

A Two-Part Webinar/Teleconference Series on Managed Care and the Independent Living Movement - Part 1: Managed Care 101 presented by Merrill Friedman, Bill Henning and Suzanne Crisp on August 28, 2012

Questions and Answers from Day 1: On day one of this two-day webinar, we were unable to get to every participant question. The following are answers provided by the presenters to these questions.

Question: Didn't some states decide managed care did not save states money?

Answer: There are some studies suggesting it may not, along with other studies suggesting that it does. We are not aware of states that have made a final determination. It also is not yet clear that managed care for broad populations of people with disabilities saves money, but we are clear that it increases access for more people with disabilities to receive services.

Question: Who decides about services? What about the right to be heard and protest service you are denied?

Answer: Any solid plan should build in the following, at minimum: participation of consumers in assessment of service needs; grievance and appeals rights and processes; and ombudsman protections.

Question: What about people who want out of a nursing facility, but the managed care company thinks it would cost more at home?

Answer: The consumer and/or advocate would need to contest this, holding the plan (and state) to Olmstead rights compliance and protections. There are always going to be instances where community living is more expensive for an individual than in a nursing facility. This is why there is peril to hanging our hats on economic arguments.

Question: How does a managed care system assure an individual can continue to be served in the community with a high level of home care needs as well as health care issues such as the person with severe wounds that are hard to control/ heal?

Answer: An assessment and plan of care must consider all these factors and ideally an MCO benefit package will have adequate coverage and a qualified network for these needed services.

Question: Will the ACA provide greater opportunities for PWD to serve on MCO Advisory or Governing Boards?

Answer: We do not know if ACA has any prescription for this, but advocates can demand this with CMS for any plan in their state, the state Medicaid office, and the MCO. Engagement with these bodies, formal or otherwise, is highly necessary on an ongoing basis. Many states include the establishment of advisory boards in their contract requirements.

Question: What typical CIL services would you suggest a CIL market to a MCO?

Answer: Service coordination, peer mentoring, homemaker, trainings on various disability matters such as IL philosophy, respite, personal assistance services.

Question: What should we do when the ADA compliance plans we have FOIA (Freedom of Information Act) request from the MCOs are clearly deficient?

Answer: Advocate, agitate—This becomes a basic CIL advocacy issue, which would include highlighting deficiencies, proposing solutions, engaging technical experts, and pursuing the issue in a matter that works (meetings or protests or media or lawsuits or all of these). There is emerging TA available on accessibility in healthcare settings. We will provide an example link. See the training page.

Question: In Oregon we've been successful so far in carving out LTSS from all medical, dental, etc. "care" as our new Coordinated Care Organizations (CCOs) have been implemented. We know, while we have strong legislative support for keeping them separate (as long as the "joint accountability" agreements continue to be successful in the needed coordination), that we may eventually have to accept LTSS rolled into CCOs. BUT... our core belief that having LTSS "managed" by a medical model organization is contrary to the foundation of HCBS being directed by consumers who are seen as the employers of their PAs. Opinions about the principle? How to guarantee HCBS remain a social support versus a "medical" service?

Answer: There are those who admire the separation in Oregon, because it can continue to keep the service free from medical incursions. The attraction of integration, conversely, is that HCBS and LTSS are intrinsically connected to positive health outcomes and independence, and when distinct from the medical may not be adequately used or coordinated. It also gives the opportunity to streamline services, coordination, self-direction, habilitation, housing, transportation, employment and many other services that provide the foundation for living independently. The promise of savings, which drives states to implement MCOs, will lessen, and there may remain conflicts for those on both Medicare and Medicaid on which insurer covers a service, delaying provision of the service (something especially problematic with DME).

Question: It seems like a good idea to push for any managed care organization to hire a person or people with disabilities to help with ensuring that this side of their business works for the customers they are trying to serve. Let's get our people inside to help with making this service accessible. ...Possible advocacy goal. (Patricia Yeager)

Answer: Absolutely! Definitely! A vital, essential way to make change! Some states are even including incentives for companies to employ people with disabilities. Make sure you are submitting your resumes to the MCOs. Don't wait for them to ask!!

Question: Thank you Bill, great to hear you again. How do we get the attention of all the CILs and CILs' staff to understand that this is Everyone's role to get involved in this Systems Change advocacy?

Answer: Keep spreading the message—healthcare rights are disability rights! HCBS and LTSS are funded by Medicaid primarily, and after years of being out of the major discussions on cost control and health reform, are now very much on policymakers' (and budget cutters') radar screens.