

Transition of Aged, Blind and Disabled Populations to a Managed Long-term Care System Examples, Concerns, Recommendations

Though managed care programs have only penetrated 2.3% of the long-term care market, there are indications that their prevalence is expanding, albeit slowly. By 2003, managed long-term care (MLTC) of some form had taken root in 7 states, while MLTC specifically for the elderly existed or was in development in 17 states. A significant motivating factor for this restructuring has been to improve the quality and efficiency of service provision over the traditional fee-for-service system. A number of factors have contributed to the slow growth: “complex program design choices (including payment methodology), relatively long planning and start-up periods, resistance of long-term care providers and advocates, difficult state-federal policy issues, the need for a substantial population base, limited interest among potential suppliers, and inadequate state infrastructure”

(Saucier, Burwell, & Gerst, 2005, p. 1).



The National Leadership Consortium on Developmental Disabilities analyzed and compared transition to managed care in four states: Arizona, Michigan, Vermont and Wisconsin. Salient points of this analysis are presented to provide an overview of transition strategies, obstacles, implications and recommendations. It is important to note at the outset that none of the four states featured adopted a managed care approach with the primary purpose of reducing state spending on long-term care services. The goal, rather, was to achieve enhanced statewide equity in access and to improve the cost-effectiveness and quality of services. The report also notes that the federal statutory waivers upon which the programs in the examples are based were initially approved years ago. It is not clear whether the Centers for Medicare and Medicaid Services (CMS) would negotiate similar agreements with other states today, although the recent recession and the significant numbers of individuals on long waiting lists for services in most states puts pressure on policy makers for solutions to meet the need.

Areas of Concern

A number of concerns have arisen as a result of this shift from a fee-for-service to a managed care system.

Risk Sharing

The featured states took several different approaches toward sharing risk in the implementation of long-term managed care. In Vermont and Arizona, the state government assumes 100% of the financial risk. In Michigan and Wisconsin, the state government shares the financial risks of cost overruns with county or multi-county managed care entities. In these two states, the state specifies the minimum financial reserves that a Managed Care Organization (MCO) must retain and offers incentives to build their cash reserves. Michigan limits the Pre-paid In-patient Health Plans' (PIHP) risk exposure to 7.5% over the total amount of the plan's annual contract with the state. Neither Michigan nor Wisconsin has a clear contingency plan for the possibility of an MCO or PIHP insolvency, though. In the case of such an outcome, it is presumed that the state would be the ultimate guarantor of the plans.

Management and Administration

The management and administration of the managed long-term care systems present another area in which a variety of frameworks have been demonstrated, both at the state and local level.

At the state level, Arizona and Vermont have established shared responsibility between the state Developmental Disabilities (DD) program agency and the single state Medicaid agency. In this arrangement, the DD program agency is responsible for overseeing the service procurement and the delivery process. The Medicaid agency is responsible for the oversight of the state's section 1115 waiver/demonstration program. For Michigan and Wisconsin, all activity is conducted by the single Medicaid agency which serves as the DD program agency as well.

All of the states presented here for comparison adopted different structures for local level management and administration. In Arizona, seven district offices manage all aspects of delivery services and state-funded DD services including the direct provision of support coordination. In Michigan, the state mental health (MH) and substance abuse (SA) divisions contract with a network of 18 PIHPs to obtain all Medicaid-funded specialty services for individuals with MH, SA and DD needs. The functions of the PIHP are supplemented by 46 Community Mental Health Services Programs (CMHSPs), which are the single-point-of-entry for all public MH, SA and DD services. For Vermont, a network of ten non-profit designated agencies across the state operates as the single-point-of-entry. Participating counties in Wisconsin appoint an MCO to be responsible for planning and procuring all long-term services. A separate network of Aging and Disability Resource Centers (ADRCs) is responsible for assisting individuals and families with finding resources and determining eligibility.

Eligibility

In all four states, eligibility is a two-tiered process. Individuals must first meet the state's statutory definition of having a "developmental disability" or "mental retardation." Individuals must then prove sufficient severity in order to qualify for the long-term services program. Michigan and Wisconsin have adopted the federal definition of DD, which contains only functional descriptors. Arizona and Vermont link eligibility to the definition of "mental retardation," other etiological conditions and the federal definition's functional descriptors.

