

Understanding More About Massachusetts' Managed Care Systems for People with Developmental Disabilities

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By the end of the session.....

We hope you:

- understand more about how to maximize the opportunities and minimize the threats of managed health care systems.
- become more comfortable in navigating the different managed care organizations.
- share what you learn today with your friends, colleagues, and relatives.

Why is it important for you to know how managed care works?

- you are in a unique position to help your clients or family members access health care services.
- understanding more about the health care system for your clients may help you to identify other community, support services.
- to better serve your clients with a broader understanding of their health care issues and related needs.
- as a consumer of health care, this information can help you understand more about the options for you in the managed care system

Today's Agenda

- Introductions
- The Basics of Managed Care
- The Health Care System for People with Developmental Disabilities
- Managed Care for People with Developmental Disabilities
- Advocacy Opportunities
- Questions and Answers

Basics of Managed Care

What is Managed Care?

Managed care is a health care system that strives to provide every person **access** to **complete, quality, and cost effective** health care.

How is this different?

In the past,

- your health insurance coverage probably paid for services from any provider or in any hospital and in any location which accepted your insurance coverage.
- “traditional” fee-for-service

Now, once enrolled in a managed care organization,

- you choose or are assigned to a health care network.
- your choice of physician, hospital, and other health services agencies are those within the managed care plan.
- your health care is coordinated by a primary care provider.

Characteristics of Managed Care

- consumers must use the health care clinicians associated with the managed care organization
- the managed care organization assumes the financial risk of care, giving it an incentive to limit care or to keep its members healthy
- managed care organizations are responsible for providing quality-driven, preventative health services.

Rationale for Managed Care

1. Cost

- A new health care system was needed to contain rising health care costs.

2. Access

- Improve access to primary, preventative care.

3. Quality

- More accountability for health care providers to administer appropriate, coordinated, and quality care.

How does managed care work?

There are three dimensions at work in managed care:

1. clinical
2. financial
3. organizational

1. Clinical Dimension

Primary Care Provider is the point person or “gatekeeper” for the health plan who puts the principles of managed care to practice.

- to provide health care (routine, preventative services)
- to refer to specialty care
- to coordinate care
- to interface between different service agencies (DMH, DMR, residential facilities, etc.)
- to monitor the use of medications and/or equipment

2. Financial Dimension

fee-for-service

- a payment system where each service is billed and paid for once it is delivered.
- this is the “traditional” Medicaid and other insurance payment system.

capitation

- a method of payment for health services in which a health plan is paid a fixed amount per person regardless of the number of services the individual consumes.

2. Financial Dimension (cont.)

Most managed care plans are paid through capitation.

However, some states offer a fee-for-service case management option under managed care.

3. Organizational Dimension

This refers to the policies or the procedures that glue the other two dimensions together. These are primarily internal policies that reinforce managed care principles, such as:

