The Need to Ensure Local Competition and Individual Choice in Managing Long Term Support Arrangements for People with Disabilities: A Call to Action.

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Abstract

This paper describes two seminal movements: the move to self-determination and community inclusion in the disabilities field and the move to managed care arrangements in the health care field. It points to the powerful advantage of marrying the two, but warns that the marriage will work only in a competitive community marketplace. Policy-makers, administrators, advocates and providers interested in improving long term supports for people with disabilities are urged to foster managed competition and to avoid the excesses that have stemmed from unmanaged competition for the health care dollar.

Two Movements Worth Marrying

Over the past decade the disabilities community has come to strongly embrace the values of inclusion (community membership), and personal choice (self-determination). The preservation and strengthening of family ties and natural supports are central to the movement as are circles of support, peer counseling, and other individually-directed approaches to the planning and managing services and supports. More and more it is people with disabilities and families themselves deciding which services, supports and providers to employ. Underlying this movement is an interest in community engagement and civic responsibility. Underlying this movement is an economic interest. Natural supports hold down the demand for public services and supports; and individualized, locally-created long-term support solutions are proving more cost effective than uniform ,solutions regulated from afar (Ellison and Ashbaugh, 1990; Smith, 1990, Smith, G., 1994; Agosta and Kimmich, 1997).

At the same time, managed health care systems have demonstrated some success in containing runaway physical and behavioral health care costs. Health care expenditures, once increasing at a double digit pace, have been reined in. These reported successes are leading a number of states to start planning managed care approaches to contain the costs of long term services and supports for people with life-long disabilities'. Should these initiatives prove successful, they will likely be replicated across the country, spreading rapidly in much the same way as have the managed care models in the health and behavioral health areas.

Defining a Good Marriage

The National Association of State Directors of Developmental Disabilities Services, Inc., Human Services Research Institute, United Cerebral Palsy Associations, Center on Human Policy at Syracuse University and others have taken similar positions on the principles that should guide the application of managed care technologies in providing long term services and supports for people with developmental disabilities. Without exception, they support the principles of inclusion and individual choice. To quote from one such position statement:

> "Assisting people with developmental disabilities to lead full and productive everyday lives in their communities must remain the central, defining aim of a state's service system. Public supports are a means toward an important end: assisting people with developmental disabilities to achieve full citizenship as active and valued members of their communities. This aim can be accomplished best by constantly striving to offer flexible, high quality, personalized supports that honor individual choice and promote interdependence with others in the community.

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[1] Long term services and supports are defined as supervision or assistance provided persons with disabilities to help them with self-care skills, activities of daily living, to participate in community life, and to maintain a sense of safety and well-being.

> Managed care should expand not diminish opportunities for people with developmental disabilities and their families to choose services and supports that will improve the quality of their lives.
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> A managed care system must be structured in a manner that decentralizes decision-making and promotes innovation. NADDDS is concerned that conventional managed care approaches may narrow, rather than broaden, the choices available to consumers and families and stifle the search for creative solutions to the unique support needs of each individual. The foundation of a service delivery system that promotes such values is a strong commitment to decentralized decision making and the empowerment of local communities to make individuals with developmental disabilities an integral part of community life."
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> .National Association of State Directors of Developmental Disabilities Services (July, 1995).

Caution: Private Markets Anticipate and Run Ahead of Public Policy

Various states are planning managed long term support systems for people with developmental disabilities that are consistent with these principles. *These participant-driven managed care* approaches are variously described by (Smith and Ashbaugh, 1995; National Institute on Consumer-directed Long-Term Services, July, 1996; Nerney and Shumway, September, 1996; Harkins, 1997; Agosta and Kimmich, et. al.., 1997). *Participant-driven managed care* is one part "self-determination"--designed to empower individuals to make informed choices. It is one part "managed care"--designed to assure a cost effective network of services and supports that operates within the limits of existing resources.

Yet, as the saying goes: *Plans are what you do while other things happen.* State plans, notwithstanding, there are market forces at play in these states and others that stand to undermine efforts to achieve these principles. it is important that these forces are recognized and addressed. They cannot be ignored.

