The Challenges of Medicaid Managed Care for People with Developmental Disabilities

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Disclosures

• I was a trustee and independent consultant to the Community Care Alliance of Illinois until 2017 (not-for-profit Medicaid health plan).

• I have no commercial or financial conflicts of interests
Are you experiencing moral distress in your professional life as a nurse?

• Definition: *knowing the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.* (Jameton 1984, Hamric and Blackhall 2007)

• Write out at least one scenario describing how you experience moral distress in caring for your patients, particularly if it involves working with Medicaid Managed Care.
Learning Objectives

1. Describe changes in the Medicaid program since the passage of the Patient Protection Affordable Care Act (ACA in 2010), including the specific features of the law that impact people with disabilities.

2. Articulate at least 3 of the most effective models of care for people with disabilities and generate ideas for how to advocate/ work in partnership with MCO’s in such a way as to align the interests and needs of their patients with the interests and needs of managed care organizations.

3. Describe and analyze potential advocacy efforts that a professional can engage in on behalf of his/her patients from a personal/ local, professional and structural levels.
My journey to Medicaid Managed Care
Brief history of health insurance

» 1930-earliest prepaid health insurance (HMO coined in 1970; also known as managed care)

» Health care costs were 5.1% of GDP in 1960

• Social Security Amendments of **1965**: Medicare (elderly) and Medicaid (low-income children, caretaker relatives, the elderly, the blind, and individuals with disabilities)

• **1972**: expansion of Medicare to include ESRD and those covered by SSDI (Disabled)

• Health Maintenance Organization Act of **1973**
Experimentation with payments for unsustainable rising expenditures; marked rise of for profit health care*
Brief history of public health insurance

• **1983**: Health care costs had risen to 10.8% GNP

• **1983**: MCR diagnostic related groups (DRG’s) as prospective payment

• **1980’s-90’s** RISE OF MANAGED CARE
  – Focus on cost containment & utilization
  – Rise in for-profit MCO’s
  – PCP’s as “gate keepers”; preapprovals
  – Narrow networks and providers, esp. specialists
  – Backlash; resultant POS and PPO options, legislative restrictions
How well did these policies work?
State of the Union in 2010

• About 20% of GDP goes to health care. IOM estimates about 30% of expenditures are wasteful

• US spends 2x as much as any other industrialized nation on health care

• In its 2000 assessment, the WHO ranked the US 37th healthiest nation out of all nations in the world, behind Costa Rica

• Compared to other industrialized nations the U.S. ranked last on infant mortality rates, and deaths before age 75

Commonwealth Care alliance/IOM/ WHO 2012
• Nearly 50 million Americans uninsured, additional 40 million underinsured.

• 54% with a chronic medical condition are unable to afford recommended treatments/tests

• Pre-existing conditions/ insurance discriminations

• Lifetime caps on health insurance

• Medical bills contribute to about ½ of bankruptcies; recently shown to play a role in increasing income inequalities

• Huge costs discrepancies and geographic variability in practices (Dartmouth Atlas Project)

(HealthPAC)
• Worst in patient safety: (1/7 hospitalized Medicare patients has a harmful medical mistake each year!)

• High re-hospitalization rates and ER use (Nearly 20% of Medicare patients discharged from the hospital are readmitted within 30 days)

• Focus on acute care and technology; much less attention to chronic and LT care yet growing #’s of people needing this care

• Relatively little attention to public health and prevention measures (despite the ROI that every $1 invested in public health preventive measures is estimated to return $5.60 savings)
Patient Protection and Affordable Care Act

...is a federal statute signed into law by Obama on 3/23/10. This act and the Health care and Education Reconciliation Act of 2010 make up health care reform laws. Will be fully enacted by 2014.
- reforms private insurance,
- extends coverage (Medicaid and HIE)
- reforms drug coverage Medicare Part D
Major highlights of ACA and Medicaid….

- Medicaid is a STATE program with federal matches. When ACA offered Medicaid expansion the Federal government guaranteed covering 90+% of costs (100% thru 2016).