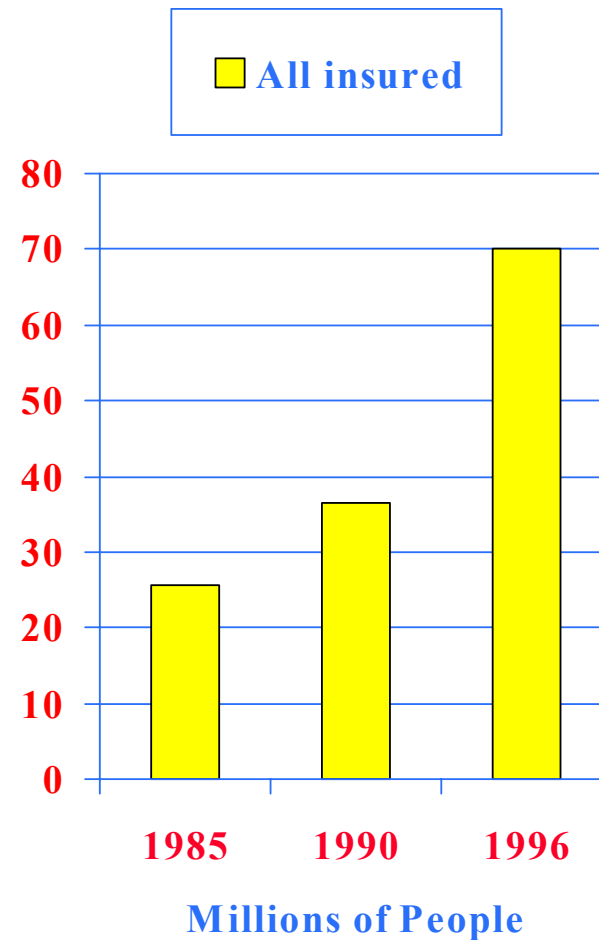
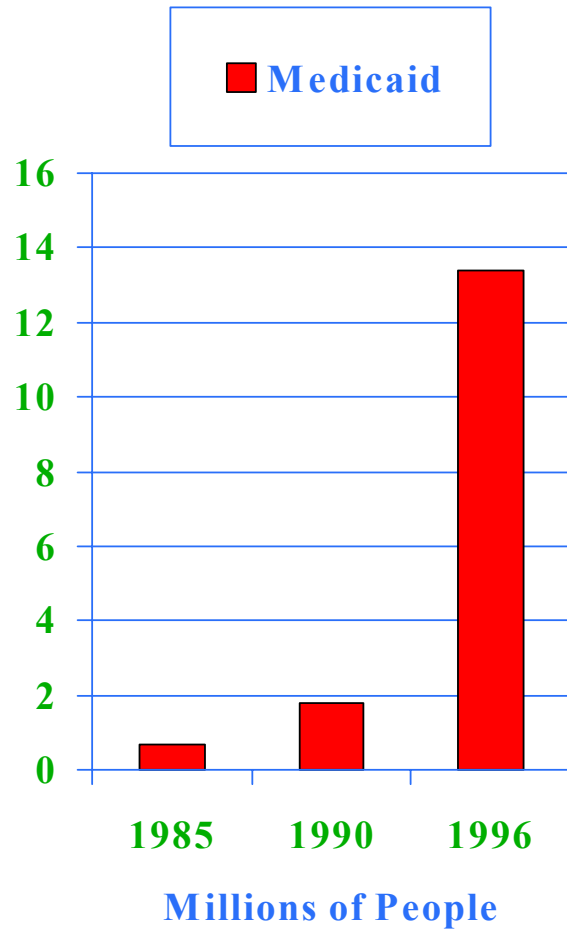
quality monitoring, utilization management, and care coordination that ensure managed care is working effectively

- relationships/contracts with health care providers and health services agencies
- public and private regulation reinforcing these principles, and providing safeguards

What is the impact?

- managed care has become mainstream
- both public agencies and private companies offer managed care plans
- new language
 - ➔ PCP, appeals, utilization, risk, capitation, etc.

Enrollment Trends in Managed Care



Differences Between Managed Care Options

HMO Staff Model	HMO IPA Model	PCCM Model
<ul style="list-style-type: none"> • HMO receives capitation payment from Medicaid and pays providers a salary 	<ul style="list-style-type: none"> • HMO receives a capitation payment from Medicaid and pays providers a salary or fee-for-service 	<ul style="list-style-type: none"> • no capitation -- providers are paid fee-for-service from Medicaid; PCPs receive an enhancement payment for case management
<ul style="list-style-type: none"> • “one-stop-shopping” -- most care delivered at a single site 	<ul style="list-style-type: none"> • care delivered at provider offices or clinics 	<ul style="list-style-type: none"> • care delivered at provider offices or clinics
<ul style="list-style-type: none"> • referral to most specialists in same clinic 	<ul style="list-style-type: none"> • referral to network specialists in their own offices 	<ul style="list-style-type: none"> • referral to network specialists in their own offices

Differences Between Managed Care Options

HMO Staff Model	HMO IPA Model	PCCM Model
<ul style="list-style-type: none"> less provider choice 	<ul style="list-style-type: none"> more choice than staff model 	<ul style="list-style-type: none"> more choice than HMO models; less than fee-for-service
<ul style="list-style-type: none"> answering service / covering physician available 24 hours per day for emergencies to direct member to appropriate care 	<ul style="list-style-type: none"> answering service / covering physician available 24 hours per day for emergencies to direct member to appropriate care 	<ul style="list-style-type: none"> answering service / covering physician available 24 hours per day for emergencies to direct member to appropriate care
<ul style="list-style-type: none"> primary care physician serves as case manager 	<ul style="list-style-type: none"> primary care physician serves as case manager 	<ul style="list-style-type: none"> primary care physician serves as case manager
<ul style="list-style-type: none"> mental health and substance abuse services provided at clinic site 	<ul style="list-style-type: none"> mental health and substance abuse services provided by network providers at their sites 	<ul style="list-style-type: none"> mental health and substance abuse services managed and authorized by outside company

What happens once you're in a managed care system?

