Managed Care and Stakeholder Partnerships

Managed Care: Nuts and Bolts
Partnerships: Beyond Public Forums

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What We Will Share

- Managed care basics
- Why states are looking at managed care with a focus on long term services and supports
- Where managed care is currently & moving (from both state I/DD agencies’ and providers perspective’- they are different!)
- What factors/actions contribute to good implementation
- Why stakeholders are Key, with a capital K
State Plan Benefits

Mandatory services – must be provided to everyone eligible

Optional services – if provided by the state, must be provided to everyone eligible
## Basic Medicaid Structure

### Mandatory Benefits
- Physical Health
- Acute Care
- EPSDT

### Optional Benefits
- ICF/DD
- ICF/SNF
- Personal Care
- Home Health Nursing
- Rehab
- 1915 (i)
- 1915 (j)
- 1915 (k)

### Home and Community Based Waiver 1915 (c)

### Section 1115
- Demonstration Waivers
- Managed Care and Other Innovations

### Section 1915 (b) Waiver
- Managed Care
<table>
<thead>
<tr>
<th>Feature</th>
<th>1915 (c)</th>
<th>1915 (i) SPA</th>
<th>1915 (j) SPA</th>
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<tr>
<td><strong>Services</strong></td>
<td>Home and Community Based Waiver</td>
<td>State Plan Home and Community Based Services</td>
<td>Self-Directed Personal Assistance</td>
<td>Community First Choice Option</td>
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<td>HCBS Services</td>
<td>HCBS Services</td>
<td>Personal care; HCBS 1915 (c) services; items</td>
<td>Assists with ADLS</td>
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<td>that increase independence and replace human</td>
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<td>Transition Costs</td>
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<td><strong>Provisions</strong></td>
<td>Waiver state wideness</td>
<td>Target populations</td>
<td>Waiver state wideness; Target populations</td>
<td>Income rules for medically need people</td>
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<td>Target populations</td>
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<td><strong>Duration</strong></td>
<td>3 years for new 5 yrs. for renewal</td>
<td>One time approval</td>
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<td>If targeting, then 5 yr. renewal</td>
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<td><strong>Eligibility</strong></td>
<td>HCBS to people who would otherwise be in an</td>
<td>Medicaid eligible up to 150% of poverty;</td>
<td>Eligible for 1915 (c) or state plan services</td>
<td>Medicaid eligible up to 150% of poverty;</td>
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<td>includes people who don’t meet level of care</td>
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<td>poverty</td>
<td>as well as those who do</td>
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<td><strong>Target Groups</strong></td>
<td>Aged or disabled; I/DD; MI 22-64</td>
<td>May define and limit target groups</td>
<td>May define and limit target groups</td>
<td>No targeting; must be provided to all</td>
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<td><strong>Limits Allowed</strong></td>
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Waivers and Authorities

- **Section 1915 (c) Home and Community-Based Services Waivers**: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

- **Section 1915 (b) Managed Care Waivers**: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers through mandatory enrollment.

- **Concurrent Section 1915 (b) and 1915 (c) Waivers**: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.
• **Section 1115 Research & Demonstration Authority:** States can apply for program flexibility to test new and innovative approaches to financing and delivering Medicaid and CHIP.

➢ **Section 1915 (a) Authority:** States can enter into contracts with organizations to provide services in the state plan; Must be voluntary; only existing services and cannot limit contractors

➢ **Section 1932 (a) Authority:** States may mandate enrollment in managed care. Certain groups are exempt. Rural areas must have at least 2 options
Medicaid Authorities Expand Over Time Cont.

Congress adopted additional waivers

- Section 1915 (c) Home and Community-Based Services Waivers
- Section 1915 (b) Managed Care Waivers
- Concurrent Section 1015 (b) and 1915 (c) Waivers
- Section 1115 Research & Demonstration Projects

And additional State Plan Authorities

- 1915 (i) State plan - Home and Community Based Services
- 1915 (j) State plan - Self-Directed Personal Assistance Services
- 1915 (k) State plan - Community First Choice Option
Why States are moving to Managed Care

- Can 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 and support
- Creates the potential to provide services to more people and create flexibility in service provision - *if done very carefully and all components are in place*
Before Jumping into Managed Care

- Ask why managed care?
- Managed care is a tool.
- States selecting managed care as a service delivery system for long term services and supports must have clear problem identification from the start to ensure that managed care is the tool most appropriate to address the problem and provide the best supports for people.
- Managed care in the early days was for acute/medical care services cost control and quality improvement and did not initially contemplate managed long term services and supports (MLTSS).
- Recent uses for MLTSS have included increasing budget predictability and improving communication among service providers for individuals, along with budget predictability and quality.
- Managed care is not the only means available to states to achieve these goals, so careful analysis is necessary to ensure that managed care is the proper approach.

