ABC's of Managed Care and What It Might Mean for Home & Community-Based Services

This project is supported by a grant from the Pennsylvania Developmental Disabilities Council.

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Glossary

- **HCBS- Home and Community Based Services**
  Long term support services provided outside of institutions & nursing facilities. These include the waivers, Act 150, LIFE program, Options and ACAP

- **LTSS- Long Term Services and Supports**
  Nursing Facility services & HCBS

- **MLTSS- Managed Long Term Services and Supports**
  LTSS provided under a managed care model (described later)

- **Dual eligibles-** Persons enrolled in both Medicare and Medical Assistance (Medicaid). Generally low income adults age 65+ & adults under 65 on Social Security Disability for at least 2 years
• **OLTL - Office of Long Term Living**
  An Office within DHS that administers the Attendant Care, Independence, CommCare, OBRA and Aging waivers as well as the Act 150 program

• **ODP - Office of Developmental Programs**
  An Office within DHS that administers the PFDS, Consolidated and Adult Autism waivers as well as ACAP

• **Act 150** - A purely state funded program covering a portion of the costs of attendant care and certain ancillary services for adults with physical disabilities whose income/assets exceed waiver limits. Does not include Medical Assistance coverage
• **ACAP** - A provider-managed MLTSS model for adults with autism residing in Chester, Lancaster, Cumberland or Dauphin counties (described later)

• **LIFE** - A provider-managed MLTSS model for adults age 55 (60 for some providers) or older who are NFCE (described later) and live in certain areas

• **NFCE** - Nursing Facility Clinically Eligible
  Person whose functional limitations meet a certain level based on an assessment (the “LCD”). Required for Attendant Care, Independence, CommCare and Aging waivers
Health Insurance

- Medicare
  - Medical Providers
- Medical Assistance
  - HMOs
  - Behavioral Health MCOs
  - Network of Medical Providers
  - Network of Behavioral Health Providers
Home and Community Based Services

HCBS

Office of Long Term Living
- Service Coordinators
- Providers

Office of Developmental Programs
- Supports Coordinators
- Counties "AEs"
- Providers

ISP
MLTSS Model Proposed by DHS & Aging

- Would exclude anyone eligible for services through ODP programs
- Would apply to:
  - Dual eligibles (Medicare + Medical Assistance) age 21 (or over 21?) + including those not in need of HCBS (318,000 people)
  - Adults age 18+ in need of LTSS and determined NFCE
  - Persons eligible for Attendant Care, Independence, CommCare, Aging (& OBRA?) waivers
  - Persons in nursing facilities or seeking admission
- Would be mandatory (no opt out)
- Would be a model using health plans as central managers of services
Managed LTSS (OLTL/Aging Version)

- Medicare
- Medical Assistance
- OLTL Waivers

HMO's ("Vendors")

- Service Coordinators
- Medical Providers
- HCBS Providers
- Behavioral Health Providers
Key Concepts

“Provider network”- Consumers will need to use service providers who have a contract with their health plan (“in network”) unless they get permission from their health plan to use an “out-of-network provider” (also called “non-participating provider”). Standards for getting permission to use out-of-network providers very important.
“Network adequacy” - Health plans do not have to contract with any willing and qualified provider. But, health plans must have an “adequate” network of providers, as determined by state and federal law and the contract between DHS and the health plan. Adequacy is determined by the number of participating providers of the same type in a geographic area.

How HCBS provider types are defined and the geographic areas determined are important in determining whether network adequacy requirements will ensure access to quality services for people with different needs.
• Because health plans do not have to enroll all willing and qualified providers, an individual may have one physician he/she uses in the network but not another. This could become a bigger problem when trying to choose a health plan that has the individual’s current medical providers and HCBS providers in it’s network. Consumers may have to “transition” to other providers who are “in network.”
• Health plans also specify what medications, durable medical equipment and assistive technology they cover. Currently, Plans must have a process to review requests for meds/equipment that isn’t on the covered list but if denied, a consumer may have to choose a different brand of equipment or a different medication.
Financial Incentives

