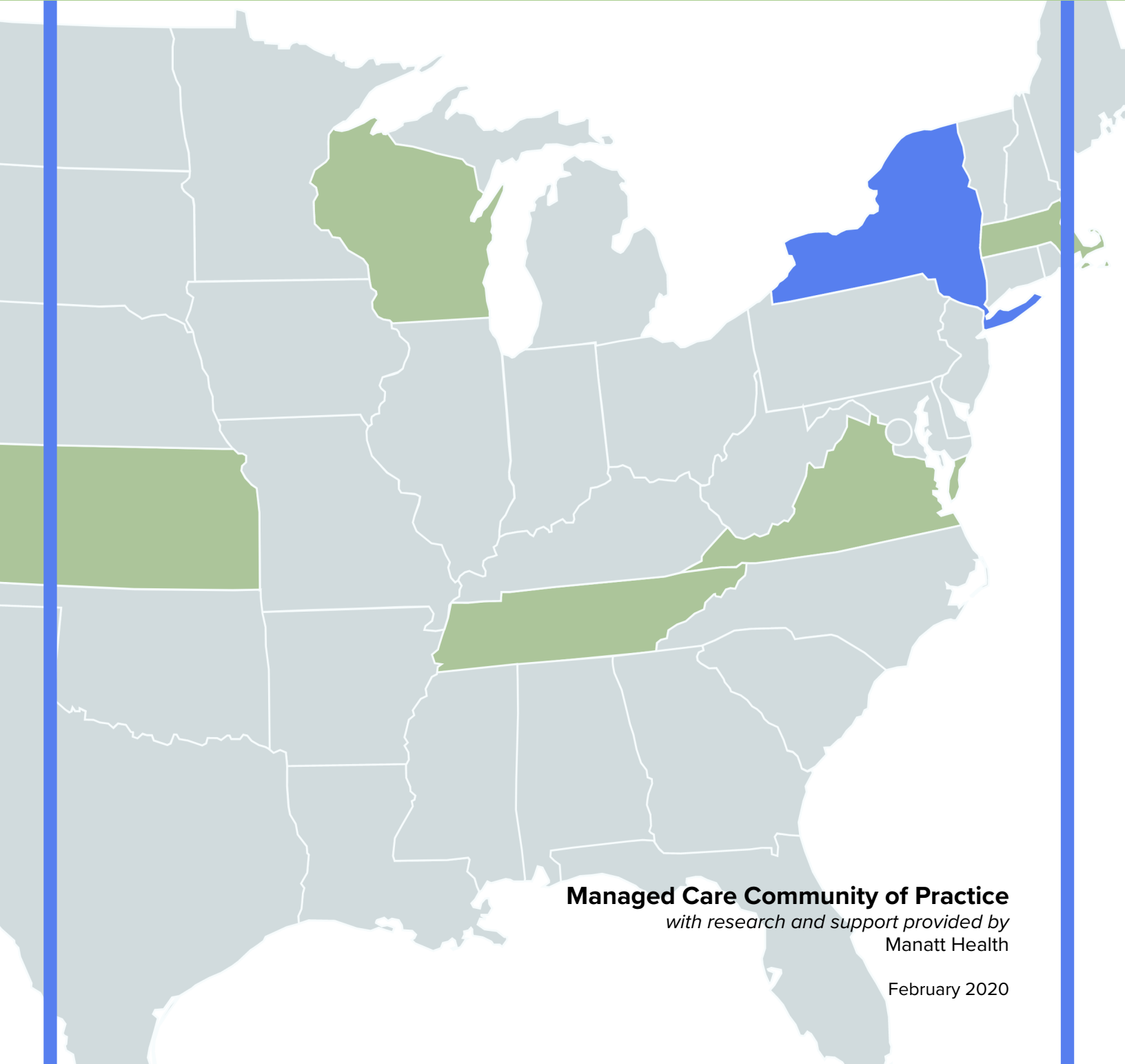


Lessons Learned from Managed Care for
Individuals with Intellectual and Developmental Disabilities:
Informing New York's Transition



Managed Care Community of Practice
with research and support provided by
Manatt Health

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**ALLIANCE FOR
INCLUSION & INNOVATION**

The New York Alliance for Inclusion and Innovation is a statewide association representing 175 not-for-profit agencies that provide supports and services to people with disabilities. The NY Alliance is the result of the merger of NYSACRA and NYSRA: each association has a long and distinguished history supporting disability service provider organizations in New York State. We are stronger together, envisioning a society where people with disabilities are contributing citizens with equal rights and the ability to live full, productive and meaningful lives.



Managed Care
Community of Practice
Preparing the IDD Field for Managed Care

The Managed Care Community of Practice was established by the New York Alliance for Inclusion and Innovation through funds provided by New York State in order to provide technical assistance and foster collaboration to successfully guide and assist the field of developmental disabilities in the transition to managed care. The objectives of the Managed Care Community of Practice include:

- Creating a common understanding of managed care
- Establishing a managed care resource center for individuals with developmental disabilities, their families and supporters
- Providing technical assistance and the tools necessary to transition to and operate in a managed care environment
- Developing data and IT tools to assist providers in collecting and interpreting data required in managed care



Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future.¹

¹ Megan Sherman and Olga Deshchenko led the research and drafting for Manatt Health.

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Introduction

New York State has had a Medicaid managed care program for several decades, with the state's first programs beginning in the 1980s. In 2006, the state sought a waiver under section 1115 of the Social Security Act (frequently referred to as an 1115 waiver) to expand its Medicaid managed care enrollment and institute mandatory enrollment into Medicaid managed care.

Since that time, the state's Medicaid managed care program has continued to expand by carving in new populations and creating specialized managed care programs for individuals with special needs, including those with physical disabilities, frail elders in need of long-term services and supports, and individuals with serious mental illness and substance use disorders. As of October 2019, more than 4.6 million New Yorkers were enrolled in some form of Medicaid managed care.^a In total, Medicaid managed care now represents two-thirds of the state's Medicaid spending.^b However, individuals with intellectual and developmental disabilities (I/DD) are largely exempted from (or "carved out" of) Medicaid managed care.²

For several years, the state has considered carving the I/DD population into managed care, most recently proposing the formation of provider-led specialty plans that would be responsible for covering all of an enrollee's Medicaid benefits, including acute and primary care, behavioral health services, long-term services and supports, and I/DD services, including home and community-based services (HCBS) and some residential services.

As the state continues to deliberate on the best way to implement managed care for this population, the Managed Care Community of Practice has partnered with Manatt Health to undertake a survey of several states that have implemented some form of managed care for this population. The goal of this white paper is to provide an understanding of the options for delivering coordinated care to this population, the design elements of managed care plans for individuals with I/DD chosen by our target states, the implementation decisions made by these states, and the experience and consequences of those decisions in an effort to inform New York policymakers in order to ensure a successful transition of individuals in need of I/DD services to managed care in New York State.

As of October 2019, more than 4.6 million New Yorkers were enrolled in some form of Medicaid managed care.

² Individuals with I/DD enrolled in one of the state's 1915 (c) home and community-based services (HCBS) waivers are excluded from enrollment in managed care, which means that they are prevented from enrolling in managed care. Individuals with I/DD who are receiving services outside of the waiver are exempt from enrollment in Medicaid managed care, which allows them to choose to enroll in the program voluntarily but does not require them to do so.