- In all states: you can qualify for Medicaid based on income, household size, disability, family status, and other factors. **Eligibility rules differ between states.**

- As of Jan 2018, 33 expanded their Medicaid programs to cover all people with household incomes based on income alone. (In general, below 133% of the federal poverty level, you qualify).
Current Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KFF tracking and analysis of state executive activity. *AR, AZ, IA, IN, KY, MI, MT, and NH have approved Section 1115 expansion waivers. KY initially adopted expansion through a state plan amendment but received CMS approval for the Kentucky HEALTH expansion waiver on January 12, 2018; implementation will start in April 2018 with full implementation by July 2018. ME adopted the Medicaid expansion through a ballot initiative in November 2017; the ballot measure requires submission of a state plan amendment within 90 days and implementation of expansion within 180 days of the measure’s effective date. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Has Medicaid expansion worked?

Expansion states saw a decrease in their rate of uninsured adults from about 16% during the third quarter of 2013 to 7% in the first quarter of 2017. During the same time period, the rate of uninsured adults in states that did not expand Medicaid dropped from 20% to 15%.

More than 50% of Medicaid patients are now in an MCO (i.e., state contracts with them to provide coverage). These insurance markets are evidencing some instability ....

(KFF/ Commonwealth)
Potential advantages of ACA for PWD’s

• Advances community living including extending the Money Follows the Person program
• Improves Medicaid home-and-community-based services (HCBS) option
• Prohibits discrimination in coverage based on health status
• Bars the use of preexisting condition exclusions; guarantee the renewability of coverage
Potential advantages of ACA for PWD’s - continued

• Bars lifetime and annual limits on coverage;
• Creates new options and incentives making it easier for states to provide HCBS;
• Enhances health care delivery by establishing standards for medical diagnostic equipment.
Adults with Medicaid are both poorer and sicker than low-income adults with private health insurance.

Selected characteristics of adults <139% FPL:

- **< 100% FPL**:
  - ESI: 57%*
  - Medicaid: 36%
  - Uninsured: 18%*

- **No Fair/Poor Health**:
  - ESI: 82%
  - Medicaid: 72%*
  - Uninsured: 11%*

- **Fair/Poor Mental Health**:
  - ESI: 11%
  - Medicaid: 18%*
  - Uninsured: 26%

- **>1 Chronic Condition**:
  - ESI: 48%
  - Medicaid: 32%*
  - Uninsured: 32%*

- **Any Limitation**:
  - ESI: 53%
  - Medicaid: 21%*
  - Uninsured: 29%*

*Difference from Medicaid is significant at .01 level.

Medicaid high utilizers/ complex patients

• 5% of patients drive more than 50% of total spending in Medicaid. 83% of spending goes to poorest 40%

• 80% of high cost beneficiaries have three or more chronic conditions and 60% have 5 or more.

• High rates of SMI, substance abuse, polypharmacy, diabetes, heart failure, physical disabilities, complex social problems

*Kaiser Commission on Medicaid and the Uninsured, KFF May 2012.*
Case study– Illinois before ACA:
The “old” world of Medicaid….

- Fragmented
- No or poor care coordination
- Fee for service- focus on quantity of services
- Bias toward institutionalization
- No care transitions and linkages
- No incentives for quality outcome
- Very little managed care (about 5%)
Illinois’s Medicaid Metamorphosis post ACA

• Public Act 96-1501 (also known as "Medicaid Reform") required that 50% of Medicaid clients be enrolled in care coordination programs by 2015.
• Illinois elected to start with seniors and adults with disabilities with the Integrated Care Program in 2010 (e.g., the highest utilizers of services and the most expensive).
Why?