Consider the physical and behavioral health care markets. Initially, the idea in the private health care industry was one of "managed competition"--a notion really no different than *that of participant-driven managed care.* As Berenson explains: The expectation was "that within each market, [service] networks with different and distinct organizational characteristics and internal cultures would form and compete initially on price and style of care and later on quality and value. Individual consumers would be able to recognize differences among plans and make plan selections based on their own assessment of comparative value."(Alpha Center, November, 1996, p. 1)

Unfortunately, those who have followed the managed care developments in the health care arena know that "managed competition (a. k. a participant-driven managed care) have not played out as expected. The competition has been more unmanaged than managed. The competitive play has been in the board rooms of large corporations, not in our communities. Managed health care and behavioral health care organizations aggressively seek market share

and control through mergers, acquisitions, asset consolidations, and other takeover tactics. Once done, they use their "market leverage to achieve large price discounts from providers and so reduce market capacity and costs."(Berensen in Alpha Center, November, 1996, p. 1). In so doing, they "successfully" limit, often eliminate, local competition and individual choice. Managed competition envisioned consumers shopping for the best plans in their communities; instead, they have become *covered lives,* bartered and sold by corporate interests.

As Winslow observes, "The [health care] market, in the view of many experts, is proceeding in a headlong rush... The speed of the consolidation of the health care market is an enormous issue that concerns all-of us."(Alpha Center, Mar 96, p.2). Well it should. Mergers and acquisitions among health care providers hit a rate of 2.4 per day in the first half of 1996; among hospitals alone, one deal (typically involving multiple facilities) has been reported every 3 days for the past two and one half years (The Partnership for Behavioral Healthcare, December, 1996).

State officials and the public are concerned with the concentration of market power and its ability to thwart the advantages of competition (Tye and Pham 1997). Initial studies of hospital mergers are showing that as the markets become more concentrated (with fewer, more powerful players) the hospitals are able to extract higher payments from payers (Simonson, in Alpha Center, March, 1996, p. 3). There is mounting concern that health care markets are coming under the control of a small number of economically and politically powerful players. They are concerned with undue restrictions on the ability of patients to choose among providers.

Public Lawmakers and Private Employers are Running to Catch-up

Better late than never. There has been a flurry of bills around the country designed to limit the excesses that have come with unmanaged competition in the health care arena. Bills,

1) to prohibit managed care insurers from entering into exclusive arrangements with physicians or physician organizations (I 8 bills at last count).

2) to allow patients to obtain needed services outside of a particular plan (point of service options); to assure prompt claims payment and fair utilization review practices;

3) to protect small, community-based non-profit agencies from takeover by larger enterprises seeking to elate competition, to obtain the assets of displaced agencies at prices below fair market value, and to control the market to the point where they can eventually dictate price and assure long term surpluses or profits.

4) to require managed health care organizations (MHCO)to contract with any provider viewing to meet the terms of an MHCO contract.

5) to protect providers from unfair contract award and termination practices on the part of managed health care organizations (MHCOs),

6) to require MHCOs to continue to cover the cost of consumer care with providers terminated from the plan for reasons other than performance .

Families, USA (1996)

Public lawmakers and private employers alike are engaged in a market correction designed to reinvigorate local competition and in so doing widen individual choice. A recently enacted bill prohibiting exclusive contracts between managed health care entities and providers in New Hampshire is indicative of the strong sentiment of state policy-makers in favor of competition:

"Free and fur competition m the trades and industries is an inherent and essential right of the people and should be protected against all monopolies and conspiracies which tend to hinder and destroy it.". . . Competition is fostered by minimal barriers to entry and exit in the relevant market, and exclusive arrangements between physicians and managed care insurers have created barriers to entry..... (House Bill 1613, New Hampshire Senate and House of Representatives).

Managed health care companies lobby against such measures claiming that such bills impede their ability to control costs. What they are really saying is that these bills prevent them from taking control of markets and then using their market leverage to engage in "take it or leave it" contract negotiations with community providers who must knuckle under to survive.

The rush to legislation to "manage managed health care" comes none too soon. It is needed to shore up old and anachronistic state health insurance regulatory schemes. As Grant, a prominent health law attorney, explains: "Many of the relevant laws and regulations that are currently on the books were passed 50 to 100 years ago and they did not contemplate the level of activity or type of activities that we see today." (Alpha Center, March, 1996, p. 1).