In addition, New York began a demonstration for individuals with I/DD who are eligible for both Medicare and Medicaid under the federal financial alignment initiative (discussed in more detail below) in 2016, which is called Fully Integrated Duals Advantage for Individuals with I/DD (FIDA-IDD). The program, which is available to individuals living in New York City, Long Island, and Rockland and Westchester Counties, currently has approximately 1,500 voluntary enrollees. Authority for the demonstration is set to expire at the end of 2020.

Methodology

For the purposes of our review, we selected a variety of states that chose different designs to ensure that our review included programs that utilized a range of methods to manage care for the I/DD population. For example, we wanted to include states that chose to incorporate I/DD HCBS within their managed care programs and states that kept these services in the fee-for-service delivery system, while delivering physical and behavioral health services through managed care. As a result, we decided to focus on the following states: Tennessee, Massachusetts, Virginia, Wisconsin, and Kansas.

In reviewing each state's program, we identified several elements that we believed were key to understanding the design of a Medicaid managed care program and to addressing the needs of the I/DD population. These key elements included the following:

- Authority for managed care
- Benefit design, including which benefits are carved into managed care and which remain the responsibility of the fee-for-service program
- Type of plan that the state contracts with, whether it is a not-for-profit, provider-sponsored or traditional managed care company
- Integration with Medicare
- Development and adequacy of plan rates
- Treatment of residential services
- Care coordination model
- Treatment of dental and optical services, including any methods used to increase access for the I/DD population
- Strategies to address workforce shortages and development
- Value-based payment arrangements
- Employment services
- Coverage and use of assistive technology
- Enrollee protections
- Provider protections
- Coverage and use of telehealth services
- The availability and extent of self-direction within the program

We note that, depending on the model of managed care pursued by a given state, not all of these elements are applicable, or a state may not be actively addressing one of these elements through its managed care program. For this reason, while we evaluated all of the elements for each state, we have chosen only to highlight elements where the state has implemented a strategy to address that element and we believe that the strategy selected will provide New York with insight on how to structure its program.

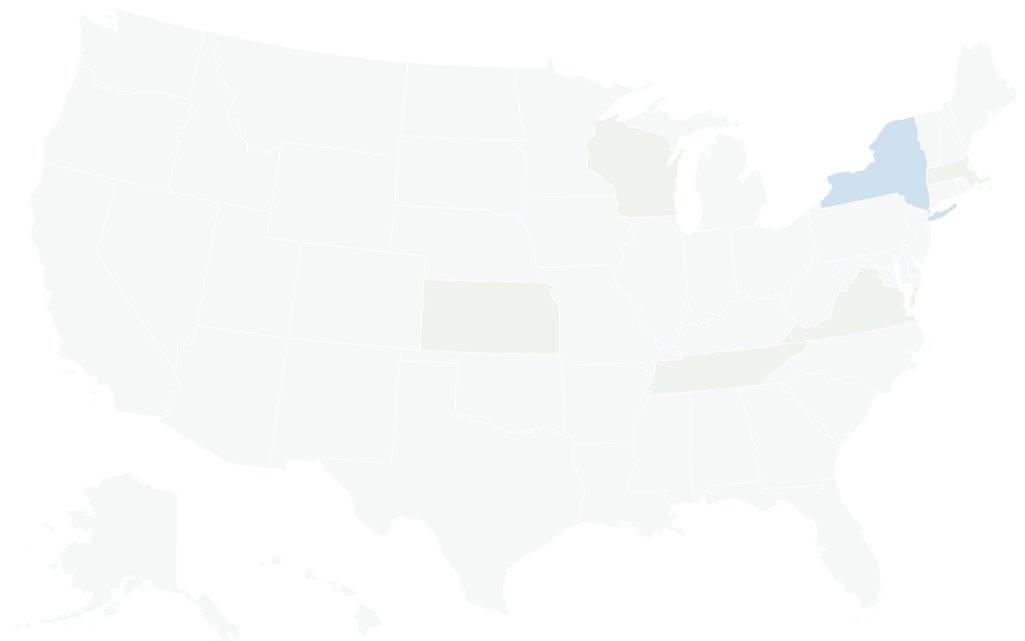
In order to determine how states designed and implemented their programs, we reviewed publicly available documentation, such as so-called model contracts between managed care organizations (MCOs) and the state, relevant waivers (including 1115 and 1915 (c) and (b) waivers), legislative reports, reports on and analyses of the implementation of managed care for individuals with I/DD done by national organizations, and various other documents.³

In addition, we conducted extensive interviews with stakeholders of various types in each of the states we reviewed. For each state, we aimed to speak with at least one

³ In conducting our research, we have compiled detailed matrices that contain relevant Medicaid managed care contract requirements. In order to view these, please contact MCCOP.

representative from the following organizations: the state’s Medicaid program, an MCO operating in the state, a provider association, and a group that advocates for individuals with I/DD and/or their families or a self-advocate. In an effort to obtain candid and meaningful feedback, we have decided not to name these stakeholders in this report but will refer to their comments throughout the paper.

To inform our analysis, we convened an advisory committee that included a diverse group of stakeholders. The advisory committee provided informed and valuable guidance on the programmatic elements we evaluated and directed our research to particular areas of importance. Participants included representatives from the I/DD provider and larger New York healthcare provider communities, the managed care industry and state agencies, including the New York State Office for People with Developmental Disabilities and the Department of Health, as well as national experts in the I/DD field.



What is Managed Care?

For several decades, states across the country have been moving to a “managed care” model to arrange for and deliver Medicaid benefits to Medicaid beneficiaries. The federal government has also opted to use a similar model to deliver Medicare benefits to Medicare beneficiaries who choose to receive care through an MCO, commonly called Medicare Advantage. There is a belief that managed care provides states—and the federal government—with the opportunity to reduce healthcare expenditures and better manage utilization, while improving quality and outcomes.

In order to understand the options available to a state when seeking to manage care, and inform the discussion below on the strategies implemented by our selected states, we thought it would be helpful to provide an overview of the vehicles that are available to states and the federal government. Because a large number of individuals with I/DD are dually eligible for both Medicare and Medicaid and, therefore, the programs share responsibility for coverage of an individual’s medical care, we include an overview of the vehicles that are used to deliver Medicare benefits, as well as those that are used to align coverage between the two programs.

- **Medicaid Managed Care^c** is an arrangement where the state contracts with an MCO to provide Medicaid benefits under a capitated payment arrangement, which provides payment on a per member per month (PMPM) basis for a certain set of services. The MCO is “at risk” for these services, meaning that the MCO must provide reimbursement for all healthcare services covered by the contract regardless of whether the capitated payment covers those expenses. The authority to deliver Medicaid benefits through managed care is provided by a waiver from the federal government.⁴
- **Medicare Advantage (MA)^d** is a model under which an MCO contracts with the federal government to provide coverage of Medicare benefits on a capitated basis. Coverage includes Part A and Part B Medicare benefits, but most plans also offer prescription drug coverage (often referred to as Part D). Under federal law, the member chooses to enroll in an MA plan; individuals cannot be required to do so.
 - **Dual Eligible Special Needs Plan (D-SNP)^e** is a type of MA plan that provides coverage of Medicare benefits to individuals who qualify for both Medicare and Medicaid. This type of plan seeks to align the provision of Medicare and Medicaid services by coordinating, to some extent, both Medicare and Medicaid benefits. There are various types of D-SNPs that are able to offer increasing levels of integration between Medicare and Medicaid by, for example, integrating the disparate appeals processes across both programs into a single process. Plans that offer both D-SNPs and Medicaid managed care plans are able to “align” care by enrolling members in two products offered by a single organization that is responsible for all of their healthcare benefits—and states can choose to implement policies that encourage this alignment.
- **Accountable Care Organizations (ACOs)^f** include groups of doctors, hospitals and other healthcare providers who come together to provide coordinated, high-quality care to their patients. ACOs have a target budget for each patient and can partake in shared losses, if the cost of care

⁴ Depending on the benefits delivered through managed care and the features of a state’s managed care program, authority for such waivers comes from sections 1115, 1915 (a) or (b), or 1932 (a) of the Social Security Act. For more information, see Managed Care Authorities, available at <https://www.medicaid.gov/medicaid/managed-care/authorities/index.html>.

exceeds that target budget, or shared savings, if the ACO achieves cost savings and succeeds in meeting certain quality metrics.

