Friday Morning Collaborative Webinar

State Advocate Experiences with Managed Long-Term Services and Supports

August 17, 2012
Friday Morning Collaborative

With support from The SCAN Foundation, NCOA leads a coalition of national aging and disability organizations working to protect and strengthen Home and Community-Based Services.

For more information about The SCAN Foundation visit:

www.TheSCANFoundation.org
Friday Morning Collaborative

- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer’s Association
- Balezon Center for Mental Health Law
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Leading Age
- Lutheran Services in America
- National Association of Area Agencies on Aging

- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Domestic Workers Alliance
- National Health Law Program
- National PACE Association
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Spinal Association
- VNAA – Visiting Nurse Associations of America
Webinar Overview

• Introduction
  – Joe Caldwell (National Council on Aging)

• Speakers
  – Gordon Bonnyman, Tennessee Justice Center
  – Valerie J. Bogart, Evelyn Frank Legal Resources Program, Selfhelp Community Services, Inc.
  – Mitch Hagopian, Disability Rights Wisconsin
  – Meg Cooch, Consortium for Citizens with Disabilities

• Questions and Answers
  – 20 – 30 minutes
Questions and Comments

All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Function
Power Point

• Can I get a copy of the Power Point?
• Will an Archive of the webinar be available?

YES! YES! YES!

• You will received copies in a follow up e-mail early next week. Please share wit others!
Setting the Stage

• Number of States with Managed LTSS Programs grew between 2004 and 2008
  – From 8 to 16 states operating 19 different programs
  – From 105,000 to 389,000 individuals receiving LTSS services through managed care programs.

• By 2014, 26 states projected to have Managed LTSS programs.

• New CMS Environmental Scan of Managed LTSS Programs

  www.medicaid.gov
Medicaid Managed LTSS:
Great Opportunities, Big Risks

August 17, 2012

Gordon Bonnyman
Tennessee Justice Center
gbonnyman@tnjustice.org
The Tennessee Context

• Tennessee has mandatorily enrolled *all* Medicaid beneficiaries in capitated managed care organizations since 1994. (This includes SSI & groups protected by 1997 Balanced Budget Act amendments.)

• Until 2010, LTSSS were carved out and reimbursed by the state on a fee-for-service basis.
The Tennessee Context

• Heavy emphasis on institutionalization - Tennessee consistently ranked 50th in % of LTSS $$ spent on HCBS.

• A 2003 settlement of a class action, *Newberry v. Goetz*, committed the state to development of capitated LTSS.

• Consumer advocates supported capitation as a way to redistribute LTSS $$. 
Tennessee’s Experience

• Tennessee began phasing in capitation of LTSS in 2010 with a program called “TennCare CHOICES.”

• In less than two years, enrollees receiving HCBS have increased from 18% to 33% of CHOICES enrollment.

Managed LTSS: An Opportunity

• **Rebalancing**: If consumers’ preferences for home and community-based services are consistent with MCOs’ drive for lower cost services, consumers are more likely to avoid institutionalization.

• **Integration**: Offers incentives and opportunities to integrate care across continuum of acute and chronic, physical and behavioral needs.
Managed LTSS: An Opportunity

• **Prevention**: For MCOs that also manage acute care, managed LTSS may create “reverse woodwork effect”, i.e., MCO has incentive to identify enrollees at risk for nursing home care and proactively provide preventive support services. Program design can enhance incentive by, e.g.:
  – Authorizing MCOs to cover cost-effective alternatives to covered services.
  – Capitation payment design.
Managed LTSS: The Risks

Funding:

• State may use it as vehicle to squeeze overall Medicaid funding of LTSS.

• But squeezing may be better than alternative of wholesale service or rate cuts to meet budget.
Managed LTSS: The Risks

Quality:

– Longstanding concerns about LTSS quality across all settings.

– Medicaid managed care has had its own issues with quality. E.g.,
  • P. Galewitz, Kaiser Health News, “Medicaid managed care programs grow; so do issues,” USA Today (11/12/10)

– The financial imperatives of managed care can compound potential for abuse in LTSS settings.
Managed LTSS: The Risks

– Capitation creates incentives not just to divert from nursing homes but also to underserve.