*Sowers and Brent*
Generally, Managed Care Includes:

- A defined network of providers, as opposed to the freedom to choose any qualified provider under Section 1902 (Social Security Act, that then describes CMS authority)
- Selective contracting on the part of the Medicaid program, as opposed to giving an agreement to any qualified vendor
- Most managed care includes capitated payments, in which the managed care contractor accepts a set monthly amount to provide a package of services, as opposed to being reimbursed for each service provided. This is often referred to as “per member per month”
- Managed Long Term Services and Supports (MLTSS) refers to an arrangement between State Medicaid programs and contractors through which the contractors receive capitated payments for LTSS and are accountable for quality, cost and other standards set in the contracts, although capitation can be for all or selected services for every person covered by the contract
- Contractors can be local, regional or national
- LTSS populations can include persons with age-related, physical or intellectual/developmental disabilities. Many people also have co-occurring disorders such as mental illness.
Managed Care Authorities

- 1115 Demonstration Waivers
- 1915 (b) (c) Concurrent Waivers
- 1915 a – alone or in combination
- 1915 b- several types

The applications don’t look like the 1915 (c), except for the c portion of the 1915(c). Important to get familiar with the authorities and applications.

But first---determine what does the state want to accomplish through managed care? What problem does the state believe managed care might solve?
1915(b) Waivers are one of several options available to states that allow the use of Managed Care in the Medicaid Program. When using 1915(b), states have four different options:

- **1915(b)(1)** - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- **1915(b)(2)** - Allow a county or local government to act as a choice counselor or enrollment broker in order to help people pick a managed care plan
- **1915(b)(3)** - Use the savings that the state gets from a managed care delivery system to provide additional services
- **1915(b)(4)** - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation)

In long term services and supports, it is more typical to see 1915(b)(3) used concurrently with 1915(c)
States can provide traditional long-term care benefits (home health, personal care, and institutional services), as well as HCBS services (e.g. homemaker services, adult day health services, community navigator, and respite care) using a managed care delivery system.

By combining a 1915 (c) with a 1915 (b), or other authorities outlined in the Managed Care Delivery System section, the managed care delivery system authority is used to either

- Mandate enrollment into a managed care arrangement which provides HCBS services or
- Limit the number or types of providers which deliver HCBS services.
Section 1115 Demonstrations

- Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs including managed care.

- Purpose: to give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:
  - Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
  - Providing services not typically covered by Medicaid
  - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

- Section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years.

- Demonstrations must be “budget neutral” to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.
Managed Care

Who is served:

- Approximately 80% of Medicaid participants are in managed care in America for some or all of their services - and this is growing.
- In MLTSS, many more people who are seniors, have behavioral/mental health support needs or have physical disabilities receive services through this vehicle.
- Relatively few states support people with I/DD through MLTSS
Who is in MLTSS-Depends on Program Objectives, Design, Infrastructure

- **Age** – children? Adults under 65? Over 65?
- **Population Served** – People with I/DD, Physical Disabilities, Behavioral Health Needs, Aging, TBI?
- **Service Settings** – Supported employment, shared living, own home, group home? Or ICF/ IDD, NF? (although one clear purpose of MLTSS is to increase community life)
- **Program eligibility** – Individuals who are Medicaid-eligible or for dually-eligible, Medicare-Medicaid individuals. Is there consideration of individuals who do not meet LOC but receive state-funded LTSS?
This is inclusive of all populations and does include those carved out (I/DD mostly carved out)
# Managed LTSS Care Including I/DD

## In MLTSS
- Arizona (1115)
- Michigan (b/c)
- Wisconsin (b/c)
- North Carolina (b/c)
- Kansas (1115)
- Tennessee (1115 rolling out for I/DD July 2016)
- Texas – piloting IDD
- New Hampshire * (1115), I/DD rolling out soon
- New Jersey (1115)
- Illinois- submitted (1115)
- Iowa- fast track roll-out