- **Financial Alignment Initiatives (FAI)**⁹ were made available to states under the Affordable Care Act and were intended to provide a mechanism for further aligning financing and care coordination for dually eligible beneficiaries across Medicaid and Medicare. Under the FAIs, the Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for overseeing the Medicaid program—was empowered to waive certain federal requirements around the delivery of Medicare and Medicaid benefits to improve integration between the programs. FAIs are time-limited demonstrations that states—including New York—have used to test mechanisms to better integrate the two programs. Under the FAIs, the federal government offered three different models:
 - **Capitated models** involve a three-way contract between CMS, the state Medicaid program and participating health plans called Medicare-Medicaid Plans (MMPs).⁵
 - **Managed fee-for-service models** allow states to be accountable for coordination of all Medicare and Medicaid services and quality improvement. In exchange, the state is eligible to receive some of the savings that accrue to the Medicare program.⁶
 - **Alternative models** were also authorized by CMS, whereby states could develop and implement a program that was neither a capitated nor a managed fee-for-service program. One state is testing a model that is focusing on aligning administrative aspects of Medicare and Medicaid to improve the beneficiary experience.
- **Programs of All-Inclusive Care for the Elderly (PACE)**^h are fully aligned Medicare and Medicaid programs that focus on the delivery of community-based care to dual eligible individuals.⁷ PACE programs provide care and services in the home,

Washington State's Managed Fee-for-Service (MFFS) Demonstration

Washington launched its MFFS model in July 2013. It targets dual eligibles with at least one chronic health condition who are at risk of developing another condition. Eligibility criteria for the demonstration are based on a risk score generated by PRISM, a predictive modeling tool that incorporates Medicare and Medicaid claims information in an individual profile for each enrollee.

The demonstration uses health homes to better integrate care across primary, acute, LTSS and behavioral health services settings. The state contracts with health home lead entities that contract with care coordination organizations; together, these entities provide the six required core health home services.

The Washington demonstration achieved an estimated total of \$107 million in Medicare savings over the demonstration's first three and a half years. As of November 2018, CMS has made three interim performance payments to Washington State totaling \$36.5 million.

In a State Medicaid Director letter issued in April 2019, CMS noted that it's open to working with additional states to test MFFS through demonstrations that use an approach similar to Washington's.

⁵ This was the model chosen by New York State for the FIDA and FIDA-IDD demonstrations.

⁶ Sources used for information on the Washington MFFS program include Integrated Care Resource Center, Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences (February 2019), available at https://www.integratedcareresourcecenter.com/sites/default/files/Washington%20case%20study_Final.pdf; CMS, SMDL #19-002 (April 24, 2019), available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>.

⁷ Individuals eligible for Medicaid only may choose to purchase the Medicare benefit package from the PACE program.

A Closer Look at a Provider-Led Model: The Provider-Led Arkansas Shared Savings Entity (PASSE) Program

In 2018, Arkansas launched the PASSE program, which aims to coordinate and integrate physical and behavioral health and HCBS for individuals with behavioral health issues or I/DD through a provider-led managed care model. The PASSE model requires that MCOs have at least 51% ownership by Arkansas-based providers and include an I/DD specialty provider, a behavioral health provider, a hospital, a physician, and a pharmacist on the governing body. The three organizations currently operating PASSEs are partnerships between providers and large national MCOs.

Arkansas rolled out the PASSE program in two phases. In the first phase, PASSEs were responsible for just the provision of care coordination services to their auto-assigned members. In March 2019, PASSEs began receiving capitated payments and managing all services for their enrollees.

The state experienced some challenges with the transition to the second phase of the program. Providers struggled to adjust to multiple PASSE billing systems and reported significant delays in receiving payments. In response to stakeholder feedback, Arkansas delayed the open enrollment period for the program to give individuals more time to learn about their plan options. With the goal of ensuring that PASSEs develop adequate and stable provider networks, the state also extended the timeframe during which PASSEs were required to honor existing service authorizations and reimburse all Medicaid providers with “in-network” rates.

Today, the three PASSEs serve about 45,000 Medicaid beneficiaries. States considering a transition to managed care across the country are likely to continue following the developments of the PASSE program in Arkansas.

in the community, and at PACE centers. The program contracts with many specialists and other providers in the community. In order to be eligible for PACE, enrollees must be 55 or older, live in the service area of a PACE organization, need a nursing home level of care and be able to live safely in the community with the help of PACE. However, several years ago, Congress passed the PACE Innovation Act of 2015, which provides CMS with the authority to develop pilots using the PACE model for individuals under the age of 55 and those at risk of needing nursing home care. Unfortunately, CMS has yet to move forward with any such pilots.

Federal “Floor” for Medicaid Managed Care Programs

In examining how states have implemented managed care for the I/DD population, it is important to understand that the federal government, through CMS, has established certain minimum standards for managed care programs, which provide some protections for MCOs, providers and members. Though each state may have its own additional, and often more stringent requirements for its respective Medicaid managed care programs, all states must generally follow these federal provisions. As these provisions apply to all managed care programs, we did not highlight areas where states were simply meeting the federal standards in our state-specific analyses. However, we thought it was important to provide an overview of some of the protections that will create the foundation of New York State’s managed care program for individuals with I/DD.

- **Enrollment and disenrollment protections.** CMS requires that Medicaid beneficiaries be given a choice of managed care plans and be provided an opportunity to disenroll both without cause and for specific reasons.ⁱ
- **Network adequacy.** States are required to adopt and enforce network adequacy standards for several different provider types, including providers of LTSS. States must consider “access indicators” when developing network adequacy standards, such as the numbers of providers accepting new Medicaid patients, language access, cultural competency, and physical access for Medicaid enrollees with physical and mental disabilities.^j