You experience the clinical, financial, and organizational dimensions of managed care at work.

1. care coordination/ case management/ gatekeeping
2. utilization management
3. provider network
4. service substitution
5. health promotion

Care Coordination/Gatekeeping

GOAL: TO ENSURE THAT EACH MANAGED CARE PLAN MEMBER HAS A “MEDICAL HOME” AND THAT APPROPRIATE SERVICES ARE RECEIVED

- This can be a constructive means of improving patient care while holding down costs
- In reality this potential is not always realized
- This has significant implications for people with developmental disabilities

Utilization Management

GOAL: TO ENSURE THAT THE SERVICES BEING FURNISHED ARE NECESSARY, EFFECTIVE AND THE LEAST COSTLY AVAILABLE.

- based on approved clinical practices and benefit package limitations
- core principle of managed care
- at work in all types of managed care organizations

Utilization Management: Different Forms

- **prior authorization by PCP/ health plan**
 - need approval from health plan before physical therapy
- **concurrent/ recurrent review**
 - repetitive services that need to be approved regularly (B-12 shots)
- **benefit limits**
 - limit the number of therapy services per month
- **retrospective analysis**
 - after a service has been provided, the plan can deny payment if the service was not authorized

Provider Network

GOAL: TO ENSURE THAT THE MANAGED CARE ORGANIZATION HAS A GROUP OF SPECIFIED PROVIDERS WHO WILL PROVIDE CARE TO MEMBERS.

This is done by directing individuals to preferred health care suppliers rather than giving them free rein in picking providers

Service Substitution

GOAL: TO ENCOURAGE INDIVIDUALS TO
SELECT LOWER COST PROVIDERS

Common service substitutions include:

- Physician Assistant/Nurse Practitioner for physician
- Outpatient for inpatient procedures
- Respite care for inpatient psychiatric stays

Health Promotion

GOAL: TO KEEP HEALTH PLAN MEMBERS HEALTHY AND TO DETECT SERIOUS ILLNESSES EARLY

One of the key tenets of managed care is this concept of health promotion and preventative care.

examples,

- up-to-date immunizations
- nutritional counseling
- exercise plans

Health Promotion (cont.)

Most managed care programs have built in primary care and prevention as the cornerstone for controlling costs.

The challenge for many managed care plans is to ensure that health promotion activities are accessible for all members

Health Care System for People with Developmental Disabilities

Framework

Medicaid (SSI)

- Disability (of enrollee) + Low Income (of enrollee)
- Medicaid is the most common form of health insurance for people with disabilities
- In Massachusetts, if you receive SSI benefits you are automatically eligible for Medicaid

Framework (cont.)

Medicare (SSDI)

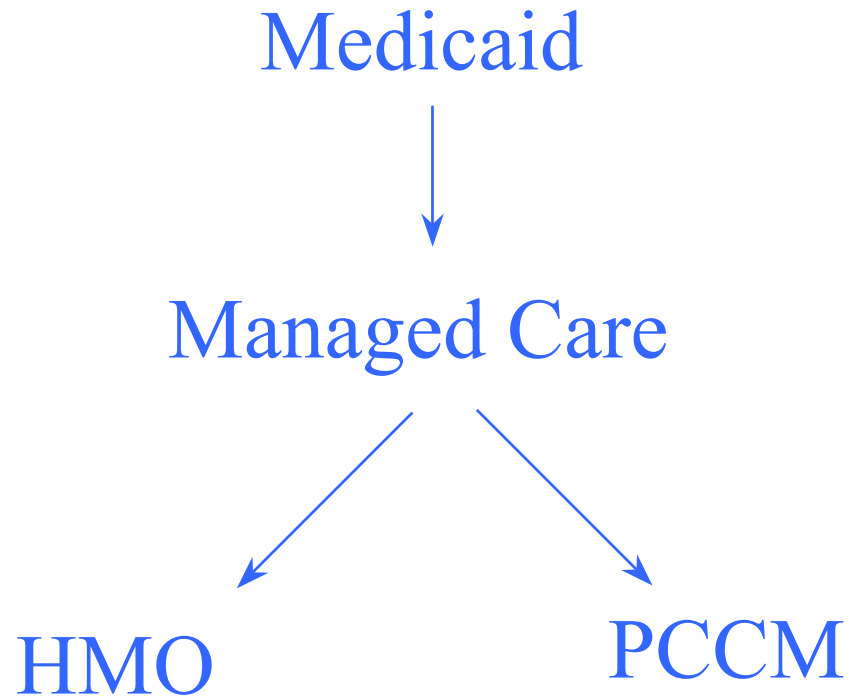
- Disability (of enrollee) + Work History (of enrollee or of enrollee's retired, deceased, or disabled parent).
- No relation to income
- In all states, if you receive SSDI benefits you are eligible for Medicare 2 years after you start receiving SSDI

