

POLICY POSITION
PENNSYLVANIA ASSOCIATION OF AREA AGENCIES
ON AGING, INC.

Components for Inclusion in a Managed Care System

As Pennsylvania looks for ways to control the growth of Medicaid expenditures and to meet the long term care needs of people with disabilities and older Pennsylvanians, we, like other states, are considering the expansion of managed care into the area of long term services and supports (LTSS). Consumers and consumer advocates are concerned that the growing integration of acute and long term services and supports could result in the rationing of services and supports, create a barrier to accessing care and could move away from the essential model of consumer control.

The organizations listed below believe that any integrated managed care implemented in Pennsylvania should adhere to the following principles:

Basic Program Design

- To the greatest extent possible, the program should utilize existing service systems and supports and promote improved care integration.
- A variety of risk models, including non-traditional managed care models, should be considered to better enable existing service organizations to participate in the program.
- The program should utilize pilots, have a staggered rollout and be tested for effectiveness and financial impact before it's expanded further.
- The program must subcontract with community-based organizations with expertise in serving older people and others with disabilities, for ongoing consumer education and outreach beginning three months (3) prior to rollout in each area.
- Expansion statewide should not take place until thorough independent evaluations are conducted, problems are rectified, and positive outcomes and cost savings proven.
- The program must have a mechanism for gathering meaningful consumer input both in program design and ongoing operations. Advisory Committees should include at least 51% consumer/family representation.
- Indicators of success must include community integration and measure:
 - numbers of people diverted from nursing facilities;

- numbers of people transitioned out of nursing facilities;
 - access to durable medical equipment and other assistive technologies needed to support health and the greatest degree of independence and participation possible;
 - availability of back-up and emergency attendants;
 - availability of accessible, affordable, integrated housing including home modifications; and
 - access to accessible affordable transportation including vehicle modifications.
- The development of integrated LTSS should go hand in hand with the right-sizing and conversion of facility-based services. Consideration should be given to bond issues and other mechanisms to support conversions.
 - The state shall carefully monitor and limit both administrative costs and profit margins/excess revenue.

Social model

- Long term services and supports must be delivered with assurances of a social/independent living model based on choice and control with person-centered planning and not on a medical model.
- Linkage to acute services must be seamless. Access to LTSS must not be fragmented.
- The individual receiving services, and those in need of a surrogate advocate, should partner with a Service Coordinator/Care Manager to agree on a Plan of Services (POS).
- Coordination between acute care and LTSS should be greatly improved. If acute care services are integrated, medical decisions must be made by treating professionals, and those with special health care needs should be permitted to use a willing specialist as a primary care provider. People must be able to receive the acute care services that they need to maximize their independence (as well as a seamless transition to community services and supports when needed)
- Participation in integrated LTSS by consumers should be voluntary.

Service coordination

- Long term services and supports must have service coordination with coordinators qualified by:
 - experience working with people with disabilities and older people;
 - demonstrated knowledge of consumer control/self determination;
 - expertise and knowledge of community-based service programs; and
 - demonstrated knowledge of person-centered planning.
- Service coordinators must have access to community based services to assure ease of access to services for the individual. Gatekeepers/care managers must have the ability to initiate services in a timely and direct way without requirements that entail navigating multiple levels of approvals.
- Care management must include regular and periodic face-to-face contact and not be exclusively done from a remote location.

- Care management must be comprehensive, enhancing and connecting LTSS to other systems, and it must be available long before the person is presenting for a nursing facility.

Decision Making

- LTSS authorizations must be made by persons who know the person and his/her support needs rather than by reading a written record.
- Both a timely, informal internal and a formal external appeal process must be available if the person/surrogate advocate and the managed care system disagree with a decision, with an expedited process to accommodate emergencies.

Consumer directed services options

- Consumers should have a choice of service delivery options. Those options must include a consumer control model, and when that is not the option of choice, a full service agency or combination model should be available.
- Service coordinators must offer and explain the consumer-control model and other models without bias to all consumers/surrogate advocates.
- The program should be designed to ensure that consumers and/or their surrogates are in control of their services. (This is sometimes referred to as consumer direction or self-determination.)

Eligibility for community services

- The program will develop and implement a plan to reduce the waiting lists for community services.
- Eligibility should be for those who meet nursing home functional and financial eligibility requirements and are at risk of institutionalization.
- No one should be admitted to a nursing facility without being fully informed of community-based options.
- Consumers and family members should be educated about options through public education efforts and timely assessments.

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Supporting Organizations:

Anthracite Region Center for Independent Living
 Center for Advocacy for the Rights and Interests of the Elderly (CARIE)
 Center for Disability Law & Policy
 Center for Independent Living Opportunities
 Community Legal Services
 Community Resources for Independence Inc.
 Disabilities Law Project
 ElderNet
 Liberty Resources Inc.
 National Multiple Sclerosis Society—PA Chapters
 Neighborhood Interfaith Movement
 Pennsylvania Alliance for Retired Americans
 Pennsylvania Association of Area Agencies on Aging, Inc.
 Pennsylvania Council on Independent Living (PCIL)
 Pennsylvania Protection and Advocacy, Inc. (PP&A)

Pennsylvania Statewide Independent Living Council (SILC)
Pennsylvania's Initiative on Assistive Technology, Institute on Disabilities at Temple University
Unitarian Universalist House Outreach Program
Unite Here State Retirees Council
United Cerebral Palsy of Pennsylvania (UCP of PA)
United Cerebral Palsy of Southern Alleghenies Region, Inc.
United Disabilities Services

P4A

Representing Pennsylvania Network of 52 AAAs & the Older Pennsylvanians They Serve

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