Shaping policy, sharing solutions, strengthening communities

Building the Plane While Flying and Other Tales of Managed Long Term Supports and Services

Presented by Diane McComb
ANCOR Liaison to State Associations
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ANCOR is…
A national nonprofit trade association advocating and supporting

- Over **1,000 private providers** of services and supports to
- Over **600,000 people with disabilities** and their families
- And employing a workforce of over **500,000 direct support professionals** (DSPs) and other staff
- *Membership benefits include robust government relations representation at federal level and access to exclusive ANCOR content, as well as exclusive discounts on technology and I/DD products through the ANCOR marketplace.*

Why Are States Looking at Managed Care?

- Allows State officials achieve budget stability over time through capitation
- Limits states' financial risk, passing part or all of it on to contractors by paying a single, fixed fee per enrollee
- Allows one entity to be held accountable for controlling service use *and* providing quality care

What is Managed Care?

- 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
- Capitation can be for all services or selected services
- Contractors can be local, regional or national
- LTSS populations include persons with age-related, physical or intellectual/developmental disabilities. Many of these also have serious mental illness.

Target Populations

- **Age –** children? Adults under 65? Over 65?
- **Disability –** IDD? PD? BH? Aging? TBI?
- **Setting of care –** residential? ICF/IDD NF? Own home?
- **Level of care need -** institutional level of care or persons who do not meet the institutional level of care or both?
- **Program eligibility** - Medicare-Medicaid beneficiaries or only those with Medicaid? Are you including persons who do not qualify for Medicaid but receive state-funded LTSS?

Federal Government

- Establishes basic rules and criteria States must follow in the design and operation of a Medicaid program
- Covers a significant portion of the costs of Medicaid (varies by state and population)
- Approves contracts and rates between states and managed care entities

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State Governments

- Establish program rules, benefits, eligibility, contract provisions and the rates health plans will be paid to administer the Medicaid program
- Compensates the health plans using a per member per month capitated rate

Managed Care Entities

- Administer the Medicaid program according to the terms of the contract with the state for their assigned Medicaid beneficiaries
- Measured on ability to support their members in receiving preventive treatment, achieving state goals, and meeting other quality metrics established by the state
- Established contracts with providers

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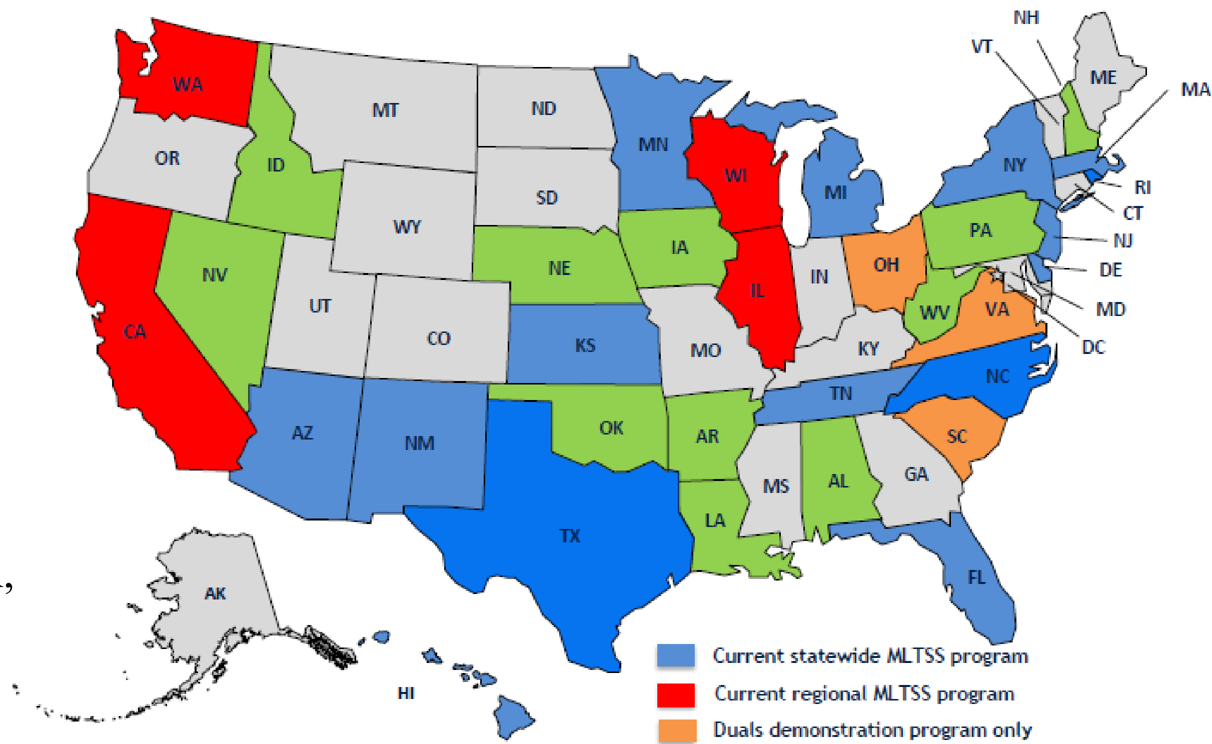
35 STATES HAVE MLTSS PROGRAMS in 2016 or are Projected to Move to MLTSS in the Next Year

