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

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Need for Paper

- 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

- 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

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

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
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

- 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 (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

In 23 states as of July 2018

Source: NASUAD survey; CMS data
Why Do States Implement MLTSS?

- 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?

- **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?

- **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

- 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:

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* I/DD and MH populations only
# Financial Alignment Demonstration
MLTSS Program Lifecycle

I. Goal Identification

II. Data Analysis, Program Design and Authority Selection

III. State Infrastructure Planning & Alignment

IV. Procurement, Contract, and Rate Development

V. Detailed Policy and Procedure Development

VIII. Quality Oversight and Program Improvement

Adequate Planning Time

Stakeholder Engagement
(Priority on consumers and families)
Adequate Planning Time

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

- **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

- 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

- **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.
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
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

- 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
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

- 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

- 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)
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.
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
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
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

- 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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