- **Stakeholder engagement.** CMS requires that states ensure that the views of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders are solicited and considered during the design, implementation, and oversight of a state’s managed care program that includes LTSS. Additionally, the state must require that MCOs establish and maintain a member advisory committee that includes at least a reasonably representative sample of the populations in receipt of LTSS.^k
- **Continuity of care.** CMS requires that states establish standards to ensure continuity of care when members move from one plan to another. These standards must address continued access to services and existing providers and transitions to appropriate in-network providers.^l
- **Care coordination.** The federal regulations require that MCOs assess members’ needs within 90 days of enrollment and coordinate care of all services the member receives—through the MCO, another MCO, or fee-for-service. For individuals with LTSS needs or special needs, MCOs must identify and assess member needs, develop a service plan, and ensure access to necessary specialists.
- **Service authorizations and utilization review.** MCOs are permitted to impose utilization controls on covered services but cannot do so in a way that disadvantages individuals in need of LTSS. MCOs are required to respond to requests for services within a certain period of time, depending on the services requested and the condition of the member.^m
- **Grievances and appeals.** The federal regulations provide beneficiaries with the right to file grievances and appeals about any aspect of their coverage, including the approval or denial of covered services, and require that plans respond to these grievances and appeals within a specific period of time. Members are permitted to request a fair hearing before an administrative law judge to review coverage determinations made by MCOs.ⁿ
- **MCO quality.** States are required to implement a strategy for assessing and improving the quality of healthcare and services provided by MCOs, which includes implementing a quality rating system and engaging in external reviews of MCO quality by third-party reviewers.
- **Rate setting for MCOs.** All capitation rates paid by the state to MCOs must be “actuarially sound” for the time period and population covered under the terms of the state’s contract with MCOs—meaning that the rates must be developed by an independent actuary in accordance with generally accepted actuarial practices and principles and certified by said actuary. The federal regulations require that the state and its actuary follow a specific process for developing MCO rates and consider certain factors in doing so.^o
- **Minimum loss ratio (MLR).** States are required to set an MLR—i.e., the percentage of premium an MCO receives that must be spent on medical care—for MCOs. The federal regulations require a minimum MLR of 85%, but states can set a higher MLR if they choose to do so. When an MCO fails to meet the MLR, CMS encourages states to require plans to return capitation amounts and requires states to take into account past and anticipated MLRs when establishing future plan capitation payment rates.^p

It is important to note that, in November 2018, the current administration released a proposed rule that would revise these regulations. The proposed regulations, which have not yet been formally adopted, leave the vast majority of the current regulatory framework in place but do make targeted revisions to certain provisions of the regulations.

State Analyses

In this section, we provide an overview of each of the target states' managed care programs and highlight unique and interesting aspects of each program.

Tennessee

Tennessee has a longstanding Medicaid managed care program, referred to as TennCare, which began in 1994 and is administered by three large national MCOs. Over time, TennCare has been expanded to include long-term services and supports. In 2016, the state's 1115 waiver was amended to include the Employment and Community First (ECF) CHOICES program, which provides comprehensive coverage, inclusive of physical and behavioral health services, LTSS, and HCBS for individuals with I/DD as an alternative to institutional services or to prevent placement in a nursing facility. The expansion was taken primarily to increase access, contain costs, and increase employment and community integration of the I/DD population.

At the time that ECF CHOICES was implemented, Tennessee closed its 1915 (c) HCBS waivers and required that all individuals with I/DD seeking HCBS enroll in ECF CHOICES in order to access such services.⁸ The eligibility criteria for ECF CHOICES are broader than the eligibility criteria for the state's 1915 (c) waivers and, for the first time, allowed individuals with development disabilities (and not an intellectual disability) to access HCBS, which has helped achieve Tennessee's goal of increasing access.

ECF CHOICES has five categories of eligibility based on age, condition and acuity of members. Each category has a varying HCBS benefit package and is subject to an annual expenditure cap on ECF CHOICES HCBS expenditures, which range from \$15,000 to approximately \$90,000 annually.⁹

Employment Services

As indicated by the name, a key feature of the ECF CHOICES program is the focus on obtaining competitive employment for individuals with I/DD. All individuals enrolled in the program have available to them a robust package of employment-related services, which are designed to help individuals achieve sustained employment or self-employment at or above the minimum wage. These services help individuals understand and explore employment options, provide ongoing support to individuals who have obtained employment, and prepare individuals for employment through supported employment and pre-vocational training.

MCOs are required to follow the "employment informed choice" process with all members aged 16 to 62 who are not currently employed or self-employed. Support coordinators must provide members with an orientation to employment and the services available to them; authorize exploration services that allow members to explore various employment options that are aligned with their interests, aptitudes, experiences and/or skills; address concerns or questions; and ensure an informed choice regarding employment or self-employment.

TennCare has designed the ECF CHOICES benefit package to incentivize individuals to seek employment. Individuals must complete the employment informed choice process in order to receive day services (i.e., services that help them participate in community activities and build

⁸ Individuals who were enrolled in one of the state's 1915 (c) waivers were permitted to continue to receive services through those waivers.

⁹ There is a process for exceeding both "soft" and "hard" spending caps set by appealing to TennCare. TennCare also recently added two new eligibility categories for individuals with I/DD who have co-occurring behavioral health conditions, which have expenditure caps that are based upon the comparable cost of institutional care and may exceed the range stated above.

skills to live independently). Individuals who do complete the process but ultimately choose not to seek employment are subject to a lower cap on these services than those individuals who are employed.

The state reports that reimbursement for employment benefits reflects value-based approaches and is outcome-based. Reimbursement for services that help individuals carry out their plan to get a job or start their own business are tiered and based on outcomes;

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reimbursement for job coaching takes into account the length of employment and the ratio of paid supports to hours worked. These reimbursement strategies are designed to “incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time.”^q

To date, Tennessee has had promising results with the program. Approximately 25% of working-aged individuals with I/DD are employed, which is 50% higher than the national average. On average, these individuals work 17 hours per week and earn \$8.66 per hour.^r

Robust Care Management Standards

All care management—support coordination, as it is called in the state—is done by support coordinators employed by MCOs. The state has established rigorous requirements related to the provision of support coordination. MCOs are required to provide comprehensive, holistic and person-centered support coordination to all ECF CHOICES members. Service coordination not only includes ensuring the delivery of necessary physical and behavioral health services and LTSS, but also focuses on identifying and achieving members’ goals related to lifestyle, employment, community involvement, and independent living.

Support coordination is primarily delivered by support coordinators, who must have specific credentials or experience with the I/DD population.¹⁰ The state has established limits on the number of individuals that a support coordinator may work with, which are weighted to account for the varying needs of members in the various ECF CHOICES eligibility categories. The state has also established minimum frequencies for interactions between support coordinators and members, which range from weekly to bi-annually, depending on the member’s eligibility category.

Through the support coordination process, MCOs must assess members’ needs in face-to-face visits, conduct caregiver assessments to determine caregivers’ abilities and needs, develop a person-centered service plan (PCSP), and authorize and provide services provided for in the PCSP. The state has set aggressive timeframes for these activities to occur; for example, MCOs must determine the need for and authorize HCBS within 10 business days of enrollment and complete the required assessments and develop the PCSP within 30 business days. MCOs are also required to reassess members and update the PCSP at least annually or upon a significant change in circumstances or as the support coordinator deems necessary.

Despite these robust standards, providers and advocates report that some MCOs have difficulties understanding and meeting the requirements set forth by the state and have not achieved real “person-centeredness” in their approach to service coordination.

¹⁰ Individuals with co-occurring behavioral health conditions receive support coordination through a team that includes a support coordinator and a behavioral supports director.

Stakeholder Engagement

Tennessee has required—and continues to provide for—substantial stakeholder engagement in the development and operation of ECF CHOICES.

When the state began to consider the transition of I/DD services to TennCare, it released a concept paper, solicited comments and held various stakeholder engagement events, including nine community forums held across the state, and other webinars. While not all stakeholder feedback was incorporated into the concept paper or ultimately into the program’s design, many stakeholders reported feeling “heard.” Stakeholders also highlighted the importance of grant funding that the advocacy community received to organize families and consumers to help shape the design and implementation of ECF CHOICES. These stakeholders noted that robust engagement with these groups was key in guiding state decision making.