AR, AZ, CA, DE, FL, GA, HI, ID, IA, IL, KS, LA, MA, MI, MN, MO, NE, NV, NH, NJ, NM, NY, NC, OH, OK, OR, PA, RI, SC, TN, TX, VA, WA, WV, WI

MLTSS Programs - 2015



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Sources: NASUAD Survey; Discussions with States; CMS data

16 States Include People with IDD

- Arizona
- Delaware
- Hawaii
- Iowa
- Kansas
- Michigan
- New Jersey
- New Mexico
- New Hampshire
- North Carolina
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Vermont
- Wisconsin

Ten in all HCBS and ICF settings

Delaware and New Jersey do not enroll people already in IDD HCBS Settings

Hawaii doesn't include HCBS/ICF but provide all other services in a MLTSS Framework

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Arizona and Vermont state gov't acts as the MCO

Burwell, Brian, and Jessica Kasten. *Transitioning Long Term Services and Supports Providers Into Managed Care Programs*. May 2013; Truven Health Analytics, Print. Prepared for the Centers for Medicare & Medicaid Services (CMS), Disabled and Elderly Health Programs Group.

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New States Emerging

- Arkansas
- California
- Florida
- Illinois
- Indiana
- Louisiana
- Massachusetts
- Nebraska
- New Hampshire
- New York
- Ohio
- Virginia

- Illinois has submitted an MTLSS 1115 that will include all populations
- New York DISCOs
- Louisiana and Nebraska in 2017
- Pennsylvania expansion
- Duals programs

Burwell, Brian, and Jessica Kasten. *Transitioning Long Term Services and Supports Providers Into Managed Care Programs*. May 2013; Truven Health Analytics, Print. Prepared for the Centers for Medicare & Medicaid Services (CMS), Disabled and Elderly Health Programs Group.

