HEALTH MANAGEMENT ASSOCIATES

State Approaches to Enrolling Individuals with Intellectual and/or Developmental Disabilities in MLTSS

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HMA

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OUR FIRM

We are a leading independent, national healthcare research and consulting firm providing technical and analytical services.

We specialize in publicly-funded health programs, system reform and public policy.

We work with purchasers, providers, policy-makers, program evaluators, investors and others.

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OVERVIEW OF RESEARCH METHODOLOGY

- **Research funded by the Medicaid and CHIP Payment and Access Commission (MACPAC)**
  - The findings, statements, and views expressed in this presentation are those of the authors and do not necessarily reflect those of MACPAC.
- Reviewed 8 state contracts for comprehensive managed care programs or prepaid inpatient health plans including the majority or all HCBS (AZ, IA, KS, MI, NY, NC, TN, and WI)
- Conducted 10 interviews with:
  - 3 State Medicaid MLTSS officials
  - 6 managed care organizations
  - 2 HCBS provider organizations
  - 2 consumer/advocacy organizations

BACKGROUND - LTSS NEEDS FOR INDIVIDUALS WITH ID/DD

LTSS needs of individuals with ID/DD differ from other LTSS populations, and are more often provided in the community

Often activities of daily living (ADL) support and instrumental ADL (IADL) in addition to other supports: supervision; cueing to independently complete tasks

Utilize services across life span: *Younger* Early Intervention Services, school-based services, home and family supports; *Adults* - services related to employment, residential

Younger individuals with ID/DD receive services that support the goal of completing ADL/IADL tasks independently, or with lower supports

Often need intensive and constant case management

Some may need support with challenging behavior, including individuals dually diagnosed with mental health disorders

BACKGROUND – DELIVERY SYSTEM FOR INDIVIDUALS WITH ID/DD (SLIDE 1 OF 2)

- Medicaid is the largest payer of LTSS in the US, and the predominant payer of LTSS for people with ID/DD
- Medicaid LTSS for individuals with ID/DD has evolved from funding services in large-scale state-run institutions toward community-based supports
- 1980s and 1990s states:
  - *Expanded use of HCBS waivers* to support individuals in the community who would otherwise require institutional levels of care
  - *Began to enroll Medicaid enrollees in managed care*
    - For individuals with ID/DD these two efforts often occurred on parallel tracks

BACKGROUND – DELIVERY SYSTEM FOR INDIVIDUALS WITH ID/DD (SLIDE 2 OF 2)

- 1999 US Supreme Court ruling, *Olmstead v. L.C.*
- ACA of 2010 included provisions to further deinstitutionalization
  - Money Follows the Person Demonstration Extension
  - Balancing Incentive Program
  - Community First Choice Option
- 2014, CMS issued the HCBS Rule defining HCBS as having core characteristics, including community integration, rather than any settings other than institutionalization

EXCLUSION OF INDIVIDUALS WITH ID/DD IN MEDICAID MLTSS

- While many states include the provision of acute and primary care via managed care for individuals with ID/DD, their LTSS is most often excluded and provided through FFS
- Factors:
  - Lack of MCO experience serving ID/DD population and their unique needs
  - Lack of MCO experience with ID/DD providers (and vice versa)
  - Concerns of highly-engaged stakeholder community
  - Low HCBS provider reimbursement rates that do not allow for expectation of cost-savings through review of service allocation
  - Lack of utilization data needed to set sound rates
  - Lack of quality measures for LTSS - especially HCBS for people with ID/DD - relative to outcomes and those needed to enable value-based contracting

TAILORING MLTSS PROGRAMS FOR INDIVIDUALS WITH ID/DD - WHAT CONTRACT REVIEWS REVEALED

- ID/DD-specific or tailored contract provisions:
  - More prevalent for separate programs designed for individuals with ID/DD (AZ, NY, TN)
  - Correlate with states that have underlying ID/DD policy goals (TN goal to increase employment for the population; NY focus on integration of Medicare/Medicaid services for individuals with ID/DD)
  - Very few for states moving to managed care for all populations (KS, IA)

