assist special populations, such as persons with DD, seeking coverage through the exchange will depend on who is selected to serve as a navigator and what training they will receive.

The challenges around enforcement of the healthcare coverage disability prohibition, the definition of habilitation services, and implementation of health exchange navigators all underscore the need for policy engagement and input from the disability community.

**Medicaid Reforms**

The ACA recognizes that not every person can afford to purchase private health care coverage. Therefore, the ACA allows for the expansion of Medicaid to all 19 to 64 year olds with incomes up to 138% of the federal poverty level.

The Medicaid expansion opportunity is of less significance to persons with developmental disabilities because a very small percent of this population reports being uninsured. Most are already eligible for coverage through Medicaid and/or Medicare due to their disability.

According to our survey of individuals with DD, only 3% of the respondents were uninsured, while 72% had Medicaid, 43% private coverage, 24% Medicare, 4% other state of Ohio health care assistance, and 4% had some other coverage. The 2012 Ohio Medicaid Assessment Survey confirms the survey’s findings that for children under 19, Medicaid covered 68% of the population with a developmental disability while 20% of the population were covered by private insurance and only 3% were uninsured (OMAS, 2012).
Several other ACA Medicaid provisions have important implications for persons with disabilities. The two most significant provisions are:

- The option for states to integrate the spending on the dual eligible population, those who have both Medicaid and Medicare coverage
- The option for states to create Medicaid health homes

Ohio is actively implementing programs under both of these options that directly involve care for persons with developmental disabilities. Ohio’s Integrated Care Delivery System (ICDS) initiative is to begin operation in April 2014. This effort will move most of Ohio’s Aged, Blind and Disabled adult population into one of five Medicaid managed care plans, including a substantial number of individuals with DD. In July 2013, Ohio Medicaid began moving non-waiver, community-based children with disabilities from fee-for-service to Medicaid managed care.

Ohio Medicaid’s health home initiative is focused on the integration of primary care and behavioral health care at community mental health agencies. Ohio Medicaid and the Ohio Department of Developmental Disabilities are exploring a DD health home option, as well.

**Payment Reform Innovations**

Additionally, Ohio is pursuing multi-stakeholder payment reform through a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model grant. Ohio’s payment reform focus is twofold. First, create a payment model that advances the spread of patient-centered medical homes across Ohio. Second, create a set of episode-of-care payments. Both of these efforts will likely encompass patients with DD. This payment reform policy seeks to shift payment away from fee-for-service and could be the first step toward payment by a global budget.

**New Provider Access Standards**

Section 4203 of the ACA seeks to remove barriers and improve access to wellness for individual with disabilities. It pursues this aim by amending Title V of the Rehabilitation Act of 1973 to establish standards for accessible medical diagnostic equipment. According to the Association of University Centers on Disabilities, the ACA mandates the Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration Board, to, “disseminate minimum technical regulatory standards for medical diagnostic equipment used in (or in conjunction with) a physician’s offices, clinics, emergency rooms, hospitals, and other medical settings. These standards are to ensure that such equipment is accessible to and usable by individuals with accessibility needs, and will allow independent entry to use of and exit from the equipment by such individuals to the maximum extent possible. Equipment covered under this Section includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures) weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals” (Association of University Centers on Disabilities, 2010).

**Non-ACA Reform Activity**

Even without the ACA, people with developmental disabilities were facing mounting market-based changes to their health care coverage. These changes include:
• A long-term decrease in the number of people covered by employer-based coverage. According to the Ohio Family Health Surveys of 2004, 2008 and 2010 and the Ohio Medicaid Assessment Survey of 2012, the percent of Ohio adults with employer-based coverage has fallen from 64% in 2004 to 56% in 2012.
• An increase cost sharing obligation under private health plans, whether through the use of high deductible health plans or greater levels of copayments for medications and other services.

Findings

Findings from Individuals with DD and Representatives from Organizations Serving Them

The survey responses and focus group discussions provided insights into the healthcare financing and care delivery successes and challenges facing persons with DD. These findings underscore frustrations from many perspectives but also demonstrate how others are not experiencing any challenges in accessing health care. Some of this difference in experience may reflect the variation in intensity of need and complexity of health care issues facing different people with DD. The findings also uncover doubt or confusion among people with disabilities about whether the future of health care will be better with reform.

This discussion on the findings divides them into the following categories:

• Difference in health care intensity among the DD population
• Success and challenges in finding healthcare providers
• Issues with accessibility of provider practices
• Issues with interactions with healthcare providers
• Success and challenges in working with health plans
• Expectations of the future

As discussed earlier, the results referred to throughout the report from the online survey represent the sample of those individuals and parents/guardians who responded to the survey only. The results may or may not be indicative of the general population. Even though the results do not represent the entire population of individuals with DD, they can provide important insights into what challenges and patterns the broader population may be facing.

