Bridging Aging and Disabilities in Managed Care

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National Context

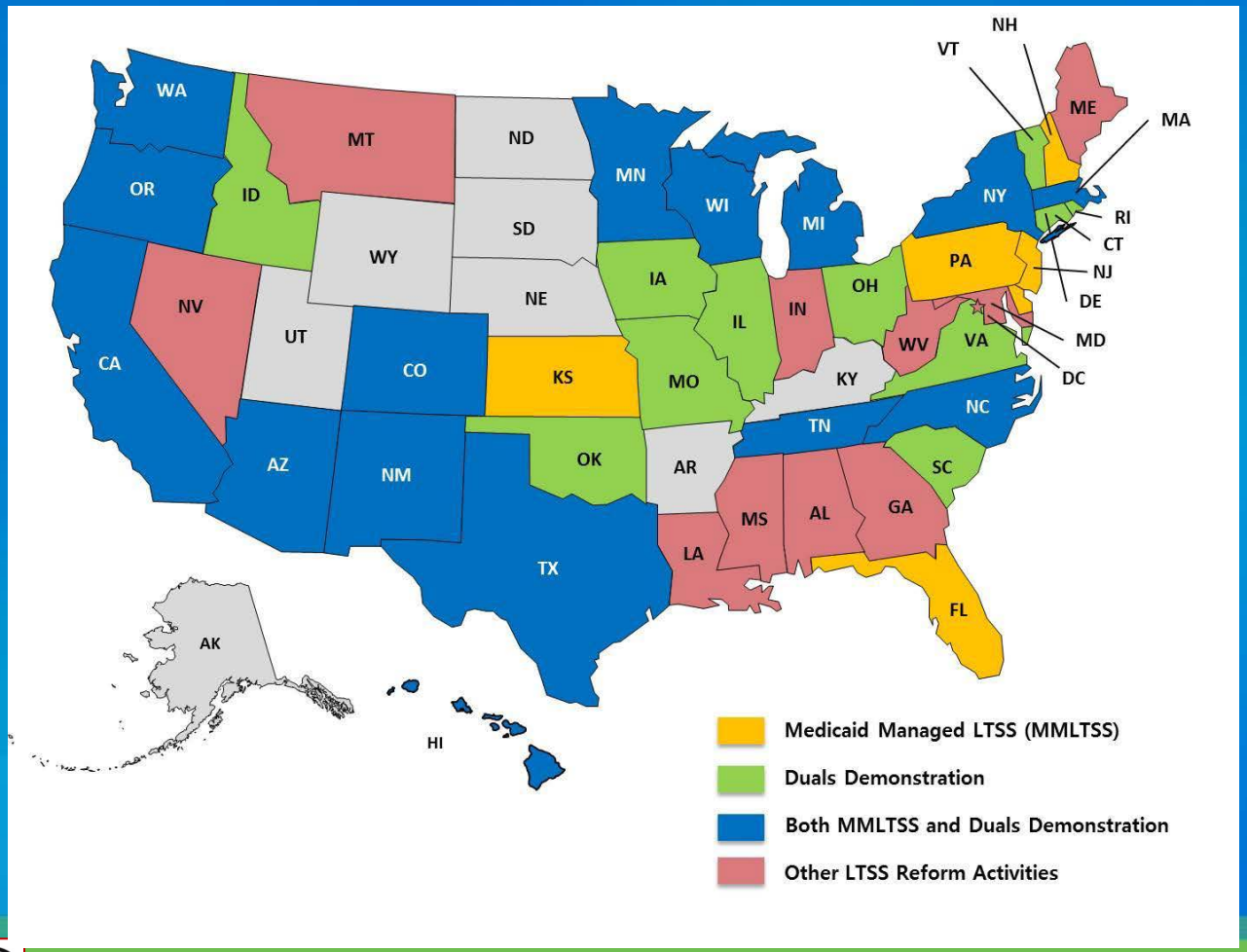
- By 2010 Managed Care in 47 states and DC served 71% of Medicaid population
- Often integrate health and long term services and supports (21 states)
- 5-18% of “dual eligibles” have I/DD
- Carve outs for DD in 18 of 26 states in Duals Demonstrations Proposals

Goals of Managed Care Programs

- Integrate care by improved coordination
- Reduce cost by reducing ER and hospital use
- Improve quality –better health and quality of life
- Provide more equitable access
- Streamline services and funding streams
- Fixed point of accountability
- Incentive for health promotion and crisis prevention