## In Planning or Pre Implementation Stage
- Illinois- submitted (1115)
- Florida – legislative exploration
- Louisiana* (1115) delayed
- New York* (b/c)  
  * pre-implementation
- DISCOS implementing (dual eligible, including I/DD)
<table>
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<tr>
<th>Acute Care Services</th>
<th>LTSS without Acute: <em>Pennsylvania Adult Community Autism Program</em></th>
<th>OR</th>
<th><em>Arizona Long Term Care System (all populations, acute, long term services and supports, behavior supports)</em></th>
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<td>Medicare Services</td>
<td>Medicaid-funded Services Only: <em>New York Managed Long Term Care Does not include I/DD)</em></td>
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<td>OR</td>
<td>Partial-Risk Capitation: <em>Wisconsin Family Care Partnership</em></td>
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Some Potential Benefits of Well Planned MLTSS- Social Determinants of Health & Well Being

- PWDs employed = lower health care costs
- PWDs with friends = quality of life and longevity
- PWDs with coordinated medical care = lower emergency room visits and re-hospitalizations
- PWDs with integrated systems = better health outcomes
- PWDs with stable housing = lower costs, better health outcomes, better quality of life
Two important learning documents

1. CMS Guidance for Managed Care Long Term Services and Supports - 10 Key Elements

2. National Council on Disability - 20 Principles for Managed Care
1. Adequate Planning and Transition Strategies
2. Stakeholder Engagement
3. Enhanced Provision of HCBS (ADA/Olmstead)
4. Alignment of Payment Structures with MLTSS Programmatic Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive and Integrated Service Package
8. Qualified Providers
9. Participant Protections/States Oversight
10. Quality

1. The goal must be to assist individuals with disabilities to live full, healthy, participatory lives in the community.

2. Managed care systems must be designed to support and implement person-centered practices, consumer choice, and consumer-direction.

3. Employment is a critical pathway toward independence and community integration. Enrollees must receive the supports to secure and retain competitive employment.

4. Families should receive the assistance they need to effectively support and advocate on behalf of people with disabilities.

5. Key disability stakeholders are fully engaged in designing, implementing and monitoring the outcomes and effectiveness.

6. The service delivery system must be capable of addressing the diverse needs of all plan enrollees on an individualized basis.

7. States should complete a readiness assessment before deciding when and how various sub-groups of people with disabilities should be enrolled.

8. Each network should have sufficient numbers of qualified providers in each specialty area to allow participants to choose among alternatives.

9. CMS should require states to include providers of institutional programs as well as providers of home and community-based supports within the plan’s scope.

10. The existing reservoir of disability-specific expertise should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system.
11. **Responsibility for oversight** must be assigned to highly qualified state governmental personnel.

12. The federal government and the states should actively **promote innovation** in long-term services and supports for people with disabilities.

13. Savings achieved through reduced reliance on high-cost institutional care, reductions in unnecessary hospital admissions and improved coordination and delivery of services should be used to **extend services and supports to unserved and underserved individuals with disabilities**.

14. **Primary and specialty health services** must be effectively coordinated with any long-term services and supports.

15. Participants in managed care plans must have **access to the durable medical equipment and assistive technology**.

16. The state must have in place a **comprehensive quality management system** that not only ensures the health and safety of vulnerable beneficiaries but also measures the effectiveness of services in assisting individuals to achieve personal goals.

17. All health care services and supports must be furnished in **ADA-compliant settings**.

18. **Enrollees should be permitted to retain existing physicians** and other health practitioners who are willing to adhere to plan rules and payment schedules.

19. **Enrollees should be fully informed of their rights and obligations** under the plan as well as the steps necessary to access needed services.

20. **Grievance and appeal procedures should be established** that take into account physical, intellectual, behavioral and sensory barriers to safeguarding individual rights under the provisions of the managed care plan as well as all applicable federal and state statutes.
Planning, Design & Implementation: IDD, & Seniors, and those with Physical Disabilities are not the same - state I/DD systems view

- **Focus**
  - Seniors – Comfort, quality, and keeping/building connections in remaining years of life
  - I/DD - “Getting a Life”

- **Length of Service**
  - Seniors- Averages 3 years – but hopefully can be more
  - I/DD - up to 60 years or more

- **Community Supports**
  - Seniors- Many people have friends, family, relationships from spiritual community, clubs, etc. to rely on, focus is on helping people stay connected to
  - I/DD - need to build and maintain relationships and supports throughout life