Differences in Health Care Intensity among the DD Population

Assessment of the implications of health reform for the DD population and recommendations on how to make reform better work for the DD population must appreciate the diversity in health care needs among this population. There is a wide variation in the extent of health care needs and the types of health care challenges facing the DD population.

Two examples in the variation in service utilization are: 1) the extent of need for habilitation services; and 2) the number of physicians used in the last month. According to the online survey results, the extent of need for habilitation services ranged from no need in the last week (34%) to 41 or more hours (11%) (see figure I). Figure II shows that while 10% of the respondents reported not seeing a provider in the last month, 53% saw one or two providers, 29% reported seeing three to five providers and 8% reported seeing six or more providers.
Another dimension of variation among the DD population is related to the nature of the disability. The population varies by whether their disability is physical, intellectual, or both. Among the survey participants, 67% reported having a physical disability and 65% reported having an intellectual disability.

In addition, the population varies by the need for mobility or other assistive technology. According to the survey, 40% reported never needing mobility assistance, while 31% reported always needing mobility assistance and 29% reported sometimes needing it. In terms of needing to use assistive technology to communicate, 17% reported always needing such technology compared to 16% sometimes needing such assistance and 65% reporting not having such a need.

A portion of the DD population also has a behavioral health disability. Of those surveyed, 25% reported having a behavioral health condition.
Focus group and summit participants reinforced the importance of how variation in type of disability and level of need affect the healthcare experience of persons with disabilities. For people with mobility limitations, there were much greater challenges with accessibility to health care both in entering facilities and with being served well within a health care facility. For individuals with greater habilitation service, there are more challenges in getting the needed level of services through their health plan. Finally, for individuals with intellectual disabilities, there were more challenges in the interpersonal experiences with their health care providers.

While there are differences among the DD population, they all have the common experience of having a preexisting condition when seeking health insurance coverage. This experience puts them at greater risk of being unable to obtain private health insurance, especially on the individual or small employer market. However, differences within the DD population suggest the effects of reforms and the ongoing need for further reform will vary among the DD population.

**Successes and Challenges in Finding Providers**

According to the survey and focus group results, individuals with developmental disabilities see their primary care doctor regularly. This may be the result of poorer health (Krahn, Hammond, & Turner, 2006) and higher levels of some chronic illnesses (Havercamp, Scandlin, Roth, 2004) in this population. Participants reported more difficulty in finding specialists than in finding a primary care provider. This difficulty was often greater for those with Medicaid and those living in rural areas. According to one parent, “the biggest problem is there are so few providers who take medical cards and know anything about Autism and severe intellectual disabilities.” Another parent stated, “I cannot find any psychiatrist in a 100 mile radius who accepts new Medicaid patients.”

The focus group participants noted the challenge in finding providers gets easier over time as the individual and/or his/her family becomes more experienced with navigating the healthcare system. Individuals new to the DD health care system, however, encounter many challenges in finding providers willing and able to meet their health care needs.

**Issues with Accessibility of Provider Practices**

While two-thirds of survey respondents reported no issues when seeing their primary care provider, individuals with mobility limitations did express a greater degree of accessibility problems. These problems were not merely about being able to easily enter the provider’s office building. Individuals with mobility limitations reported several accessibility challenges within a facility, including:

- Trouble getting into the exam room
- Exam rooms that were too small to accommodate the patient, parent, aide, physician, and nurse
- Lack of accessible exam beds and other equipment designed to handle the needs of patients with mobility limitations
- Lack of means of being transferred from the wheel chair to the exam table

A recent study underscores accessibility challenges that people with mobility limitations face within a provider’s office. (Lagu et al, 2013). Of the 256 subspecialty practices studied, 22% report they could not accommodate a patient in a wheelchair who could not self-transfer. Of the 160 practices that required
transfer for adequate care, 26% indicated they could not accommodate the patient. The subspecialty with the
greatest inability to accommodate such patients was gynecology, where 44% of the practices reported they
could not accommodate such patients.

This variation in provider practice accessibility increases the time and difficulty in finding an appropriate
provider when needed. Individuals with mobility limitations expressed the desire for provider listings that
would indicate which practices are able to accommodate people with mobility limitations.

**Issues with Interactions with Healthcare Providers**
Survey respondents and participants in the focus groups reported varying degrees of frustration with the
interpersonal interactions with providers and their staff. The challenges expressed include:

- Tendency of the provider to not regard the person with a disability as they would a person without a
disability. As one focus group participant stated, “The doctor didn’t look at me, [and] didn’t talk to me.
This implied I had no value.”
- Failure to accept insights from parents, guardians, or the individuals with a development disability
when assessing the patient’s health and making treatment decisions. As another participant stated, “A
spirit of partnership is necessary between families and doctors. Parents have the wisdom and
professionals have the knowledge.”
- Lack of treating the whole person. As one parent stated, “We are not going to park the disability at the
door.”
- Limitations in knowledge about treating people with disabilities
- Lack of adult care providers being ready to take care of children with disabilities as they age into
adulthood
- Lack of effective sharing of information between different providers who are working with a given
patient.