Funding

All states consolidate a variety of funding streams to form a single, flexible source of funding and cite this feature as one of the main motivating factors in switching from fee-for-service to long-term managed care. Arizona combines Medicaid funding for home and community-based services (HCBS) and Intermediate Care Facilities for the Mentally Retarded (IMF/MR), health plan coverage, and behavioral health coverage. Michigan and Wisconsin both combine the HCBS waiver and ICF/MR dollars, certain state plan coverage, and the state and county match. Vermont combines the HCBS waiver and ICF/MR dollars with the flexible family grants.

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Implementation

The primary concern with implementation is mitigating the impact of an overhaul of the state system. In Wisconsin, five pilot counties implemented a Family Care program for all eligible target populations, while one county limited services during the pilot period to eligible seniors. Five years later, after

assessments, plans were announced to expand statewide by the end of five years. Planning grants were awarded to groups in various catchment areas across the state. There was an expectation that all of the participating organizations would band together to form a Managed Care Organization to contract with DHS. The MCOs would serve multi-county catchment areas with the pilot counties serving as the base.

Of the four states profiled, only Arizona's program covers the entire state. The majority are limited to a county or multiple counties with urban centers. Most state and plan officials consulted believe that managed long-term care needs an urban base to be viable. There needs to be an adequate volume of participants and supply of providers.

States that proposed models of fully integrating acute and long term care by combining Medicaid and Medicare financing streams experienced protracted planning periods of more than five years. Other states reduced planning periods by taking Medicare off the table and working with CMS to develop unprecedented approaches to HCBS waivers. To keep the door open to Medicare, Texas included incentives for dually eligible consumers to join Medicare + Choice plans (now Medicare Advantage).

Across the board, there has been strong resistance to fully integrating acute and long term care.

Challenge of maintaining an adequate provider network

The AZ Division of Developmental Disabilities (DDD) maintains a network of over 3,000 "qualified vendors" (under formal contract with DDD) and "individual independent providers" (IIP) (who must meet DDD qualifications and enter into an Individual Service Agreement). Individuals and families may: a) identify their own IIP or individual willing to become an IIP or select from a list, b) choose a qualified vendor, or select from a list, or c) be automatically assigned a qualified vendor.

The Consortium report makes the claim that "the available support options often are broader under a managed care approach, especially in sparsely populated areas of the state." Enrollees are assured of having access to at least two providers of any covered service, unlike in the fee-for-service system. However, they do not explain how the states address provider capacity.

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One executive director at a statewide provider agency in WI expressed a need for supports for community provider agencies and recommended offering start-up funds to help provider agencies, especially small independent providers, make the transition. The CEO of a large residential provider agency in another state voiced concern that without the ability to offer providers fair compensation, reasonable benefits, a positive work environment, and recognition for their services, services would be seriously compromised.

Texas addressed protection for the long term care providers by giving three years of transition protection.

Massachusetts requires Senior Care Organizations to subcontract with at least one Aging Services Access Point (ASAP), the state's traditional portal for community long term care services.

One approach to protecting existing LTC infrastructure is to ensure that traditional providers can themselves become risk-bearing managed care organizations. In FL, certain long term care providers

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are authorized to become diversion program contractors by virtue of their state provider licensure status.

Most organizations that have entered the managed long-term care business are provider-based organizations that have developed a managed care capacity.

Strengths and Weaknesses

The consortium report sought feedback from key stakeholders in the four states featured. Key stakeholders included: state and county program administrators, directors of advocacy organizations, state officials, and provider agency executives. Some of their input is presented below in the form of transition strengths, weaknesses and recommendations.

Strengths

One beneficial outcome of the system transition is that it obligates states to make services and supports available to all eligible individuals according to when, where and how they need them. This eliminated the need for waiting lists. One observer commented, “It’s hard to see how a fiscally conservative state like Arizona could have expanded services so broadly in a fee-for-service environment.”

Many explained that combining relevant Medicaid and non-Medicaid funding streams allowed greater flexibility to design supports around the needs and preferences of each individual.