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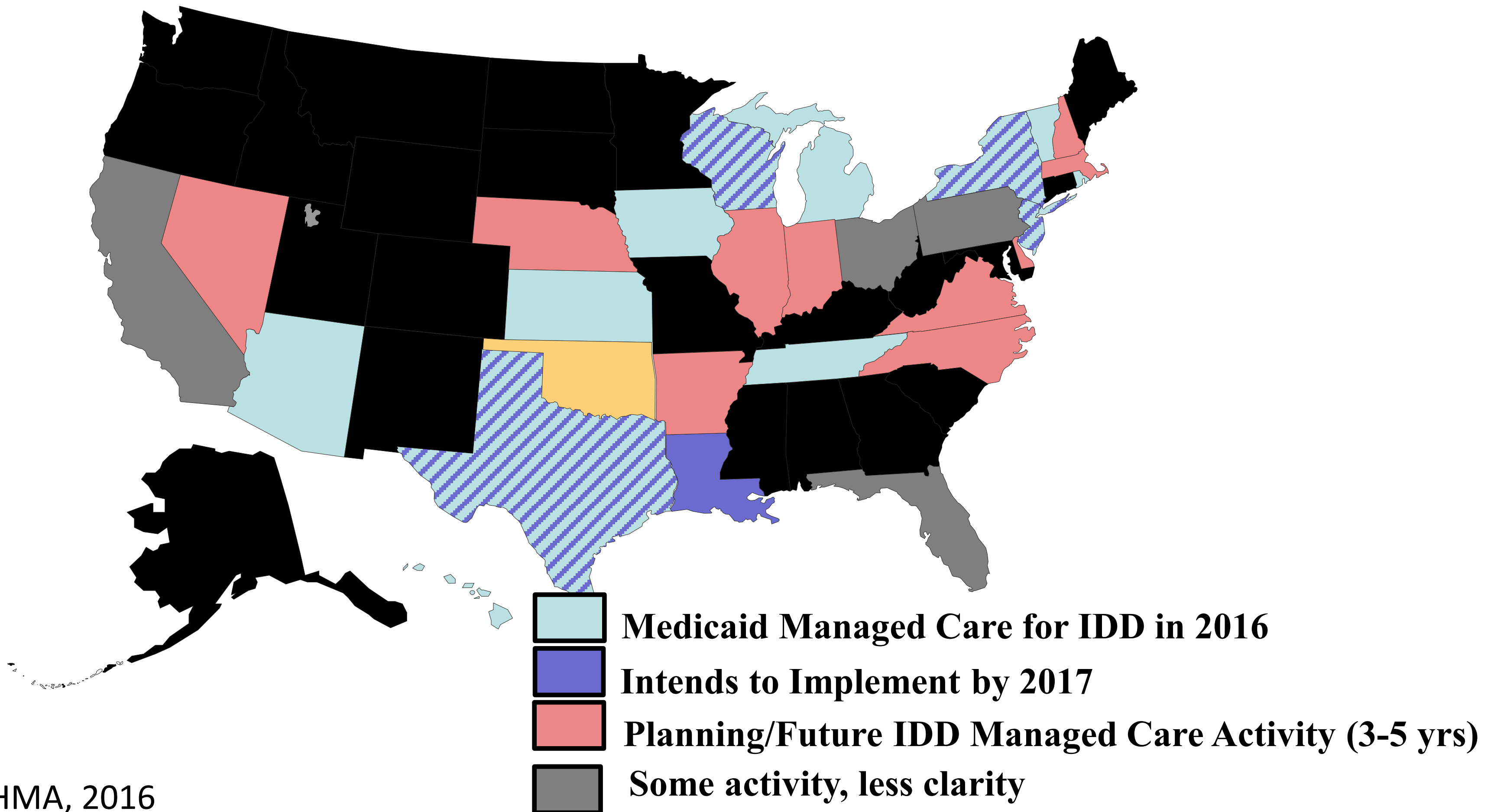
MLTSS and IDD