These challenges with provider interactions increase the care coordination responsibility of the individual or
his/her parent or guardian. As one parent explained, “Doctors are very specialized now, they don’t look at the
whole patient which means that I have to take the role of quarterbacking related and unrelated symptoms and
issues and figuring out on my own what to do.”

Some parents reported that they would value effective professional care coordination support. To that end,
they expressed a desire for better medical record software that could integrate the tests, information, and
symptoms for the DD population with complex health challenges. Parents also expressed a need for an
individual to assist them with care coordination. According to one parent, “It would be nice to have someone
to work with us so all our doctors know what the other one is doing, or sometimes we don’t know what doctor
to call for problems that she is having.”

**Successes and Challenges in working With Health Plans**
The survey and focus group participants all expressed the importance of having health insurance. Because of
Medicare and Medicaid programs aimed specifically to cover people with DD, the uninsured rate among
Ohio’s DD population is very low. Among the survey population, only 2.7% reported being uninsured.
While appreciative of having health care coverage, the survey respondents and focus group participants expressed much less satisfaction with their health plans than with their providers. Only 14% of survey respondents agreed or strongly agreed that their health plan gave them information about providers that could meet needs associated with their disability. Similarly, only 17% agreed or strongly agreed that their health plan helps coordinate the health care services they need.

The primary frustrations expressed during the focus group sessions revolved around lack of flexibility in meeting the needs of persons with disabilities. These frustrations included:

- Lack of coverage for habilitation services
- Limits on frequency of upgrading medical equipment
- Limits of amounts of therapy services
- Confusion over how to determine an individual’s need for a service versus a global rule on availability of a service often seen as made without regard to the needs of individuals with disabilities

As one participant commented, “Don’t just assume that one wheelchair in a lifetime will be good enough. It’s not. Assess each individual case!”

The participants also expressed issues with the provider network, including:

- Lack of sufficient in-network provider capacity capable of meeting needs of people with disabilities
- Low Medicaid provider reimbursement rates that limit the number of providers willing to see any or additional patients with Medicaid coverage

Finally, the participants expressed a need for clearer information from health plans including:

- Benefits covered
- Easier to understand denials of coverage
- Better information on who in the provider network is able to meet the needs of patients with disabilities

It is interesting to note that while participants criticized Medicaid for its low reimbursement rates, they also praised it for having a better package of benefits, especially related to habilitation services.

While being critical of their health plan experience, most survey and focus group respondents reported their health plans were not managed care plans. Only 2% reported getting their coverage through a managed care plan while 58% reported not being part of a managed care plan. The other 17% were uncertain if they were part of a managed care plan.

The participants in the focus group composed of representatives from organizations that serve people with disabilities reported positive interactions with the managed care plans selected to participate in Ohio’s dual eligible integration initiative. These participants all noted that these plans have been reaching out to them to identify opportunities for making managed care work well for their communities.

**Expectations of the Future**

The survey and focus group respondents are apprehensive about what the future will bring. Figure III shows only 11% reported expecting their health care options to improve in the future. Another 20% were uncertain if
things would improve or worsen, while 41% expect their options to worsen and 27% either did not know or refused to respond.

**Figure III. Perceptions of Impact of Future Health Care Options**
**Online Survey Responses**

<table>
<thead>
<tr>
<th>Perception</th>
<th>Likely/very likely to Improve</th>
<th>Could improve or worsen</th>
<th>Likely/very likely to worsen</th>
<th>I don’t know/Refused to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely/very likely to improve</td>
<td>11%</td>
<td>20%</td>
<td>41%</td>
<td>27%</td>
</tr>
</tbody>
</table>

When discussing the future options under health reform the focus group respondents expressed a need for:

- Information about coverage options that is easier to understand
- Assistance in making choices among options from people who understand the health care needs of persons with disabilities
- Benefit packages that include habilitation services
- Benefit packages that include more flexibility in tailoring services to the particular needs of persons with disabilities
- Payment systems that take into consideration the complex needs of persons with disabilities and do not reward providers for skimping on needed care

**Findings from Interviews with Medicaid Health Plan Representatives**
Ohio Medicaid has selected five managed care plans to participate in Ohio’s Medicare-Medicaid Integrated Care Delivery System (ICDS): Aetna, Buckeye Health Plan, CareSource, Molina, and United Health. A portion of this Medicare-Medicaid dual eligible population has DD. These plans are expected to begin covering individuals in April 2014. Four of these plans also serve as Ohio’s existing Medicaid managed care providers. This population includes children and adults with DD that are not covered through any Medicaid waiver.
Researchers working on this project individually interviewed representatives from each of these plans to obtain their perspective on issues facing the DD population and to obtain their reaction to concerns expressed by individuals in the survey and focus groups. Each of the health plan representatives expressed optimism that they can bring value and benefits to individuals with DD. Most notably, insurers see their responsibility as aiding the individual and their family with care coordination needs and with finding providers to serve them.