- Because the state was broke and had escalating health care costs
- Because of the Affordable Care Act expansion of Medicaid and system restructuring efforts
- Because managed care allows the state a more predictable way of controlling costs/budgeting.
- Because if it is done well it *should* improve access and care coordination for clients, allow delivery system innovation and improve outcomes.
Integrated care program (ICP)

• Medicaid program for seniors and adults with disabilities
• Since 2014—all are now in a MCO
• Interdisciplinary Care team: PCP + Behavioral Health+ care coordinator
• Integrate medical with longterm services and supports (LTSS)- except for I/DD
• Minimum Medical Loss Ratio (MLR) of 88% for IL ICP (85% MLR for ACA)
The “new” world of IL Medicaid

• Focus on **care coordination**
• **Transitions** between level of care
• Opportunities for **financial innovation**, less waste
• **Quality** (HEDIS measures, enrollee satisfaction, etc)
• **Community Services**/care in least restrictive environment; Three consent decrees (federal lawsuits) require service redesign for SPD. (Ligas, Colbert, Williams)
• 100% of seniors and adults with disabilities (SPD) in care coordination program for ICP”
The Ligas v. Hamos lawsuit was filed in Illinois on July 28, 2005, on behalf of adults with developmental disabilities living in private, state-funded Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) who want to move to community-based services or settings and on behalf of adults with developmental disabilities living at home who want community-based services or settings. In June 15, 2011, the Ligas v. Hamos Consent Decree was approved by the Court.

http://www.dhs.state.il.us/page.aspx?item=66987
United States Supreme Court’s decision in Olmstead v. L.C.

• “[s]tates are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”
“Accordingly, this Court finds that defendants are not in compliance with the Consent Decree by failing to provide the resources of sufficient quality, scope, and variety based on the ample evidence presented to the Court that individuals protected by the decree have experienced a reduction of services and have suffered substantially as a result. The dire financial situation of the State of Illinois and the attendant competing demands for resources are not lost on the Court. The Court directs that State to devise a plan to address the issues causing the reduction in services and to bring the State into substantial compliance.”

And watchdog groups and reporters keep the heat on….

“Reforms promised but group homes still suffering from problems.”
Chicago Tribune Front page story, Michael J. Berens 2/23/18

“Dixmoor health care facility is 'deplorable’”
Chicago Tribune/ Southtown, Mike Nolan and Robert McCoppin, 2/23/18
Eligibility for Medicaid NOT determined by MCO

- Dept of Human Services determines eligibility for Medicaid (annual redetermination)

- Determination of need (DON) by state screeners not MCO; tool screens for nursing facility level of care. Current proposal to increase DON from 29 to 37. DON determines who gets personal assistance services and homemakers
Who is eligible for a HCBS Waiver?

1. Individuals must be U.S. citizens or legal aliens and residents of the state
2. Individuals must meet Medicaid financial eligibility criteria.
3. Individuals must require an institutional level of care as specified by each waiver.
4. Individuals' service needs must be able to be provided cost-effectively
Where does your state rank? (In 2015, Illinois was up to 45% in 2015...)

Increasing role for Medicaid Managed Care in provision of MLTSS…

“LTSS provided through managed care continued to grow more rapidly than overall Medicaid LTSS, increasing 24 percent in FY 2015 from $23 billion to $29 billion. Managed care accounted for 18 percent of FY 2015 LTSS spending. The $29 billion figure is a conservative estimate; some managed care data are missing because of ongoing data collection challenges. Starting in FY 2016, CMS required states to estimate institutional and HCBS expenditures within Medicaid managed care, which will improve managed LTSS data availability.”

The “new” world of IL Medicaid managed care

- Focus is on *quality* (though costs are still a factor)
- Narrow networks still common, esp. for Medicaid
- Most MCO’s are for-profit; limits on medical loss ratios (MLR’s)—88%
- Care coordination/ integration prominent theme
- Minimum benefit packages required; can go above and beyond though
- Opportunities for clinical and financial innovation
- Integration of medical and LTSS!
Sinai Health Systems and Schwab Rehabilitation Hospital
The Philosophy of CCAI.....

Higher quality care, improved patient satisfaction and cost savings can be achieved by:

- Preventing secondary complications through care coordination
- Empowering consumer voice and utilizing community peer resources
- Facilitating life as part of the community with needed supports and out of institutions
- Decreasing ER visits
- Decreasing hospitalization rates

★Adapted from the model of care of the Boston Commonwealth Care Alliance and Disability Practice Institute Principles
Leading Healthcare Practices And Training: Defining And Delivering Disability-Competent Care

“The CMS Medicare-Medicaid Coordination Office (MMCO) facilitated an optional webinar series for interested providers and health care professionals, front-line staff with health plans and practices, and stakeholders to introduce and explore the many uses of the Disability-Competent Care (DCC) Model.”

