Managed Care: Solutions for Improving Integration and Care/Service Coordination

September 2012
What Is Managed Care?

• Managed care is an approach to delivering and financing health care aimed at improving the quality of and access to care and services while also saving costs by reducing fragmentation.

• The fundamental idea is twofold:
  – (1) Improve access to and coordination of care and services.
  – (2) Rely more heavily on preventive and primary care.
  – (3) Eliminate unnecessary and duplicative services
  – (4) Increase collaboration between providers and MCOs

• An example of where this is an ideal approach is consumers who are dually eligible for Medicaid and Medicare.
Why Medicaid Managed Care

- Holds an entity responsible for a member’s care and cost
- Creates a single point of accountability for access
- Preserves model fidelity
- Standardizes measurement and care delivery
- Creates budget savings and predictability
- Can eliminate waiting lists for HCBS
- Improves overall wellness and member outcome
Managed Care Basics

• **State-wideness:**
  – Could states implement a managed care delivery system in specific areas of the state (generally counties/parishes) rather than the whole state.

• **Comparability of Services:**
  – Could provide different benefits to people enrolled in a managed care delivery system.

• **Freedom of Choice:**
  – Could require people to get their Medicaid services from a managed care plan or primary care provider.
Federal Managed Care Authorities

- **Section 1932(a)**
  - State Plan authority – cannot include Duals, American Indians, or children with special needs

- **Section 1915(a) Managed Care Waiver**
  - Voluntary program with companies competitively procured

- **Section 1915(b) Managed Care Waiver**
  - Mandatory program limiting freedom of choice – can Duals, American Indians, and children with special needs
  - Must be cost-effective, efficient & consistent with principles of the Medicaid program; permits additional services; and are limited to no more than 5 years

- **Section 1115 Research & Demonstration Project**
  - Permits expanded eligibility; services not typically covered; innovative delivery models that improve care, increase efficiency, and reduce costs (including mandatory managed care)

- **Concurrent Section 1915(b)(c) Waiver**
  - Permits implementation of HCBS in a managed care environment
Managed Care Provider Types

• Managed Care Organizations (MCOs)
  – Like HMOs, these companies agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state

• Limited benefit plans (PAHP & PIHP)
  – May look like HMOs but only provide one or two Medicaid benefits (like mental health or dental services)

• Primary Care Case Managers
  – Typically individual providers (or groups of providers) agree to act as an individual’s primary care provider, and receive a small monthly payment for helping to coordinate referrals and other medical services.
  – Emerging are Health Homes, PCMH and ACOs
Home and Community Based Services

- **State Plan Options**
  - Home Health, personal care, TCM
  - 1915(i) and (k) permit certain community based services to target populations, including participant direction

- **Waivers**
  - **Section 1915(c) Home and Community-Based Services Waiver**
    - Long-term care services in home and community settings rather than institutional settings
    - Can provide a combination of standard medical services and non-medical services. like case management, homemaker, home health aide, personal care, adult day health services, habilitation, and respite care.

Waivers Must:

- Show that providing waiver services won’t cost more than providing these services in an institution (on average or individual)
- Ensure the protection of people’s health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services follow an individualized and person-centered plan of care
- State-wideness, Comparability, Income Rules
Member Benefits

• Traditional Medicaid Covered Services
• Non-traditional Medicaid Covered Services
  – Flexible benefits
• Go to point of contact
• Coordination and hassle-free access to care and services
• Value-Added Services
• AAA, ADRC, CIL partners
• Wellness and Health Promotion
What are Long-term services and supports (LTSS)?

• A means to provide medical and non-medical services to seniors and people with disabilities in need of sustained assistance.

• Includes services to aid individuals with:
  – *Activities of Daily Living (ADL)*- eating, grooming, dressing, toileting, bathing, and transferring.
  – *Instrumental Activities of Daily Living (IADL)*- meal planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores, communicating by phone or other media, travel, and participation in the community.
What is Coordinated LTSS?

• Effective coordination of Medicaid LTSS for people with disabilities and those who are aging, helps:
  – Improve the quality of care and services.
  – Provide support to family members and caregivers.
  – Enable independence at home and in the community.
  – Coordinate with the health team, care giver, family, and consumer to ensure consistent, holistic care.
  – Lower overall program costs.
  – Increase consumer direction of their own health care.
A Successful LTSS Program Should:

• Be comprehensive and integrated.
• Highlight personal responsibility and self-sufficiency.
• Build in accountability and outcomes.
• Demonstrate cost-effectiveness and savings.
• Emphasize personal care/service plans with attention given to individualized needs.
• Build on the concept of enhancing home and community based services – increase capacity of the CILs, AAAs, ADRCs.
• Build on independence and choice and moving persons with disabilities into the workforce.
• Have best practices built into any and all care/service plans.
Issues for LTSS Programs

• Many programs for seniors and people with disabilities fall short because of operational issues, such as:
  – Long waiting lists.
  – Limited provider capacity.
  – Fragmented delivery models.
  – Limited benefits packages.
  – Providers are not knowledgeable of LTSS and its role in independence, integration, and wellness.
  – Providers seek savings by limiting LTSS.
  – Continuance of the medical model.