*Takes honest conversations on why managed care, types of services, costs, support coordination*
Planning, Design & Implementation: IDD, & Seniors, and those with Physical Disabilities are not the same- I/DD state systems view

- **Primary Services and Supports**
  - Seniors - medical care, home health and personal assistance
    - Support to keep family relationships and socialization
  - IDD – habilitation(learning) and growing over a lifetime, finding and keeping a job, supporting families, in home supports

- **Family Care Giving**
  - Seniors – In the later years of life
  - IDD - Begins at birth and continues through a lifetime

*Takes honest conversations on why managed care, types of services, costs, support coordination*
All individuals should be able to access comprehensible information and usable communication technologies to promote self-determination and engage meaningfully in major aspects of life.

Beneficiaries must have access to the durable medical equipment, assistive technology and technology enabled supports to function independently and live in the most appropriate integrated setting.

Primary and specialty health services must be effectively coordinated with any long-term services and supports an individual might require.
ANCOR Core Values

- MLTSS must promote an employment first philosophy. Working-age enrollees with disabilities must receive the supports necessary to secure and retain competitive employment or other meaningful daytime activity. For people who have not succeeded in being able to sustain employment with appropriate supports, there must be meaningful alternatives that meet that person’s needs available during any period of unemployment.

- All eligible individuals must be included in the transition, including those residing in state institutions. Resolving waitlists, including addressing the needs of individuals who are underserved, should be addressed in state plans, such as using any savings to reduce the waitlist.

- MLTSS must design and implement health information technology and electronic health records prior to the implementation of the MLTSS system.
ANCOR Core Values

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- All eligible individuals must be included in the transition, including those residing in state institutions. Resolving waitlists, including addressing the needs of individuals who are underserved, should be addressed in state plans, such as using any savings to reduce the waitlist.
- States should design, develop, and maintain state-of-the-art management information systems with the capabilities essential to operating an effective managed long term services and supports delivery system.
- Assessment and Rate Setting Methodology - MLTSS rates and/or payment methodology and the provider rate-setting mechanisms must be actuarially sound, transparent, adequate to attract and retain a highly valued, stable, and qualified workforce; and, geared to achieve valued outcomes.

Implementation

MLTSS implementation must require states to complete a readiness assessment before enrolling people with disabilities
ANCOR Core Values

- **Performance Measures**
  - Must include non-medical metrics focused on LTSS (in addition to acute and behavioral health into the RFP and contract). These metrics must incorporate equality of opportunity, independent living, economic self-sufficiency and full participation as defined in the Americans with Disabilities Act (ADA) and the integration mandate of the ADA and the Olmstead Supreme Court decision. Performance reports on these metrics will be shared with all stakeholders.

- **State Responsibilities and Regulations**
  - Accompanied by regulations which encourage and support innovation; modified to reduce process burden in exchange for performance outcome measures as the accountability standard; and, allow provider creativity on how to meet the regulation.
  - Individuals are safe and secure without compromising an individual’s civil rights, choice, informed decision making and dignity of risk.
  - Transparency in the contract procurement process, monitoring, and quality assessment.
  - Define financial risk between the state and the MLTSS entities and providers.
  - Cover the full range of services and supports needed to address the diverse needs of people with disabilities on an individualized basis across the life span.
  - Build upon existing services and supports needed by beneficiaries to live in the community, including services for acquiring, restoring, maintaining and preventing deterioration of function or acquisition of secondary disabilities.
ANCOR Core Values

- **Appeals and Grievances**
  - MLTSS must safeguard individual rights and all applicable federal (e.g. ADA/Olmstead) and state statutes.
  - Enrollees with disabilities should be fully informed of their rights and obligations under the plan, as well as the steps necessary to access needed services in accordance with the requirements of the Social Security Act.
  - Grievance and appeal procedures must be established that take into account physical, intellectual, behavioral, and sensory barriers to safeguarding individual rights.