Each of the plans indicated they had begun, to varying degrees, outreach to organizations serving the DD population and to individuals themselves. One purpose of this outreach was to better understand the challenges and needs of the DD population. A second purpose was to commence creation of a network of resources for the plan to work within serving their DD population.

Based on this outreach and other experiences serving people with disabilities, the health plan representatives expressed many similar thoughts, including:

- There are variations across disabilities such that “one size” cannot work for all persons with DD.
- Under non-managed care health plans, the services covered are set by the specifics of the contract with the purchaser of that coverage, but under managed care, the plan has more flexibility with the service package.
- Care coordination programs serve to create the relationship between the plan and the individual that allows for care that is more effective and tailoring of coverage to meet the unique needs of each individual with DD. This coordination will require augmentation of existing case management protocols to meet the specific health and non-health needs of the DD population.
- There are significant access to care problems for people with disabilities both in terms of getting into a provider’s office and within a provider’s office, but it is unclear how to best get information on provider office accessibility.
- Issues such as housing and employment needs have surfaced as tasks that the plans will be asked to assist with.
- The health plans need to understand how to partner with County DD Boards and other service providers to leverage health plan services with existing resources.

**Recommendations for Improvement**

The findings from the survey and focus groups show the health care experience for persons with DD has many challenges that predate healthcare reform. The challenge for policymakers, organizations serving the DD community, and individuals with DD and their families is how to take advantage of opportunities from health reform while minimizing any risks from reform.

To identify such opportunities, this project brought together representatives from individuals with DD, health plans, organizations serving people with DD, and representatives from state government. The findings above served as the basis for the discussions at this summit. The summit focused on three general issues:

1. What can be done to improve the patient experience?
   a. What can be done to improve physical access?
   b. What can be done to improve interpersonal interactions with clinicians?
2. What can be done to help people make more informed choices between coverage options?
3. What should effective care coordination look like?
The discussions at the summit, along with discussions during the focus groups, generated recommendations in the following areas:

- The ability of individuals and their representatives to make informed choices among coverage options either on the health insurance exchange or between Medicaid managed care plans.
- The ability of individuals to have better information on the accessibility of provider practices and experiences of providers serving people with DD.
- The accessibility of provider practices.
- The effectiveness of providers in serving patients with DD.
- The ability of new individuals and their families new to the DD health care and support system to be effective navigators.
- Inclusion of the DD perspective in the development of ACA program elements, including the basic benefit package, monitoring for plan discrimination, and payment reform initiatives.
- Innovations to increase patient access to specialists and promote care coordination.
- Evaluation of the effects of health reform on persons with disabilities.

The ability of individuals and their representatives to make informed choices among coverage options

In the coming year, individuals with DD will face new opportunities for selecting health care coverage. One opportunity will be the ability for individuals to choose between private health plan options available through the health insurance exchange. The second opportunity will be for individuals to choose between Medicaid managed care plan options through Ohio’s ICDS initiative.

Recommendations for assisting individuals in making choices on the health insurance exchange include:

- Create a checklist of questions to answer for any health plan choice.
- Train the certified patient navigators on health coverage issues and needs for persons with DD.
- Establish patient navigators specifically trained to assist persons with DD.
- Create an online summary of information on all health plan options that are pertinent for persons with DD.
- Train DD County Board staff and staff at other organizations that serve people with DD on how to assist people with DD in making choices among health plan options.
- Hold community forums to discuss health plan options and strategies for choosing between the choices.

Recommendations for assisting individuals in understanding their Medicaid managed care plan options are similar to those identified for choosing private health plan options. There is an added information sharing need because the Medicaid managed care plans can not directly market their plans to individuals. To that end, the summit participants recommended:

- Creating education materials that explain the ICDS program in clear, accessible language.
- Developing a resource guide that compares options between the Medicaid managed care plans in a given region.
- Training individuals and organizations to assist individuals and families in understanding the ICDS program and options between plan choices.
For all materials created, the Summit participants agreed they must be in plain language that addresses issues of health literacy and cultural sensitivity.