Two administrative officials responded to effects of an emphasis on cost-effectiveness and the related tools to craft support plans that make more sense and cost less. One stated, “[we] can focus on services and supports appropriate to the person rather than struggling to obtain whatever scant resources are available.” Another observed that, “[the] waiting lists in fee-for-service systems gave consumers either ‘a Cadillac [program]’ or nothing at all.”

- Many respondents cited the benefit of having a fixed point of accountability.
- Interviewees expressed that the global management of dollars promotes an incentive to intervene before a major crisis occurs.
- Stakeholders emphasized the importance of the right to choose between qualified providers.
- It was observed that the additional federal dollars resulting from the managed care agreement with CMS helped to stabilize the financial status of the state’s Medicaid program.
- A number of respondents praised the commitment to achieving geographic equity that resulted from the change from fee-for-services to managed long-term care.

Weaknesses

Stakeholders expressed that geographic equity in access to services had not yet been fully achieved. While the statutory and regulatory goals were seen to be highly progressive, it was noted that opportunities to receive supports in new and creative ways was not readily available.

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A number of challenges were expressed by respondents:

- There was uneven access to individualized services between counties.
- Problems acquiring and maintaining adequate number of qualified personnel were cited.
- Stakeholders commented that transition involves a steep learning curve because it is an entirely new manner of administering services. This shift often involves re-training.
- A high turnover rate in administrative staff was observed, even after re-training.
- Concern was expressed by advocates that “natural supports” and “family stabilization” were often used as code words for reasons to deny adults access to out-of-home living arrangements they need and desire.

“America’s Health Insurance Plans (AHIP) and ADAPT, a national disability rights organization, support the following guiding principles for serving individuals with disabilities through Medicaid health plans”

- *Regional Training*
- *Ongoing dialogue with stakeholders, including individuals with disabilities*
- *Community integration*
- *Outreach and education*
- *Community integration and consumer directed services*
- *Control of individual health maintenance activities*
- *Access to medical equipment and assistive technology*

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Perspectives of Managed Care Companies toward ABD Design

With proposals for wrapping ABD populations into managed care service provisions on the table in many states, nationally-based managed care companies have expended resources soliciting feedback from disability advocates, and a few have submitted policy papers, statements of intent, or philosophy to guide on-going discussions.

America’s Health Insurance Plans (AHIP) and ADAPT, a national disability rights organization, support the following guiding principles for serving individuals with disabilities through Medicaid health plans to promote availability of services that are responsive to these individuals’ interests and concerns.

1. **Regional training:** National, regional, state-based, and local training should be designed and conducted through collaboration of individuals with disabilities, health plans, States, and other stakeholders. These initiatives should focus on how the integration and delivery of acute and community long term services advance community integration principles such as:
 - 1) consumer directed services;
 - 2) person centered planning;
 - 3) accessible, affordable, integrated housing;
 - 4) voluntary service coordination;
 - 5) delivery of services in the most integrated setting;
 - 6) access to independent community-based service coordinators;
 - 7) service plan responsive to the unique needs of individual enrollees, including access to network and out of network specialists, who have experience in serving individuals with disabilities;