- **States must have Non-Clinical Outcomes in Contracts**
  - Advocate for state to hold managed care companies accountable to achieve certain outcomes.
  - Insist the state incentivizes achievement of outcomes by MCOs/providers.
  - Ensure that outcomes are meaningful and measureable
Conduct a Careful Readiness Assessment- Take Time

- Stakeholder engagement should start as soon as possible
- Identify program goals—what do we want to achieve and why (even before determining Medicaid authority)
- Assumptions about savings should be tested
  - It isn’t just about enough physicians, psychiatric hospitals or home health agencies ...it’s about employment services, respite, and supports to families. Health is important but it isn’t the main service used by most adults with I/DD. And people are in services longer.
Considerations & Cautionary Notes: Readiness is Key-state I/DD perspectives

Conduct a Careful Readiness Assessment- Take Time

- Provider Networks- There is already a network of service providers known by many families, consumers and the DD state agency. Keeping continuity and availability of these providers within the new MCO networks takes support and intentional planning.

- Small providers are the most creative and the most at risk - no cash flow or I.T. system and will need support

- Stakeholders in I/DD are accustomed to have to having a meaningful seat at the table, strong voice and close connections with the state I/DD agency. People with I/DD and families are the heart of the system and need to be involved first - way before plans are completed

- LTSS providers in I/DD may need assistance with billing when switching to new systems

- More data is needed in MLTSS for quality improvement, trends, network development and tracking in HCBS services-need infrastructure
- Make integrated services more cost effective - build incentives for community based services in the capitation rate
- Keep institutions in the capitation rate, ICF/DD and nursing homes - where are biggest cost savings otherwise?
- Make expectations about self determination, community integration, work clear in the MCO contracts
  - School to work transition
  - Service approvals based on desired outcomes, not just an assessment
- Use manuals to communicate policies about roles and responsibilities i.e. case management/support coordination
• Build expectations into provider qualifications
• Measure the delivery of services for integration value
  ○ In family homes with support
  ○ In own homes
  ○ In shared living
  ○ Age appropriate for children and adults
  ○ Employment outcomes
  ○ Integration regardless of medical or behavioral labels
    ▸ People with trachs, g-tubes, suctioning, ventilators, medical frailty
    ▸ People with behavioral reputations; criminal offenders
    ▸ *State I/DD Perspective
Spend sufficient time on capitation methodology. *Capitation in (MLTSS) is unique for people with I/DD.* In past, or in less experienced states, capitation often relied/relies primarily on what was spent in past year(s), plus regulatory changes & basic demographics.

*To drive innovation, realistically predict costs, attain desired outcomes & achieve rebalancing over time, capitation should not look solely at factors listed above.*

Also factor in:

- Desired policy changes, valued outcomes-examples: more in home supports, crisis support to prevent out of home placement, employment, early intervention, aging caregivers, smaller homes, youth coming out of school needing employment and community support, best/promising practices in alignment with HCBS settings rule

- MLTSS capitation in I/DD is new, except in a few states such AZ and MI. Extensive data is needed to develop actuarially sound capitation rates, especially those predicated with all factors.

- If state does not have robust data system and analytics readily available, more time needed to pull data for first capitation (and ongoing)

- The new CMS Managed Care rules recently released heighten expectations for actuarially sound rates and capitation requirements.
Aligning Payment Structures with Goals and Network Sufficiency

- **Rate setting** - decide which components will be retained by state vs. what authorities MCOs will have:
  - When state sets rates, may be more guarantees for core service expectations, but will MCO sign contract if not some flexibility? Can there be balance-state sets rate for some services especially when MLTSS for I/DD begins?
  - Does state provide rate guidelines for desired outcomes such as HCBS employment & in home support, or does MCO have full ability to design rates as long as enough providers in network?
  - **Defining strong network adequacy standards** and monitoring regarding LTSS outcomes. Networks must include robust HCBS services

- **Network oversight to ensure rate structure supports desired outcomes, such as increase in home based support, supportive living, supports to families, employment**
  - Network development and oversight can/should reach beyond traditional “adequacy”. More than about sufficient doctors, hospitals, therapists (while important!), day programs and group homes. Should be specific about desired & needed services to achieve program's purpose (e.g. x # of families need respite in x area, x providers needed to meet need for employment, x # of providers need to transform day or prevoc programs for x # people to comply with HCBS rule, and more. Should be reviewed, approved and monitored by the state staff with I/DD expertise.
  - Need strong I/DD state oversight of MCO networks.

NASDDDS and Delmarva
People with I/DD and their families (and others such as advocates, providers, and state I/DD staff) can fear losing the true essence of support coordinators and receiving traditional care managers instead. Care management is better known in managed care and is only newly beginning to contain elements known for decades in the I/D community.