HMA, 2016

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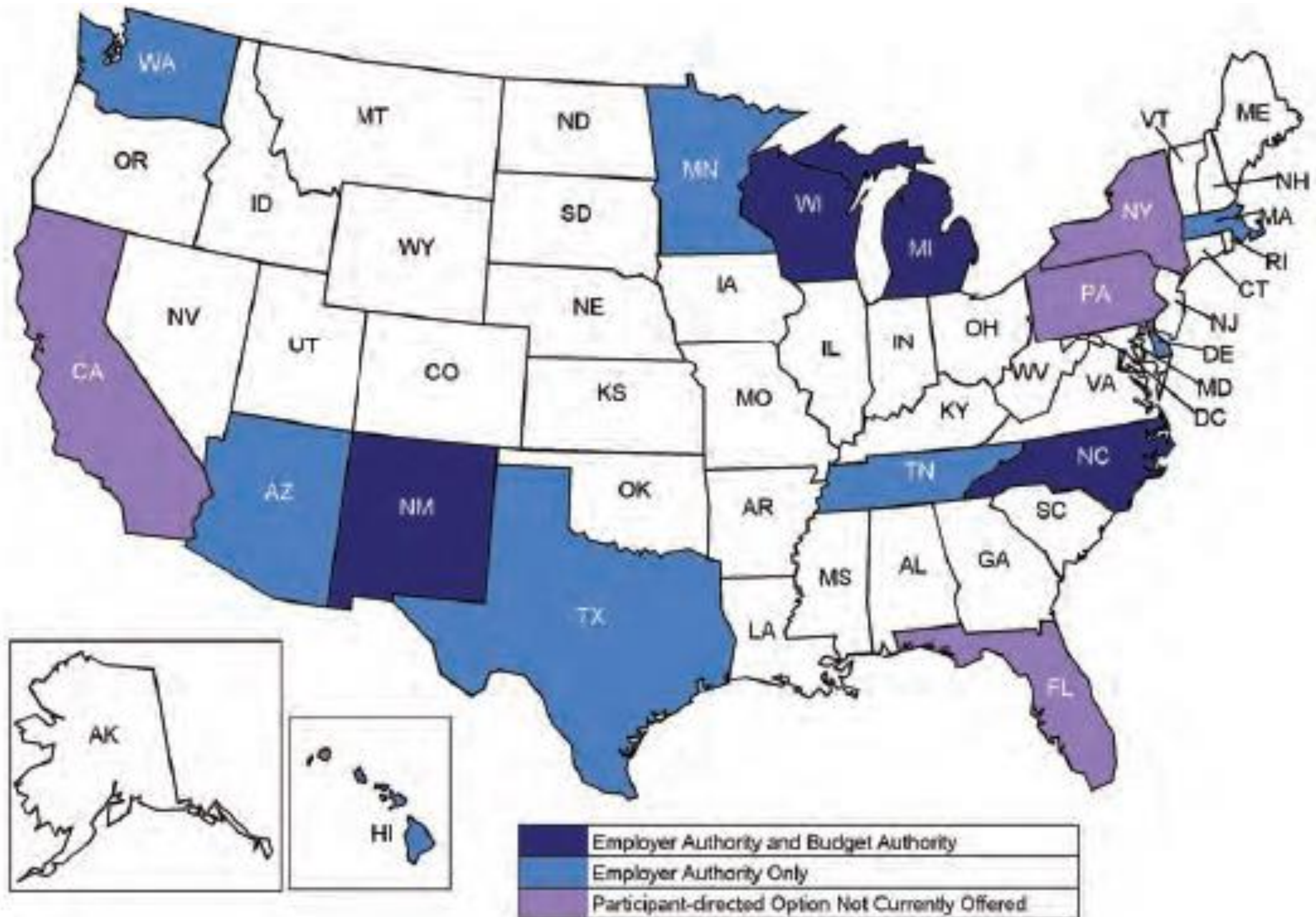
States with Self-Direction in MLTSS



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MLTSS Examples Include a Diverse Range of Program Models

Acute Care Services	**LTSS without Acute: *Pennsylvania Adult Community Autism Program***	**OR**	***Arizona Long Term Care System***
Behavioral Health Services	LTSS without Behavioral Health: *New Mexico Coordinated Long Term Services*	**OR**	LTSS with Behavioral Health: *TennCare CHOICES*
Medicare Services	Medicaid-funded Services Only: *New York Managed Long Term Care*	**OR**	Medicaid- and Medicare-funded Services: *Minnesota Senior Health Options*
Populations	Adults of All Ages and Levels of Care: *Hawaii QUEST Expanded Access*	**OR**	Older Adults with Institutional Level of Care Needs Only: *Florida Nursing Home Diversion*
Contractors	National Contractors: *Texas Star+Plus*	**OR**	Local Contractors: *Wisconsin Family Care Partnership*
Payment Methods	Full-Risk Capitation: *Massachusetts Senior Care Options*	**OR**	Partial-Risk Capitation: *Wisconsin Family Care*