State Medicaid Integration Tracker

(National Association of State Units on Aging and Disability, October, 31, 2012)



Dual Eligibles and DD

- DD not carved out: CO, CT, ID, IA, MN, NY, VT, WI (only nursing home)
- DD carved out:
  - AZ, IL, NC, RI, SC (only aging), TX,VA
  - CA: receiving DDS services
  - HI, OH, WA*: waiver
  - MA*, NM, OR: waiver, except for health care
  - MI: can opt out but wont receive care coordination with acute care
  - MO, OK: can keep waiver but receive care coordination through demonstration
  - TN: except for health care

* Approved by CMS

Managed Care/LTSS and DD (National Leadership Consortium, 2009)

- AZ: 20 years experience in LTSS and MC
  - Entitlement without waiting list, mostly family support, low costs
- MI: since 1998
  - Addressed waiting list, includes employment, controlled costs, survived budget cuts
  - Operated by county mental health boards
- Wisconsin
  - Run through ADRCs and MCOs
  - County based

California and Medicaid MC (Breslin, 2012)

- California Medicaid Managed Care 1115 Waiver 2011 - 2012
- Mandatory enrollment of seniors and people with disabilities into Medicaid (Medi-Cal in California) managed health care
- 240,000 seniors and PWDs from fee-for-service into managed care between June 2011 and May 2012
- Combined waiver programs anticipate savings of $2.1 billion over 5 years

Implementation Challenges

- Inadequate outreach
- Confusing medical exemption policy
- Difficulty maintaining continuity of care
- Improper enrollment
- Difficulty sharing beneficiary claims data
- Challenges with rate setting
- Performance measures lacking

Breslin , APHA 2012

Illinois Medicaid Integrated Care

- History of fragmented fee-for-service, traditional Medicaid
- Illinois has been moving towards managed care
  - General Assembly Legislation
    - Require 50% of Medicaid eligible individuals to be in systems of coordinated care
    - Provide for opportunities to have non-traditional partners in future
  - Economic Efficiency
  - Save State $200 million over 5 years
  - To improve health outcomes
    - New focus on prevention
    - New focus on community integration

Integrated Care Program

- Impacts 40,000 in collar counties of Chicago
- Medicaid-only seniors and adults with disabilities
- Move from traditional Medicaid to MC run by two MCOs (Aetna or IlliniCare)
  - Establish medical homes and care coordination
  - Phase I: Acute health
  - Phase II: Long-term supports and services (except DD)
  - Phase III: DD Long-term supports and services

ICP Evaluation Design

- UCEDD Evaluation team independent of MCOs
- Solicits input from stakeholders / participatory process
- Uses quantitative and qualitative data
- Process evaluation
  - MCO capacity
  - Capacity building framework & focus groups
- Outcome evaluation
  - Encounter data
  - Quality of care
  - Consumer Survey

ICP Evaluation Components

- Survey
  - Uses both standard Medicaid quality indicators and ones "customized" for people with disabilities
    - CAHPS
    - AHPPPAL
    - SF/RAND-12
    - Activities/Instrumental Activities of Daily Living
  - Participatory process
    - Input of State and MCO staff
    - Pilot testing with people with disabilities
- Focus Groups
- Medicaid claims data

ICP Evaluation Status

- Year 1 Survey
  - 2195 originally sampled
  - 1216 in ‘final sample’
  - 419 responses (34.4% response rate)
  - Difficulty reaching nursing facilities
- 16 focus years (77 participants) conducted with consumers, caregivers, providers, MCO staff
- Stakeholder meetings and interviews

Demographics of Respondents (N=419)