*The ability of individuals to have better information on the accessibility of provider practices and experiences of providers in serving people with DD*

The Medicaid ICDS managed care plans noted that they are obligated to provide individuals with more information about providers. The existing Ohio provider common credentialing form includes questions about external accessibility to provider practices. Summit participants recommended adding questions related to internal accessibility to the form.

Disability-related information collected on this form has not been widely used in provider directories. While ensuring this information is collected and shared in provider directories helps address the issue of accessibility of provider practice, it does not provide information on the experience of providers in serving people with disabilities.

Summit participants suggested creating a certificate program that providers could complete to get a designation that could be included in any provider manual.

*The accessibility of provider practices*

The summit participants reaffirmed the challenges existing provider practices often have in serving people with mobility limitations. The ACA requirement to develop voluntary standards for medical equipment to serve people with DD provides a new guide to assist provider practices in addressing this need.

Participants recommend working with provider associations, the Medical Board, and others to communicate these new guidelines. The initial goal is to encourage that all new provider facilities address the office space and medical equipment recommendations for serving people with DD.

This recommendation has value beyond serving people with DD. Dr. Stanley F. Wainapel (2013) captured this sentiment in his response to the *New York Times* article on the study about the inability of many provider practices to serve people with mobility limitations, where he stated;

“The inadequate medical care of people with physical disabilities also affects a considerably larger patient population. Frail elderly individuals would find it difficult to climb onto a nonadjustable exam table. So, too, would anyone with acute back pain. A large proportion of adults can anticipate experiencing some form of physical disability, be it temporary or permanent, at some point, and all would benefit from an optimally accessible environment.”

*The effectiveness of providers in serving patients with DD*

Summit participants all agreed that too many providers lack sufficient experience and consideration when caring for people with DD. Some of the concerns raised related to the need for better interpersonal skills in communicating and treating people with DD. Other concerns related to the depth of knowledge in handling the health needs of people with DD.

To address this training need, the summit participants recommended the following:
• Update and improve medical education as it relates to serving people with disabilities with special focus on those who will serve the adult population
• Create continuing education programming with an opportunity to obtain a certificate for serving people with DD
• Create a manual for providers that includes information on how to address common issues of people with DD
• Create a workgroup to develop a training program that includes individuals with DD to ensure that specific issues that individuals identify are included in the training program

The ability of new individuals with DD and their families to be effective navigators

The summit participants affirmed the challenges that new individuals and families face in how to best support someone with DD. These challenges not only relate to understanding the health circumstance itself, but also in how to navigate through the different programs and systems established to help people with DD.

To address these challenges, summit participants recommended:

• Create a training program for individuals and their families who are new to the service system
• Establish a network of experienced parent mentors who are paid to assist individuals and families who are new to the service system (e.g. parent consultants in schools)

Inclusion of the DD perspective in the development of ACA program elements, including the basic benefit package, monitoring for plan discrimination, and payment reform initiatives

The ACA contains provisions related to creating a better system for the financing and payment of health care. These provisions include rules related to the sale of health insurance, definition of a basic benefit package, monitoring of health plan discrimination, and support for payment reform innovations. All of these issues have important implications for people with DD.

Many of these provisions leave enforcement or innovation development efforts to the states. For example, the final EHB rule leaves primary enforcement of this unspecific discrimination provision to the states. At the same time, there remain avenues for states and persons with disabilities and their advocates to engage with federal officials implementing specific provisions.

Summit participants agreed the DD community will need to actively engage in state and federal efforts to define and develop these provisions. Potential solutions include:

• Participating in Ohio’s State Innovation Model payment reform activities to make sure that the Primary Care Medical Home and episode-of-care recommendations appropriately take into account the needs of persons with DD
• Working with the Ohio Department of Insurance to create a system to monitor plans to determine if they violate prohibitions against health plan discrimination for people with disabilities
• Assessing how health plans are implementing the habilitation service requirement under the basic benefit plan
• Working with state and federal officials on any final definitions of habilitation

Innovations to increase patient access to specialists and promote care coordination
The ACA allows states to pursue innovations to increase patient access to specialists and promote care coordination. Even without the ACA, such innovations are possible to pursue. Innovations that summit respondents encouraged Ohio Medicaid and others to explore are:

- DD health homes that emphasize improved coordination of care especially around assisting people in accessing specialists
- Examination of the viability of Ohio’s mental health home providers to meet the needs of individuals with a dual diagnosis of DD and Mental Health
- Specialty-based patient centered medical homes for individuals whose care is better managed by specialists than by a primary care provider
- Physically-based medical communities that give patients easier access to an array of specialty services, including dental and vision care or virtually-based medical communities that allow for more effective monitoring and coordination of care

### Evaluation of the effects of health reform on persons with disabilities

All of the ACA and non-ACA changes to health insurance coverage, health payments, and health care financing will have significant effects on individuals with disabilities. What these effects actually are remain uncertain and will not be actually known without a strategy to evaluate what takes place. Often such evaluations focus on how many people are uninsured, or how many are insured by different sources of coverage. Often these evaluations also lack sufficient sample size to assess the effects of specific groups, such as people with disabilities. Given these reforms are expected to be refined over time, the disability community should seek to have evaluations done that explore the effects on their community.

