Lessons Learned: Managed Care Transitions for Individuals with I/DD

Ann Hardiman
Megan Sherman
Olga Deshchenko

New York Alliance for Inclusion and Innovation
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Agenda

- Project Overview
- State Findings
- Lessons Learned
Project Overview

Project Objective

Given that New York is considering how to implement managed care for this population, we wanted to review:

1. How other states have designed managed care programs for individuals with I/DD
2. The implementation decisions made by these states
3. The experience of those states as a result of these decisions and consequences of those decisions for individuals with I/DD and providers of I/DD services.

We selected five states that have implemented managed care in some form for this population and conducted a survey to determine what worked, what hasn’t and what we might borrow in New York.
Selection of States

We selected states that represent a wide range of managed care models for individuals with I/DD.

- Wisconsin
- Virginia
- Tennessee
- New York
- Massachusetts
- Kansas

We selected states that represent a wide range of managed care models for individuals with I/DD.

- Provides all services, including HCBS waiver services, through managed care
- Provides specialized benefit packages for individuals with I/DD through managed care
- Provides only Medicaid State Plan LTSS and HCBS waiver services through managed care
- Excludes individuals on HCBS waivers from managed care, but has a duals demonstration for individuals with I/DD that do not otherwise qualify for the waivers

Elements of Managed Care Programs

We reviewed several programmatic elements for each state.

- 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 that is a non-for-profit, provider-sponsored or traditional managed care company
- Development and adequacy of plan rates
- Treatment of residential services
- Treatment of dental and optical services, including any methods used to increase access for the I/DD population
- Integration with Medicare
- Care coordination model
- 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 not all states will address all of these elements in their managed care programs.
**Tennessee: Overview**

TennCare is the state’s Medicaid program, administered largely through three national MCOs, which has specialized benefit packages for individuals with physical and intellectual and developmental disabilities.

The ECF CHOICES benefit package, which includes a wide range of HCBS, is available to individuals with ID and DD.

- ECF CHOICES has **five enrollment categories** that are based on varying level of need.
- Each enrollment category has a **different benefit package and annual spending cap**.
- **2,586 individuals** were enrolled in ECF CHOICES as of December 2018.

Upon launch of the ECF CHOICES program in 2016, **the state closed its 1915 (c) waivers** and required that individuals in need of HCBS enroll in TennCare.

Rationale for move to managed care: Increase access to individuals with a broader number of diagnoses and contain cost.
Tennessee: Employment

TennCare utilizes an “employment informed choice process,” which provides for various employment-related supports and services to explore employment options that are aligned with an individual’s interests, aptitudes, experiences and/or skills, to address concerns or questions, and to ensure an informed choice regarding employment.

- Exploration and discovery
- Benefits counseling
- Situational observation and assessment
- Job development or self-employment plan
- Job development or self-employment start up
- Job coaching (including competitive, integrated employment and self-employment)
- Supported employment-small group
- Co-worker supports
- Career advancement
- Integrated employment path services (time-limited pre-vocational training)

Initial Results of the Employment Program are Promising
- Approximately 25% of working-aged individuals with I/DD working in competitive integrated employment (50% higher than national average)
- Average wages: $8.66/hour
- Average hours worked: 17 hours per week


Tennessee: Stakeholder Engagement

Tennessee has offered opportunities for robust stakeholder engagement both prior to launch and during ongoing operations.

Prior to launch of ECF CHOICES

TennCare released a concept paper, solicited comments and held various stakeholder engagement events, including nine community forums held across the state and other webinars.

- Not all stakeholder feedback was incorporated to the concept paper, but many stakeholders did feel “heard.”
- Tennessee Disability Coalition received a grant from Community Catalyst and the Robert Wood Johnson Foundation to organize family- and consumer-based advocacy to shape Tennessee’s implementation of ECF CHOICES. Stakeholders reported that this engagement helped shape the program for the better.
Tennessee: Stakeholder Engagement (cont’d)

**ECF CHOICES Advisory Group**

- 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.

**Enrollee-Only Advisory Group**

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

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Tennessee: Support Coordination

Tennessee set forth extensive requirements around the delivery of support coordination.