In addition to engagement during the implementation phase, MCOs are contractually required to have two stakeholder advisory groups. MCOs are required to establish a statewide ECF CHOICES advisory group to provide input and advice to the MCO’s executive management and governing body and to TennCare regarding the health plan’s ECF CHOICES program, policies, and operation. MCOs are required to invite participation from several specified provider and advocacy groups, as well as enrollees. MCOs must work with the ECF CHOICES advisory group to convene community forums and ECF CHOICES providers at least annually in order to provide education to enrollees, families, and providers, and to gather input and advice regarding the plan’s ECF CHOICES program, policies, and operation.

MCOs must also establish a member-only advisory group composed exclusively of individuals with I/DD that meets quarterly. Concerns from the member-only group must be elevated to the ECF CHOICES advisory group.

Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative

Tennessee is currently working on implementing the QuILTSS initiative for the I/DD population, which aims to effectuate value-based purchasing for LTSS and include performance measures based on what is most important to people who receive these services.

The QuILTSS initiative for the I/DD population is focused on workforce development and comprised of three components: collection of data from I/DD providers, analysis of that data to inform and implement workforce strategies, and a competency-based training for direct care workers. TennCare partnered with the University of Minnesota to develop and implement the program, which has yet to be fully implemented.

TennCare and the University of Minnesota developed a set of metrics and collected data across all sectors involved in the care of individuals with I/DD. That data was then leveraged to help I/DD providers assess their workforce challenges and inform the development and implementation of a workforce plan. The University of Minnesota provided technical assistance to providers free of charge and TennCare provided a \$2,000 incentive for completing the process.

While not all stakeholder feedback was incorporated into the concept paper or ultimately into the program’s design, many stakeholders reported feeling “heard.” Stakeholders also highlighted the importance of grant funding that the advocacy community received to organize families and consumers to help shape the design and implementation of ECF CHOICES.

The last component of the QuILTSS initiative is a workforce development, a competency-based training program for direct care workers that is being implemented. This program will be offered through local colleges and provide college credit and will require direct care workers to demonstrate knowledge and skills to earn these credits. **TennCare hopes to link this training to a value-based payment model that, at least in part, measures quality based on the course work completed by the direct care workforce.**⁵

Massachusetts

Massachusetts has a number of programs that aim to “manage care” for Medicaid beneficiaries. We chose to focus on the state’s financial alignment demonstration, One Care, which provides coverage to individuals eligible for both Medicare and Medicaid (commonly referred to as “dual eligible”) ages 21 through 64 who have disabilities, but are not receiving services through an HCBS waiver. One Care launched in 2013 and offers a variety of “HCBS-like” services to enrollees who previously did not have access to these types of services. The program is administered by two locally based, non-profit MCOs.

The state’s main goal in developing and implementing the One Care program was to increase access to services for a population that had historically been underserved. The One Care population is comprised of individuals who fail to meet the HCBS waiver criteria because they either have aged out, were never enrolled into the waivers as a child, or do not otherwise meet the financial and clinical criteria for the waivers.

Integration with Medicare

One Care is the nation’s only capitated program under the financial alignment demonstration for the non-elderly dual eligible population. Participating MCOs enter in three-way contracts between the state and CMS to operate as a Medicare-Medicaid Plan (MMP) and provide Medicare and Medicaid benefits to dual eligibles. One Care integrates the full array of functions performed by Medicare and Medicaid, including eligibility and enrollment; the delivery of all medical, acute, pharmacy, and LTSS; coordinated quality management processes and systems; and a coordinated grievance and appeals process for enrollees.

Care Coordination

One Care plans must offer care coordination to all enrollees for medical and behavioral services through a care coordinator and, for enrollees with complex needs, through a clinical case manager. Plans are required to coordinate services for each enrollee in all care settings, including those received from community and social support providers. Care coordination is particularly extensive for One Care enrollees, as a single plan is responsible for managing the full set of Medicaid and Medicare covered benefits.

One Care’s detailed assessment exemplifies the state’s comprehensive care management standards. The assessment must not only address immediate needs and services for each enrollee, but also cover a number of other domains, including sexual and reproductive health, use of leisure time, community involvement, and personal goals, including health goals and activities enjoyed by the enrollee and barriers to participation in those activities. Massachusetts also reserves the right to add other domains to the plans’ assessment tool as

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necessary. One Care plans are responsible for using the assessments to develop individualized care plans, which must reflect each enrollee’s preferences and needs, as well as how services and care are integrated and coordinated among providers.

Enrollees may also choose to work with an LTS coordinator for assistance with coordination of LTSS. MCOs are required to contract with multiple community-based organizations (CBOs) for the LTS coordinator role. As a member of the enrollee’s interdisciplinary care team, LTS coordinators participate in the assessment of enrollees with LTSS needs, coordinate the provision of community-based LTSS, determine community-based alternatives to institutional long-term care services, and assist enrollees with accessing personal care services.

The stakeholders we interviewed note that while LTS coordinators serve as an additional “checks and balances” mechanism for One Care plans, the level of training and knowledge of LTSS often varies among the contracted CBOs, which can complicate the care coordination process and cause confusion for members.

Member Satisfaction

Across multiple data sources—including focus groups and consumer satisfaction surveys—most One Care enrollees express satisfaction with their plan, services, and providers. This is often attributed to the availability of new and expanded services offered through One Care, as well as care coordination activities.

Virginia

Virginia’s experience with managed care programs dates back to the 1990s. The state initiated the launch of Commonwealth Coordinated Care (CCC) Plus in 2017 in response to a legislative mandate to improve care quality and budget predictability for individuals who use LTSS. CCC Plus is a managed care program for dual eligibles who are 65 or older, adults and children with disabilities, nursing facility residents, and individuals on HCBS waivers. The state implemented CCC Plus through a combined 1915 (b)/(c) waiver. Individuals on the DD waivers are enrolled in CCC Plus for their medically necessary, non-waiver services only, including physical health, behavioral health, and non-waiver LTSS transportation services. However, HCBS waiver and case management services are carved out of managed care.

Integration with Medicare

CCC Plus is administered by six MCOs that are required to also operate a D-SNP as part of their contract with the state. Dual eligible members have the option of having their CCC Plus and Medicare services coordinated by the same MCO. Health plans must educate individuals on the benefits of alignment and encourage dual eligible members to also enroll in their companion D-SNP for the Medicare portion of their benefits. Enrollees have the option of receiving their Medicare benefits from fee-for-service Medicare or through another Medicare Advantage/D-SNP product, and MCOs are responsible for coordinating care and services for individuals who do not enroll in their companion D-SNP.

Care Coordination

As part of the CCC Plus care coordination model, each enrollee is assigned a care coordinator to work with the enrollee and his or her interdisciplinary care team (ICT) to develop a person-centered individualized care plan (ICP). A care coordinator must be a registered nurse or a licensed practical nurse and have at least one year of experience working directly with individuals who meet the MCO’s target population criteria. Enrollees on DD waivers also

continue to receive targeted case management services through their waivers. Health plans' care coordinators are required to incorporate—but not duplicate—services provided by targeted case managers into the ICP.

Value-Added Services

While HCBS waiver services are carved out of managed care, all CCC Plus members are able to take advantage of value-added services offered by the MCOs. These services are funded by the MCO and not part of the premium paid by the state. Value-added services include dental care (such as exams and cleanings, X-rays, and fillings); vision and hearing services; wellness rewards and incentives; free cell phones; transportation to community events, grocery stores, and other locations; and time-limited meal deliveries to the home after an inpatient discharge. Stakeholders note that many enrollees with I/DD are satisfied with their ability to access such services, many of which were unavailable prior to managed care.