### Next Steps

The recommendations from the summit require concerted effort to achieve. Participants all indicated willingness to work on these activities. However, they acknowledged that each of these activities require leadership and resources to allow the staffing needed to bring people together to refine and create the proposed solutions.

A question remains as to who will serve as the convener of such activities. The summit participants wondered if the Ohio Development Disabilities Council could be that convener. Funding could then be pursued from national and local foundations, along with federal and state government resources.

### Conclusion

The Affordable Care Act contains a range of provisions that promise to affect access to health care coverage, the range of services included in basic benefits, the financing of health care services, and the reimbursement system for providers. It also contains several other provisions of interest for persons with disabilities.

This project affirms persons with DD have been facing many challenges in accessing providers able to serve them and working with health plans to meet their needs. Through the focus groups and the Summit, this project has identified different action steps to improve the ability of people with disabilities to benefit from health reform. The challenge for the disability community is to ensure that these provisions improve the health and well-being of persons with disabilities.
References


Appendix A: Online Disability Health Care Access Survey

HEALTH CARE ACCESS FOR PERSONS WITH DISABILITIES
CONSUMER SURVEY
FEBRUARY 21, 2013

I. INTRODUCTION

What is this about?

The Ohio Developmental Disabilities Council (DD Council) is sponsoring a study to understand how healthcare reform may affect how individuals with disabilities access health care services. The Ohio Colleges of Medicine Government Resource Center (GRC) is conducting the study. The survey will gather information about your experiences in accessing medical care.

The online survey will take approximately 10 minutes to complete and should be completed by the consumer of disability services or the parent or guardian who is able to answer for the consumer.

Your participation is voluntary and you can choose to stop participating at any time. Please complete the survey only once. We would greatly appreciate if you could complete the survey by March 29, 2013.

What will happen to my completed survey?

All survey information will be summarized. Your individual responses will be kept strictly confidential and will not be reported.

Is someone available to take my survey answers over the phone?

Yes. We are glad to give the survey to you over the phone. Please contact Barry Jamieson at barry.jamieson@osumc.edu or (614) 366-0939.

Questions about this study?

If you have additional questions, please contact Barry Jamieson at barry.jamieson@osumc.edu or (614) 366-0329.

II. WHO IS COMPLETING THE SURVEY

NOTE: All survey questions are written from the perspective of the individual. If you are the parent or guardian please answer each of survey questions from their perspective.

1. How is the person completing this survey related to the consumer of disability services?

   □ Self  □ Grandparent  □ Sibling  □ Non-family legal guardian
   □ Other relative □ Parent  □ Prefer not to answer

The next few questions are about the nature of your disability.

III. DISABILITY STATUS

2. So we can understand how you use health care services, please tell us the nature of your disability? Is your disability: (Check all that apply)
Making Healthcare Reform Work for People with Developmental Disabilities

3. Approximately how many hours of habilitative services do you receive per week?
   □ None  □ 1 to 10 hours  □ 11 to 20 hours
   □ 21 to 30 hours  □ 31 or 40 hours  □ 41 or more hours
   □ I prefer not to answer

4. How often do you currently require assistance to increase your mobility?
   □ Always  □ Sometimes  □ Never  □ I prefer not to answer

5. How often do you currently use a device or other technology to aid in communication?
   □ Always  □ Sometimes  □ Never  □ I prefer not to answer

6. How often do you currently require the use of a service animal?
   □ Always  □ Sometimes  □ Never  □ I prefer not to answer

7. How often do you currently have access to regular transportation?
   □ Always  □ Sometimes  □ Never  □ I prefer not to answer

The next few questions relate to your experience with physical health care providers

IV. YOUR EXPERIENCE WITH PHYSICAL HEALTH CARE PROVIDERS

8. Have you visited any physical health care providers in the last 12 months? (These may include primary care doctors, advanced practice nurses, dentists, ophthalmologists, and others).
   □ Yes  □ No  □ I prefer not to answer

9. How many physical health care providers have you seen over the last month?
   □ None  □ 1 to 2  □ 3 to 4  □ 4 to 5  □ 6 or more
   □ I prefer not to answer

10. Consider your primary physical health care provider (e.g. doctor or nurse). Please indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>My provider gives me all the information I need about my medical condition(s).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
My provider refers me to specialists who are able to meet my needs.

