NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

Managed Care and Financial Management Services (FMS)- National Overview

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Managed Care Defined

- Traditional System is Fee-for-Service (FFS)
- For-Profit/Non-Profit entities receive fixed amount to provide health care to a target population or populations (per member per month)
- Began with acute – now includes acute, primary, behavioral and long-term services & supports (LTSS) including nursing facility services

Managed Care Defined (cont.)

- Health Plans selected by State through a request for proposal process (RFP)
- Contract determines target population, service package, reimbursement, level of risks, reporting, incentives, and value-added options
- The Centers for Medicare & Medicaid Services (CMS) use the term Managed Care Entities (MCEs)

Managed Care is Changing the Health Care Landscape

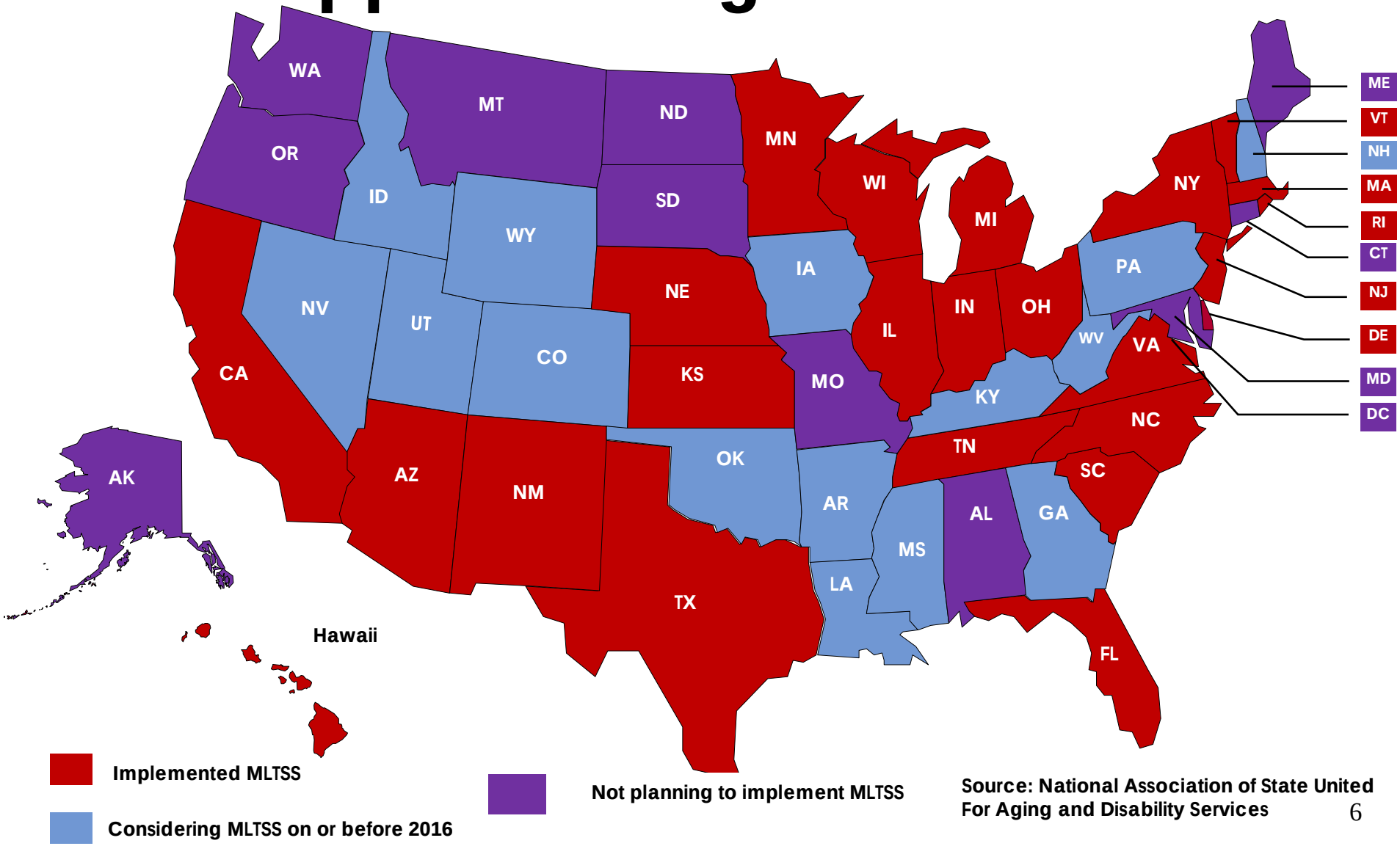
- Medicaid Agencies shift from implementation of the Medicaid program to contract oversight and assuring quality
- Existing provider network may or may not continue to be engaged
- Provider performance is evidence-based
- Achieving personal outcomes is now a focus of quality
- Waiting lists are disappearing
- Incentives provide services in the least restrictive/most cost effective setting

Growth of Managed Care

- In 2014, 43.5 million Medicaid adult beneficiaries, or 2/3 of all Medicaid adult beneficiaries, were enrolled in Medicaid Health Plans
- Additionally, 30 million children were enrolled in Medicaid Health Plans
- Currently, 183 Medicaid Managed Care Health Plans provide service in 40 states
- State programs range from 10.3 million in California to a few thousands

Source: www.mhpa.org/_upload/201501StateofMedicaid2014.pdf

Managed Care Long-Term Services and Support Managed Care



Source: National Association of State United For Aging and Disability Services

Why the Growth?