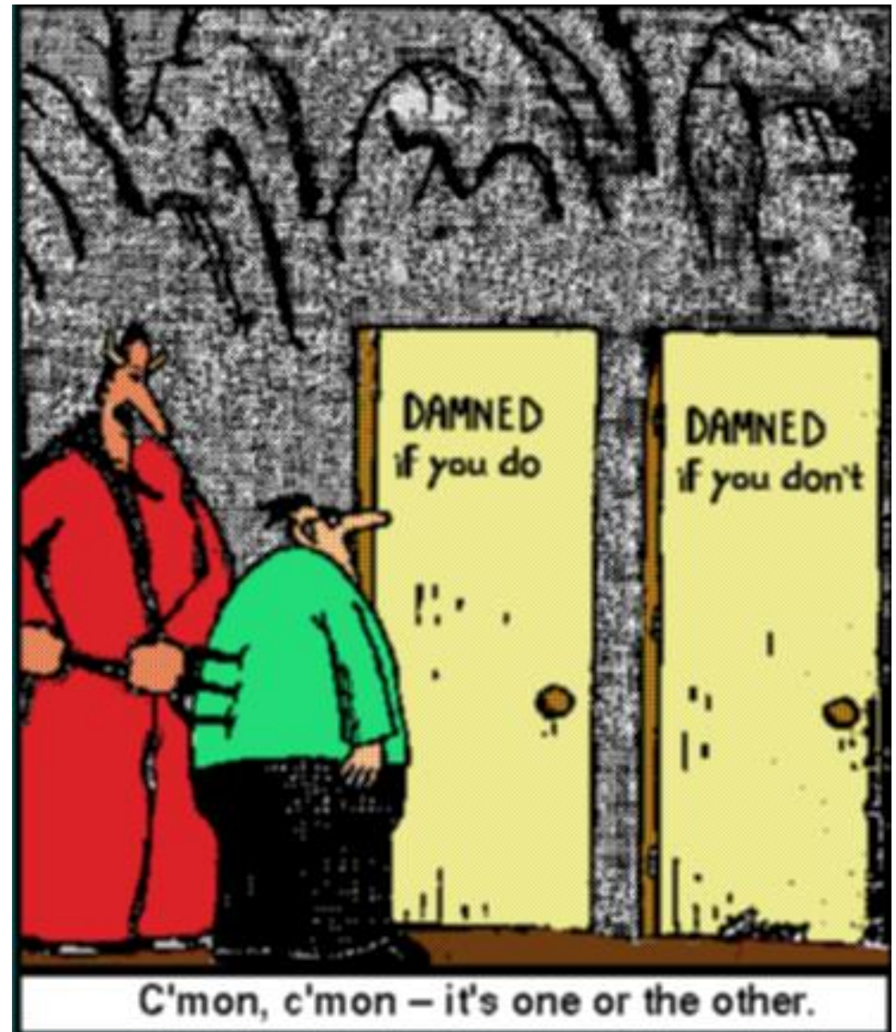
Authorities for Managed Care

Authority	Description	Limitations
Section 1115	Gives Secretary of HHS broad authority to approve demonstration programs that test innovative Medicaid policy.	Proposal must be truly innovative, not simply replicating an idea already demonstrated elsewhere.
Section 1915(a)	Statutory authority to enter into contracts with organizations to provide services already offered under the state plan.	Voluntary enrollment only; Existing services only; Number of qualified contractors may not be limited.
Section 1915(b)	Waiver authority for mandatory enrollment in managed care.	With exceptions for rural areas, must offer at least 2 options.
Section 1932(a)	Statutory authority for mandatory enrollment in managed care.	Certain groups are exempted from mandatory enrollment; with exceptions for rural areas, must at least 2 options.

Authorities for LTSS

Section 1915(c)	Waiver authority to offer HCBS services to beneficiaries who would otherwise meet institutional level of care.	Beneficiary must meet institutional level of care.
Section 1915(i)	Statutory authority to offer HCBS as a state plan service, whether or not a beneficiary meets institutional level of care.	State may not limit the number of eligible participants or have a waiting list. Service must be offered statewide.
Section 1915(j)	Statutory authority to offer self-directed personal assistance services option in a 1915(c) waiver program, or under state plan personal assistance services.	Not a service authorization per se, but rather a delivery option for services otherwise provided under the state plan.
Section 1915(k)	Statutory authority to offer attendant services and supports controlled by the beneficiary (Community First Choice Option).	State may not limit the number of eligible participants or have a waiting list. Service must be offered statewide.
Other State Plan Services	States must offer certain services (such as nursing home and home health) and may offer optional services (such as personal care and targeted case management).	State plan services must be offered to all eligible beneficiaries without waiting lists. Services must be offered statewide.

What's a Person to Do?



CMS Guidance to States

- Adequate Planning and Transition Process
- Stakeholder Engagement
- Enhanced Provision of HCBS (Olmstead/ADA)
- Alignment of Payment Structures and Goals
- Support for Beneficiaries
- Person-centered Processes
- Comprehensive, Integrated Service Package
- Qualified Providers
- Participant Protections/State Oversight
- Quality

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

States Must Identify 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.