The state intends to carve DD waiver services into managed care in the future, but the timeline for this transition is uncertain. Many I/DD consumer advocacy and provider groups oppose the move. **The stakeholders interviewed want to ensure that MCOs, providers, and enrollees are adequately prepared for this transition well before it is implemented.**

Wisconsin

Wisconsin's Family Care program is available for individuals 18 years of age and older who require nursing facility level of care or non-nursing home level of care who have either physical disabilities or developmental disabilities or are frail elders. Family Care covers Medicaid State Plan LTSS and HCBS waiver services, but does not cover physical health, most behavioral health, pharmacy, and dental services. Enrollment is mandatory, unless an individual chooses to opt out and enroll in the state's self-direction program—known as "Include, Respect, I Self-Direct (IRIS)"—which is discussed in more detail below.

The history of delivery of LTSS in Wisconsin is key to understanding how the Family Care program has developed. When the state first implemented its 1915 (c) waivers, they were administered by the counties. Some counties chose to invest significant resources in I/DD services while others did not, which created inequities in access across the state.

In order to equalize access and create an "entitlement" program while reducing institutionalization, the state proposed implementing managed care statewide. Implementation of the Family Care program began on a county-by-county basis more than 20 years ago and was just implemented in the final county in 2018. The program was originally overseen by MCOs that were created by multiple counties and local governments coming together to create regional, quasi-public MCOs. Over time, the market has transformed, with several of these MCOs merging or closing and the remaining MCOs transitioning to private, not-for-profit entities.

IRIS Program

In 2008, Wisconsin created the IRIS program to ensure that all beneficiaries had a choice, due to the fact that many areas of the state had only one MCO in operation. Individuals are permitted to opt out of Family Care and into the IRIS program, which provides individuals with an annual budget for services and allows them to self-direct the full range of services and

supports available to them.¹¹ An annual budget is set by the state, and members are then allowed to arrange for all needed services as they so wish.

Individuals are permitted to opt out of Family Care and into the IRIS program, which provides individuals with an annual budget for services and allows them to self-direct the full range of services and supports available to them. An annual budget is set by the state, and members are then allowed to arrange for all needed services as they so wish.¹¹

Participants are supported by both an IRIS consultant agency and an IRIS fiscal employer agency. IRIS consultant agencies provide support to self-directing individuals by providing guidance and education on IRIS requirements, assistance with completing paperwork, development of an individual support and service plan, and managing self-direction on a daily basis. The IRIS consultant must regularly meet with the individual. IRIS fiscal employer agents provide background checks, payroll processing, tax deductions, and other employer tasks.

The program is hugely popular, with close to 20,000 participants as of November 2019—which is nearly as many as are enrolled in Family Care. Stakeholders report high satisfaction with the program but acknowledge that the program requires that participants, or their families or support systems, be able to devote a significant amount of time and energy in order to successfully self-direct.

Ombudsman Program

Through statute, Wisconsin extended the state’s existing long-term care ombudsman program to provide assistance to individuals younger than age 60 who are enrolled in the Family Care or IRIS programs.^t The state was authorized to contract with an independent third party to administer the program, and it ultimately selected Disability Rights Wisconsin to create the Family Care and IRIS Ombudsman Program (FCIOP).

FCIOP is available to answer questions for individuals who are enrolled in either Family Care or IRIS, or who work with IRIS agencies, MCOs, service providers, and others to informally resolve complaints and assist individuals with filing and pursuing state fair hearings. FCIOP also tracks issues that arise from implementation of new, or changes to existing, state policies and works with the state to address any unintended consequences.

FCIOP reports high levels of success in resolving member issues (both through informal and formal channels) and a high rate of success when assisting members with state fair hearings.^u FCIOP reports on its activities annually, which provides great transparency as to how the state’s MCO and managed care program at large is operating. **Stakeholders, particularly advocates for individuals with I/DD and their families, report that they feel FCIOP has been an essential component of ensuring that individuals can navigate the state’s managed care system and have continued access to needed services.**

Kansas

Kansas launched its managed care program, called KanCare, in 2013. The state utilizes section 1115 waiver authority concurrent with 1915 (c) waiver authorities to operate the program. With the move to managed care, Kansas sought to improve integration, coordination, and quality of care, as well as to control Medicaid costs.

Unlike most other states, Kansas chose to carve the majority of Medicaid beneficiaries into managed care at the same time. However, I/DD consumer advocacy groups successfully advocated for a delay in the transition of individuals with I/DD to KanCare. During the year-long

¹¹ There is a self-direction option in Family Care, but it only allows members to self-direct a portion of the benefit package.

delay, the state operated a small managed care pilot for 550 members with I/DD to give MCOs and providers an opportunity to better understand the unique needs of this population before the full transition in 2014. Today, individuals with I/DD receive all of their physical and behavioral health services, HCBS, and LTSS through KanCare. The state contracts with three MCOs to administer the program.

MCO Oversight

Since the launch of KanCare, the state has experienced several challenges with management and oversight of the program. In response to complaints to CMS by beneficiaries, providers, and advocates, CMS conducted an on-site review of KanCare in 2016. Per the audit, the state was out of compliance with several federal and state regulations. Among other issues, CMS found that Kansas lacked clear responsibilities and communication channels related to the administration of KanCare across state agencies and that the state failed to engage in adequate oversight of the MCOs.^v As a result, CMS required Kansas to develop a corrective action plan to address the identified noncompliance. Since the audit, Kansas has made numerous improvements in its oversight processes, including enhancing its network adequacy monitoring tools and critical incident reporting system.

Employment Services

As part of the most recent section 1115 waiver renewal, Kansas received CMS approval to implement a Disability and Behavioral Health Employment Support Pilot Program for eligible KanCare enrollees. The goal of the pilot is to help eligible enrollees obtain and maintain employment through a set of services, including supported employment, independent living skills training, assistive technology, and transportation.^w In addition to beneficiaries with certain behavioral health needs, pilot participation would be open to individuals between the ages of 16 and 65 who are receiving SSI and are on the DD waiver (and would be willing to leave the waiver) or are on the DD waiver waitlist. The stakeholders we interviewed are enthusiastic about the pilot and are interested in moving forward with implementation. Kansas is in the process of engaging stakeholders in discussions around pilot planning and design with the intent to launch in 2021.

LESSONS LEARNED

As was the aim of our review, both the research and interviews imparted several lessons learned from implementation of managed care for individuals with I/DD in the states we reviewed. These lessons learned are explained in greater detail below, but include the following:

- A clear articulation of the vision and goals for managed care is a critical first step.
- Meaningful stakeholder engagement and education are vital for program success.
- Member education is key.
- I/DD providers require dedicated training and communication resources before, during, and after the transition to managed care.
- MCOs must have significant expertise in serving the I/DD population and their needs.
- Care management roles must be clearly defined.
- Provider networks must account for longstanding relationships between members and their providers.
- Independent ombudsman programs are key to ensuring individuals can successfully navigate the managed care system.
- States must define meaningful quality metrics for the I/DD population.
- State oversight of MCOs must be strong in order to ensure continued access to services and compliance with consumer and provider protections.
- Managed care can be a vehicle for creating access.
- Managed care can exacerbate workforce shortages.
- Evidence on cost savings is limited.
- Developing MCO rates can be very challenging.

A clear articulation of the vision and goals for managed care is a critical first step.

