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MLTSS FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES: STRATEGIES FOR SUCCESS

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Need for Paper

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- Programs serving people with intellectual/developmental disabilities (I/DD) in managed care programs are few in the country
- States with MLTSS programs for older adults and people with physical disabilities express interest in expanding/creating programs for people with I/DD
- There is significant concern from participants and their families about the impact of managed care on their services

Need for Paper

- Little written about this topic
- States, health plans, participants and other stakeholders can use promising practices from states operating MLTSS I/DD programs
- Approach:
  - NASUAD partnered with Ari Ne'eman and NASDDDS (subject matter experts on serving individuals with I/DD)
  - Conducted lit search and interviewed states and plans

History of I/DD Advocacy

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- Late 1940s to mid 1950s - Parent Movement
  - Families across the US began asserting a different vision, different lifestyle and different future
  - Question wisdom of institutionalization
- 1950
  - Isolated Independent small groups of parents coalesced
  - Demanded services for their sons and daughters outside of an institutional setting
  - Advocacy groups sprang up across the country
  - National Association for Retarded Children – The Arc

History of I/DD Advocacy

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- 1970's – 1980's
  - Alternatives to large institutions
  - Education for all Handicapped Children Act (IDEA)
  - Section 1915(c) of the Social Security Act enacted
  - Oregon received approval for HCBS waiver – the first state to do so

History of I/DD Advocacy

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- Parents and Families as Pioneers for Progress
  - People with I/DD live in their homes and communities
  - Closing institutions
  - Supports in the family home
  - Person Centered Services and Supports
  - Self-Determination
  - Employment
  - In all states, have been instrumental in the development of publically financed human services system
  - Expertise, passion, experience and love

History of I/DD Advocacy

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- Mid 1980's – mid 1990's
  - Day Habilitation/Supported Employment
  - Deinstitutionalization/Balancing

"In the 1980s, as a growing number of people with I/DD made lives for themselves outside of institutions, many worked to form 'self-advocacy' organizations run by and for people with I/DD themselves."

Self-Advocates and Parents

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- Voices of self-advocates and parents just as vital today as in the 1950s
- Bring expertise, passion and experience and love for their family member
- Their knowledge and wisdom must be the foundation of any I/DD service model design

Managed Long-Term Services and Supports

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- Managed Long-Term Services and Supports (MLTSS) is the delivery of long term services and supports (state plan, waiver or both) through capitated Medicaid managed care plans
- Plans can be a managed care organization, pre-paid inpatient health plan, or a pre-paid ambulatory health plan (depending on scope of benefits provided)
- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for consumers