- MCOs are required to provide person-centered support coordination to all ECF CHOICES enrollees that not only addresses physical and behavioral health needs, but also the supports and services needs to achieve the enrollee’s goals for community involvement and employment.
- Support coordinators must be a health care professional (nurse, social worker or QDDP/QIDP).
  - The state established minimum ratios for support coordinators to enrollees.
- Support coordinators must conduct a face-to-face visit with the enrollee, a comprehensive assessment and a caregiver assessment, develop a PCSP and authorize and initiate services within 30 days of enrollment.
  - The comprehensive assessment must be completed annually, as otherwise deemed necessary by the support coordinator or within five business days of an enrollee’s significant change in needs or circumstances.
  - Support coordinators are also required to periodically visit with enrollees, either by phone or in person. The frequency of contacts depends on the acuity of the enrollee and range from quarterly to bimonthly.
Commonwealth Coordinated Care (CCC) Plus is a Medicaid program administered by six MCOs across the State. CCC Plus serves dual eligibles who are 65 or older, adults and children with disabilities, nursing facility residents, and individuals receiving HCBS through one of the state’s waivers.

- **Individuals on the state’s DD waivers are enrolled in CCC Plus for their medically necessary, non-waiver services only**, including physical, behavioral health, and non-waiver LTSS transportation services. DD waiver and case management services are carved out of CCC Plus.

- **MCOs must also operate a D-SNP plan.** Members may enroll in the companion D-SNP for coordination of their Medicare and Medicaid benefits.

- **207,722 individuals** were enrolled in CCC Plus as of September 2018 (includes all eligibility groups, not just individuals with I/DD)

**Rationale for move to managed care: Improve the quality of care and increase budget predictability.**

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).

Care coordinators 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 receive targeted case management services through waivers. MCOs’ care coordinators are required to incorporate—but not duplicate—services provided by targeted case managers into the ICP.

- Both MCOs and enrollees find it challenging to understand the roles of the care coordinators and case managers in supporting the enrollees.
- Enrollees have longstanding, trusted relationships with their case managers. Much less frequent contacts with care coordinators make it difficult for enrollees with I/DD to build the same rapport with the MCO’s staff.
- At least one MCO is developing an in-house team dedicated to growing medical expertise on the needs of enrollees with I/DD in order to improve care coordination.
Virginia: Value-Added Services for Enrollees

Although DD waiver services are carved out of managed care, MCOs provide some additional benefits to all CCC Plus enrollees. These services include:

- Dental care, such as exams and cleanings, X-rays, and fillings
- Vision and hearing services
- Wellness rewards and incentives
- Free cell phones
- A set number of rides to community events, grocery stores, and other locations
- Time-limited meal deliveries to the home after an inpatient discharge

Since these additional services are offered and authorized by the MCOs, stakeholders note that accessing these services has been a positive and smooth experience for enrollees with I/DD.

Virginia: Stakeholder Engagement

Prior to and at Launch of CCC Plus

Virginia held provider and enrollee town halls (two for each group). MCOs were present to discuss benefits, care coordination, and answer questions.

- Stakeholders report difficulty in participating in the State’s engagement efforts—the town halls were not broadcast or recorded for later viewing—and many were not easily able to travel to the locations where town halls were held.

Current State

Both state officials and advocates agree that communication is essential throughout the transition to managed care, and stakeholders do note improvements.

- The state meets with a small selection of advocacy groups on a bimonthly basis to address any issues.
- Stakeholders have direct contacts at the state to go to with questions.
- Virginia’s Long-Term Care Ombudsman – Advocate Program is available to all CCC Plus enrollees, including individuals with I/DD.
Kansas: Overview

KanCare is the state’s Medicaid program, administered through two large MCOs. Enrollment in KanCare is mandatory for most Medicaid beneficiaries, including individuals on the state’s I/DD waiver.

- **MCOs assume responsibility for all Medicaid benefits**: physical health, behavioral health, HCBS, and LTSS.
- **8,974 individuals with I/DD** were enrolled in KanCare as of June 2019.
- Kansas **delayed the transition** of individuals with I/DD into managed care for a year. The State began with a pilot by allowing 550 individuals with I/DD to opt into managed care. The pilot gave providers, MCOs, and enrollees an opportunity to become familiar with the unique needs of this population before making the full transition.

Rationale for move to managed care: Better integration and coordination of care, better care quality, and control of Medicaid costs.

Kansas: MCO Oversight

A 2016 CMS audit identified several shortcomings in the state’s management of the KanCare program

**Among Other Issues, CMS Found:**

- MCOs failed to comply with federal regulations related to person-centered planning for individuals with disabilities. MCOs required enrollees to sign incomplete person-centered plans, made changes to the plans without the enrollee’s input, or failed to obtain the enrollee’s signature.
- Limitations to the state’s approach to tracking, monitoring, and overseeing provider network adequacy and access to care for enrollees.
- A lack of a formal, comprehensive system for reporting, tracking, and trending of critical incidents.