Understanding what the state intends to achieve by transitioning to managed care is key to informing design decisions. Stakeholders recommend that states take time to define the vision and goals for the move to managed care, which should serve as the foundation of all design decisions. Stakeholders noted that a lack of clarity related to the benefits and goals of transitioning individuals with I/DD to managed care by Medicaid officials in several states often made the transition more challenging. The program vision and goals must be articulated and shared with, and vetted by, key consumer and provider stakeholders from the outset.

The program vision and goals must be articulated and shared with, and vetted by, key consumer and provider stakeholders from the outset.

Meaningful stakeholder engagement and education are vital for program success.

Stakeholders interviewed across all selected states emphasized the importance of engaging stakeholders early, often, and through various forums before, during, and after the transition to managed care.

States should ensure that there are meaningful opportunities for stakeholder feedback during the design phase of the program. Stakeholders in both Tennessee and Massachusetts stated that their states provided meaningful opportunities to engage in the design process. As discussed earlier, Tennessee offered opportunities for robust stakeholder engagement both prior to launch and during ongoing operations through engagement with its concept paper.

Massachusetts established a formal framework for stakeholder engagement to support One Care design, including the creation of a consumer-chaired implementation council to advise on demonstration design features and to ensure accountability and transparency of program operations.

However, stakeholders in Virginia cited limited engagement leading up to the launch of CCC Plus and expressed frustration at the lack of opportunities to participate in the implementation of managed care. While the state held provider and enrollee town halls on the transition to managed care, these meetings were not broadcast or recorded for later viewing, and many individuals found it difficult to travel to the locations where the town halls were held. For example, stakeholders noted that town halls held in Northern Virginia were limited and held during rush hour, making it particularly difficult for beneficiaries and families to make it to these sessions.

Once managed care is operational, ongoing engagement is key to ensuring that MCOs are complying with program standards and delivering on the promise of managed care. As discussed earlier, MCOs in Tennessee are required to have two different stakeholder advisory committees and invite specific groups to participate in the advisory committees. In Virginia, Medicaid officials now meet with a selection of advocacy group representatives on a bimonthly basis to discuss any managed care issues, and stakeholders report that they have direct contacts at the state to go to with questions.

Member education is key.

Building on the previous recommendation, investment in education for individuals and families so that they truly understand the implications of the move to managed care and how to navigate the system is critically important. Stakeholders in several states commented that individuals and families did not understand the implications of the transition to managed care. Educational materials and notices relating to the transition to managed care must be written in a way that individuals with I/DD and their families can easily understand.

I/DD providers require dedicated training and communication resources before, during, and after the transition to managed care.

I/DD providers often have little experience interacting with insurance companies or MCOs. Stakeholders in several states reported difficulties with plan-provider relations, particularly with payment. Providers in several states experienced significant lags in payment after moving to managed care. I/DD providers must understand the regulatory framework in which managed care operates and need dedicated resources and trainings to ensure that they understand how to contract with managed care plans, to complete the credentialing process, and to ensure that they have the capability to bill managed care plans for services.

Moreover, managed care is administratively burdensome for providers. I/DD providers transition from a system with a single payor—the Medicaid program—to a system with multiple payors, each of whom may have unique authorization and billing requirements. This places a significant burden on providers, many of whom have reported in our interviews that they have hired additional staff to interact with MCOs. In addition, I/DD providers often have to invest in electronic medical records or other technology in order to be able to interface with and bill MCOs for services.

Both technical and financial assistance are necessary to ensure the continued viability of I/DD providers as the transition to managed care occurs.

MCOs must have significant expertise in serving the I/DD population and their needs.

Individuals with I/DD have unique needs. MCOs must understand these needs in order to best serve this population and to work with the I/DD delivery system. Stakeholders we interviewed noted that many of the MCO challenges around care coordination, service authorization, and provider networks and relations are associated with the plans' limited understanding of the I/DD population. These stakeholders recommended that MCOs be required to invest in developing expertise in the unique needs of individuals with I/DD and I/DD providers.

Care management roles must be clearly defined.

Before transitioning individuals with I/DD to managed care, states should thoroughly evaluate and understand the value of any existing care management models for enrollees.

Stakeholders in most of the states we evaluated cited a level of confusion among enrollees, MCOs, and providers around the approach to care management after the transition to managed care, which was particularly apparent in states that split care management functions.

In order to avoid potential confusion, duplication of services, and administrative complexities, states must thoroughly evaluate existing care management models and engage in a thoughtful planning process for the delivery of care management following the transition to managed care.

For example, many One Care enrollees in Massachusetts struggle with understanding the roles of plan-employed care and community-based LTS coordinators, while stakeholders in Virginia report difficulties in distinguishing between the responsibilities of their CCC Plus-assigned care coordinators and waiver case managers.

Moreover, enrollees reported that it is challenging to build relationships with MCO care coordinators for a variety of reasons, including limited MCO care coordinator contact requirements, a lack of familiarity with the unique needs of individuals with I/DD and available services on the part of the care coordinators, and frequent staff turnover. Many enrollees prefer to work with their waiver case managers, who have a better understanding of their needs but may be unable to manage all of their physical, behavioral, and other health services under the managed care design.

In many cases, MCOs and states seemed to be aware of some of the confusion. In Massachusetts, state Medicaid staff and MCOs have developed provider and enrollee guidance aimed at improving understanding of care team member roles. Similarly, at least one MCO in Virginia is in the process of developing an in-house team dedicated to growing expertise on the needs of enrollees with I/DD in order to improve the quality of care and better understand their care coordination needs.

In order to avoid potential confusion, duplication of services, and administrative complexities, states must thoroughly evaluate existing care management models and engage in a thoughtful planning process for the delivery of care management following the transition to managed care.

Provider networks must account for longstanding relationships between members and their providers.

Stakeholders in many of the states we examined reported that the transition to managed care caused disruption to the relationships between individuals with I/DD and their providers. This disruption is not limited to providers of HCBS—it also extends to medical providers, such as

neurologists, who have extensive experience treating physical health conditions associated with an individual's I/DD.

Given the nature of managed care, which operates with a network of providers, individuals were often placed in the position of having to choose an MCO that had a majority, but not all, of their existing providers. Stakeholders reported that members then struggled to find new providers who had sufficient experience and expertise to treat them. Even more concerning, one individual with I/DD interviewed reported that physicians in her MCO's network were not equipped to communicate effectively with her, due to her speech impairment, and she was often hung up on when she was attempting to make appointments.

When implementing managed care, states must explore policies that preserve these existing patient-provider relationships and ensure that individuals have access to providers who can appropriately serve them.

Independent ombudsman programs are key to ensuring individuals can successfully navigate the managed care system.

Navigating the managed care system, with all of the rules and regulations associated with seeking approval of services and pursuing appeals and grievances, can be complicated. Individuals with I/DD and their families face even greater challenges when interacting with managed care.

Ombudsman programs have proven to be a key element of ensuring that enrollees can both navigate the system and have continued access to the services they need, while providing the state with insight into trends and arising issues.

In Wisconsin, advocates for individuals with I/DD and their families report that they feel FCIOP has been an essential component of ensuring that individuals can successfully navigate the state's managed care system and of tracking problematic trends, both within MCOs and across the program. FCIOP's annual publication of the work that the program has engaged in throughout the year provides stakeholders with an important line of sight into the program and MCOs. Stakeholders in Virginia also report satisfaction with the availability of Virginia's Long-Term Care Ombudsman–Advocate Program to individuals with I/DD enrolled in CCC Plus.

