



Disability Rights Education & Defense Fund

What's Managed Care Got to Do, Got to Do with It?

**Saint Louis University Law School
Annual Health Law Symposium
March 2015**

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Disclosures

I am fond of things that begin with the letter “c” (e.g., cats, cookies, chocolate)

What is Managed Care?

- Way of paying for and delivering health care and/or long-term services and supports (LTSS)
- Generally, payer gives a managed care organization (MCO) a set (capitated) monthly payment per member, which the MCO uses to provide services and supports to its members
- Provide an array of services to members through an established network of contracted providers
- MCOs assume and manage some or all of the financial risk for their members
 - As such, they have a financial incentive to keep members healthy, and to coordinate members' care

Managed Care (continued)

- Under Medicaid, managed care has taken 3 forms
 - *Comprehensive, risk-based capitation* (State Medicaid agency [SMA] pays per member per month rate/premium to an MCO to provide a comprehensive set of services for members)
 - *Non-comprehensive* (SMA pays MCO to provide certain types of services – e.g., behavioral health only)
 - *Primary care case management* (SMA pays certain primary care providers a monthly fee to provide care management)

Managed Care – National Trends

- States have increasingly relied on Medicaid managed care since the early 80's
- In 2010, about 2/3 (35 million) of Medicaid enrollees were in Medicaid managed care
- Increasingly, Seniors and PWD are being enrolled in *mandatory* Medicaid managed care
- Also increasing: delivery of Medicaid LTSS into managed care

Managed Care in California

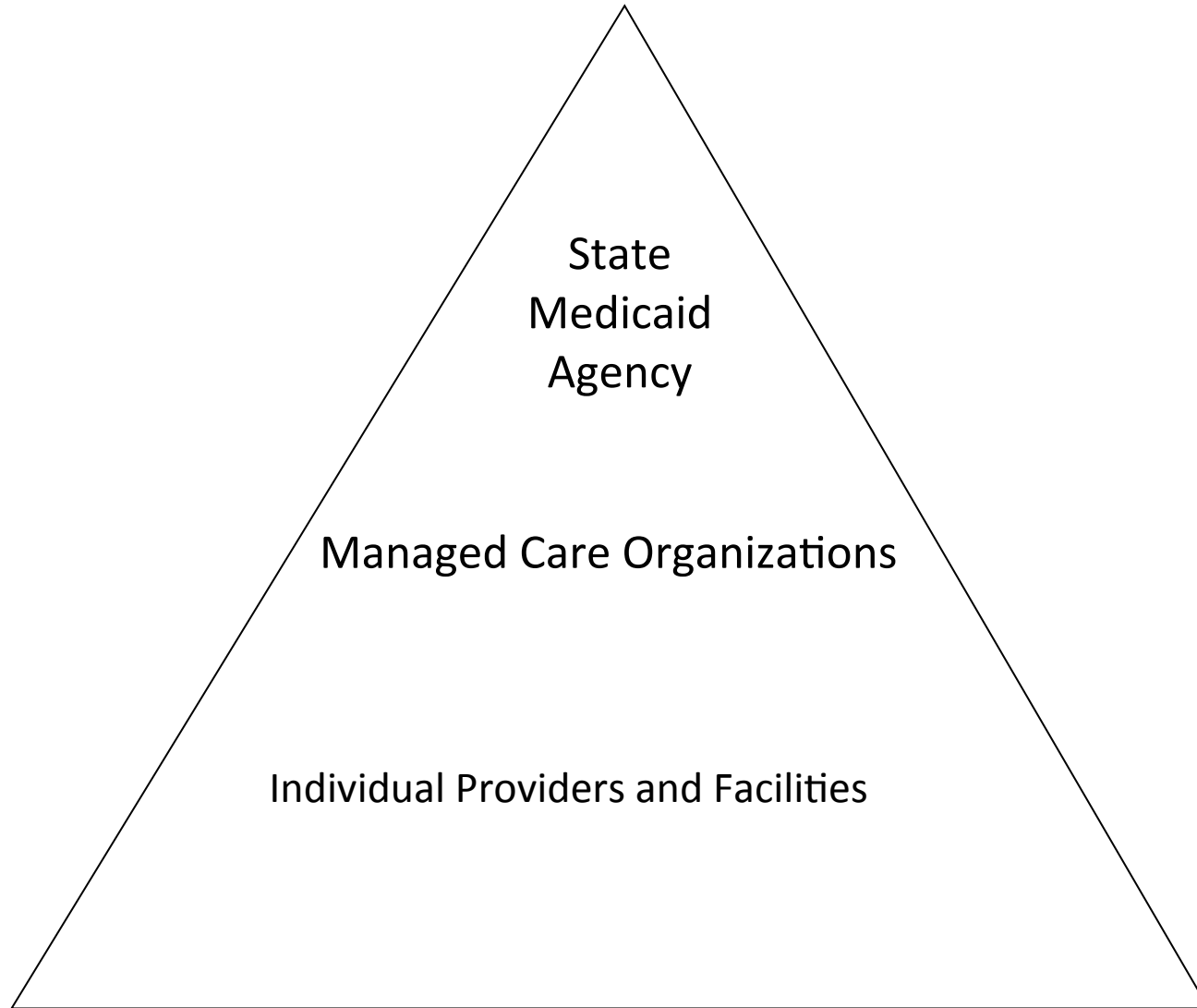
- 584,000 Medi-Cal only eligible seniors and PWD in Medi-Cal managed care
- Up to 485, 948 Medi-Cal and Medicare eligible seniors and PWD in integrated managed care
- Transition of children and healthy families into Medi-Cal managed care
- Expansion of Medi-Cal managed care into 28 rural counties; over 400,000 as of July 2014
- Newly eligible under Medi-Cal expansion since October 2013 (a little over 2 million)