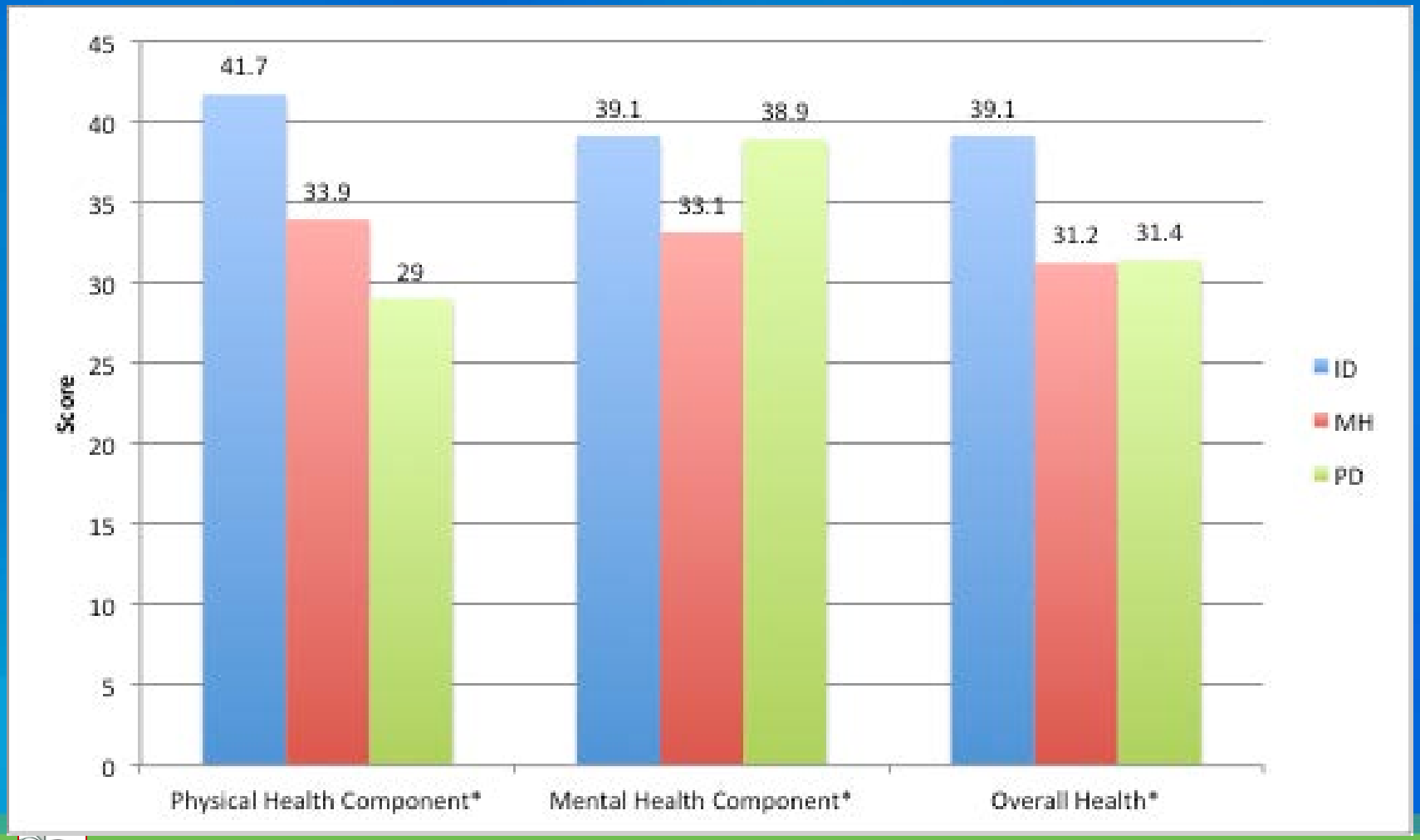
Demographic	ICP Eligible Population (n=39,420)	Survey Respondents (n=419)
Gender	53.9% Female 46.1% Male	57.2% Female 42.8% Male
Race*	49.0% White 40.8% Black 9.9% Asian 0.4% Other	44.2% White 32.2% Black 8.5% Asian 15.1% Other
Ethnicity*	17.2% Hispanic	13.0% Hispanic
Mean Age	48.9	49.7
ICP Group*	74.6% Community 9.0% Nursing Fac 6.3% DD waiver 4.8% Phys. Dis. waiver 2.9% Aging waiver 2.5% Other	80.2% Community 4.5% Nursing Fac 5.3% DD waiver 6.0% Phys. Dis. waiver 1.9% Aging waiver 2.1% Other