I understand why my provider requests various tests and treatments for me.

My provider values my opinion.

My provider listens to me.

My provider helps coordinate my care with other providers.

11. Which one or more of the following issues related to your disability have you had when visiting your primary physical health care provider?

- I did not have transportation to my provider's office.
- I had trouble getting into my provider’s building
- I had trouble getting into the exam room
- My provider did not have the right equipment or technology for my needs
- I had difficulty communicating with my provider
- I have not had any issues
- I prefer not to answer
- Other (please specify)

12. How often do you have problems related to your disability when you try to visit your primary physical health care provider?

- Always
- Sometimes
- Never
- I prefer not to answer

13. Has your experience with other licensed physical health care providers been significantly different than with your primary physical health care provider?

- Yes
- No
- I don’t know
- Not Applicable to me
- I prefer not to answer

If Yes, why has your experience been different?

14. What changes can be made for you to have a more positive experience with your physical health care providers?

These next few questions are about your experiences with your health insurance plan(s).

V. YOUR EXPERIENCE WITH YOUR HEALTH INSURANCE PLAN

15. Which type or types of health insurance plan(s) do you currently have? (Check all that apply)

- I am uninsured
- Private health care insurance plan
- Medicaid
- Medicare
- State of Ohio health care assistance program
16. Are you currently enrolled in a managed health care plan?

☐ Yes  ☐ No  ☐ I don’t know  ☐ I prefer not to answer

17. For the questions below, please consider your primary health insurance plan and indicate how strongly you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health plan gives me the information I need to help me choose physical health care providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My health plan provides me with information to help me understand my coverage.</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>My health plan gives me information about how providers can meet the needs associated with my disability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have difficulty paying the out of pocket expenses my health insurance plan charges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My health plan has an easy method to help me search for providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My health plan helps me coordinate the healthcare services I need.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Please describe how your primary health insurance plan has helped you get the services you need.

19. Please describe any problems you have had with your primary health insurance plan in getting appropriate health care services.

20. Please describe how your primary health insurance plan can improve your access to health care services.

21. With all the changes that are occurring in the health care system, how do you believe your healthcare options will change?

☐ Very likely to improve  ☐ Likely to Improve  ☐ Could improve or worsen
☐ Likely to worsen  ☐ Very likely to worsen  ☐ I don’t know
☐ I prefer not to answer

*The following questions are written from the perspective of the individual. If you are the parent or guardian please answer each of survey questions from their perspective.*
VI. **DEMOGRAPHIC SECTION: QUESTIONS ABOUT YOURSELF**

22. How old are you? (Please answer question to the nearest year)

23. What is your race? (Please check all that apply)

- □ White/Caucasian
- □ Black/African American
- □ Latino
- □ Asian
- □ American Indian or Alaska Native
- □ Two or more races
- □ Hawaiian or Other Pacific Islander

24. Are you Hispanic or Latino?

- □ Yes
- □ No
- □ I prefer not to answer

25. What is your sex?

- □ Female
- □ Male
- □ I prefer not to answer

26. What is your current annual income?

- □ Less than $10,000
- □ 10,000 to $19,999
- □ 20,000 to $39,999
- □ 40,000 to $59,999
- □ 60,000 to $79,999
- □ $80,000 or more
- □ I prefer not to answer

27. Do you live with your parent or guardian?

- □ Yes
- □ No
- □ I prefer not to answer

28. In which county of Ohio do you live most of the time?

VII. **FOCUS GROUP SOLICITATION**

29. As a part of this research study we are also conducting focus groups of individuals with disabilities and/or their family members or guardians.

Participants to the focus group(s) will discuss in detail their health care experiences. Each focus group will have 8 to 10 people and will last for about an hour. You or your guardian will need to provide written consent to participate in the focus group. Focus group sessions may be recorded. The focus groups will be scheduled in April. The location of the focus group will be in the Columbus area. The meeting time of the focus group will be arranged at a convenient time to all participants.

If you are interested in participating in one of the focus groups, please provide your contact information so that we can reach you. We will only use your contact information for this study and will not share it with anyone else.

If you have questions regarding the focus groups, please contact Barry Jamieson by email at barry.jamieson@osumc.edu or by phone (614) 3660329.

□ Name:
□ Address:
□ City:
□ Zip:
□ Email Address:
□ Phone Number:

VIII.  **THANK YOU!**

Thank you for completing the health care access survey. Your responses will assist the Ohio Developmental Disabilities Council in advocating for appropriate improvements in the health care system for individuals with disabilities.
Appendix B: Health Care Access for Individuals with Disabilities in Ohio: Consumers’ Focus Groups

Focus Group Script
Welcome and introduction of Facilitators
Facilitators introduce themselves and explain their role.
Thank you for coming today. I am Maria Mone and this is Barry Jamieson, Bill Hayes. We are researchers employed by The Ohio State University and are working on a project to inform health insurers regarding improvements in the delivery of health care services to individuals with disabilities. I will be helping to guide the conversation today and Barry and Bill will be taking notes. We will also be recording the discussion.