TAILORING MLTSS PROGRAMS FOR INDIVIDUALS WITH ID/DD – OTHER KEY FINDINGS FROM CONTRACT REVIEWS

- Most frequent ID/DD-specific requirements related to training and experience of case managers (TN, NY)
- Three states (KS, NC, and TN) require plan staff to have ID/DD-specific experience, esp. for medical directors and LTSS directors
- One state (TN) requires experience in integrated employment services
- ID/DD specific stakeholder engagement requirements primarily included in contracts for MLTSS programs targeted to people with ID/DD (AZ, NY, TN)
- Five states include ID/DD-specific quality provisions or measures (NY, TN)

TAILORING MLTSS PROGRAMS FOR INDIVIDUALS WITH ID/DD – KEY FINDINGS FROM INTERVIEWS (SLIDE 1 OF 2)

- Clear identification and articulation of program goals and outcomes sought to be achieved essential for program design and effectiveness
- Stakeholder engagement is critical to programmatic and policy success. Examples:
  - Hire member advocate on staff. Hire family members and people with disabilities
  - Involve advocacy and stakeholder organizations in service coordinator training and review of training materials
  - Support and participate in local disability-related events
  - Convene regularly scheduled stakeholder meetings in a variety of locations

TAILORING MLTSS PROGRAMS FOR INDIVIDUALS WITH ID/DD – KEY FINDINGS FROM INTERVIEWS (SLIDE 2 OF 2)

- Slow, incremental program transitions (by region, eligibility category, or both) cited as success factors (TN, WI)
- Workforce shortages cited in nearly every interview as a challenge to receiving ID/DD services, regardless of finance structure
- Providers and consumers/advocates are concerned about accountability of MCOs
- MCO transitions or exits cause significant disruption for a population for whom continuity of care is paramount

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MACPAC

State Approaches to Enrolling Individuals with ID/DD in MLTSS

Medicaid and CHIP Payment and Access Commission

Kristal Vardaman

Overview

- Introductions
- Background on the enrollment of people with intellectual or developmental disabilities (ID/DD) into managed long-term services and supports (MLTSS)
- Results of MACPAC-funded research: HMA
- State perspective: Tennessee
- Consumer perspective: The Arc
- Questions

Speakers

- Kristal Vardaman, MACPAC
- Sarah Barth and Rachel Patterson, Health Management Associates
  - Results of research on MLTSS programs enrolling people with ID/DD
- Patti Killingsworth, TennCare
  - Tennessee's program design and lessons learned
- Nicole Jorwic, The Arc
  - Consumer perspective with focus on experience in Wisconsin

People with ID/DD

- People with ID/DD use a variety of LTSS that may vary across their lifespan
  - Children may receive school-based services
  - Working age adults may use supported employment services
  - Living arrangements may depend on functional needs and can change over time and with availability of family caregivers
- MACPAC analysis of fee-for-service HCBS users found that for high-cost users:
  - About 60 percent had diagnosis of intellectual disabilities and related conditions,
  - About 16 percent had been diagnosed with cerebral palsy, and
  - Average HCBS spending across all diagnoses was over $100,000 per year

State Adoption of MLTSS for People with ID/DD

- 24 states have MLTSS programs, but only 8 cover most LTSS for individuals with ID/DD
  - Arizona, Iowa, Kansas, Michigan, New York, North Carolina, Tennessee, and Wisconsin
- State programs vary on many dimensions including:
  - managing entities (e.g., state agency or managed care organization),
  - mandatory versus voluntary enrollment, and
  - inclusion of other LTSS populations

Reasons Fewer States Include People with ID/DD in MLTSS

- Underdeveloped relationship between managed care organizations (MCOs) and ID/DD service providers
- Resistance from the ID/DD stakeholder community
- Difficulty in achieving cost savings
- Lack of data for capitation rate development
- Silos in administration of services for individuals with ID/DD

MLTSS Continues to Evolve

- Increasing enrollment of people with ID/DD
- Focus on rebalancing and opportunities for community integration
- Increased attention to quality and outcomes
  - Development of quality measures for home- and community-based services
  - Patient experience surveys
  - Pay-for-performance initiatives
- Integrated care for beneficiaries dually eligible for Medicare and Medicaid