– MCOs purchase institutional care from the lowest bidder and may be able to exert continuing pressure to reduce facilities’ costs and possibly affect quality care. In many localities, Medicaid’s market share will give the MCO enormous leverage.
Who’s at Risk? – High Need, High Cost Patients

- MCOs may focus cost-containment efforts on heavy care patients, restricting access to medically necessary services.
  - Budget neutrality and other cost caps, combined with “consumer safety” requirements, will deny HCBS to heavy care patients.
  - At same time, access even to nursing home care could be curtailed.
Who’s at Risk? - The Poor

• HCBS assumes you already have housing in which to receive LTSS.

• HCBS won’t be an option for those who are poor and do not own their homes, unless subsidized housing agencies and resources are engaged in the design and implementation.
Who’s at Risk? - The Poor

• In the name of “rebalancing,” acuity requirements for nursing facility care may be increased, assuming the availability of HCBS for less acute individuals.

• Those without housing who cannot meet the more stringent acuity requirements may be unable to access either NF or HCBS.
Risks: Potential Impact on Racial Disparities

• Sharp racial disparities in access to Medicaid LTSS is longstanding problem receiving little attention from policy makers. [See: David Barton Smith, Health Care Divided: Race and Healing a Nation, (Ann Arbor: 1999).]

• Because of lower rates of home ownership, HCBS will not be option for many minorities, unless the housing issue is addressed.
Managed LTSS: Inevitable?

• **The Willy Sutton Principle**: In many states, nursing homes are the last big piece of the Medicaid budget that offers untapped savings. Cutting nursing home rates directly is politically fraught.

• **“Honey Badger Don’t Care”**: A state can use MCOs, which are immune to nursing home industry political pressure, to ratchet down LTSS costs.
Managed LTSS: Inevitable?


• As Medicaid’s legal and programmatic distinctions between acute and LTSS erode, the ability of the nursing home industry to resist managed care will fade.
The Implications of Inevitability: “No About Us Without Us!”

At the systems level:

• Consumer engagement in planning and design is crucial.

• Consumer advocates must be engaged *early* in the process, to maximize the opportunities and minimize the dangers and must *stay engaged* as implementation takes place, to identify and respond to unforeseen problems.
“No About Us Without Us!”

At the **individual** consumer level:

Consumer choice of:

– managed care plans
– providers
– services and
– consumer-direction options

is vital.
A Steep Learning Curve for MCOs

Most MCOs have little prior experience with LTSS, which is profoundly different from the acute care benefits they typically administer.

– Dementia care, in particular, is foreign to most MCOs.

– Advocates need to help MCOs understand the needs of a new enrollee population.
Details are Crucial

- The promise of managed care means nothing unless it is properly designed, and the incentives are aligned to produce benign results. The vulnerability of many consumers requires close attention to:
  - Single point of entry/eligibility
  - Contract terms
  - Contract compliance
  - Case management
  - Access to quality services
  - Ancillary services/functions (housing, advocacy, appeal rights.)
Intake & Care Planning

• **Front End Procedures Matter:** For people not already eligible for Medicaid when they need LTSS, their chance of avoiding institutionalization is largely determined not by the MCO, but by the State’s eligibility and care planning processes, and service availability.

• **Try this mental exercise:** Think how quickly HCBS must be put into place for a stroke victim about to be discharged from hospital. Unless the process moves very quickly, patient will default to a SNF or NF before ever being enrolled in an MCO. Housing and natural supports often erode after institutional placement.
Initial Assessment

• **Quality of assessments & care planning.** CMS is properly requiring that care needs be initially assessed by an agency without a financial interest in the care the person will receive. That agency must be accountable for the quality, timeliness and responsiveness of its services.

• **Consistency** – The states struggle to develop instruments that will ensure consistency in evaluations and inform capitation rates.

• **“Natural Supports”** – There can be pressures to place to rely too heavily on family and other informal caregivers.
Location, Location, Location

- **Housing is key.** As noted above, HCBS is only an option if the person already has housing, which Medicaid won’t provide. Program design must take housing needs into account.

