ML Strategies Alert

Medicaid Managed Care Transitions' Impact On Brain Injury Waiver Populations

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BY ELI GREENSPAN AND ALEXANDER HECHT

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As of June 2015, 24 states utilize a traumatic or acquired brain injury waiver,[1] as provided under section 1915(c) of the Social Security Act, which are designed to help individuals with traumatic brain injury (TBI) live in the community setting of their choice. The waiver services are intended to help an individual achieve maximum independence in the community, thus improving overall quality of life.

For the past decade, individual states have pursued unique and oftentimes novel approaches to managing their Medicaid population. However, as more states look to transition their Medicaid populations into managed care as a potential way to save money, several serious consequences have arisen, impacting the quality of care and the level of collaboration between providers and state officials. Through state-specific research, we found that as states look to incorporate waivers into their managed care models, rapid transitions have caused unnecessary disruptions for those with traumatic brain injury and negatively impacted the delivery of care. As a result, states that are interested in pursuing a managed care model should learn from the experience and lessons learned in other states. These lessons include easing vulnerable populations, such as TBI waiver populations, into managed care models in addition to conducting robust stakeholder outreach, which includes beneficiary, insurer, and provider education.

This article surveys how three states handled their TBI waiver population as the state transitioned into managed care and the lessons that can be drawn from the different approaches these states took. We also detail the role of advocacy on the state and federal level in ensuring a smooth transition for vulnerable populations.

Background

The Medicaid Home and Community Based Services (HCBS) waiver program was established by the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35). OBRA created section 1915(c) of the Social Security Act, which enabled states to provide home and community-based alternatives to institutionalized care upon federal approval. Initially, waivers were used to treat the elderly and disabled, as well as those with developmental disabilities. Over time, the waivers have broadened to include treating those with HIV/AIDS, mental illness, those with medically fragile and palliative care needs, and those with TBI (sometimes referred to as acquired brain injury for the purposes of the waiver), among other population groups.[2]

Currently, 41 states contract with private insurers to run some or all of their health programs, with 70% of Medicaid enrollees being treated through private plans.[3] States consistently look to this model for a host of reasons, including as a way to save money, particularly as a greater number of individuals become eligible under expanded Medicaid due to the Affordable Care Act (P.L. 111-148). While some states have opted to continue under a fee-for-service model, more states are drifting towards managed care. For example, two current hold-outs—Oklahoma and North Carolina—are planning to initiate a managed care transition as early as next year.[4]

States have increasingly touted the cost savings behind these proposals, but the results of the initiatives are often mixed. Some states saw modest savings due to reduced inpatient utilization, but peer-reviewed literature found little savings from managed care on the national level.[5] Still, states continually push the cost-saving argument, and the federal government appears willing to take, as New York's Medicaid director describes, "a leap of faith," to improve access and quality, with the potential for cost savings.[6]

Given this trend, as well as the broad federal guidelines concerning Medicaid, it is imperative to address the impact of individual state plans to transition their waiver populations into managed care so states and providers can learn from past, often avoidable mistakes, and to identify a potential model for success when transitioning vulnerable populations.

Case Studies

Examining How Three States Chose Three Different Approaches with Different Outcomes

Kansas

Rapid Transition Caused Turbulent Roll Out

In November 2011, Kansas initiated its transition to Medicaid managed care, known as KanCare. Governor Sam Brownback touted the cost savings associated with the move, which brought the entirety of the state's Medicaid population into managed care by January 2013. The process was mired in controversy almost immediately following the initial announcement, receiving bipartisan criticism from the state legislature to remove certain waiver populations from the transition, or to postpone the transition plan altogether.[7] Despite these concerns, the state pressed forward, awarding three companies – Amerigroup Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan for Kansas – with contracts to operate statewide under KanCare in early 2012.

The rapid transition was especially problematic for the TBI community. In a memo dated August 2012, the state encouraged people currently employed as case managers for physically disabled and elderly Medicaid enrollees to apply for similar jobs with the three companies chosen to operate KanCare.[8] Case management specialists—a core, specialized service for the TBI population—are responsible for determining how many Medicaid services an individual needs. This is an especially important service for those individuals with complex needs who usually find themselves on 1915(c) waivers. This consolidation resulted in statewide downsizing, as the three companies were solely responsible for providing these services throughout the state.

In one instance, a local company that provides management and rehab services for about 500 people with brain injuries laid off 26 case managers.[9] This was not unique to this one company, as dozens of smaller programs also closed or decided to forego providing case management services.[10] In this new environment, the managed care organizations (MCOs) were taking on larger than normal caseloads, which led to them managing patients over the phone rather than in person. The new system was so poorly articulated that those with brain injury did not know how to find or request services they needed.

This also negatively impacted providers, who were forced to take on additional responsibilities to prevent service lapses.[11] By consolidating the service into three companies and aggregating care at a county level, it became increasingly difficult to get people connected with the services needed in their community.

Kentucky

Excluding Waiver Populations from Transition

Kentucky has been involved in managed care for nearly three decades. As of 2011, almost 90% of Medicaid beneficiaries in Kentucky were enrolled in managed care.[12] However, that same year, the state began to gradually redesign its Medicaid program, terminating its original managed care program, known as the Kentucky Patient Access and Care (KenPAC) Program, and incorporating those covered by KenPAC into its second managed care foray, known as the Kentucky Health Partnership (KHP). Furthering its goal to transition nearly its entire Medicaid program to a managed care model, in 2011 the state implemented a mandatory risk-based managed care program referred to as Medicaid Managed Care.