- Current HCBS system - DHS pays providers based on the number of units of service they provide.
- DHS pays health plans a “capitated rate”. Health plans determine reimbursement rates for its providers.
- “Capitated rate” - Plans receive a flat $ amount per “member” (person enrolled in that plan) per month. That amount typically adjusted based on how the state categorizes enrolled consumers. A plan would typically receive a higher capitated rate for an individual with disabilities or an older adult than for a child without disabilities. However, those categories are usually broad.
Financial Incentives - 2

- The idea is to have the costs of low service utilizers balance out the higher costs of high service utilizers. Doesn’t always happen.
- Since health plans have limited ability to get additional $ from the state if they pay out more to providers than they get through the capitated rate, plans have a financial incentive to keep costs down.
- In theory, this provides a financial incentive to plans to provide HCBS to avoid much costlier nursing home placement, since they would be responsible for that cost as well.
- However, for persons needing a lot of services, the financial incentives on the health plan may be the opposite.
Utilization Management & Rates

- Health plans keep from losing money by “utilization management” and provider rate setting.
- Utilization management- health plans get to decide what services they will authorize for a consumer. They may do that before services are delivered (“prior authorization”) or while the individual is receiving services (“concurrent review”). They may also limit or exclude certain services, if permitted by law and contract.
- Provider rate setting- the health plans determine what they will pay providers. We have seen providers drop out of a health plan’s network because they felt the rates were too low. This can result in consumers using that provider having to switch to a different provider.
For consumers, what happens first?

1. Eligible consumer obtains information about health plans from enrollment broker
2. Consumer chooses health plan through enrollment broker
3. Enrollment broker processes choice
4. Consumer assigned service coordinator by health plan
5. Consumer’s physical, psychosocial and functional needs & preferences assessed by “standardized and validated assessment tool”
Welcome
Steps to enroll
• Health plans in your county
• How to choose a doctor (PCP)
Benefits and services
• Health benefits
• Mental health and substance abuse
• Children, teens and young adults
• Transportation assistance
HealthChoices Consumer Advisory Committee Meetings near you
Frequently asked questions (FAQ)
Charts and brochures
• Comparison Charts (Quick link)
• Consumer Guides (Quick link)
• Hospital Lists (Quick link)
Contacts and links
LOG IN, so you can:
• ENROLL NOW!
• Make new choices
• Change your address and phone
• Comments and Questions
FIND A DOCTOR
Find doctors near you
QUESTIONS? Just call us.
Monday – Friday, 8 am – 6 pm
(http://enrollnow.net/PASelfService/en_US/home.html)
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<td><strong>What happens next?</strong></td>
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<td><strong>6.</strong> Service coordinator works with consumer to develop person-centered plan (ISP?), presumably based on assessment tool</td>
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<td><strong>7.</strong> “Self-direction of services will be emphasized”</td>
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<td><strong>8.</strong> Consumer chooses provider from among network providers or self-directed services? (next slide)</td>
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<td><strong>9.</strong> Health plan reviews person-centered plan (ISP) and authorizes or denies requested services</td>
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<td><strong>10.</strong> Consumer has appeal rights if health plan denies services</td>
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Self Directed Services- Questions

- By “self-direction in services”, does DHS mean consumer-employer model or some degree of direction within agency model services?
- For consumer-employer model services, who would get background checks and process worker enrollment info (“good to go”)?
- Who would do payroll and pay taxes?
- Health plans don’t have any experience paying unlicensed attendants except through an agency. Will they use existing financial management service entities (like PPL) or will they try to do this in house?
Self Directed Services- Questions - 2

- What qualifications will plans impose on attendants?
- What will be the legal status of consumer employers?
- Currently for home health aides, plans determine the times of day when staff can be paid to work. Will they have the authority to determine times of day when consumer-directed staff can work?
- Will Services My Way survive?
- How can we avoid the problems that occurred when Christian Financial and then PPL took over enrolling/paying consumer-employed aides?
Other Questions