For More Information

- Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution

  https://www.macpac.gov/publication/managed-long-term-services-and-supports-status-of-state-adoption-and-areas-of-program-evolution/

- Medicaid Home and Community-Based Services: Characteristics and Spending of High-Cost Users

  https://www.macpac.gov/publication/medicaid-home-and-community-based-services-characteristics-and-spending-of-high-cost-users/

MACPAC

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The Arc

For people with intellectual and developmental disabilities

Managed Care-Consumer Perspectives

Presented by: Nicole Jorwic, J.D.

Director of Rights Policy, The Arc of the United States

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Why Managed Care?

- Allows states to achieve budget stability over time and assist in predicting costs
- Assists in limiting states' financial risk, passing part or all of it on to contractors by paying a single, fixed fee per enrollee
- Allows one (or more depending on design) entity to be held accountable for controlling service use *and* providing quality care
- Creates the potential to provide services to more people and create flexibility in service provision - if done very carefully and all components in place

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What Managed Care Includes

- A network of providers
- Contracting that is selective, instead of agreements with any qualified vendor.
- Per member, per month. Capitated payments, MCO accepts a pre-set monthly amount to provider a pre-approved package of services.

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Current Trends

- Focus on quality
- States also looking at expanding pay-for-performance/value-based purchasing from providers
- More and more involvement by MCOs in states' Olmstead plans, as well as housing and employment first initiatives
- Quality and cost are inextricably linked.

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Models

- Arizona
- Wisconsin
- Michigan
- Iowa, Kansas

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Wisconsin

- Locally-run– until recently
- Low Admin costs- 4.2%
- Capped profits- limits MCO to 2% surplus
- Significant stakeholder input with time to build buy-in. Counties brought in one by one.
- Push for Family Care 2.0- private companies
- Integration and coordination of services must be balanced with self determination and inclusion.

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Kansas-Provider

- Three entities instead of one
- Increased administrative overhead costs
- Credentialing/Contracting
- MCO Lack of experience in I/DD services – waiver rules, etc.
- MCO Care Coordinator Turnover - Reorganization
- Waiting list grew

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Iowa

- Cuts in Services
- Longer Waiting Lists
- Denials and Appeals

Tennessee's Approach to Enrolling Individuals with I/DD in MLTSS

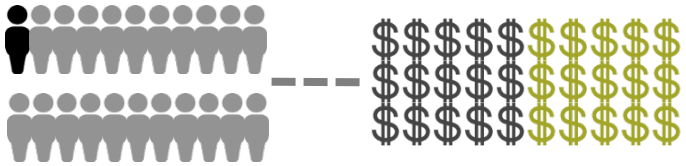
It's not "just another set of benefits to manage…"

Service Delivery System in Tennessee

- TennCare managed care demonstration began in 1994
- Operates under the authority of an 1115 demonstration
- *Entire* Medicaid population (1.4 million) in managed care since 1994
  - Including dual eligibles and people with disabilities
- Three health plans (MCOs) operating statewide
- Physical/behavioral health integrated beginning in 2007
- Managed LTSS began with the Statewide ***CHOICES*** program in 2010
  - Older adults and adults with physical disabilities *only*
- 3 Section 1915(c) waivers and ICF/IID services for individuals with I/DD carved out; operated by State I/DD Department
  - People *carved in* for physical and behavioral health services
- New Statewide MLTSS program for individuals with I/DD began July 1, 2016: ***Employment and Community First CHOICES***

Why managed care for people with I/DD?