Ombudsman programs have proven to be a key element of ensuring that enrollees can both navigate the system and have continued access to the services they need, while providing the state with insight into trends and arising issues.

States must define meaningful quality metrics for the I/DD population.

To measure accurately the value of managed care for beneficiaries with I/DD, the stakeholders we interviewed emphasized the importance of selecting quality metrics that reflect the unique needs of individuals with I/DD. However, many states struggle with this process due to a lack of standardized LTSS quality measures. Additionally, many stakeholders believe that existing measures fall short of capturing the experience of this population. As with other aspects of program design, interviewees recommend that states engage with consumer and provider stakeholders to validate the relevance of the available quality metrics. For example, Massachusetts is considering ways to approach quality measurement through a health equity lens based on input from its stakeholders.

State oversight of MCOs must be strong in order to ensure continued access to services and compliance with consumer and provider protections.

Stakeholders note that MCO oversight, particularly of plans that may be new to managing the needs of individuals with I/DD, is essential for ongoing success. States must be able to monitor MCO compliance with program standards effectively and inform stakeholders of their oversight activities.

For example, consumer advocacy and provider groups in Virginia reported reductions in service hours by plans and significant lags in response times from care coordinators, issues that may have been mitigated with more robust monitoring by the state. While the state tracked authorizations, at least early in the transition, stakeholders reported that they were not aware of this oversight and were not provided with any data on the level of services authorized by the MCOs. Transparency with regard to oversight activities and plan performance is key to ensuring that individuals and families have confidence in the program.

Managed care can be a vehicle for creating access.

One of the promises of managed care is increased access to services. Managed care plans are motivated to address member needs in order to control costs and to comply with standards set by the state, such as network adequacy and access requirements. Stakeholders in several of the states reported that they felt managed care had increased access to services, particularly medical, dental, and other value-added services.

For example, stakeholders in Massachusetts reported that, after realizing the long wait times that their members experienced to get their wheelchairs repaired, one MCO created its own durable medical equipment (DME) clinic. This allowed the MCOs to provide its members with immediate access to professionals who could repair their wheelchairs and other DME that members needed to safely and successfully live in the community.

Moreover, states often provide MCOs with the authority to offer value-added or in-lieu-of-services to supplement the existing Medicaid benefit package. As discussed in greater detail above, Virginia MCOs were able offer value-added services, and all chose to offer a limited dental benefit. Stakeholders reported that many individuals with I/DD were able to access teeth cleanings for the first time in many years as a result of these services being covered by the MCO.

Managed care can exacerbate workforce shortages.

As discussed earlier, it is important that MCOs recruit and employ individuals who have experience working with individuals with I/DD. While this is key to ensuring that MCOs understand and can appropriately serve this population, stakeholders across several states reported that MCOs often hire these employees directly from providers, exacerbating already existing workforce shortages.

Anticipating that the move to managed care will exacerbate workforce shortages and pursuing policies that help mitigate the effect is an important consideration in the move to managed care.

Evidence on cost savings is limited.

While many states look to move to managed care in order to control costs, there is very limited data to demonstrate that implementing managed care for the I/DD population has

produced savings.^x In many states, the transition to managed care is still relatively young, and while states are collecting data in an effort to evaluate savings achieved, this data is not yet available.

Moreover, achieving savings on physical health services is often not possible. A large percentage of individuals with I/DD are eligible for both Medicare and Medicaid. As the payor of last resort, Medicaid is usually only liable for co-payments on services covered by Medicare, such as hospitalizations and physician services. Accordingly, if a Medicaid program drives down the use of hospitals or emergency rooms through effective care management, much of the savings associated with the decrease in utilization accrues to Medicare. In Wisconsin, where these services have been managed for several years, stakeholders reported that this provided a strong disincentive to carve physical health services into the Family Care benefit package.

Developing MCO rates can be very challenging.

States that transitioned to a managed care model for individuals with I/DD have experienced challenges in setting MCO rates, due to a lack of reliable data needed to inform the rate setting process.^y

Tennessee, for example, has not put MCOs at risk for ECF CHOICES HCBS services because the benefit package varies so greatly from that of the state's 1915 (c) waivers that it does not have the data necessary to develop capitation rates for these services.^z

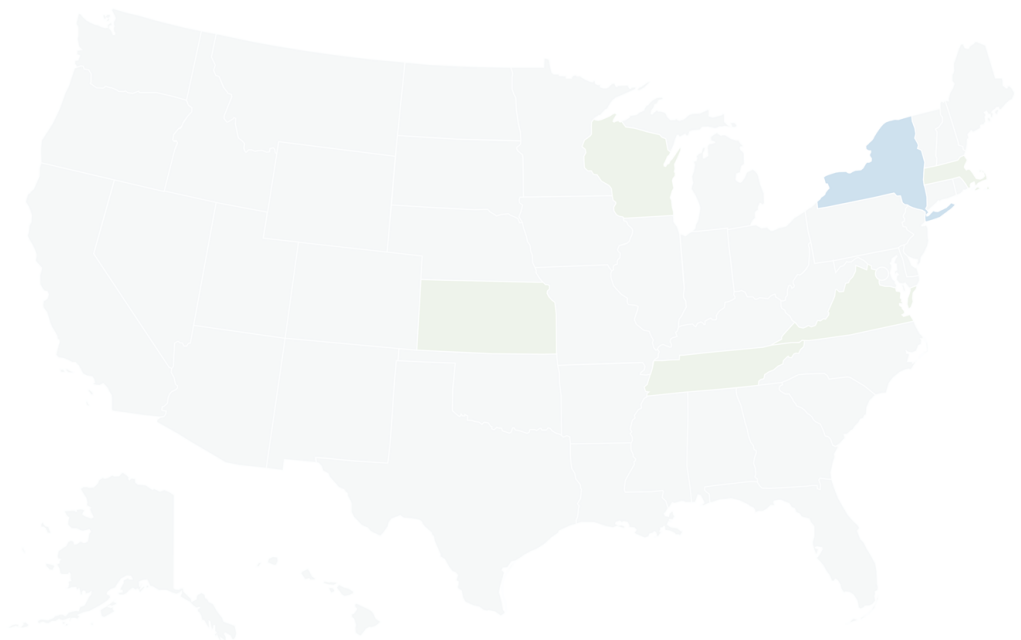
Access to accurate and reliable data and the development of strategies to work around data issues if necessary, are key to ensuring that MCO rates can be appropriately set and that plans are able to deliver the services for which they are responsible.

Stakeholders in Massachusetts acknowledged that data challenges caused financial pressures for MCOs participating in One Care and contributed to one MCO exiting the program. Because rates were based on the fee-for-service experience of enrollees, who often were not able to access the HCBS now available to them through One Care, the state was not able to accurately predict utilization. While Massachusetts was able to revamp the rate setting to accurately reflect the costs incurred by plans, it does provide an example of the pitfalls that a state can experience in a transition to managed care.

Access to accurate and reliable data and the development of strategies to work around data issues if necessary, are key to ensuring that MCO rates can be appropriately set and that plans are able to deliver the services for which they are responsible.

CONCLUSION

Implementing managed care for individuals with I/DD is a highly complex endeavor. States that have instituted managed care for this population have experienced a wide variety of successes and failures. As New York continues to ponder the transition of individuals with I/DD from a fee-for-service model to a managed care system, learning from the choices made by other states in designing, implementing and operating their managed care initiatives, and the implications of those choices, will be key to informing a successful transition—and avoiding the pitfalls experienced by other states.



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