- Will the proposed uniform assessment take the place of the LCD?
- Who will determine functional eligibility (NFCE)?
- Who will determine program eligibility (proper diagnosis etc.)?
- Will the waivers continue?
- If so, how will waiver slots be allocated between health plans?
- Will consumers have choice of service coordinators?
- Will there by global ISPs that include medical, behavioral and HCBS services?
Other Questions - 2

- Plans typically require a physician’s order or an eval from some licensed health care professional for services. What kind of justification of need will plans require for non-medical services?
- What standards will DHS adopt to ensure a sufficient number and range of HCBS providers to ensure choice and accessibility?
- What resources will DHS devote to monitoring network adequacy?
- How will DHS determine the capacity of plans to review and cover non-medical supports like supported employment and accessibility adaptations (home & vehicle mods) that they have never covered before?
Other Questions - 3

- How will capitated rates be adjusted to reflect the likely support needs of the enrolled consumers?
- What will happen to LIFE programs?
- Your questions???
VI: Public Meetings

The Administration will hold six public input meetings throughout this Commonwealth to receive comments on the MLTSS discussion document. The locations and times of these public meetings are listed below.

Erie – Wednesday, June 10, 2015
Bayfront Convention Center
1 Sassafras Pier
Erie, PA 16507
9 a.m. to 11 a.m.

Pittsburgh – Thursday, June 11, 2015
Allegheny County Courthouse
Gold Room
436 Grant Street
Pittsburgh, PA 15219
9:30 a.m. to 12:30 p.m.

Altoona – Tuesday, June 16, 2015
Blair County Convention Center
One Convention Center Drive
Altoona, PA 16602
1 p.m. to 3 p.m.

Scranton – Wednesday, June 17, 2015
Hilton Scranton & Conference Center
100 Adams Avenue
Scranton, PA 18503
9 a.m. to 11 a.m.

Harrisburg – Tuesday, June 23, 2015
PaTTAN – Harrisburg
Conference Room 1
6340 Flank Drive
Harrisburg, PA 17112
9 a.m. to 12 p.m.

Philadelphia – Friday, June 26, 2015
Temple University Center City, Room 222
1101 Market Street
Philadelphia, PA 19122
1 p.m. to 4 p.m.

Additional opportunities to provide input, including interactive webinars, will be announced.
Appendix A

Managed Long-Term Services and Supports (MLTSS) Discussion Document Comment Matrix

The discussion document is available at http://www.dhs.state.pa.us/efraud/managedlongtermsupportsIndex.htm or by contacting the Department of Human Services, Office of Long-Term Living at (717) 783-9412. If you wish to request a copy of the discussion document in an alternate format, please use the number listed above.

Please use the matrix below to assist you in compiling and organizing your comments on the MLTSS discussion document. The document specifically solicits comments on program design, planning phase, implementation, oversight, and quality. Please enter your comments in the most applicable category.

Thank you in advance for your participation and comments.

Please return comments via email to: Pa-MLTSS@pa.gov Or by mail to: April Levenson, Department of Human Services, Office of Long-Term Living, Bureau of Policy and Regulatory Management, P.O. Box 8025, Harrisburg, PA 17105-8025.

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<td>Organization (if applicable):</td>
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<td>how do you identify yourself?</td>
<td>Consumer</td>
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| Program Design: | |
| Planning Phase: | |
| Implementation: | |
| Oversight: | |
| Quality: | |

Comments are due by July 15, 2015.
Provider-Manager Model (ACAP & LIFE)

- Health plans not part of this model
- DHS or Aging contracts with one or more service providers
- HCBS service provider receives capitated rate to manage and provide HCBS services + pay for certain medical services
• If provider can reduce utilization of more costly medical services - particularly nursing facility under LIFE - provider will have more $ available for HCBS
• Type and amount of HCBS services determined by the provider (within menu of services set out in contract)
• Medical services typically provided under contract with medical providers or fee for service Medical Assistance
MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS WAIVERS HAVE BEEN APPROVED IN 19 STATES AS OF JANUARY 1, 2015.