"Due to the severe and pervasive nature of the on-site review findings and the resulting impacts this has on the beneficiaries and providers, CMS is requiring Kansas to develop a Corrective Action Plan (CAP) describing the actions it will take to correct the identified noncompliance.”

– CMS, January 2017
Kansas: MCO Oversight (cont’d)

Kansas has implemented various improvements to its MCO oversight processes. Since the audit, the state:

- Updated its policies for the person-centered planning process and clarified the roles of the MCOs in the completion of the plan. The I/DD person-centered service plan policy requires the MCO’s care coordinator to obtain a signature of the enrollee or the enrollee’s representative at the time of plan development and whenever content adjustments are made to the plan. The state also established an external HCBS waiver quality review policy.

- The state’s network adequacy data and analysis tools were moved from Excel into a dedicated database on a secure server. MCOs are required to submit quarterly network adequacy reports, which are used by the state to monitor network quality and provide more robust and timely feedback to plans.

- The state continues to enhance the Adverse Incident Reporting (AIR) database to comprehensively capture critical incidents. Additional requirements have been implemented to confirm review and resolutions regarding instances of seclusion, restraint, restrictive intervention, and death.

Kansas: Employment Supports

As part of the most recent 1115 waiver renewal, Kansas received CMS approval to operate a Disability and Behavioral Health Employment Support Pilot Program for eligible KanCare enrollees through managed care.

Pilot Eligibility

- Pilot participation is open to individuals between the ages of 16-65 on SSI and the DD waiver waitlist or on the waiver and willing to leave the waiver.
- Per CMS, the state must limit pilot participation to 500 individuals to assure appropriate service delivery.

Pilot Services

Designed to help eligible enrollees obtain and maintain employment, pilot services include:

- Pre-vocational services
- Supported employment
- Personal assistant services
- Independent living skills training
- Assistive technology
- Transportation

Employment is defined as a minimum of 40 hours per month in a competitive, integrated setting at the federal hourly minimum wage.

Kansas is working through billing systems issues that would enable the state to launch the Pilot.
Wisconsin: Overview

- The Family Care program is available statewide 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;
  - Developmental disabilities; or
  - Frail elders.
- The program is administered by five not-for-profit health plans that were originally started by local governments.
- There are currently 23,252 enrollees with I/DD.
- Family Care covers Medicaid State Plan LTSS and HCBS waiver services, but does not cover physical health, most behavioral health, pharmacy and dental services.

Wisconsin: IRIS Program

Wisconsin created the Include, Respect, I Self-Direct (IRIS) program, which allows beneficiaries to self-direct the full range of services and supports.

- In order to provide choice to individuals (and comply with CMS requirements), Wisconsin created the IRIS program. 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.
  - As of November 1, 2019, there were nearly 20,000 program participants.
- Participants are supported by both an IRIS consultant agency and an IRIS fiscal employer agency.
  - IRIS consultant agencies provide support to individuals self-directing by providing guidance and education on the 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 state contracts with DisabilityRights Wisconsin to administer the Family Care and IRIS Ombudsman Program (FCIOP), which provides assistance to individuals under age 60 enrolled in the Family Care and IRIS programs.

**Wisconsin: Ombudsman Program**

FCIOP reports high levels of success in resolving enrollee issues and when assisting enrollees with state fair hearings. Stakeholders, particularly advocates for individuals with I/DD and their families, report that they feel FCIOP has been an essential component to ensure individuals can successfully navigate the state’s managed care system.

- **Answer questions** for individuals enrolled in both Family Care and IRIS.
- **Work with IRIS Agencies, Family Care MCOs, service providers and others to informally resolve complaints.**
- **Assist individuals with filing state fair hearings.**
- **Track issues** that arise from implementation of new or changes to existing state policies and work with the state to address unintended consequences.

**Massachusetts: Overview**

One Care is a fully integrated Medicaid and Medicare program for dual eligible individuals between the ages of 21-64. One Care is administered through two locally-based, nonprofit MCOs.

- **Individuals on the state’s I/DD waivers are excluded from One Care.** However, individuals with I/DD who are not eligible for the waivers receive their physical, behavioral, dental, and LTSS through One Care, including several HCBS-like services (personal care, habilitation, respite).
- **23,493 individuals** were enrolled in One Care as of September 2019.
- **One Care was developed with a formal framework for stakeholder engagement to support design and implementation,** including the creation of a consumer-chaired implementation council to advise on demonstration design features and to ensure accountability and transparency throughout the demonstration.

**Rationale for move to managed care:** Improve access to services, alleviate fragmentation of care, improve coordination of services, enhance quality of care, and reduce costs.
Massachusetts: Medicare and Medicaid Integration

One Care is the nation’s only capitated program under the CMS Financial Alignment Demonstration for the non-elderly dual eligible population.