Disability Practice Institute
http://www.disabilitypracticeinstitute.com/

• Founded by three pioneering organizations:
  1. Commonwealth Care Alliance/ Commonwealth Community Care (Boston) http://www.commonwealthcarealliance.org/
  2. Independence Care System (New York) http://www.icsny.org/
The Disability Care Practice (DCP) model

....”comprises patient-centered disability-competent care, and incorporates all services and supports covered by Medicare and Medicaid (including state waiver-card benefits). The model promotes integration of disability-competent care and services across all settings (hospitals, medical offices, residential), types of care and support (MDs, nurses, therapists, behavioral health), and community-based services, including informal (family) and formal (paid) caregivers, all with the goal of enabling people to function with maximum independence and self-sufficiency in their homes and communities as they choose”.

http://www.disabilitypracticeinstitute.com/
Critical component of the DCP model: **interdisciplinary primary care/care coordination team:**

- performs in-home comprehensive assessments, develops Individualized Care Plans (ICPs),
- provides 24/7 continuity of clinical management with electronic health/medical record (“EMR”) support.
- The team is staffed for same-day/rapid response to new clinical problems in all settings and at all times

  - http://www.disabilitypracticeinstitute.com/
• The primary care priorities include:
  – comprehensive assessments, ICP development/monitoring,
  – early intervention to prevent complications or exacerbations of chronic conditions,
  – continuity and clinical management of all transitions when hospitalization is necessary.
  – Behavioral health services are fully integrated with the primary care/care coordination team and an open-access specialty care network is maintained.
  – Decision-making about personal care and medical equipment allocation resides with the clinical team
  – Pharmacy formulary is customized to include specific medications
    http://www.disabilitypracticeinstitute.com/
Mission statement

The Community Care Alliance of Illinois is a health plan dedicated to consumer-directed, community-based innovative health services specializing in the care of seniors and people with disabilities.

https://www.ccaillinois.com
The Community Care Alliance of Illinois

- Only managed community care network; Also now a HMO (Medicare Advantage Plan)
- Wholly owned by Family Health Network
- Not for profit health plan
- Designed to provide comprehensive person-centered care to seniors and adults with disabilities for the Medicaid and Medicare Advantage population in Illinois.
CCAII biopsychosocial model of care

- Social Support
- Psychological
- Financial
- Environmental
- Functional
- Medical

Patient
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As of Jan 2018…new contracts for Medicaid Managed went “live”

- 80% of IL Medicaid recipients are now in some form of managed care.
- New Medicaid Managed Care (HealthChoice) contracts went ”live” Jan 2018.
- CCAI could not meet the criteria to even apply and is thus no longer involved in Medicaid Managed Care
- The challenges….and lessons learned…..
Opportunities for Providers:
Think about aligning interests

• MCO’s are interested in preventing unnecessary hospitalizations and ER visits
• Interested in keeping people in least restrictive environment
• Need to now manage LTSS/ Waiver services. THIS IS NEW FOR MOST OF THEM!
• Have flexibility in managing benefits (can go beyond the basics!)
• Innovation is possible– e.g.- pilot projects, financing, etc
• Interested in improving quality and better use of available dollars
• Be active partners with MCO’s! Invite them in. Monthly meetings? Targeted care coordinators and LTSS?
• Educate patients, MCO’s and providers about range of rehab services and outcomes research (IRF, SNF, Subacute, etc)
• Actively help the MCO’s wisely manage the rehab continuum of care and transitions of care
• What else??
Strategies for managing moral distress...

- Advocacy and policy efforts through our professional organizations
- Work with like-minded partners (grassroots efforts can work—e.g., transparency and accountability)
- Partner with independent living organizations, UCP, ARC, etc.
- Cultivate relationships with state legislators
- Understand the rules and contracts for Medicaid MCO’s in your state.