- **Program must be nimble enough** to respond as person’s capacities/needs change

- **Nursing homes with chandeliers?** MCOs and LTSS providers may offer assisted living as an answer to a person’s need for housing and LTSS. This can raise serious quality issues, as such facilities are not subject to the federal quality and patient protections that apply to nursing homes, even though those served have similar needs and vulnerabilities.
Other Important Pieces

• Ombudsman & Public Guardian Services. Older Americans Act funding for ombudsmen is inadequate to meet needs of the over-60 population on which funding is based. Public guardian programs are inadequate, too. They often don’t serve younger consumers, or those in HCBS settings.

• Appeal Procedures. Individuals must have recourse to user-friendly, timely appeals procedures to challenge eligibility, assessment and care planning decisions by the state or its contractors. The design of these procedures requires careful attention, as they must be adapted to the complexities of these programs.
An Existential Challenge?

The vulnerability of LTSS consumers makes stringent MCO oversight, supported by effective performance monitoring, critical.

Is it possible?
Gordon Bonnyman  
Tennessee Justice Center  
301 Charlotte Avenue  
Nashville, TN 37201  
(615) 255-0331 or toll free: 877-608-1009  
info@tnjustice.org  
www.tnjustice.org

TJC is a non-profit, public interest law and advocacy firm serving low income families.
Managed Long-Term Care
New Mandatory Program in New York State

Evelyn Frank Legal Resources Program
Valerie Bogart, Director
(212) 971-7693
vbogart@selfhelp.net

See more information at http://nyhealthaccess.org
Dual Eligibles New to Managed Care in NYS

- Though Medicaid managed care has been mandatory for 20 years in NYS, with 3 million now enrolled, new to dual eligibles --
  - **Has always EXCLUDED Dual Eligibles** and people with a “spend-down” (medically needy).
  - SSI recipients without Medicare were excluded until 2010.
  - **Service packages “carved out” all long term care until 8/2011**- when *personal care services* carved in, affecting 5000 members who before had accessed these services through a prior approval system run by local Medicaid programs.
  - Long-term nursing home care, waiver programs still carved out.
LTSS in NYS before 2012

- State still heavy institutional use but has had robust HCBS options – mostly Fee for Service (FFS):
  - **Personal Care Services** – NYS is largest user of PCS in the USA, plan of care up to 24 hours/day available subject to local Medicaid program’s prior approval system. Billed FFS
  - **Certified home health aide** – Has been available beyond short-term post-acute needs if long-term need for skilled nursing care or supervision. Billed FFS but changed this year to DRG-like lump sum payment for episode of care.
  - **1915(c) waivers** – very limited in NYS for Aged/Disabled – mostly used by DD population
  - **PACE & Medicaid Advantage Plus** – relatively small optional programs – covering all Medicaid & Medicare primary and LTSS
  - **Managed Long Term Care** (MLTC) – This is what is shifting from voluntary to mandatory under a pending 1115 Waiver request.
## NYS LTSS Users/Expenses 2011

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Average # users/ mo.</th>
<th>Medicaid $ Spent</th>
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</thead>
<tbody>
<tr>
<td>Nursing Home/ICF-DD</td>
<td>90,826</td>
<td>$7.35 billion</td>
</tr>
<tr>
<td>Personal Care/CDPAP</td>
<td>61,488</td>
<td>$2.23 billion</td>
</tr>
<tr>
<td>Home Health (about 1/2 are short-term [ST] users)</td>
<td>82,696</td>
<td>$1.77 billion (includes ST)</td>
</tr>
<tr>
<td>Waiver - DD</td>
<td>51,000</td>
<td>$5.54 billion</td>
</tr>
<tr>
<td>Waiver – Aged/Disab.</td>
<td>24,000</td>
<td>$55.4 million</td>
</tr>
<tr>
<td>PACE, Medicaid Advantage (covers all Medicare/Medicaid)</td>
<td>5,707</td>
<td>$168 million PACE Medicaid Advantage N/A</td>
</tr>
<tr>
<td>Managed LTC (no Medicare services)</td>
<td>39,487</td>
<td>Not available</td>
</tr>
</tbody>
</table>
What is MLTC in NYS?