National MLTSS Footprint

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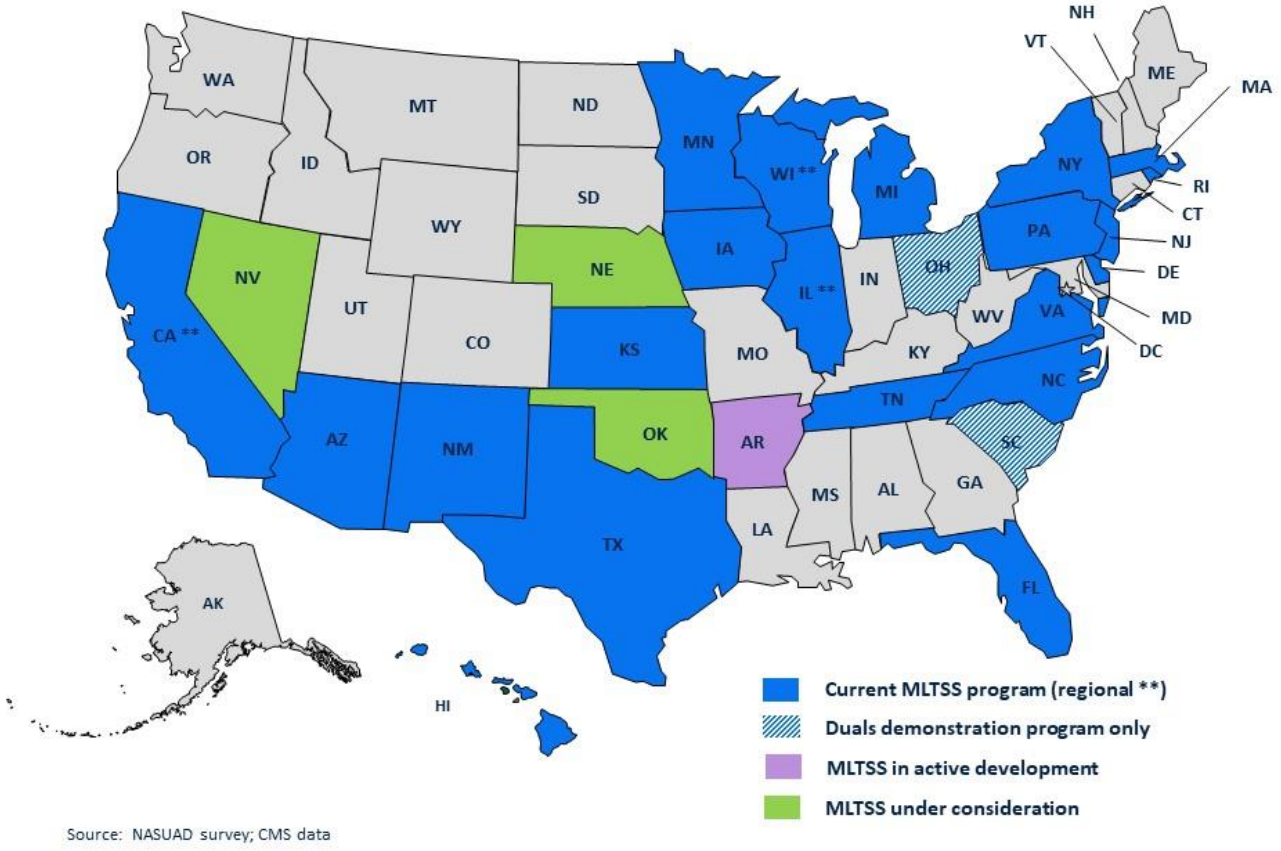
- In 23 states as of July 2018



Source: NASUAD survey; CMS data

Why Do States Implement MLTSS?

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- Accountability rests with a single entity
  - Financial risk for health plan provides opportunity to incentivize/penalize performance
  - Plans can integrate siloed streams of care (primary/behavioral/long term care) more effectively
- Administrative simplification for state
  - Eliminates need to contract with and monitor hundreds/thousands of individual providers
  - Managed care plans take on claims payment, member management, utilization review, etc.

Why Do States Implement MLTSS?

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- Budget Predictability
  - Capitation payments greatly minimize unanticipated spending
  - Can more accurately project costs (especially with LTSS as enrollment doesn't have as much variation based on economic circumstances)
- Shift services to community settings
  - Most consumers express preference for community-based services
  - Health plans have demonstrated effectiveness in diverting and reducing institutional stays

Why Do States Implement MLTSS?

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- Innovation and Quality
  - MCOs can deliver services more flexibly than states
  - National companies, in particular, can bring best practices from other states/product lines
  - Local plans are grounded in their communities
  - Demonstrated improvement in quality outcomes (HEDIS) over FFS
- Consumer becomes the center, not their services
  - LTSS interventions can lower acute care costs
  - Increased likelihood of 'bending the cost curve'

MLTSS for People with I/DD

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- Most MLTSS programs include HCBS services for older adults and persons with physical disabilities
- If people with I/DD are included, it is typically only for their medical services; HCBS services are excluded
- Only 8 states include waiver services for people with I/DD in their MLTSS programs:

Arizona	Iowa	Kansas
Michigan *	New York #	North Carolina *
Tennessee	Wisconsin	

* I/DD and MH populations only

\# Financial Alignment Demonstration

MLTSS Program Lifecycle

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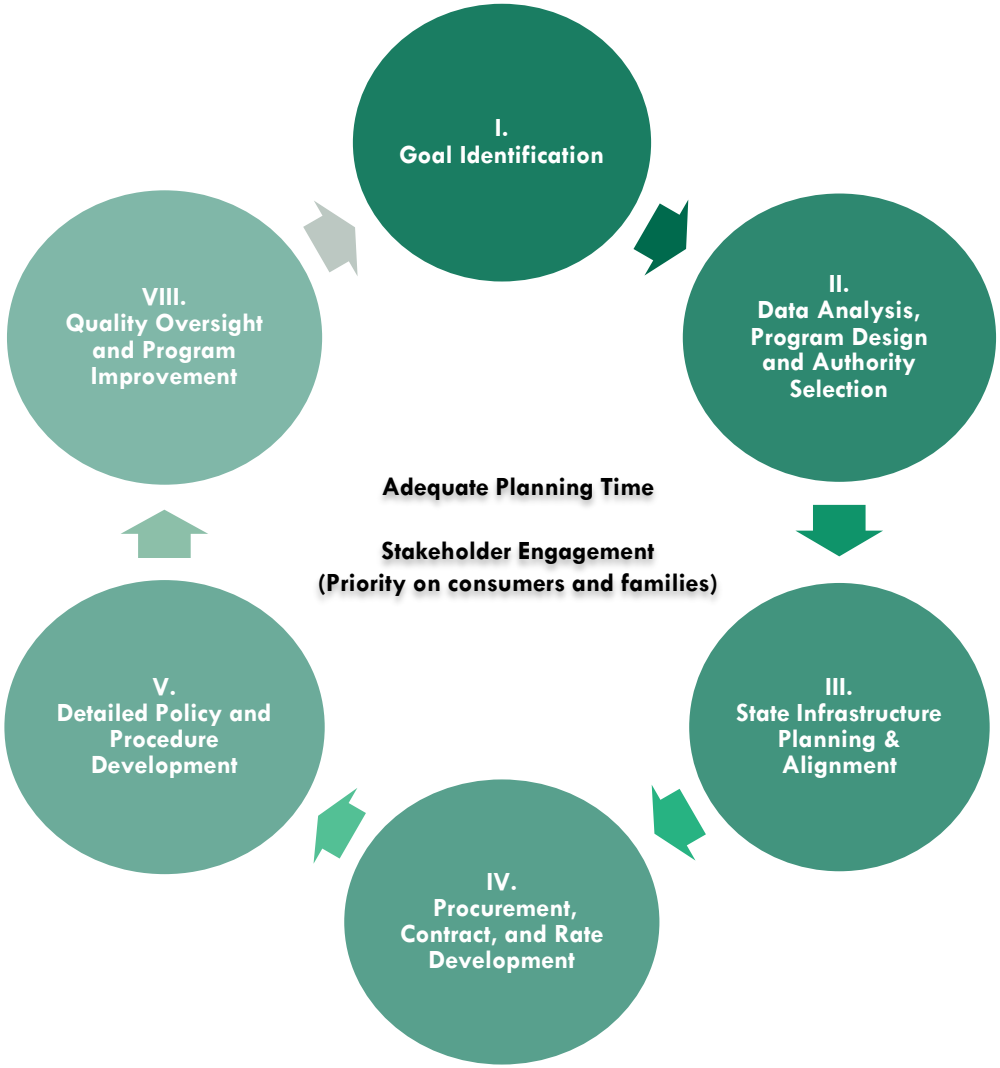

Adequate Planning Time

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- Adequate planning time is critical pre-requisite for success
  - CMS recommends two year planning process, minimum
  - Thoughtful planning and design
  - Incorporate stakeholder input
  - Safeguards to insure smooth transition
  - Education about MLTSS for people with I/DD and their families
  - Health plans need to familiarize themselves with LTSS for people with I/DD and their local provider network
  - Provider network may need more time to adjust to health plan requirements

Adequate Planning Time – Examples

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- **Tennessee** spent more than two years in planning their MLTSS program for people with I/DD, called Employment and Community First CHOICES (ECF)

- **Wisconsin** phased in its FamilyCare program gradually across the state by county

Stakeholder Engagement

- Stakeholder engagement cuts across all phases of the lifecycle
- Should be broad-based
  - Advocates
  - Providers
  - Health plans
  - Community-based organizations
  - Parents/families (more to come)
- Two-way street
  - Incorporate stakeholder recommendations into program design
  - Providing TA to self-advocates, families, providers

Stakeholder Engagement

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- Health plans must have process for stakeholder engagement
- Stakeholder engagement – families/caregivers should get particular attention
  - Meaningful roles in the design and implementation of managed care for people with I/DD and their families
  - States and managed care partners must have strong transparent systems for meaningful stakeholder engagement
  - Opportunities for input and response to stakeholders
  - Adequate time for engagement and review of successes and challenges of implementation
  - Ongoing, not just during design and implementation

Stakeholder Engagement – Examples

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- **Tennessee's** Medicaid agency and DD agency facilitated stakeholder feedback by holding in-person meetings with key provider and advocacy groups, community meetings around the state, as well as an on-line survey.