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Social Determinants of Health & Well-Being

- PWDs employed = lower health care costs
- PWDs with friends = quality of life and longevity
- PWDs with care coordination = 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

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National Quality Forum Domains

- Workforce/Providers
- Consumer Voice
- Choice and Control
- Human and Legal Rights
- System Performance
- Full Community Inclusion
- Caregiver Support
- Effectiveness/ Quality of Services
- Service Delivery
- Equity
- Health and Well-Being

http://www.qualityforum.org/ProjectMaterials.aspx?projectID=77692

ANCOR Principles of MLTSS – Core Values

- Must treat people with disabilities with dignity and respect.
- Designed to honor, support and implement person-centered practices and consumer choice. People with disabilities will be able to hire and fire providers; choose outcomes important to their lives; and change priorities as dictated by life events or as needed.
- Capable of addressing the diverse needs of all beneficiaries on an individualized basis.

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ANCOR Principles of MLTSS – Core Values

- 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.

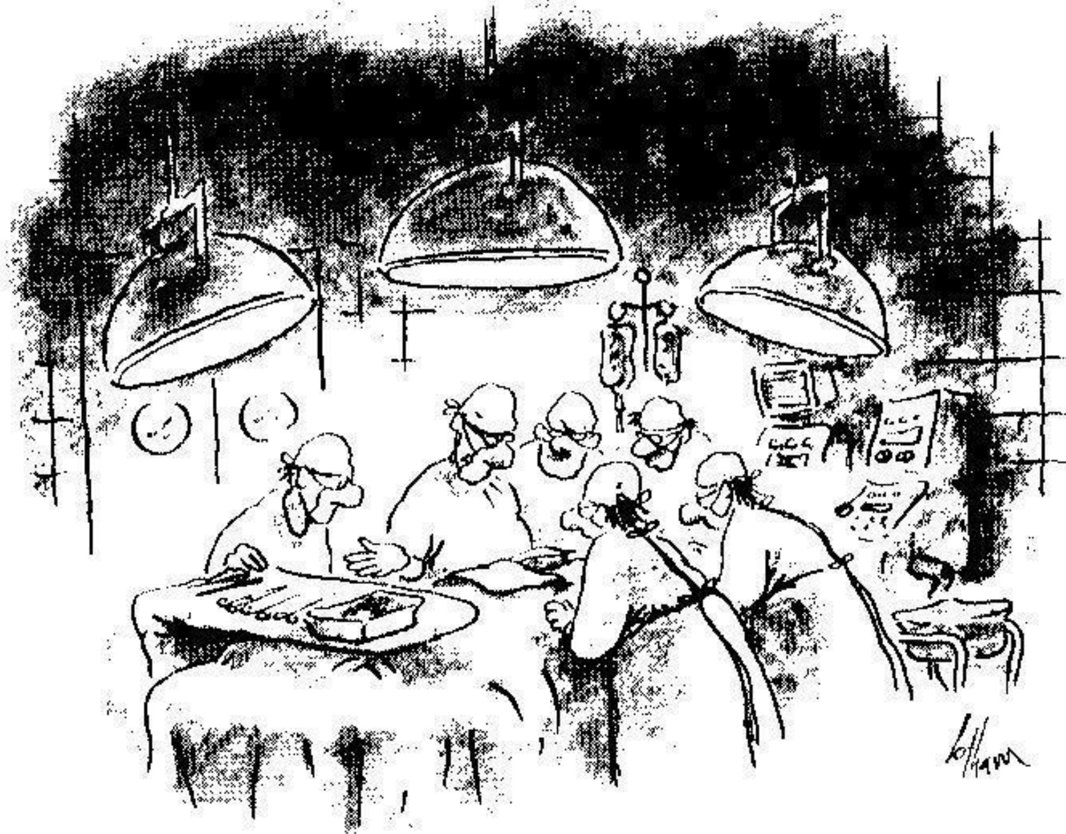
ANCOR Principles of MLTSS – Core Values

- Must result in choice for the beneficiary in the most appropriate integrated setting.
- Must plan to provide support over the lifespan in addition to a person’s episodic needs.
- Services and supports accessed through each managed care entity must be sufficiently robust and diverse to meet the contracted scope and needs of all beneficiaries with disabilities.
- Beneficiaries must have a choice among managed care entities.