- 2011 State law requires most people receiving community-based LTSS to enroll in an MLTC plan, with CMS approval.
- Plans will receive capitation premium to approve, manage and provide all Medicaid LTSS.
- MLTC already existed as a voluntary option for LTSS with huge enrollment growth over last 2 years with heavy marketing. This will make it mandatory with no opt-out.
- 3 plan options:
  - (1) “Partially capitated” MLTC – only covers Medicaid LTSS + some limited specialty care (dental, orthopedic, optometry, DME, eyeglasses, hearing aides). Retain Original Medicare or Medicare Advantage for most primary and acute care.
  - Full Capitation – (2) PACE or (3) Medicaid Advantage – plan covers ALL Medicare & Medicaid primary care services & LTSS
Plan options

- Duals receiving CB - LTSS
  - Full capitation
  - MLTC *
  - Medicaid Advantage Plus
  - PACE

- Client will be assigned to MLTC if no selection made (keep Original Medicare or Medicare Advantage for primary/acute care) OR may select PACE or MAP.
Waiver Development Process

- State submitted 1115 Waiver request immediately after state legislation authorized it in April 2011, with no consumer input. Barebones proposal not fleshed out.*
  - Consumers immediately sent comments in 5/11.**
  - State assembled Advisory Committee, without significant consumer role, which met briefly and did not tackle major policies. **No transparency** in key policy development. **No ongoing workgroups. Any comments submitted to State go into a “black hole,” not shared with other stakeholders.

- Consumers wrote CMS in 12/11*** with concerns – received no response.

- 7/12 -- CMS gave verbal approval for mandatory enrollment to start in a limited area – NYC – for a limited population – personal care recipients. Will then expand over next year statewide and to other LTSS – certified home health, adult day care, waiver programs


MLTC will be mandatory—no opt-out

Over the next year, all recipients of Medicaid home care services will be required to enroll in MLTC plans

- Only affects dual eligibles (Medicare and Medicaid)
- Mandatory enrollment will be phased in gradually from Sept. 2012 through 2013, starting with NYC personal care cases then expanding outside NYC and then to recipients of other services – home health, adult day, 1915(c) waiver
- Clients have 60 days from date of notice to select an MLTC plan or one will be auto-assigned at random
- **No opt-out.** May change plans but no other option for obtaining LTSS
## LTSS Moving to MLTC – 2012-13

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<td>82,696</td>
<td>2012-13 if long-term &gt; 120 days, dual eligible &gt; age 21</td>
</tr>
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<td>Waiver - Aged/Disab.</td>
<td>24,000</td>
<td>2013-14 mandatory</td>
</tr>
<tr>
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<td>51,000</td>
<td>Separate new DD waiver</td>
</tr>
<tr>
<td>PACE, Medicaid Advantage</td>
<td>5,707</td>
<td>Are already voluntarily enrolled in MLTC</td>
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Advocacy Concerns
Consumer Confusion

- This is a massive change in how services will be applied for, approved and delivered – changing a 40+-year old system
  - No education of community-based organizations on this major change by State or Maximus. WE have conducted dozens of trainings for thousands of professionals, with no state funding.
  - No central website explaining changes, giving updates
- State contracts with Maximus to send enrollment choice letters, info re plans and choices
  - State gave an opportunity to critique initial drafts, which were HORRIBLE. WE commented, but no further input solicited. Neither State or Maximus posts these documents online – we did in their breach. See http://wnylc.com/health/news/35/
  - No “Planfinder”-type search mechanism to compare provider networks, help choose plans. Client must call Maximus. WE posted some limited tools to compare -- http://wnylc.com/health/entry/169/
Meeting Needs of High-Need Clients

Capitation Incentive to Give Low hours

- Mandatory enrollment begins in NYC, where the Medicaid program has historically approved higher hours of Personal Care/CDPAP services, including 24/7, under prior FFS system. Enabled thousands of PWD of all ages to remain in the community.

- These people will now be assigned to MLTC plans, which until now have marketed to “voluntarily” enroll low-need clients under voluntary system. They receive same capitation rate for all clients, and will not want to provide high hours to influx of high-hour clients.