- Significant growth in Medicaid continues
  - 30 states have adopted the Affordable Care Act expansion option
  - May hold opportunities for the expansion of self-direction
- Managed Care allows states to predicted their costs and to transfer financial risk to health plans through a capitated rate and risk-based contracts
- Purported savings to States:
  - Reduction in risk of entering a Nursing Facility (MA - HCBS increased from 17% to 30% - 2011)
  - Effective payment error reductions (.2% MC to 5.1% FFS)
  - Fewer preventable hospitalizations (MN 2004)
  - Monthly medical costs for MLTSS in 2008 were $3,600 for MC compared to $5,210 for FFS
- Coordinated Care between Medicaid and Medicare/Medicaid is easier under a managed care approach

Service Coordination

- Usually MCE staff or through sub-contract
- Self-direction is an add-on to traditional duties: introduce the self-directed option, answer questions, complete enrollment and provide orientation to interested members
- Training Support Coordinators on self-direction (philosophy and operations) typically happens internally and generally is inconsistent
- Most contracts are silent on the self-directed tasks assumed by Service Coordination

Service Coordination- Issues

- Role of service coordinator is key to SD participation
- During research efforts interviewing service coordinators complained of the time self-direction takes
  - Hawaii limits caseload 1:40 for caseloads involving self direction; 1:50 for traditional HCBS
- MCEs complain that the cost of introducing, enrolling and providing on-going support to those electing the self-directed option was not calculated in their capitated rate
- Some MCEs have transferred the self-directed information and assistance to FMS vendors (FL, TN, and NJ)

Financial Management Services (FMS)

- CMS – existing SD programs should be keep and must provide FMS
- FMS is required by the State and stated in the contract
- Two methods for contracting
  - State issues an RFP to select one or more FMS vendors and MCEs subcontract with selected vendors (TN and NJ)
  - State allows individual health plans to issue an RFP and subcontract for FMS
  - Most FMS vendors are paid with administrative federal matching funds rather than offered as a waiver service

FMS

- Number of FMS providers vary greatly
  - 1 in TN; 3 in AZ; 400 in TX
  - Number of FMS providers appear to be decreasing (PA and KS)
- Typical duties for an FMS:
  - Processes timesheets
  - Generates expenditure reports
  - Files and pays state and federal taxes and insurance
  - Conducts criminal background checks
  - Brokers Workers Compensation
- Trend toward a small number of FMS providers
- Communication between service coordinators (MCE staff) and FMS staff varies

FMS- Issues

- Claims processing problems:
  - Once claim suspends – takes weeks to resolve
  - Billing strictly by unit rate is not compatible with flexible individual budgets or rate of pay differentials
- Prior authorizations may cause delays in accessing services
- Enrollment into the program is slow due to support coordinators referrals

Data Collection

- Most FMS providers are required to submit reports on the number electing the self-directed option
- Health outcomes are reported but clinical in nature
- Consider TNs:
  - # electing the option
  - Average and maximum time from electing the option to self-directing services
  - # and % using representative
  - # of scheduled visit including late or missed
  - Benchmark - % of increase from one year to the next

Implications

- Commitment to self-direction is related to the state's expectations and guidance
- Lack of self-direction standards & requirements impacts the design, operation, evaluation, and success of these programs
  - Health Plans operate self-direction differently in lieu of state required standardization
- Implementation of self-direction is delegated to MCEs who may or may not understand the philosophy, roles, and responsibilities of different self-direction supports or how to efficiently operationalize
- Lack of standardized service coordinator training results in participant experiences varying widely within and across states

Implications (continued)

- Lack of self-direction quality measures prevent most states from evaluating program performance and distinguishing high quality programs from low quality programs
- Appears health plans see self-direction as a family employment program
- Billing problems created devastating delays for members, workers, and caregivers
- Prior authorization delays can inhibit access to services

Future Considerations

- Will the Affordable Care Act expansion efforts impact self-direction?
- Can FMS providers play a role in creating employment opportunities?
  - Coaching
  - On-the-job training
  - Assistance with volunteer work
- Will self-directed information and assistance become a typical FMS responsibilities?
- Can we analyze claims data more easily through a collaboration between FMS providers and MCEs to reflect the impact of self-direction on state budgets?
- Can FMS vendors assist programs to capture information on personal outcome achievement?

Questions?

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-THANK YOU-

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