*** Statistically significant at .05 level**

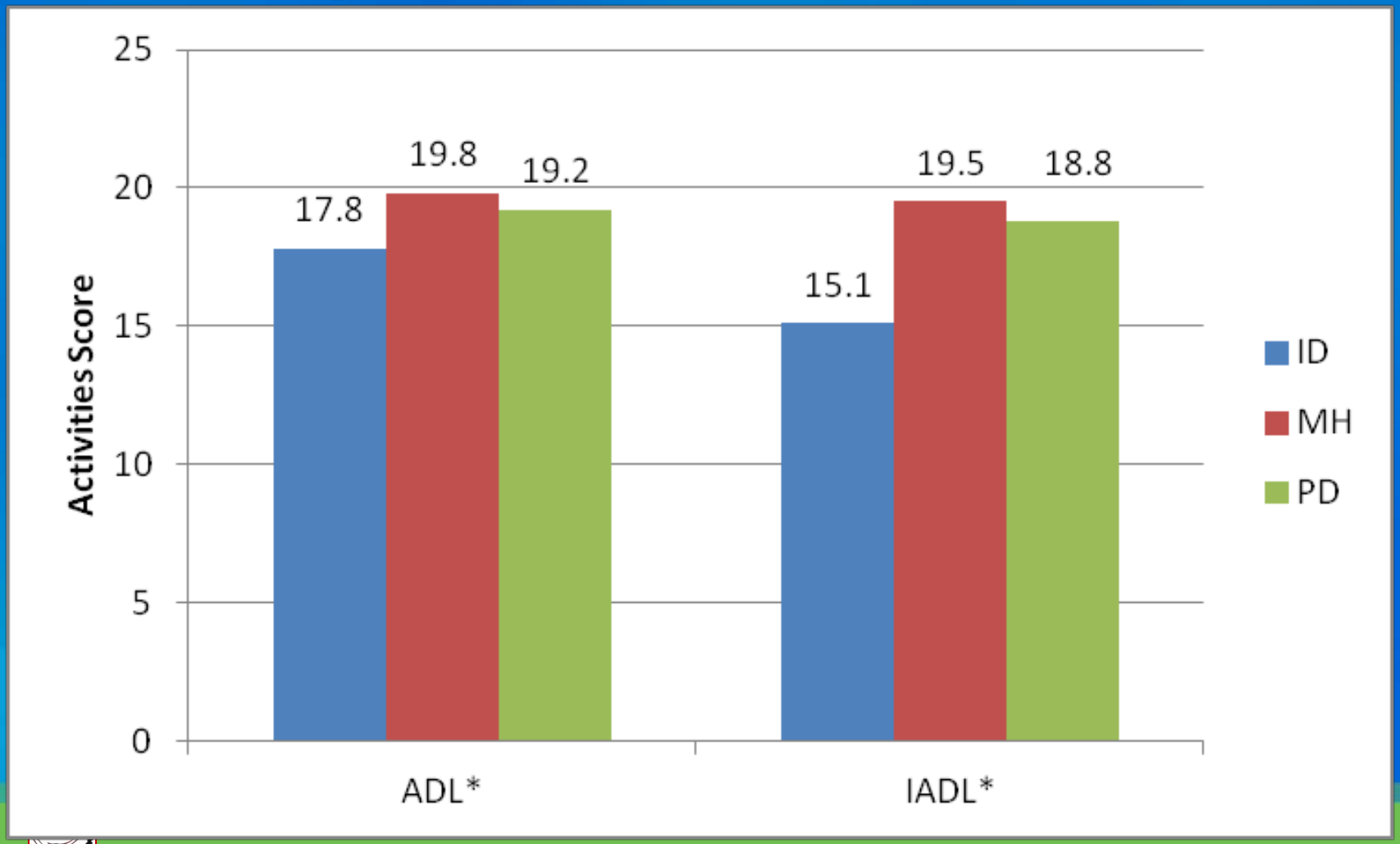
Respondent Groups (Baseline Survey)

- 75% of State-defined 'ICP Groups' were community residents
- Self-reported disability
- Intellectual/Developmental Disability (124)
- Mental Health or substance abuse (107)
- Physical Disability (125)
  - Includes visual or hearing impairments and brain injury