This program enrolled most Medicaid beneficiaries, including those newly eligible as a result of the Affordable Care Act Medicaid expansion. While Kentucky required its managed care organizations (MCOs) to expand their provider networks to ensure adequate access, the program still faced criticism regarding service delivery. Patients were being denied treatment and forced to travel long distances for care, a result of the aggressive timeline.[13] In fact, the MCOs that had applied to serve Kentucky only had four months to establish operations in the state.[14]

Kentucky stakeholders, including those in the TBI provider community, raised concerns that the potential for disruptions were high given the lack of training for the MCOs. Ultimately, the state decided to exclude certain waiver populations from the managed care transition,[15] which advocates argued would have been too disruptive to current waiver members and possibly cause service disruptions as the new program was implemented.[16]

New York

Stakeholder Engagement Leads to Delayed Transition

New York state officials have been engaged with stakeholders for nearly two years regarding the states intention to transition its Medicaid waivers into managed care. Stakeholders, who range from providers to consumer groups, identified a number of issues and concerns that need to be addressed.

For example, the Uniform Assessment System of New York is the current assessment tool being used in Medicaid managed care to determine ones level of care. Providers are especially concerned by this model as it has been shown in the early stages of development to not effectively capture the service needs of those on the TBI waiver. In fact, the New York State Department of Health increased its training of those who would assess individuals once the transition was implemented, and while there were improvements, over 25% of participants on the TBI waiver would still no longer receive the services they were receiving post-transition. This issue remained unresolved even as the state moved closer to the April 1, 2016, deadline for when the proposal would have been posted for its 30-day public comment period.

Another ongoing issue is defining a new scope of service coordination, a crucial stabilizing service under the waivers. State officials remain at odds with stakeholders over defining a new scope of service coordination as a service distinct and separate from care management, and the details of how this service will be available have not been worked out. The elimination of service coordination would be detrimental to those utilizing waivers, especially those with traumatic brain injury.

Stakeholders have been working collaboratively with the State and CMS to address these issues, in addition to working with legislators urging them to introduce legislation which would highlight their concerns. The bills introduced, which range from outlining requirements for the transition to excluding the waiver population from the

transition, reflect the advocacy work of New York stakeholders who seek to develop a plan that ensures positive outcomes for beneficiaries.

As a result of these efforts, in late March, days before it was scheduled to post a transition plan for public comment, state officials came to an agreement via the state budget process to delay the transition for those utilizing waivers until January 2018. Securing this one-year delay will provide all parties involved additional time to work out remaining issues and to educate consumers on the evolving health care delivery model.

Role of Federal Government as Backstop

The federal government's role has varied as individual states submit proposals for their managed care models. In some cases, Centers for Medicare and Medicaid Services (CMS), which oversees state administered managed care, may require a state to delay its launch to ensure beneficiaries are not placed in undue risk.

While CMS may withhold approval until a state meets federal requirements, there are also a number of federal statutes CMS may use to ensure a smooth transition. In addition to a 30-day public comment period, states must demonstrate that there was a sufficient level of meaningful input from the public, with a report of the issues raised by the public and how the State considered those comments when developing the demonstration application.[17] CMS has the authority to request additional modifications, and at its discretion, an additional 30-day public comment period.
Recently, the state of Iowa intended to launch its managed care model on January 1, 2016, but in the weeks leading up to that launch, CMS informed the state that it would have to hold off on implementation:

"Based on our review last week of Iowa's progress, as well as the information you have provided, CMS expects that we will ultimately be able to approve Iowa's managed care waivers. However, we do not believe that Iowa is ready to make this transition Jan. 1," the letter says. "CMS previously outlined the requirements to provide high quality, accessible care to Medicaid beneficiaries, and Iowa has not yet met those requirements, meaning that a transition on January 1 would risk serious disruptions in care for Medicaid beneficiaries."[18]
Critics of the Iowa transition pointed out that Iowa Medicaid beneficiaries had little information regarding the types of plans that were available, which would have caused issues on both ends of the delivery spectrum if the plan went forward as originally intended. Additionally, a tumultuous launch could have negatively impacted providers who were trying to understand the system, who could have decided to leave the system altogether. Iowa instead launched its managed care plan April 1, 2016, and early reports are that plans are operating relatively smoothly, an indication that more time was critical to ensuring the plan was operable.

The role of advocacy does not end at the state level, as the federal government maintains final authorization for a state transition plan.

Conclusion

As more states look at managed care models, it is important that stakeholders understand the options they have available to them when working with state officials. It is clear that as states look to address budget deficits, managed care is an intriguing model to pursue, but it is not without its challenges. Going forward, it has been shown that states who work with stakeholders are in the best position to ensure a smooth transition for beneficiaries.

Additionally, the role of advocacy cannot be understated for elevating important issues and ensuring the appropriate bodies are informed of ongoing matters. The New York case underscores this point, as members of the legislature introduced legislation on their behalf, and stakeholders were engaged with CMS and their federal delegation in Washington. These proactive engagement efforts ultimately lead to a one-year delay. As more states

start to look at managed care models, ensuring providers and beneficiaries have the time to understand state plans, are engaged in development of that plan, and have the tools necessary to engage with state officials, are critical to a successful roll out.

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About the Authors: Eli Greenspan is the Manager of Government Relations and Alexander Hecht is the Vice President of Government Relations at ML Strategies, Washington, DC.

View ML Strategies professionals.

Endnotes

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