ANCOR Principles of MLTSS – 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.

Assure Actuarially Sound Rates



"Let's just start cutting and see what happens."

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Rate Setting and Implementation

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.

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MLTSS State Tools to Encourage Integrated Settings-Contracts, Manuals, Rate Setting

- 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

Brent, NASDDDS

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Performance Measures and Metrics

- 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.

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Quality Oversight Metrics

- Comprehensive data collection and analysis
- Incident reporting; monitoring; demographic, providers, case managers and MCOs
- Support Coordination
- Utilization- who is receiving supports and where
- Beneficiary Feedback
- Trends in grievances, complaints, appeals, claims, provider monitoring, incidents, quality of care concerns, outcomes, PIPS, and compliance data

Oversight of MCOs quality by States is critical!

Brent, **NASDDDS**

Health Information Technology (HIT) and Electronic Health Records (EHR)

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

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What Can Be Accomplished - Aligning Payment Structures with Goals

- Spend sufficient time on capitation methodology. *Capitation in (MLTSS) is unique for people with I/DD*. F*actor in:*
- Desired policy changes, valued outcomes such as in home supports, crisis supports, employment, early intervention, aging caregivers, smaller homes, transitioning youth, 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 lacks robust data system and analytics readily available, more time needed to pull data for first capitation (and ongoing)
- The new CMS Managed Care rules heighten expectations for actuarially sound rates and capitation requirements.

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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 Brent, NASDDDS regarding LTSS outcomes. Networks must include robust HCBS services

Brent, NASDDDS

What Can Be Accomplished - Aligning Payment Structures with Goals

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".
- It is more than sufficient doctors, hospitals, therapists, 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 community 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.

Brent, NASDDDS

A Word about Regulations

From the Pasadena Weekly.

State Responsibility and Regulations

- Regulations should encourage and support innovation; modified to reduce process burden in exchange for performance outcome measures; and, allow provider creativity on how to meet the regulation.
- PWDs are safe and secure without compromising civil rights, choice, informed decision making and dignity of risk.
- Transparency in contract procurement, monitoring, quality assessment.
- Define financial risk between state , MLTSS entities and providers.
- Cover the full range of services and supports needed to address diverse needs of PWDs 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.

Support Coordination

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 IDD community

Brent, NASDDDS

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MCOs and Care Coordination

- MCOs should consistently enhance individual and family expectations of support coordinators/case managers
- Focused training (person centeredness, rights, self-direction, etc.)
- Contract expectations must be spelled out clearly
- Ongoing mentoring and monitoring should occur – MCOs of care coordinators and State regulators of MCOs
- Policies and manuals
- Clinical practice guidelines

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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 regularly) assuring services are delivered and desired outcomes achieved
- Is available for ad hoc problem solving

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Networks of Qualified Providers

- Certification, licensing, background checks, credentialing (for clinical services)
- Assure the training of non-certified DSPs
- Establish a core curriculum
- Maintain known IDD providers and array of smaller, niche providers
- Training in billing, collecting encounter data, coding & other insurance based knowledge necessary to thrive in new environment

Brent, NASDDDS

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Training for MCOs

- MCOs need training in disability specific areas, history and values base, person centered processes, IDD vs. Behavioral Health, self direction
- Involve people with disabilities and families as trainers
- Encourage people with disabilities and family members to be on advisory committees and/or boards

Brent, NASDDDS

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Acute, Behavioral Health & LTSS Benefits of Integrated Care

- Better coordinated discharge planning to prevent illness
- Wellness focus across home and community values
- Recognition of DSP value to discharge planning and execution
- Behavioral health care
- Polypharmacy
- Trauma informed care

Brent, NASDDDS

Beneficiary Rights

- Supported in the most integrated setting available
- Fair compensation for labor
- Able to own property
- Access to Human Rights Committee
- Right to presumptive competency
- Right to be free from excessive medications and regular review of medications if used to modify behavior
- Freedom from abuse, neglect and exploitation
- Privacy

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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.