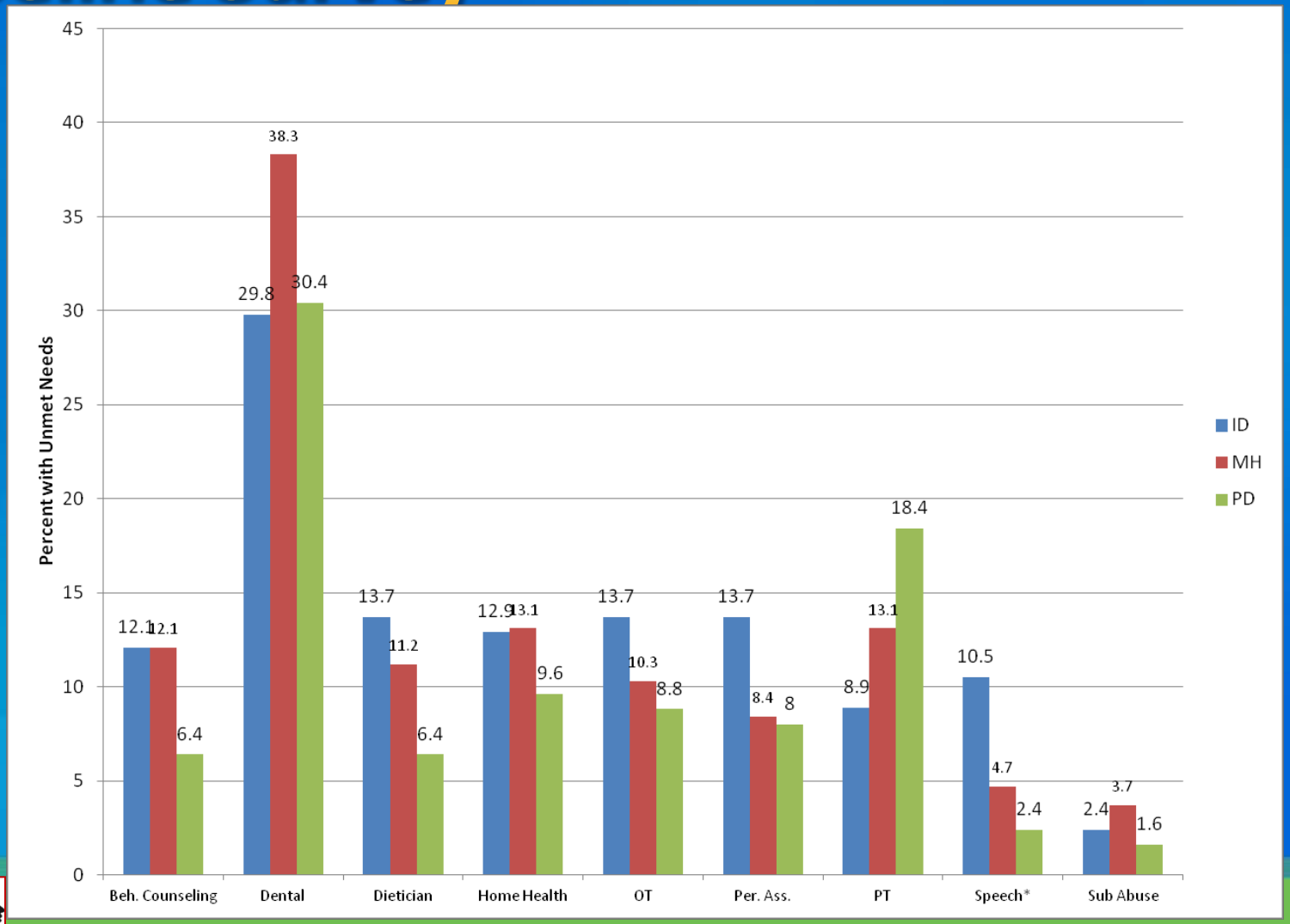
Health Status – RAND-12 Scores Baseline