MCOs need specific training, contract expectations, ongoing mentoring, outlined in policies and manuals, clinical practice guidelines, monitoring, etc. to enhance the skills and individual and family expectations of support coordinators/case managers.

- A support coordinator is a person who:
  - Does not work for a provider (conflict free)
  - Develops a relationship with the person and family over time
  - Develops the individual plan with them
  - Conducts on-going oversight (checks in) to make sure services are delivered and are achieving outcomes
  - Is available for ad hoc problem solving
AZ introduction to case management:

- The case manager must
  - Foster a person-centered approach
  - Maximize member/family self-determination
  - Promote the values of dignity, independence, individuality, privacy and choice.
  - Support the member to have a meaningful role in planning and directing their own care to maximum extent possible.
  - Facilitate access to non-ALTCS services available throughout the community
  - Advocate for the member and/or family/significant others as the need occurs
  - Assist members to identify their goals and provide information about local resources that help transition to greater self-sufficiency in the areas of housing, education and work

- Case management begins with a respect for the member’s preferences, interests, needs, culture, language and belief system
Qualified Providers

- Basics are certification, licensing, background checks, credentialing (for clinical services), credentialing agencies
- MCOs and providers need training in disability specific areas, history and values base, person centered processes, I/DD vs. behavioral health, self direction
- Assure the training of non-certified direct support professionals; establish a core curriculum.
- Keep small providers and the rich network of HCBS agencies known in the community
- Providers need training in billing, encounters, coding & other insurance based knowledge.
- Involve people with disabilities and families as trainers
- Look to see if people with disabilities and family members are on the boards of non-profits and steering policy committees of for profit MCOs and agencies (consider adding to MCO contracts)
Acute, Behavioral Health & LTSS Coordination

There are potential benefits - more coordinated discharge planning to prevent illness, wellness across home and other environments when framed around values of community living. MCOs, acute health providers and case managers need a unique set of skills/understanding. Families and people with disabilities highly active in planning and interventions, and the valued roles of direct support professionals.

There are opportunities in LTSS to better coordinate with behavioral/mental health care; polypharmacy, trauma informed care, linking mental health supports for overall support plan. Won’t stop the “hot potato” between systems, but it can reduce it.
Private MCOs are new at supporting I/DD individuals and their families and Medicaid agencies do not generally have all specific rules, statutes, policies and work that has been completed by state agencies with I/DD stakeholders and improved over decades. Encourage the Medicaid agency to reference I/DD statute, rule and policy binding by MCO contract or otherwise preserve these key areas, such as:

- Right to most integrated settings
- Fair compensation for labor
- Right to own property
- Need to have and right to contact Human Rights Committee
- Need to have Program Review Committee
- Right to presumptive competency
- Right to be free from excessive medications and review of medications if used to modify behavior
- Rights specific in residential services
- Freedom from abuse, neglect and mistreatment
- Right to date and much more!
Quality

- Comprehensive- This is likely to take more access to data than expected
- Incident management
  - Reporting; monitoring; trending individuals, providers, case managers and MCOs
- Evaluate Support Coordination
- Utilization- who is receiving supports and where
- Participant Feedback
- Utilization – who is receiving supports and where, underserved, targeted areas?
- Review and trend grievances, complaints, appeals, claims, provider monitoring, incidents, quality of care concerns, outcomes, PIPS, and compliance data
- *The oversight of the MCOs quality by the State is as important as the MCO’s system*
- *Including stakeholders in review of the data and seeking both conclusions and recommendations on an ongoing basis contribute to problem, policy changes and potential PIPs*
State Roles and Responsibilities Differ but not Lessen

State level infrastructure, partnerships and human resources are needed to support the program design and work to promote, not hinder, progress toward the identified goals.

- Payment and data systems and other structural facets of the state system are prepared for the change to managed care
- States must ensure that there are adequate state staff, with the requisite I/DD experience and skillset, to review such data and information to monitor the performance of the managed care plans against the established benchmarks, with MLTSS and HCBS in mind.
- The role of the state may shift, but will not lessen with the move to managed care. While the managed care plans may undertake certain functions previously performed state staff, the state must exercise vigilance in oversight and plan management to ensure that the program is implemented as designed and that progress is made toward established goals - network oversight, contract compliance, corrective interventions, encouraging and replicating strong practices, matching program experts with rate/business staff to improve programs.
- States must continuously bring stakeholders together for program evaluation and improvement
Managed Care LTSS – Why the Resistance?

