better get used to it and become well informed of its structure and impact on our services.

We have also added in this issue a very important piece written by Lewis Golinker on the Medicare AAC Device Funding Reform Initiative. Many of you have kept well informed on this initiative through Golinker's articles published in various newsletters and rehabilitation publications in the last 6 months. Here is your opportunity to keep informed on this very important piece of legislation.

## The Reality of Managed Health Care: Implications for AAC Service Delivery

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In 1990, the state of Oregon, Department of Human Resources, Office of Medical Assistance Programs, developed a progressive set of guidelines for purchasing augmentative communication equipment. These guidelines were written in collaboration with health care professionals from the Oregon's Medical Assistance Program and two speech-language pathologists serving the needs of both children and adults with severe communication disorders. At that time, it was viewed as one of the most innovative and progressive policies in the field of augmentative and alternative communication (AAC). Individuals with severe communication disorders who qualified for the Oregon's Medicaid funding were provided voice output communication aids (VOCA) with the following documentation: appropriate assessment of their communication needs, physician's prescription, and medical justification. The spending limit of VOCA's was approximately six thousand dollars. Funding for appropriate training in the use of the VOCA was considered essential in the totality of the dollars allocated. The state hired a certified speech-language pathologist to review and approve all of the AAC funding requests; one of the more unique aspects of this particular policy. With this policy in place, many deserving children and young adults with

Medicaid status were recipients of appropriate AAC services and tools.

In 1989, our now governor, John Kitzhaber, developed—with a group of health care providers, business leaders, and lawmakers an innovative Medicaid program, The Oregon Health Plan (OHP). The program prioritizes and rations medical procedures to ensure that health care dollars are stretched further, expanding the number of low-income state residents who have access to health care. The plan essentially was designed by applying the concepts of managed care and preventive medicine. Policy makers (Kitzhaber and colleagues) worked closely with health management organizations and developed more than 15 health care plans to manage the medical needs of qualified individuals. These plans became known as OHP providers. A more thorough discussion of the Oregon Health Plan has been included in this issue (please see Starr, J., page 8).

OHP policy initially exempted Medicaid-eligible people with disabilities and Medicaid-eligible people age 65 and over. This was due to concerns related to managed care and necessary services and equipment for these individuals. However, these exemptions were removed in 1993 and OHP providers were mandated to in-

clude individuals with disabilities who were Medicaid-eligible. The new law (Senate Bill 5530, 1993), mandated that each OHP provider employ Exceptional Needs Care Coordinators to assist individuals with disabilities in understanding the OHP and how to obtain appropriate services. This law mandated that OHP providers adhere to the original Oregon Medicaid Program policy as written in 1990 for the provision of durable medical equipment. This included AAC therapeutic services and tools, such as dedicated voice output communication aids. Speech-language pathologists serving the needs of individuals with severe communication impairments were relieved that the original Medicaid policy of 1990 would continue. However, the impact in understanding how this support can benefit individuals with severe communication impairments would not be fully realized for many years.

In the beginning months of 1995, individuals who qualified for state Medicaid were slowly shifted to OHP provider plans. In the large metropolitan areas of Portland, Salem, and Eugene, many providers were available from which to choose. In the smaller rural areas of Oregon, individuals had fewer than two choices to consider. Often though, the physicians considered part of the OHP remained the same for individuals in remote areas of the state due to the paucity of physicians in general. However, having the same physician didn't always mean continuing with the same quality of care, particularly when many of the plans developed strict capitation guidelines.

Early in the OHP development, it became difficult for many individuals to continue with the various therapies and care they were used to receiving before the implementation of the OHP. Whether they be private providers or otherwise employed, speech-language pathologists began to see dwindling

caseloads. The demise of specialized services, such as AAC, was appearing more and more possible. This was occurring even though the OHP providers were mandated to continue with the strict policy developed in 1990 for AAC services and tools.

What was apparent was a general lack of knowledge about the field of AAC. The need for trained and experienced speech-language pathologists in this area was not understood, and, thus, clients were denied services by their OHP providers. In some cases, if the OHP provider designated services only at a particular treatment center/ hospital, clients were told to go there whether or not specialization in AAC was provided. The occurrence of such situations was excessive, costing clients valuable time, instruction, and function. Clearly, the system wasn't working.

Moving through this transition was slow and painful for many. Speech-language pathologists who had worked well within the state's guidelines for AAC equipment and

service provision were frustrated and, in some cases, out of a job. Time spent in training OHP provider staff was immeasurable. It wasn't unheard of to hear responses for requests for equipment purchases such as, "Why should this client have to have such an expensive communication aid when most hearing aids cost under \$1,000?"

As Ayres poignantly states in her attached article, the months, and in some cases years, clients had to wait for adequate communication access took its toll on too many people. Had it not been for the strong policy originally written for the state's Medicaid Program in 1990, she would not have been able to assert her rights for due process. This has not been the case however for every OHP recipient. As the author of this article, I can attest to more than five circumstances where clients have been approved for purchase of a VOCA.

So, what has Oregon learned in this process of providing AAC services that they can share with U.S. citizens, in general? Clearly, we need to take note of the experiences Oregon residents have faced because managed health care is the norm and will become ever-present in the United States. It is imperative that those clinicians involved in the provision of AAC services be prepared for the future by taking a proactive stance in securing proper funding for equipment and training. Whether or not these services are strongly in place within your state Medicaid program, it is essential that policy be written at the state and federal level so that clients can at least fall back on due process of law. Most importantly, speech-language pathologists, assistive technology specialists, occupational therapists, physical therapists, physicians, and consumers need to be more assertive in their efforts to educate the health care community in understanding the importance of communication. Consumers must be educated early toward self-determination so that they can effect better awareness of the essential right to communication access.

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