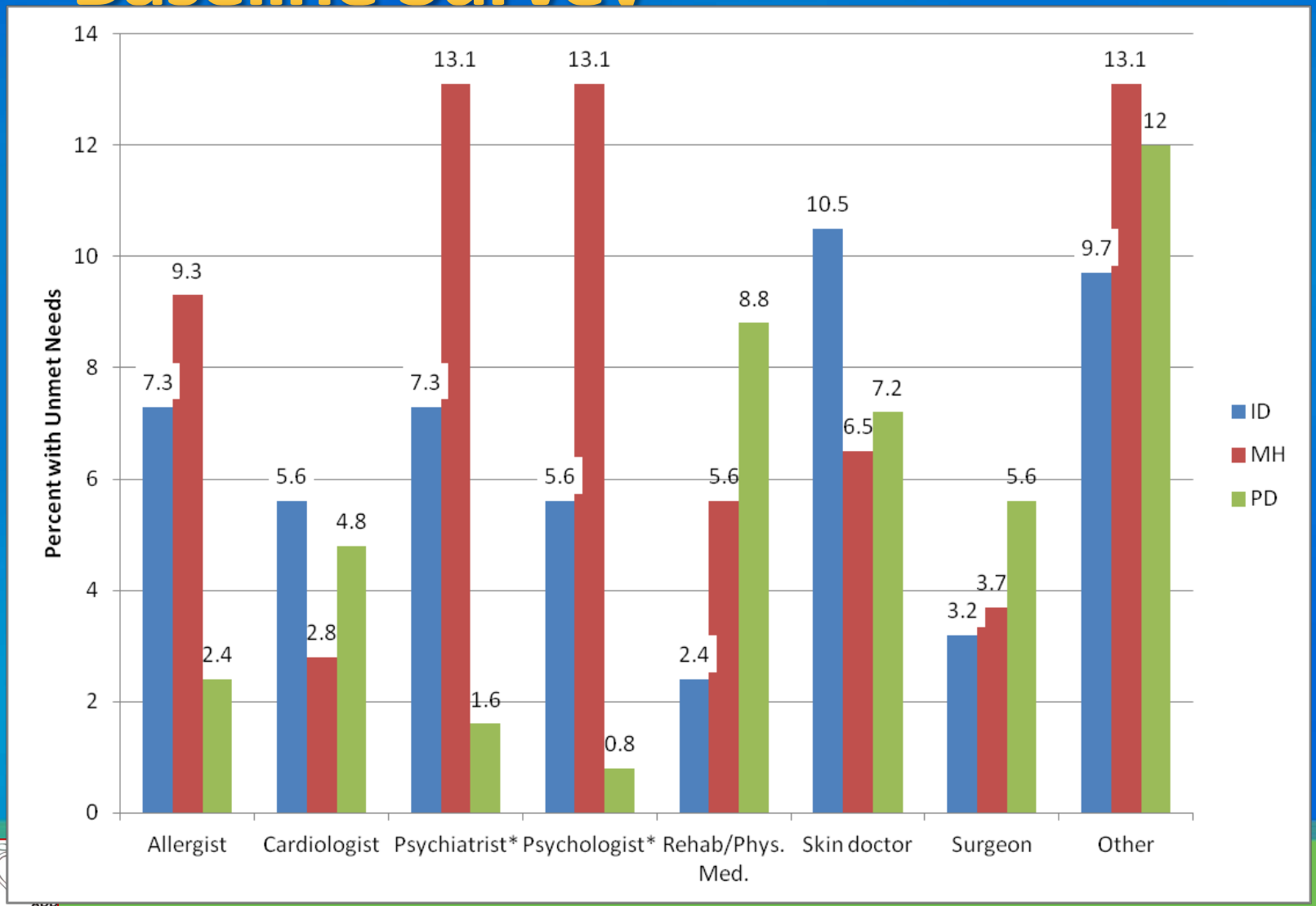
Health Status – ADL/IADL Baseline Survey