See more info at [http://wnylc.com/health/entry/114/](http://wnylc.com/health/entry/114/)
Rate-setting and Risk Adjustment

- Rates are risk-adjusted based on acuity score of members enrolled in plan at snapshot point in time.
- But – since MLTC was voluntary before, plans “cherry-picked” and recruited low-need people. Acuity scores are reportedly easy to “game” so plans increased their capitation rates even for low-need clients.
- New influx of high-need clients under mandatory enrollment will be at risk.
- Consumers advocated for protections in rate-setting to encourage community-base care.*

*Download at http://wnylc.com/health/news/30/
Meeting Needs of High-Need Clients con’d.

- Under mandatory MLTC, high-need MLTC member may transfer between plans but may not opt out of MLTC. Before, could transfer to FFS personal care, home health, CDPAP. Will have to fight plan for more hours.

- **Standards for determining eligibility and authorizing care** – State contracts do not flesh out criteria for determining hours of care, will be highly discretionary and will lose some protections – both substantive and procedural -- established in Personal Care services program, i.e.
  - criteria for eligibility for people with dementia and other mental impairments. Under PCS they are eligible if they have someone to “direct” their care. Will plans condition services on family’s ability to provide extensive “back-up” care?
  - Not eligible for MLTC unless “capable of remaining in the home without jeopardy to health/safety.” Will MLTC plans use this contract provision to avoid “risky” high-need members?
  - **Uniform Assessment Tool** now being pilot-tested. Reportedly does not dictate amount of service – still discretionary for plan.
Excess Nursing Home Usage

- MLTC benefit package includes nursing home care – plan at risk for cost
  - This is good because gives Plan an incentive to provide LTSS in community since normally less costly than NH care.
  - BUT current NH residents carved out --NOT required to enroll in MLTC for a few years. NH care still available FFS. Plans can game system.
- Plans may limit networks of NHs, not required to include all NHs. Plans may avoid high-cost care by sending high-need members to undesirable in-network NH.
  - Member “voluntarily” disenrolls because (1) plan won’t give preferred community-based care and (2) member wants a better NH. Defeats incentive to provide care in community.
- Wide variation among MLTC plans in rate of NH admission
  - People with high needs, or who are difficult to serve due to dementia, etc. are at risk of NH placement
Consumer appeals/ fair hearings

- Thousands of people now receive stable PCS/CDPAP/Home Health services under previous FFS program, many for decades. New MLTC plan will assess need and may reduce services. Must give notice and hearing rights.
  - But under 2002 federal Medicaid regulations (42 CFR 438.420), Medicaid managed care plans do not have to provide “aid paid pending/aid continuing” pending a hearing to contest reductions, if the previous “authorization period” for the service has expired. Plan can simply wait out authorization period.
  - Violates due process requirements. See *Mayer v. Wing,* prohibiting reductions in PCS unless change in circumstances – litigation is inevitable, already in NC & TX.

Continuity of Care - Transitions

Even where Plan doesn’t reduce amount of service, concern re maintaining stable relationships with long-time aides.

- Before, home care agencies contracted with ONE local Medicaid program which authorized care, billed Medicaid FFS. Most were union contracts with decent wages & benefits.
- Now, home care agencies must contract with 20 MLTC/PACE programs, each negotiating different rates.
- State issued Continuity policy* but still concerns of disruption with long-time caregivers, plans cutting rates resulting in cuts in aide wages.

Reporting and State Oversight

- With State budget deficit, and pressure to cut administrative costs, State Health Dept. lacks staff to monitor plans adequately, collect and analyze data on quality and monitor avoidable institutionalization. State asked for $$ in waiver request for staffing.
  - Quarterly reporting by plans exists but State lacks staff or initiative to analyze and follow up on data, e.g. disparity among plans in amount of home care authorized, rate of nursing home placement.
  - Reporting not sufficient re quality of life measures, outcomes, and nursing home placement.
Is Consumer-Directed Program at Risk?

