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

Sarah Barth
Rachel Patterson

NASUAD HCBS Conference
August 29, 2018
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.

Our strength is in our people, and the experience they bring to the most complex issues, problems, or opportunities.
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
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
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.
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
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
CONTACT INFORMATION

sbarth@healthmanagement.com

rpatterson@healthmanagement.com
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

• Medicaid Home and Community-Based Services: Characteristics and Spending of High-Cost Users
State Approaches to Enrolling Individuals with ID/DD in MLTSS

Medicaid and CHIP Payment and Access Commission

Kristal Vardaman

August 29, 2018
Managed Care-Consumer Perspectives

Presented by: Nicole Jorwic, J.D.
Director of Rights Policy, The Arc of the United States
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
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.
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.
Models

- Arizona
- Wisconsin
- Michigan
- Iowa, Kansas
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.
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
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:
- Receiving HCBS: 7,800
- Waiting List: 6,200
- 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
  o Managed Care Organizations
  o State I/DD Department
  o Providers and Provider Associations
    ▪ Tennessee Network of Community Organizations (TNCO)
    ▪ Tennessee Provider Coalition
  o Advocacy Groups
    ▪ The Arc Tennessee
    ▪ Tennessee Council on Developmental Disabilities
    ▪ Tennessee Disability Coalition
    ▪ Disability Rights Tennessee
    ▪ Statewide Independent Living Council
  o Most importantly, people with I/DD and their families
Stakeholder Engagement: Building Together

• Commenced in December 2013
  o Meetings with advocacy and provider groups
• January-February 2014
  o Regional community meetings with consumers, family members, providers
  o Online survey tool
• February-March 2014
  o 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
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

Group 4
Essential Family Supports

Group 5
Essential Supports for Employment and Independent Living

Group 6
Comprehensive Supports for Employment and Community Living

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.