Cost:



3% of TennCare members

Account for

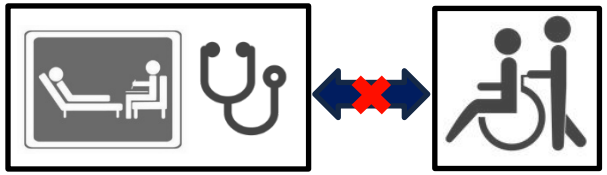
50% of total program costs

Tennessee spends nearly

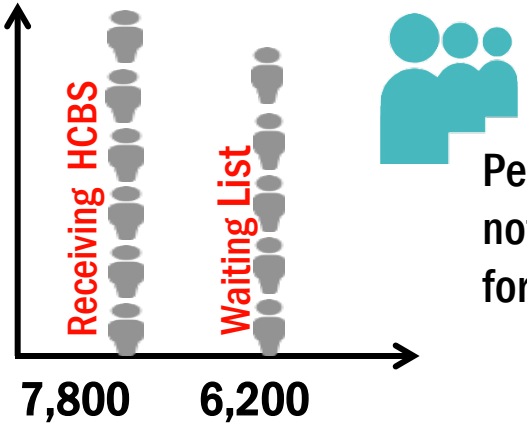
2x the national average per person for people with I/DD

Little Coordination:

between physical, behavioral and LTSS



Demand for HCBS:



People with DD (but not ID) not eligible for HCBS

Employment Opportunities:

36% of people who did not have a paid job in the community said they want one

Opportunities for Improvement

Stakeholders asked TennCare to consider an MLTSS program for people with I/DD in order to:

- Provide the services people and their families say they need most
- Provide services more cost-effectively
- Serve more people, including people on the waiting list and people with other kinds of developmental disabilities
- Offer more independent community living options (less reliance on 24/7 paid supports) and help engaging in employment and activities that are meaningful
- More focus on preventive services (not waiting for "crisis")
- Provide services targeted to young adults coming out of high school
- Improve coordination between long term services and supports and other physical and behavioral support needs
- Align incentives toward employment, community living, community integration and other things that people with disabilities and their families value most

Stakeholder Engagement

- **Build relationships, credibility and buy-in**
  - **Managed Care Organizations**
  - **State I/DD Department**
  - **Providers and Provider Associations**
    - Tennessee Network of Community Organizations (TNCO)
    - Tennessee Provider Coalition
  - **Advocacy Groups**
    - The Arc Tennessee
    - Tennessee Council on Developmental Disabilities
    - Tennessee Disability Coalition
    - Disability Rights Tennessee
    - Statewide Independent Living Council
  - ***Most importantly*, people with I/DD and their families**

Stakeholder Engagement: *Building Together*

- Commenced in December 2013
  - Meetings with advocacy and provider groups
- January-February 2014
  - Regional community meetings with consumers, family members, providers
  - Online survey tool
- February-March 2014
  - Written comments and other follow-up recommendations
- March 26, 2014 - ***Stakeholder Input Summary*** issued
- May 30, 2015 - ***Concept Paper*** posted for public comment

Stakeholder Engagement: *Building Together*

- June 2014
  - Regional community meetings with consumers, family members, providers
  - Online survey tool
  - Consumer/family-"friendly" summaries of the Concept Paper disseminated and posted online
- July 18, 2014 - ***Stakeholder Input Summary on Concept Paper***
  June 23, 2015 – ***1115 Waiver amendment***
- June 2015-July 1, 2016 ongoing implementation discussions across stakeholders, evolving into **stakeholder advisory group**
- MCOs also required to have a Member Advocate and a **statewide advisory group** *"to provide input and advice to the MCO's executive management and governing body and to TennCare regarding the program, policies and operation "*

MCO Advisory Groups

- ≥26% people served in the program
- ≥ 51% persons served and/or family members/representatives
- All key advocacy organizations, providers and provider association
- Separate member-only advisory group
- Meet at least quarterly
  - Orientation and training; travel costs reimbursed
- Include in each meeting opportunity to provide program recommendations to MCO and TennCare
  - Clearly identify in the written record and report to TennCare
- Input into MCO's planning and delivery of LTSS, QM/QI activities, program monitoring/evaluation, member/family/provider education
- Convene annual community forums for individuals, families and providers in each Grand Region to provide education, gather input on program, policies and operation

Employment and Community First CHOICES

Phased enrollment

- All ***new*** enrollment into HCBS directed to new program
  - For now, 1915(c) waivers remain carved out
  - Waiver participants can elect to transition to MLTSS, including people who need additional services