Framework (cont.)

CommonHealth

- children with disabilities under age 18
- adults with disabilities age 18-64:
 - 1) who work 40 hours a month, or
 - 2) who are not working or work less than 40 hours a month and meet a one-time deductible
- an option especially for adults with disabilities who are working.

How the system works in Massachusetts.....



If you are a Medicaid recipient, you must join a managed care plan within 30 days or you will be assigned.

* except for CommonHealth *

How the system works in Massachusetts...

Medicaid and Medicare



Fee-for-service

**except in special
circumstances**

Managed Care for People with Developmental Disabilities

Why managed care for people with disabilities?

- Expenditures for people with disabilities account for over **33%** of total Medicaid expenditures

 mechanism to control costs

- Market share and competition

 new market penetration, new enrollees

- Increased access to primary care for people with disabilities

- Clinical model has potential to improve health care and access to care

Opportunities of managed care

- Access to primary care and medical home
- A broader array of services due to delivery system innovations
- Incentives for community-based services
- Coordination of care
- Quality improvement and monitoring
- Improved provider understanding about the special needs of people with disabilities

Threats of managed care

- The possibility that managed care will reduce or eliminate access to preferred health care providers.
- Standard utilization guidelines applied without modification
- Possible trade-off between quality and the cost of care
- Managed care organizations may lack the expertise or the capacity within their network to serve individuals with disabilities due to the initial focus on the needs of relatively well persons.
- Disincentives for plans to enroll individuals with complex, high-cost health care problems

Access to Care

People without disabilities need to consider certain aspects of the health care system:

- physician access
- language/culturally appropriate
- geography
- distance
- 24 hour access

Access to care (cont)

However, the special needs of people with disabilities often require additional considerations when choosing a health care plan:

primary care expertise and sensitivity

- specialty care and mental health services that consider the needs of people with disabilities
- providers' offices and alternative sites of care are physically accessible for people with disabilities who use wheelchairs
- necessary equipment can be easily obtained or replaced
- “culture” of provider sites

Covered Services/ Benefits

Standard

- λ **Inpatient Hospital**
- λ **Emergency Room**
- λ **Outpatient Hospital**
- λ **Physician/Clinic**
- λ **Pharmacy**
- λ **Labs and X-rays**
- λ **Durable Medical Equipment**
- λ **Home Health Care**
- λ **Emergency transportation**
- λ **Mental Health/Substance Abuse**
- λ **Rehab therapies: PT, OT, Speech**

Atypical

- λ **Home modifications**
- λ **Non-emergency transportation**
- λ **Home-based mental health services**
- λ **Long-term rehabilitative services**
- λ **Personal care**
- λ **Assisted Living**
- λ **Respite care**
- λ **Adaptive equipment**
- λ **Nutritional supplements**
- λ **Adult Day Health**

Covered Services/Benefits

“HOT SPOTS” for People with Disabilities

- Durable Medical Equipment (DME) and supplies
- Dental Care
- Transportation
- Day programs
- Physical, occupational and speech therapies
- Specialty care (Neurology, Podiatry)
- Mental health and substance abuse treatment services



These are primarily determined by the managed care plan's definition of medical necessity standards

Enrolling in MassHealth Managed Care

MassHealth Enrollment Centers

- four regional offices
- determine if you meet eligibility criteria

Foundation Health Systems

- determine which MassHealth option is best for you
- all enrollment procedures
- questions about managed care practices

Advocacy Roles for Staff and Families within Managed Care

The need for advocacy

Everyone should have access to quality health care.