• As a result, many people who could benefit from a managed, organized system of care and services continue to receive care in more expensive facilities unnecessarily.

• Eliminating the institutional bias and incentivize the use of HCBS!
  – Olmstead Compliance.
Key Savings Drivers

• Rebalancing community and nursing facility care.
• Moderating the trend of nursing home placement.
• Matching the level of care needs more appropriately with service delivery.
• Substituting clinically equivalent services (e.g., providing a walker in lieu of home attendant hours when appropriate).
• Managing acute care discharge (e.g., ensuring post-discharge follow-up and support systems).
• Coordinating care and services more effectively.
• Ensuring early identification and intervention for those at risk.
• Independence and integration improves health outcomes, which in turn, saves money.
LTC Options Cost Comparison

Olmstead Decision

• On June 22, 1999, the Supreme Court issued the *Olmstead v. L.C.* decision, mandating state governments to provide people with disabilities the community-based, rather than institutional, services they deserve.

• Affirmed the right of individuals with disabilities to live in their communities and upheld the ADA’s integration mandate.

• Provides a legal basis and authority for federal and state Medicaid policymaking to support the full integration of people with disabilities into American society to live independently.

• Managed Care Organizations are a cost-efficient and quality-improving solution when fulfilling the Olmstead mandate by incentivizing LTSS and deinstitutionalization.
Impact of Olmstead Decision

• States must have an Olmstead plan in place
• Provided advocates with the ability to create positive changes for people residing in institutions
• Provides an opportunity for advocates to promote home and community based services within LTSS programs
• Supports individuals’ choice to live independently in their community with LTSS
Olmstead Implementation Struggles

• States need to keep their plans updated
• Ensuring individuals have the LTSS they need to be successful as they transition out of facilities
• Collaboration with MCO’s to ensure that person centered plans are focused on and driven by the person – not solely by cost savings
• Allowing advocates to become involved in the process
What do you think they want?!

to make my own decisions

information I can access

to be asked

to be treated with respect
LTSS Best Practices for States

• Stakeholder and Consumer Engagement:
  – Should begin early in the planning process and continue often throughout implementation.
  – Inclusive planning process that engages all stakeholders, including the state, managed care organizations, providers, advocacy groups, and associations.
  – Value of consumer-driven change initiatives.
    – Everyone can advocate based on personal experience; don’t have to be an expert in managed care.

• Eliminate the Institutional Bias.
• Redefine “Community.”
• New Managed Care.
  – Transparency, flexibility, member-driven/self-directed.
NAB’s Six Principles

1. **Enhance Self-Care through Improved Coordination:**
   - Transform America’s health care system from one that focuses on episodic illnesses to one that assists individuals in self-managing their whole health, with the support of providers and communities.
   - Encourage the fundamental and financial investment in physicians to serve as the medical home for patients.

2. **Encourage Community Integration and Involvement:**
   - Coordinate support services, housing, and transportation so people are able to participate in the social, economic, educational, and recreational activities available through community living.
   - Promote data integration, continuity, and coordination of services through the use of health information exchange.

3. **Expand Accessibility of Services and Supports:**
   - Retool programs and regulations to enable people to access the services they need to live independently without creating financial hardship for the family.
NAB’s Six Principles (con’t)

4. Uphold Personal Preference:
   – Leverage the success of long term service models that promote personal strengths and preferences and preserve dignity of participants.

5. Empower People to Participate in the Economic Mainstream:
   – Encourage the employment of people with disabilities and seniors by removing disincentives for people to work and redefine antiquated descriptions of disability.

6. Invest in Improved Technology:
   – Invest resources in the continued development of technology that improves individuals’ ability to self-monitor chronic health conditions and live independently.
Managed Care Principles

• National Council on Independent Living (NCIL)
  www.cil.org

• National Council Disability (NCD)
  www.ncd.gov

• Consortium for Citizens with Disabilities (CCD)
  www.c-c-d.org
Seniors and people with disabilities are empowered to live independent and healthy lives.

Members are able to guide services through self-directed options.

Caregivers and family members receive help supporting members.

Individuals eligible for LTSS have a single-source contact to help them navigate complex systems.

Additional service needs are identified early, thus preventing acute conditions and hospitalizations.

Encourages the “recovery model” which promotes outcomes such as health, home, purpose and community (SAMHSA def).

States are able to provide desired LTSS services to recipients at a lower cost to taxpayers.