Phased network development

- Health Plans partnered to recruit, credential and train a shared implementation network of qualified providers
  - Have since expanded and diversified
  - Preferred Contracting Standards established by the State
    - √ Shared value and vision for the program, service delivery, outcomes
    - √ Experience serving people with I/DD (existing HCBS providers)
    - √ Community relationships; demonstrated success in achieving employment, independence, and community integration

Phased capitation approach

- MCOs at risk for physical and behavioral health only; reimbursed for HCBS pending sufficient data to develop actuarially sound rate

3 Benefit Groups

Tiered benefit packages target resources more efficiently; serve more people, reduce waiting list over time

Employment and Community First CHOICES

- Designed to promote integrated competitive employment and community living as the first and preferred outcome
- Array of 14 different Employment Services create a pathway to employment even for people with significant disabilities
- Comprehensive and flexible wrap around and supportive services, including self-advocacy and family supports, and self-directed options designed to support active community participation and as much independence as possible
  - Intermittent supports; expectations of fading
- ***Employment Informed Choice*** process ensures that employment is the *first* option considered for every person of working age *before* non-employment day services are available
- Individuals engaged in competitive integrated employment have access to more benefits

Employment and Community First CHOICES

- Groups prioritized for enrollment include those who need/want support to keep or obtain competitive integrated employment (CIE), plan/prepare for CIE, or are at least willing to explore CIE
- Comprehensive person-centered assessment and planning process explores employment early in process and in significant depth
- **Value-based payment** aligns incentives with employment goals
  - **Outcome-based reimbursement** for pre-employment services
  - **Tiered outcome-based reimbursement** for Job Development and Self-Employment Start-Up based on person's "acuity" level and **paid in phases to support retention**
  - **Tiered reimbursement for Job Coaching** based on person's "acuity" level, length of time employed, and amount of support as a % of hours worked ***Payment is higher per hour if fading achieved is greater.***
- Memorandum of Agreement with VR agency operationalized through statewide joint training of VR and MCO staff

Employment and Community First CHOICES

- Significant investments in building health plan capacity to serve people with I/DD
  - Person-centered planning and person-centered organization training
  - Extensive training requirements for Support Coordinators
- MCOs required to hire Employment Specialists and Behavior Support Directors; develop Settings Compliance Committee
  - Review and approve person centered support plans or behavior support plans that include restrictive interventions; also review periodically for removal of restrictions
  - Review/address potential inappropriate use of psychotropics
- Flexible consumer direction option with budget authority
  - Statewide fiscal employer agent procured by Medicaid Agency includes supports brokerage
  - Standardized materials developed by State; MCOs must offer option to every member receiving eligible services and person must sign (yes or no)

Employment and Community First CHOICES

- **Robust critical incident management system**
  - Well-defined incident types/tiers
  - Mandatory reporting
    - *Immediately* (no more than 4 hours for Tier 1), next business day all other
    - $2,000 per occurrence health plan sanction for failure to report
  - Investigation and review; corrective action required
  - Tracking and trend analysis required at provider, health plan and state level; identify trends and patterns, opportunities for improvement, strategies to reduce occurrence and improve quality of HCBS
  - Statewide abuse and neglect registry with mandatory employee screening
  - MCO monitoring of provider compliance as part of re-credentialing
  - TennCare monitoring of MCO compliance via critical incident audits
- Significant attention on finding the right balance between assuring health and safety while honoring individual choice and dignity of risk

Some things we've learned…

- Ongoing communication, engagement, and partnership with stakeholders, including providers and MCOs, has been critical
- People who don't think they want to work oftentimes haven't had the information they need to make an informed choice
- Providers have struggled to change their organizational culture/business practices; meet new service expectations
- Statewide rollout has been challenging
- The national workforce shortage is real and will require new strategies to recruit and retain high quality staff
- MCOs are learning a different approach to network development/management
- The program is having significant positive impact on individual employment and independent living outcomes, and is helping us improve other LTSS (including fee for service) programs too