Purpose and Process
Facilitators explain the purpose of the focus group and the process.
We’ve invited you here today to get your input on how you experience the health care system and to hear your ideas for improvements given the opportunities presented by the Affordable Care Act. The focus group is expected to last approximately one and one-half hour.
Are there any questions?
Facilitator(s) respond to any participant questions. Facilitator reads the consent form and asks all participants to sign, date and return to her.

Guidelines for Group Discussion
Facilitator(s) will provide guidelines for discussion.
Let’s briefly go over a few guidelines to ensure a constructive discussion. If any of you have a cell phone with you, please turn these off so we are not interrupted. Also, so we can keep track of what people are saying, we have only one person speak at a time. My job is to make sure that we discuss all the issues that we planned to cover. If I interrupt it is not to be rude, but to keep us on track so we can cover all the topics and to make sure that everyone has a chance to share their ideas...

Transition to Discussion
Facilitator(s) ask participants to introduce themselves.
To get us started, let’s have everyone tell us your name and the organization that you are representing. First names are fine.

Questions
For the following questions, when we ask about health care we would like you to focus on medical or physical health care.

Intro Question
Q1: What has been your experience with the health care system?
Probes:
   a) What is working well for you?
   b) What problems or obstacles have you encountered?

Access to Providers
Q2: What has been your experience with finding a regular primary care provider (for example a physician or advanced practice nurse) who can meet your health care needs?
Probes:
a. What is working well?
b. What problems or obstacles have you encountered?
c. Are your experiences with other licensed medical care providers (specialists, dentists) different than those with your primary care provider?

Patient Satisfaction with Providers

Q3: What is needed for you to have a positive experience (would you go back again?) with your regular primary care provider?

Probes:
   a. How important is:
      - The provider’s knowledge of and sensitivity to your disability?
      - The provider’s assistance in helping to coordinate your care with other providers?
      - Ease of access to facilities (offices, exam rooms, labs)
   b. What would help you to have more positive experiences with your regular primary care provider?

Access to Coverage (current climate)

Q4: What has been your experience with health care insurers?

Probes:
   a. How well do insurers accommodate your specific needs?
   b. What, if anything, could be improved?

Access to Coverage (future climate)

Provide background on what is changing in the health insurance environment – both Medicaid and private insurance...

Under the Affordable Care Act, the health insurance climate will soon be changing. Beginning in October 2013 there will be new opportunities for insurance coverage in new Health Insurance Market. Consumers will have more choices ...

Q5: Given what you know about the changing health insurance climate, what information do you think you will need to select a plan to best meet your needs?

Probes:
   a. What information will be needed to make informed choices regarding providers?
   b. What information will be needed to understand the range of benefits being offered under the various plans?
   c. Is the type of information needed different for children (0-18) versus adults?

Q6: What health insurance benefits do you think are most cost effective to offer?

Probe: Are there any benefits particularly important to the 0-18 age group?

Q7: If you are (were) served under a managed care plan, what additional services do you think could be provided to improve your health care outcomes or your overall physical health?

Is there anything else that you would like to share with us with regard to anything that we have talked about today? Any additional ideas or opinions? Thank you very much for you time.
Appendix C: Questions for Health Plan Representatives

1. What unique challenges do people with development disabilities have in accessing health care services and/or health coverage?

2. How can a health plan assist people with developmental disabilities address these challenges, including
   a. finding care that is accessible?
   b. finding providers who are effective in serving patients with developmental disabilities
   c. coordinating care?
   d. making informed choices among care options?
   e. getting needed services to support being cared for in the home versus in an institution

3. What can be done to increase the number of providers with offices that are accessible for serving individuals with developmental disabilities?

4. What are the benefits and opportunities that you see in putting more people with developmental disabilities into Medicaid managed care?
   a. Risks and challenges?

5. What do you as a health plan need in order to effectively serve consumers with developmental disabilities?

6. What information do you think that people with permanent disabilities could use to make an informed choice among health plan options?
   a. How easy is it to provide that information?

7. What are the challenges in getting needed, quality health aide and other home-based services for people with developmental disabilities?
   a. What role can the health plan play in reducing these challenges?

8. How do you see the offering of coverage through a health insurance exchange effecting health coverage options for people with developmental disabilities?

9. How do you decide whether to cover an individual with disabilities is a candidate for a service such as therapy, when it may not restore functioning but might prevent or delay decreases in functioning?

10. Anything else?