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Bringing PWDs and Families to the Table

- Vision and Values – there is a purpose beyond "coordinating care and reducing costs"
- What matters to families: support to families; school to work transition; competitive employment; self-direction – control over services & budget; small, innovative providers will continue; reducing waitlists;
- Support for families - flexible, meets their needs and is consumer/family directed
- 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 …

Brent, NASDDDS

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Don’t Rush – Insist on a Readiness Assessment

- 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.

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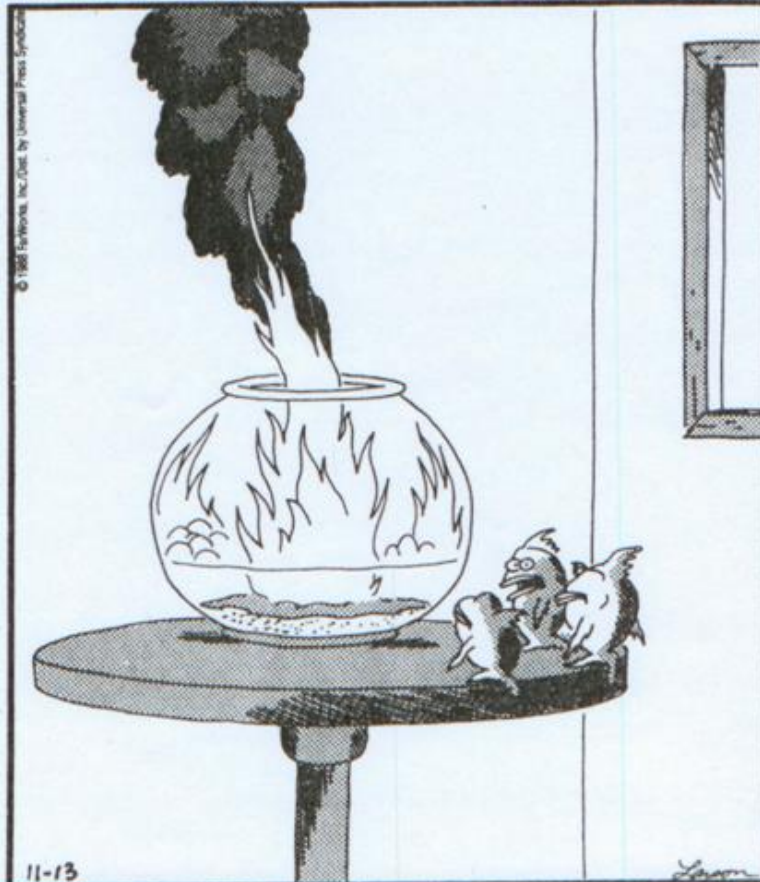
Cautionary Notes

- Provider Networks already exist and are known by many families, people with disabilities 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 IT capacity possible – They will need support.
- People with I/DD and families are the heart of the system and need to be involved first- - way before plans are completed.
- Providers may need assistance in understanding billing, data collection, and more.
- Get involved NOW, with state Medicaid agency, if managed care is being discussed – even if it is only a whisper…



Plan Ahead

Resources

CMS Managed Care Rule: http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

CMS Managed Care Guidelines: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

Managed Care State Profiles: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html

MLTSS Provisions: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-the-delivery-mltss-fact-sheet.pdf

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About the Presenter

Diane McComb is the Liaison to State Associations with the American Network of Community Options and Resources (ANCOR). Concurrently, she also works with the Delmarva Foundation, a quality improvement organization, providing technical expertise on disabilities, self-direction, individual budgets, community waiver programs, and managed care.

Prior to her current work she served as the Deputy Secretary of the Maryland Department of Disabilities and the CEO of Maryland's state association of community programs. She also directed a community agency supporting people with intellectual and developmental disabilities and their families.

Her career gives her the unique perspective of a private community agency, the CEO of a statewide provider advocacy organization, and as a cabinet level governmental official. She brings her extensive knowledge of the disability community, her demonstrated track record of innovative problem solving, and lifelong commitment to creating improved capacity in systems empowering individuals with disabilities to achieve their personal and professional goals in communities where they live.

She holds an MSEd from the Johns Hopkins University in Severe and Profound Disabilities and has a long history working as an advocate for people with disabilities and nonprofit management.

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