- **North Carolina** hosted listening sessions across the state, invited written comments and supplemented open invitation for written feedback with targeted outreach to consumers, their families and providers.

- **Sunflower Health Plan's** I/DD LTSS manager participated in development of Kansas' MLTSS program.

MLTSS Program Lifecycle – Goal Identification

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- State system goals should also incorporate goals for participants including person centeredness, employment choices, and self-determination

- The I/DD system is typically 'rebalanced' so other goals will be predominant
  - Increased access to preventive and acute services
  - Comprehensive care/service coordination
  - Budget predictability and stability

Goal Identification - Examples

- **Michigan's** program includes specific goals for all participants to pursue competitive employment.

- **Tennessee's** ECF CHOICES program was designed to make integrated competitive employment and community living the first and preferred option for people with I/DD.

MLTSS Program Lifecycle – Program Design

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- Data on FFS costs, utilization and provider distribution is critical
  - Set adequate capitation rates
  - Identify network capacity/gaps
- Populations, benefit package, geographic reach all need to be identified
- Decision on managed care authority and/or modifications to HCBS service authority
- Maintain historical I/DD quality infrastructure (ie. NCI)

Kansas continues to administer NCI survey and requires MCOs to use data in their QI activities

MLTSS Program Lifecycle – State Infrastructure

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- Close collaboration with I/DD operating agency/unit to access experience for design and implementation plans
  - Voc rehab and education play important role as well
- If feasible, transition waiver oversight staff to contract/quality monitoring; specific focus on critical incident reporting and monitoring
- Ensure beneficiary support system staff have training/experience with I/DD participants and services

Tennessee's Medicaid and Vocational Rehab agencies signed an MOU to ensure consistent delivery of employment services

MLTSS Program Lifecycle – Procurement/Rates

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- RFP should make state expectations and priorities clear
  - Include program requirements specific to I/DD populations
  - Seek demonstrated expertise/philosophy about I/DD populations
- Establish minimum standards for provider 'credentials' and other I/DD program-specific elements
- Adequate rates are essential, and should support goals of program
  - Encourage innovation but maintain stability of system

MLTSS Program Lifecycle – Contracts

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- Specific MCO staff composition and skill set (different from other populations)
- Minimize burden on providers (standardized processes across plans)
- Expectations for addressing informal support network, esp. family members
- Collect and submit data to show progress to goals (ie. competitive employment achieved and maintained)

Contracts - Examples

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- Tennessee developed 'preferred contracting standards' for ECF CHOICES provider network
  - Focused on bringing providers that were in agreement and supported the program's goals of integrated competitive employment and community integration
- Michigan includes a specific Employment Works Policy in its PIHP contracts
- Kansas specifies integrated employment outcomes that MCOs must achieve and tracks MCO success in meeting them.

MLTSS Program Lifecycle – Policies and Procedures

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- The devil is in the details
- Contract cannot enumerate the operational aspects of program implementation
- The more information the state can transmit increases likelihood of health plans implementing the program design with fidelity
- Transparent communication is critical
- Educate and train, and educate and train some more

Policies and Procedures - Examples

- 3 plans in North Carolina collaborate to deliver web-based PCP training to providers using DirectCourse
- BlueCare Tennessee and Amerigroup Tennessee collaborated on training for providers interested in participating in the ECF CHOICES program

MLTSS Program Lifecycle – Quality Improvement

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- Important to establish quality measures that will assess success in meeting program goals
- Participant input critical to defining 'success'
  - Clinical quality secondary to meeting participants goals for their lives
- Ensuring health and welfare a key quality outcome
- Wealth of NCI historical data can be instrumental in comparing experiences under MLTSS

The I/DD agency in Tennessee conducts on-site MCO performance reviews

Key Takeaways

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- MLTSS programs for people with I/DD hold great promise for expanding employment and improving health status
- Deliberate and thoughtful design, procurement and implementation plans will increase likelihood of success
- Slow and steady wins the race!
- States and MCOs should work collaboratively to support providers and achieve program goals
- Regular and bidirectional engagement with participants and their families will provide important feedback loop
- Measuring quality in meaningful ways will support program success

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