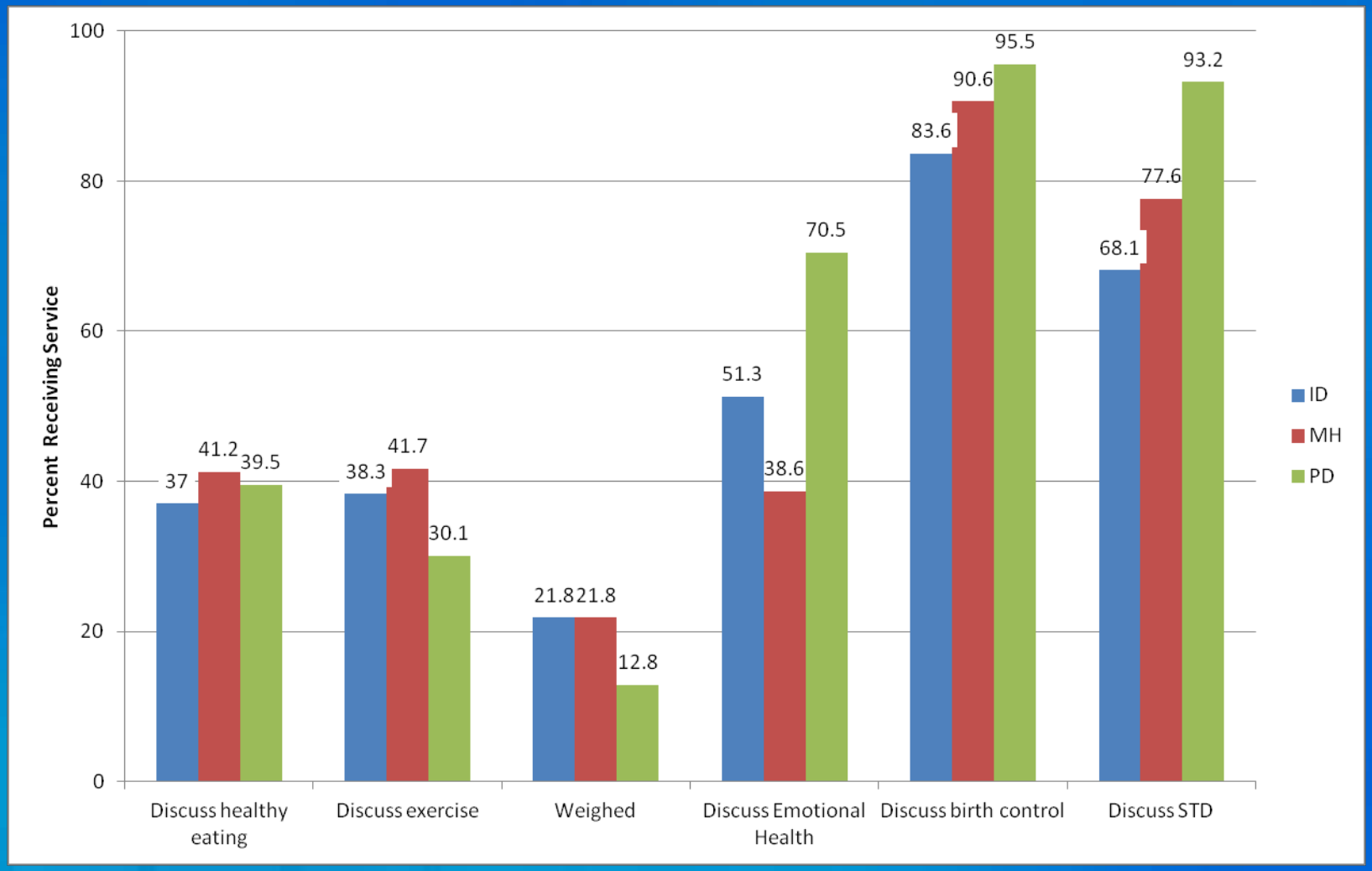
Access to Health Services (unmet) Baseline Survey