- NYS one of first & largest Consumer Directed Personal Assistance Programs – will now only be available through MLTC not through FFS.
- CDPAP has inherent conflict with “managed care” – as CDPAP is not a medical model. Unclear whether MLTC plans, which are inherently medical/nursing model, will understand CDPAP, honor consumer choices, and contract with existing CDPAP programs.
- One CDPAP privilege is to hire certain family members as aides, and not require aide certification – will MLTC plans allow?
- See more concerns in advocates letter to DOH 05/2011, 3/12 and 12/11

See more on NYS CDPAP at http://wnylc.com/health/entry/40/
Other Advocacy Concerns

- **Case Management** – will it be more than gatekeeper limiting hours? Will it actually coordinate medical care, ensure access to transportation, other MLTC services?

- **Disability literacy** – understanding needs of people with disabilities, eg. Wheelchair fitting & authorization, “dignity of risk”.

- **Capacity** – Plans now have 44,500 members, will almost double their enrollment from July – Dec. 2012. Can they conduct timely assessments, provide timely care?

- **Medicaid applications** – Entry point for applying for Medicaid shifts from local Medicaid program to MLTC plans. Will right to apply be at risk?

- **See more** in advocates letter to DOH 5/2011 and to CMS 12/11

MLTC is Prequel to Full Integrated Care for Duals

- In its proposal submitted to CMS to fully integrate Medicare & Medicaid services in 2014, State uses the mandatory MLTC program as the cornerstone.
- Even before kinks in MLTC are worked out, enrollees will be passively enrolled into the managed care plan run by their MLTC plan’s company.
- Since MLTC does not provide primary medical care, improper to assume that Dual eligible plan associated with their MLTC plan will cover their doctors.
- Many other concerns raised by consumers
Sources for data

Kaiser -- http://www.statehealthfacts.org/


For more info see http://nyhealthaccess.org
Long Term Managed Care: The Wisconsin Experience

Mitchell Hagopian, Attorney, Disability Rights Wisconsin
History

1998-1999-Managed Long Term Care Promise
• Named “Family Care”
• End Waitlists for HCB Services
• Create a LTC Entitlement in Medicaid
• Expand eligibility beyond Medicaid population
• Expand HCBS access to people with less than NH LOC
• Create a vigorous external advocate to protect consumer rights
• Pilot in 5 counties
History

• 2001: Governor abolishes the external advocate
• 2001: Restricts eligibility to Medicaid eligibles only
• 2006: Expansion begins in earnest
• 2008: IRIS (Include Respect I Self Direct)
  – Self directed support waiver (1915c)
  – Available as an alternative to managed long term care in all counties
  – CMS required WI to develop IRIS as a condition of managed care expansion to deal with choice of provider requirement
History

- 2008: “Independent” outside advocate restored
- 2008: Limits services for people not at a NH LOC
- 2008: Mandatory 24 month “phase-in” for eligibility
- 2009: Mandatory phase-in period goes to 36 months
- 2011-2012: Enrollment temporarily capped and expansion halted
History

• August 2012:
  – 46.5 counties at full entitlement-meaning a person functionally and financially eligible will get services without waiting
  – 10.5 counties working through phase-in period
  – 15 counties remain outside system, retain “legacy waivers”
Overview of Wisconsin’s “Family Care” Model

• Target groups: Frail elder/physically disabled and developmentally disabled adults
  – Mental illness not a target group

• Functional (LOC) eligibility:
  – determined by a computerized “Long Term Care Functional Screen”
  – Determines ADL and IADL and other deficits and service needs
  – Initially determined by Aging and Disability Resource Center
  – Recertification done by Managed Care Organization (MCO)
Overview of Wisconsin’s “Family Care” Model

• Capitated Payment
  – MCO gets “per member per month” payment from Department of Health Services
  – Capitated rate is determined by blending results from LTCFS results for all members

• Services Covered
  – All HCBS services
  – Some Medicaid card services (i.e. home health, personal care, private duty nursing, DME, therapies)
  – All people eligible also receive Medicaid card
Overview of Wisconsin’s “Family Care” Model

• Person chooses managed care or IRIS
• If opts for managed care, MCO does comprehensive assessment and develops individual service plan which must:
  – Reasonably and effectively address all identified needs
  – Reasonably and effectively address all of the person’s identified long term care outcomes
  – Be cost effective
  – Be agreed to by the participant
Overview of Wisconsin’s “Family Care” Model

• 10 Long Term Care Outcomes
  – Safety
  – Best possible health
  – Self-determination of daily routine, services, activities and living situation
  – Privacy
  – Respect
  – Independence
  – Social roles and ties to family, friends and community
  – Educational and vocational activities
  – Desired level and type of participation in community life
  – Spiritual needs and desired participation in religious activities
Overview of Wisconsin’s “Family Care” Model

• Due process protections
• Extensive and detailed client rights regulation
  i.e. “To the extent that provisions in this chapter differ from provisions affording a client rights under other state or federal laws or regulations, the provision that does most to promote the rights of the client shall be controlling.”