- All persons with developmental disabilities should be encouraged and assisted to participate in, and be as independent as possible in their own health care.
- In some cases, for individuals with developmental disabilities to participate fully as active consumers of health care, they require a third party to support them in their interactions with the health care system

Ways to advocate..

- Know what to do if you have a complaint
- Tips for health care liaisons
- Know the questions to ask when choosing a health plan

What if you have a complaint?

First, discuss your concerns about the quality of your care with your primary care doctor. In addition, you may be able to obtain valuable information about treatment options from non-profit health advocacy groups, such as Health Care For All and Family Voices, and Internet web sites.

If this does not resolve the problem, Massachusetts law requires HMOs to give all members a copy of its policy for resolving member complaints.

Representatives in a MCO's member services department should be able to advise you on how to initiate the appeals process.

Possible reasons to file a complaint

1. **Lack of person-centered care.** For example, a doctor denies a heart transplant to a person because she has Down's Syndrome. The doctor has not made an effort to assess her complaints.
2. **Lack of needed referral.** For example, the doctor disagrees on what is medically necessary.
3. **Denial of care.** For example a power wheelchair is needed for mobility, but is denied because it is not “medically” necessary.
4. **Non-inclusion in treatment in decision-making** (individuals or families of persons with disabilities).
5. **Inadequate attention to prevention of secondary conditions.**

Tips for liaisons

To make the most of a visit to a provider's site of care, here are some important considerations when bringing a client or family member to the doctor's office:

- Is this a routine visit or is it to follow-up on something specific?
- Have there been any recent hospitalizations?
- Consider the individual's behavior/ disposition - any dramatic changes?

Tips for liaisons (cont.)

- Document the individual's specialty physicians.
- If someone else brought this person to the doctor's office last time, be sure to obtain any relevant information.
- Write down any questions he/she may have or any questions you have. Make sure that you ask these questions while at the provider's office.
- Bring a list of medications (dosage, time taken, etc.).

Questions to ask a MCO

convenience and physical access

- How accessible are the plan's service delivery sites?
- How convenient are the plan's hours of operation?
- Are after-hours care available?
- What physical accommodations are arranged for people who need them?

travel and waiting time

- What is the approximate travel time to the sites of care?
- What is the average waiting time to receive an appointment for primary care, specialty care, and related services?

Questions to ask (cont.)

Providers

- How will gatekeeping be performed under the plan? Does the plan allow specialists to perform this gatekeeper role? Under what conditions?
- What are the policies regarding referrals to providers that are not in the plan?
- Does the plan have providers who are knowledgeable about disabilities?
- Degree to which enrollees are able to maintain relationships with physicians they have used in the past?
- What is the procedure for changing providers?

Questions to ask (cont.)

Covered Services

- What equipment is covered (power wheelchairs, assistive technology devices, hearing aids)? How often can equipment be replaced due to damage or growth?
- What therapies are covered? What are the limitations? Does the MCO contract with specialized treatment centers?
- Does the plan cover prescription medications?
- What happens when a member is out of town and becomes ill?
- Does that plan provide for exceptional needs care coordination? Under what circumstances? Who does it?

Questions to ask (cont.)

Assuring Quality

- What is the disenrollment rate and what are some of the reasons?
- How can members participate in the health plan's decision-making process regarding their health care?
- What is the process for filing appeals? Do they provide for timely resolution of disputes? Does the plan provide for surrogate decision-makers to enter grievances and appeals on behalf of an individual?

Questions to ask (cont.)

Other Questions

- Is the plan's standard utilization management protocol adapted or modified for people with developmental disabilities?
- If benefits are **not** included, how can one get them? Who makes these decisions?
- Under what circumstances can an individual change plans?

What are ways that you can help?

- Learn about managed care.
- Know which managed health care plans your clients are enrolled in.
- Are your clients receiving primary care services from a specialist or a general practitioner?
- Ask the client or guardian if there are concerns about health services s/he has received or that s/he needs but has had difficulty obtaining.
- What is his/her understanding of the managed care system.

Do you have any questions?