504 Regulations

45 CFR 85.4 (b)

(4) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same State.

MCO – legal responsibility



Physical Barriers to Primary Care

- Data from on-site reviews of over 2300 Medicaid Managed Care primary care provider facilities in 18 of California's 58 Counties
 - 8.4% of provider sites had a height-adjustable exam table
 - 3.6% had an accessible weight scale

Office of the Duals

The Affordable Care Act creates a new office within the Centers for Medicare & Medicaid Services, the [Medicare-Medicaid Coordination Office](#), to coordinate care for individuals who are eligible for both Medicaid and Medicare ("dual eligibles" or Medicare-Medicaid enrollees). The office is charged with making the two programs work together more effectively to improve care and lower costs.

What are Managed Long-Term Services and Supports (MLTSS)?

- Payer – typically the State Medicaid Agency – contracts with a managed care organization (MCO) to coordinate and provide LTSS
- May cover home and community-based services (HCBS) as well as institutional care
- May serve different populations: older adults, people with physical disabilities, and/or people with developmental/intellectual disabilities, or behavioral health needs.

Who Are LTSS Users?

- 14% of adult U.S. population has a disabling condition resulting in a complex activity limitation that affects
 - Social and leisure activities
 - Self care
 - Maintaining a household
 - Working

LTSS Users (continued)

- Propensity for disability increases with age
- 88.5 million or 20% of the total population will be people 65 and older by 2050
- 42% of people over age 65 report disability

California Managed Care Integration in Theory

- Health Risk Assessment – elevation of person-centered care and social goals
- Coordinated Care Team
- Maintenance of Self-Directed In-Home Supports and Services (IHSS) Program
- Incentives toward rebalancing – reduced hospitalizations and institutionalization
- Facility Site Reviews (FSR) of provider network *includes* physical/equipment accessibility

California Managed Care Integration in Practice

- Questions and Gaps
- Lack of nationally validated MLTSS measures
- Non-standard reporting of health risk assessments, issues of homelessness, distrust
- Provider buy-in lacking, even just on a clinical level much less a holistic, social level
- Rebalancing – challenge of short term vs long term

Integration in Practice (continued)

- FSRs are occurring
- FSR Results inconsistently available to plan members
- Not leading to improvements in accessibility
- No entity seems to bear or impose consequences for inaccessibility – not the Centers for Medicare and Medicaid (CMS), the state, plans, or providers, only people with disabilities

Abandon Hope All Ye Who Enter?

- Twin Goals of Managed Care and Integrated Care: *better* care (because coordinated) and *less expensive* care (because efficient)
- Accessibility and adherence to 504, ADA and *Olmstead* are preconditions to *better* care, but will they lead to cost savings *in time*?
- Does Medicaid Managed Care change our policy, political, and litigation options?

Contact Information

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