Why not sooner? Perhaps because, as Restuccia, executive Director of the Boston-based Health Care for All, acknowledges: "We don't have the institutional capacity and public and private bureaucracies to really manage this quite the way we would like" (Alpha Center, March, 1996, p. 1). Perhaps, because of the payer's (states' and private employers') overriding interest in reducing excess capacity; in health care, there is some merit to the argument that such consolidation was needed to reduce excess industry capacity. Insofar as long term supports for people with disabilities are concerned, however, the central problem is one of under-capacity. The challenge is how to expand capacity to meet growing demand, not reduce it.

Problem: Providers of Long Term Services and Supports are Anticipating Controlled Markets a la Health Care

Still, agencies providing long term services and supports to people with disabilities anticipate this same competitive pattern to carry over to the long term supports arena. Taking their cues from the health and behavioral health marketplace, providers feel that in order to survive they have a limited number of choices.

The few with the capital and management capacity needed to assume economic risk and acquire control of markets are busy merging and buying up potential competitors, positioning

and pitching themselves as the managed care entities (MCES) of choice to states and counties. Others--the vast majority of providers--lacking the capital needed to qualify as risk-bearing managed care entities feel vulnerable. They know their chances of surviving as independent providers are poor. They see a no-win situation. They can allow themselves to be bought out or otherwise absorbed by a prospective or existing managed care entity, or they can join an established or prospective network of providers operating in affiliation or under contract to a managed care entity. To gain affiliation, they must often pay an up-front fee so that the managed care entity will direct business their way. As a contractor, there is no up front cost, but they can expect stiff price competition from other networks or providers seeking contracts to serve individuals.

In all cases, the effect is to limit competition and individual choice. In the first two cases local markets are effectively being closed to competition. In the third case, there is competition, but for the MCE's dollar, not the individual's. As the controller of the local market, the MCE is the "customer' making the choices, not the individual with disabilities.

There is another choice--a winning choice for providers, people with disabilities, and public alike: *participant-driven managed care*.. It is a notion that is gaining new fife in the managed health care area (Tye and Pham, 1997), and a notion that is gaining strength in the long term supports area.

Under this arrangement, it is the individuals and families who choose how to expend resources for their support within pre-defined limits. They choose the supports that they need and decide where to obtain them. The job of the managed care entity is to assure that the limits are reasonable in view of the identified needs of the individual, judicious from a cost effectiveness standpoint, fair relative to the limits established for others served, manageable in view of the spending caps within which the managed care entity has agreed to operate, and that the provider chosen by the consumer has the fiscal capacity and competence to deliver the needed supports at the agreed upon price.

Call to Action:
Cultivate a Competitive Marketplace for
Providers of long Term Services and Supports

If the winning choice is to be a viable choice for providers, states must make it so by changing the long term supports marketplace from one that benignly encourages provider consolidation and so foils competition and individual choice to one that openly encourages competition and individual choice.

State disabilities authorities need to ask themselves: *Are the laws ands regulations that govern the provision of long term supports for people with disabilities any better than the flawed laws and regulations governing the provision of health care?* They need to wake up and take stock of the marketplace taking shape in their states. They need to examine the statutes, regulations and directives that govern the long term supports market, and seek those changes needed to preclude arrangements that will limit local market competition and individual choice. They

need to send a clear signal to the provider community that the long term supports marketplace of the future will be consumer-driven.

Providers need to rethink their options. Certainly, they will have to find a place in well managed, competitive networks, networks that have the capacity to assume risk and to reduce costs vis a vis the sharing of administrative supports and mass purchasing. But in doing so, they need to ask themselves, *whether this really requires giving up ownership or undue control to management entities?* Providers can network with managed care entities that act more as insurers and less as controllers (Ashbaugh and Fair, March, 1997). Provider networks can afford to self-insure; the risk with long term care provision is far less than the risk with health care provision. Where providers have the choice, they would be well-advised to steer clear of managed care entities with promises of future business hinging on anticipated market domination. In the coming participant-driven market place, any such competitive advantage, should it ever develop, is likely to be short-lived.

Conclusion

The disability market should not and need not proceed down the same road as physical and behavioral health. The wholesale consolidation of the -long term care industry in the interest of market share and control is not in the interest of people with disabilities, providers of long term supports, or the public. Lasting savings and a healthy long term supports marketplace for people with disabilities will come only when individuals with disabilities are able to choose among different supports offered by competing providers in their communities.

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