Families Built DD Systems over 50 years

- 1950s & 60s - State programs and State Statues
- 1970s Right to Education
- 1980s Deinstitutionalization litigation
- 1990s Medicaid HCBS

NASDDDS and Delmarva
Families Are Skeptical About Replacing the Current System

- State DD Director - high level executive branch-in many states this is high touch and there are concerns families, self advocates and providers can’t pick up the phone and engage
- Families are valued stakeholders
- Families and people with disabilities aren’t highly supportive of generic “call centers:
- Service coordinator to assess needs, create a person-centered plan and monitory service delivery-coming to our home and not based on a single assessment
- Services –have touched the system over time and medical is not the primary focus, especially for the majority of adults (don’t want to be medicalized)
- Provider network almost all non-profits, started by families and faith based organizations; families and self advocates sit on the board
- Oversight through licensing, certification and monitoring of providers-any states have provider report cards or other open review records
What is Important to Families

- Vision and Values – there is a purpose beyond “coordinating care and reducing costs”
- What counts
  - Support to families
  - School to work transition
  - Competitive employment
  - Self-direction – control over services & budget
  - Small, innovative providers their community will continue
- Reducing waiting lists
- Support for families that is flexible, meets their needs and is consumer/family directed
- Not to hear that MLTSS will save money and that this is the reason to do this: *Saving money means cuts to services for people living with families – it always has in the past*
- Their sons, daughters, brothers, sisters having a good and happy life with friends, family, a valued role in the community
- Collaboration with consumer and family groups & associations....they will have a say in design, implementation and review of the system
- **There will be a meaningful seat at the table**
Stakeholder Engagement –

What state agencies have learned so far

- Families and Self Advocates want a meaningful seat at the table— not just testimony at a forum. Start early, start with people with disabilities and their families. Don’t forget providers and others, but a lesson learned is not getting people with I/DD and families together early. Providers and health plans are vital stakeholders but cannot be the primary messengers to families and self advocates.

- Bring families/self advocates early in the systems redesign discussions—what problem are we trying to solve? Focus groups can be helpful, particularly if facilitated by family-to-family and self advocacy groups themselves (and don’t forget they are volunteers so assistance with transportation, time, facilitators, respite all increase participation. Other mechanisms beyond focus groups can be used, but be respectful that many families work during the week, may not have respite at night and that more than means will be important.

- Create a stakeholder group for MLTSS that is composed of one half people with I/DD, family members or agencies that directly represent them (parent information center, not a direct service provider). The group should have a clear charter with a purpose and responsibilities to impact MLTSS development, implementation and oversight.

- Communicate often, even if the updates are minimum—some information such as the proposal isn’t approved yet, is better than not knowing anything directly from the state. Have family members and self advocates review every memo the state sends out to consumers for clarity.
Stakeholder Engagement –
What state agencies have learned so far

- Ensure stakeholders have a chance to share what they want to keep and why, not just what they want changed.
- Stakeholders should have a voice in identifying quality outcomes before the managed care proposal is written.
- Consider finding a means to include stakeholders in quality oversight. Were there increased employment outcomes? More people served? Satisfaction?
- Consider contracting with family and/or self-advocacy groups to assist in consumer satisfaction; collect data on what is and is not working, provide information (AZ contracts with the Parent to Parent information Center)
- A big lesson learned in a state was not including the I/DD stakeholder community early and keeping the engagement on going—reviewing policies and deliberating together
- What stakeholder involvement will be mandated for MCO’s? Advisory, policy, work groups?
- Will there be a hotline during the managed care transition and a “warm line” after roll out to support stakeholders with questions and concerns—not a traditional call center.
The state agency (Medicaid and I/DD) has many tools to shape the design and performance expectations of MCOs. From how the RFP is written to the contract, values based services, quality metrics, strong reporting practices, data expectations and other information can be provided through the procurement process.

- The state does have other tools such as policies, manuals, clinical practice guidelines, performance measurement
- Performance Improvement Projects (PIPs)
- Provider network plan approval by the MCO and the MCO approval by the state
- Payment Incentives and Penalties
Managed care is more than a financing mechanism. Defining quality outcomes for people with disabilities, seeking opportunities for integration, and supporting more people and their families in the community = Progress.


Thank you!

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