§ DHS 10.51(3) Wis. Admin. Code
Overview of Wisconsin’s “Family Care” Model

• Comprehensive appeal rights that exceed those mandated by federal law: i.e.-enrollee can appeal:
  “An individualized service plan that is unacceptable to the enrollee because any of the following apply:
  1. The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.
  2. The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified family care outcomes.
  3. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.”

§ DHS 10.55(1)(f) Wis. Admin. Code
Overview of Wisconsin’s “Family Care” Model

• Coverage
  – Now in 57 (out of 72) counties
  – 39,000 enrollees in all MCOs
  – 19,000 frail elders
  – 13,500 developmentally disabled
  – 6,500 physically disabled
  – 10 MCOs
  – 6 counties have more than 1 MCO to choose from
  – 19 Counties have “Partnership,” includes Medicare for dual eligibles
  – IRIS has over 6,200 enrollees in 57 counties
Independent Advocacy

• Outside agency (Disability Rights Wisconsin) selected to provide advocacy services to people under age 60
  – Staffing based on ratio of 1 advocate for every 2500 enrollees
  – 1 attorney provides training and backup to advocates
  – Advocates can represent clients in negotiations, grievances and state fair hearings
  – Cannot sue

• Older people get similar services from the Long Term Care Ombudsman program
Major Issues

• Unaccountability of Computerized LTCFS
  – Screen “logic” has stricter criteria than eligibility regulation
  – Screen instructions cause screeners to underreport deficits that impact eligibility
  – Screen does not adequately capture “supervision” or needs related to mental health issues, TBI, seizures
  – Screen was developed as an LOC eligibility tool, but is now used for myriad other purposes (including rate setting)
Major Issues

• Service Cuts
  – MCO’s develop internal tools that are used to set service hours by assigning arbitrary time limits on task completion

• Bundling of services
  – MCO’s require residential providers to also provide day services, transportation and respite to the people they serve

• Discharges due to Rate disputes
  – MCO’s cut rates drastically to residential providers who then discharge residents because they cannot serve the person at the rate offered
  – State has left rate determination to individual MCOs-no consistency across state
IRIS Problems

• Overwhelming response was completely unexpected
• Lack of preparedness by State
• Lack of policy guidance from State
• Due process problems
• Poor/inconsistent performance by contractors that run the program
• Loss of self direction and choice due to *ad hoc* decisions by State to limit flexibility of service package and restrict who may provide care
Independent Advocate Cases Under 60 Population

- 460 cases opened July 2011-March 2012-up from 404 in comparable period in 2010-2011
- 6 advocates
- In 2011 98% of cases were resolved without going to hearing
- Vast majority of cases resolved in enrollee’s favor
Closing

“We are involved in a long term care reform effort that provides a model for the nation, transitioning from the progressive and innovative home and community based waiver programs to Family Care.”

Sinikka Santala, Administrator, Division of Long Term Care Resources, DHS, 1/9/2009
CCD Principles on Managed Care

Meg Cooch
Lutheran Services in America
Consortium for Citizens with Disabilities
CCD Principles on Managed Care

- Establishing Protections for Individuals with Disabilities and Chronic Conditions
- Ensuring Access to Appropriate Care and Qualified Providers
- Ensuring Managed Care Systems do not Discriminate against People with Disabilities

Signed by 34 national aging and disability organizations

Available at: [www.c-c-d.org](http://www.c-c-d.org)
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www.NCOACrossroads.org/HCBS

• Online community with over 300 aging and disability advocates across country interested in home and community-based services
  – Listserv and message board functions
  – Share information and resources with others
  – Post questions and discuss issues

• Please complete follow up survey