Access to Specialty Services (unmet) Baseline Survey

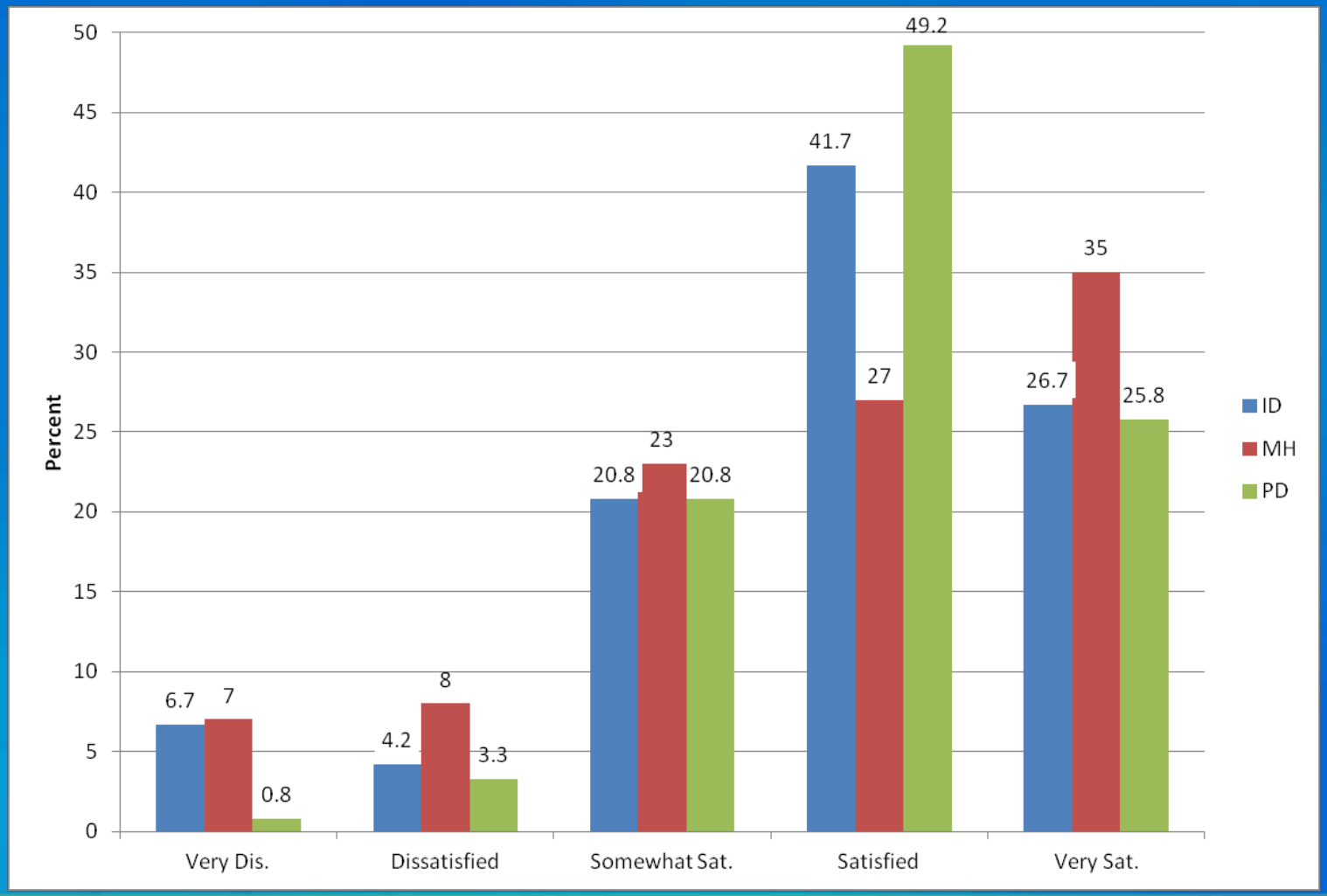


Preventative Care Baseline Survey



Satisfaction at Baseline

How satisfied are you with your overall health care services?



Development of MCO Networks

- Development of networks of baseline physicians has been slow
  - 5 to 15% of baseline after two months
  - Less than 50% of baseline after one year
- Each MCO took steps to ensure continuity of care if providers did not join the network (varied in length)
- Providers are put through a rigorous credentialing process in order to join the network

Prior Approval of Services

- Data from April 2012 indicates the following MCO turn-around times
  - 1-2 days for urgent requests
  - 2-3 days for non-urgent
- Behavioral health providers report additional problems
- Denials around 1% (inpatient and drugs)

Timely Payment to Providers

- Issues in payments for providers in the first few months, and steps have been taken to improve this
- MCO data indicates that one year after ICP, the great majority of claims are paid within 30 days
  - Only includes clean claims, not those that are rejected and resubmitted

Care Management

- One year after ICP, only half of members had initial risk screening (required within 90 days)--still trying to locate remainder
- Plans vary but together these plans had:
  - 11% in high-risk (prior to ICP, it was estimated that only 4% would be high risk)
  - 11% in moderate risk
  - 78% in low risk
- Good reports from stakeholders regarding the “one person to contact”
- MCOs pay close attention to people prescribed many anti-psychotic medications

Potential Concerns

- Adequacy of PCP, specialty provider network
- Involvement of key providers such as large medical centers and teaching hospitals
- MCOs unfamiliar with clinical needs of people with disabilities
- Disruptions in continuity of care

Next Steps

- 2,156 distributed in Year 2 (473) for ICP
  - Includes 380 person longitudinal group (168)
  - Assess ICP relative to baseline
- 2,000 distributed in Year 2 (405) in Chicago for comparison
  - Compare ICP to another sample to account for external factors
- Analysis of Administrative and Encounter data

Recommendations

1. Expand the state's "readiness review" prior to implementation of the new program.
2. Improve the enrollment and transition processes by using system "navigators" for newly targeted consumers and use trained community-based "helper" agencies to improve the enrollment process.
3. Lengthen transition period for consumers needing to change providers due to their current provider not joining a new network.

Recommendations

4. Host ongoing post-implementation meetings between MCO care management staff and community-based care management staff to ensure that working collaborative relationships between the two parties are strengthened.
5. Hire an external contractor to conduct "secret shopper" surveys on at least a quarterly basis to confirm the accuracy of information in the monthly provider listings submitted by the MCOs.

Potential Role of UCEDDs/LENDS

- Make sure DD stakeholders are at the table and consulted such as Braille and audio
- Educate and provide oversight regarding issues important to people with DD and their families
- Make sure that core values are part of the plans and adhered to
- Provide information regarding experiences of other states

Potential Role of UCEDDs/LENDS

- Provide technical assistance to MCOs
- Conduct evaluations of these initiatives
- Ensure that evaluations include relevant assessment tools and outcomes
- Provide feedback and solutions to implementation issues

RRTC ADD

Rehabilitation Research and Training Center on Aging with Developmental Disabilities: Lifespan Health and Function

www.rrtcadd.org/