- 8) delivery of services based on individual need as determined by functional assessment;
 - 9) livable wage/benefits for attendants; and
 - 10) comprehensive, continuous quality improvement programs.
2. **Ongoing dialogue with stakeholders, including individuals with disabilities:** In establishing and operating programs to provide services to individuals with disabilities through Medicaid health plans, states should ensure significant statewide and local ongoing public input in the development of Medicaid health plan contract requirements and program design including eligibility, rates, community integration principles, and program requirements. As part of this process, health plans should facilitate ongoing, active participation by individuals with disabilities.
 3. **Community integration:** State programs should include and adequately fund a requirement that Medicaid health plans provide covered individuals, regardless of age or extent of disability or place of residence, with the option for services to be delivered in the most integrated setting, and that services be based on a functional assessment outlined in a person-centered plan. To allow covered individuals to take advantage of this option, states should facilitate access to housing that meets the individual's needs. Access to community integration services should not be linked to specific types of housing.
 4. **Outreach and education:** An aggressive strategy of outreach and education for populations with all disabilities regardless of age should be implemented to ensure that these individuals have the information they need to be knowledgeable about the programs and services available to them. These efforts should include use of community based organizations, whenever available, in the development and implementation of these outreach and education initiatives.
 5. **Community integration and consumer directed services:** Medicaid managed care programs that serve individuals with disabilities should offer home and community-based services as an option for covered individuals regardless of age or extent of disability. There should be no institutional bias in the financial or functional eligibility criteria for the coverage of long term services and supports provided under state Medicaid managed care programs. Consumer-directed services should be offered as a first delivery option for all covered individuals. To allow covered individuals to take advantage of this option, states should facilitate access to assistance with locating accessible, affordable, and integrated housing not linked to their other community support services.
 6. **Control of individual health maintenance activities:** Covered individuals should have the option of developing, negotiating, and implementing plans to accept risk for and take control of their activities of daily living, instrumental activities of daily living, and health maintenance activities. Health maintenance activities should include but not be limited to: 1) medicine administration; 2) catheterization; 3) ventilator care including suctioning; 4) IV injections; 5) wound care; 6) tube feeding; 7) bowel care. To expand availability of such options, states should work with health plans and advocates, including those representing individuals with disabilities and nurses, to enact laws that amend nurse practice acts.

[Note: Georgia passed HB 1040 in 2010, giving individuals with disabilities this option, under health professional orders, and after training by a registered nurse.]
 7. **Access to medical equipment and assistive technology:** Funding should be provided under state Medicaid managed care programs for coverage that allows individuals access to appropriate medically or functionally necessary durable medical equipment (DME) and assistive technology that would enhance independent functioning and promote independent living for covered individuals, including professional assessment of need and type of equipment, and set-up and training for users.

The National Advisory Board on Improving Health Care Services for Seniors and People with Disabilities proposes “Six principles necessary to modernize our health care infrastructure.” These support AHIP’s and ADAPT’s principles.

- Enhance self-care through improved coordination
- Encourage community integration and involvement
- Expand Accessibility of Services and Supports
- Uphold personal preference
- Empower people to participate in the economic mainstream
- Invest in improved technology

While this consensus document does not specifically address managed care systems change, it reiterates principles for integrating long term care and health care through flexible funding, better use of technology, incorporation of community supports and individual, person-centered planning to enhance service delivery. Many of these same concepts have been advanced in the context of managed care.

Advice to disability stakeholders in other states

The experience of these four states describes how a managed care plan can be a vehicle that provides eligible individuals with reasonably prompt access to the long term supports they need. Most of the individuals served would say that they are better off than individuals in states with long waiting lists, despite the fact that none of the states have solved all the service design challenges. However, all would agree that hastily conceived plans that are aimed primarily at slashing state outlays can have disastrous consequences. The National Consortium concurs on the following recommendations for states considering transition to managed care:

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Design

- Assess individual states’ situations carefully before restructuring publicly-financed long-term services.
- Make sure the plan clearly reflects core values intended to be instilled in the program.
- Involve representatives of key stakeholder groups in all aspects of development and implementation.
- Take time to resolve potential issues during design and initial implementation phases.
- Understand the state’s primary motivations for adopting a managed care plan and focus on the actions necessary to secure the interests of people with DD.
- Design the plan to promote efficient use of available resources.

Implementation

- Make sure that the state agency responsible for implementing the program has the necessary resources to actively oversee and enforce performance expectations.
- Include special initiatives to ensure that the goals of community inclusion, participation, independence and productivity are reflected in the lives of program participants.

- Make sure that community provider agencies have the tools and the qualifications necessary to provide high quality supports.
- Develop provider capacity in all areas of the state to provide meaningful choice.

Three Concluding Thoughts

First, having a state agency serve as the hub of a managed care system rather than placing it in a non-governmental managed care organization makes more sense if the primary goal is to protect the interests of the tax-paying public and assure public accountability for services.

Second, integrating health, behavioral health and long term care services may provide clear benefits if one state agency can co-manage the different streams.

Finally, the importance of a value-based policy foundation cannot be overestimated if the risk of over-medicalizing long term care services is to be avoided.

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