MLTSS PROGRAMS IN 26 STATES TOTAL.
Some states structure programs as demonstration projects under the authority of § 1115
- AZ, CA, DE, HI, KS, NJ, MN, NY, RI, TN, TX, VT

Other states use combination § 1915(b)/(c) waivers for authority
- FL, IL, MI (2 waivers), MN, OH, WI

Note that states may implement Medicaid managed care through § 1932 state plan authority or § 1915(a) waivers with voluntary enrollment.
Key Themes in Capitated MLTSS

- Most (15 of 19) of the waivers are or will be providing MLTSS statewide.
- Most (17 of 19) of the MLTSS waivers (all except RI and WI) require beneficiaries to enroll in managed care to receive LTSS.
- Most (14 of 19) of the waivers cover or will soon cover a comprehensive set of benefits, including nursing facility (NF) services, HCBS, acute and primary care, and behavioral health services.
- Four states use MLTSS waivers to increase access to HCBS by expanding Medicaid financial eligibility criteria.
- *Themes identified by Kaiser Family Foundation*
The IRIS (Include, Respect, I Self-Direct) Section 1915(C) Waiver program was launched in July of 2008. Program is only available to qualified adults in participating counties. Wisconsin has not required beneficiaries to enroll in managed care to receive LTSS.

- Projected Enrollment by 2011: 1,500
- ACTUAL ENROLLMENT by early 2012: 6,000
- This unexpected surge in enrollment led to a series of problems:
  - Lack of program integrity, flawed infrastructure to support participant choice, and operational problems with budget allocation
• **Quality of Life Strategy:**
  ○ Care managers and quality assessors use a validated interview tool to assess beneficiary and care team perceptions of quality of life and whether outcomes are being achieved in the areas of self-determination and choice, community integration, and health and safety.
  ○ Includes population-based health indicators, such as changes in functional status over time
• **Wisconsin** health plans must participate in a program-wide beneficiary satisfaction survey
NEW YORK

- § 1115 waiver approved in 2012 – 2014; Extension through December 2019
- Moved from a geographically limited program to statewide services

- **NY now enrolls all beneficiaries in managed care in order to receive LTSS** - Delivered through existing Managed Long-Term Care plans
  - Advocates criticized this change due to (1) abbreviated transition periods and (2) a failure to address policy issues before making the change.
  - It appears as though NY did provide for an “opt-out” for beneficiaries
NEW YORK

- **Quality of Life Strategy:**
  - MLTSS waiver promises to incorporate performance measures for outcomes related to quality of life and community integration
  - Very little detail provided for HOW to measure

- **State Monitoring of MCOs:**
  - MCOs must report monthly on notices issued and appeals received regarding reductions in split shift, or live-in services, or reductions of hours by 25% or more
  - **New York** must report to CMS on the total number of complaints, grievances, and appeals by type of issue
INCREASING ACCESS: Eligibility Expansion

Four states have used waivers to increase access to HCBS by expanding Medicaid financial eligibility criteria:

- New Jersey – Uses a projected spend-down that qualifies beneficiaries for Medicaid “home and community-based waiver-like services” if their monthly income exceeds annual average nursing facility costs. Eliminates the five-year asset transfer look-back period for applicants seeking LTSS with income at or below 100% FPL.

- New York

- Rhode Island

- Vermont
Various States have included types of beneficiary protections in the provisions of their plans.

- Independent Enrollment Counseling (8 states)
- Ombudsman Programs (11 states)
- Access to an Independent Advocate (3 states: NJ, RI, VT)
- Managed Care Advisory Groups
  - State maintains advisory group (7 states)
  - MCO’s must establish advisory groups (6 states)
Ombudsman Program Types

- Ombudsman programs are typically charged with:
  - (1) helping beneficiaries access covered services
  - (2) tracking and assisting beneficiaries with complaints

- In 9 states, the ombudsman program is specifically authorized to assist beneficiaries with the appeals process (CA, HI, IL, KS, MN, NM, NY, OH, TX)

- 5 States include additional responsibilities such as training health plans and providers; employing staff knowledgeable about Medicaid managed care and people with disabilities; publicly reporting on complaints and appeals

- An alternative: access to an independent legal advocate for appeals
QUESTIONS

COMMENTS