- An MCO must enter into a three-way contract between the state and CMS to operate as a Medicare-Medicaid Plan (MMP), which provides integrated Medicare and Medicaid benefits to dual eligibles.
- The One Care demonstration 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.
- A Contract Management Team (CMT) is the primary vehicle for joint management of One Care by CMS and the state and includes staff from both organizations. An operational CMT group meets separately with each MCO on a biweekly basis.
- Across multiple data sources—focus groups, CAHPS survey, and Quality of Life survey—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.


Massachusetts: Care Coordination Model

For medical and behavioral health services, MCOs must offer care coordination to all enrollees through a care coordinator or, for enrollees with complex needs, a clinical case manager.

Enrollees may also choose to work with an LTS coordinator to incorporate LTSS into their care plans. MCOs are required to contract with community-based organizations for the LTS coordinator role.

MCOs must complete a comprehensive assessment of each enrollee and develop an individualized care plan (ICP), which must reflect the enrollee’s preferences and needs as well as how services and care will be integrated and coordinated among providers.

Care Coordination Challenges

- Stakeholders acknowledge persisting confusion around care coordination roles—enrollees often have difficulties distinguishing between the coordinators and their responsibilities.
- As part of their quality oversight and improvement efforts, plans are required to complete a quality improvement project related to LTS coordinators.
- The state and MCOs have developed provider and beneficiary guidance aimed at improving understanding of the care team member roles.

Massachusetts: Increased Access to Services

One Care Offers New and Expanded Benefits to Enrollees

One MCO has developed clinics, where enrollees with complex needs can receive primary care from providers experienced in delivering care to individuals with I/DD. The clinics include DME workshops, where enrollees can have their wheelchairs, lifts, etc., repaired in a timely manner.

Enrollees report access to new services and benefits, including:

- Dental
- Vision
- Smoking cessation and nutrition classes
- Weight loss coaching
- In-home behavioral health services
- Elimination of co-pays on medications

"[One Care] provided me everything for the bathroom, the railings, the showers, the chair for bathing...They [also] sent me home therapy and I can now walk."

– One Care Enrollee

"[One Care] helped pay for a lot of things I couldn’t afford...like dentists, the eyes and different medications...Then to see the zero [for the co-pay] on my medications is a blessing."

– One Care Enrollee


Lessons Learned

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Lessons Learned

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

- Understanding what the state is hoping to achieve is key to informing design decisions.

Meaningful stakeholder engagement and education is key.

- The state should ensure there are meaningful opportunities for stakeholder feedback during the design phase.
- The state must invest 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.
- The state and MCOs must engage members to ensure that managed care plans are addressing the needs of enrollees.

Leveraging successful programs in development of new managed care models, while avoiding unnecessary duplication, is essential.

- The state should thoroughly evaluate and understand the value of any existing care management models to enrollees and avoid unnecessary duplication of services.

Lessons Learned (cont’d)

Oversight is key.

- State oversight of MCOs must be strong in order to ensure continued access to services and compliance with consumer and provider protections.
- Ombudsman programs are key to 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. Such programs must be specialized in dealing with individuals with I/DD.

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

- Individuals with I/DD have unique needs and MCOs must understand how to interact with individuals with I/DD and the service delivery system.
Lessons Learned (cont’d)

Provider networks must account for long standing relationships between enrollees & their providers.

- Individuals with I/DD often have relationships with providers that have specialized in this population and may not be able to select a plan that contracts with all of their providers.
- The state must enact policies to ensure that individuals continue to have access to these providers.

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

- These providers are often not used to contracting with and billing MCOs and require training and testing to successfully do so and avoid interruption in payment.
- The transition to managed care often means that providers now have to work through multiple entities for authorization and payment—rather than just the state. I/DD providers have to make investments in staff and technology to be able to successfully work with MCOs.

Managed care can be a vehicle for creating access.

- Some MCOs are sophisticated at finding specialized providers or creating services and connecting their enrollees to them.

Managed care can exacerbate workforce shortages.

- When MCOs have to recruit individuals experienced in and qualified to provide services to individuals with I/DD, they often recruit from providers, which can exacerbate workforce shortages.

Evidence on cost savings is limited.

- The transition to managed care for this population is still very recent and, therefore, it is too early to determine if any cost savings have been achieved.
- For those few states that have longstanding managed care programs, there is some evidence that savings can be achieved for long term services and supports.
Discussion

Thank You

Megan Sherman
Associate, Manatt Health Strategies
518.431.6707
MSherman@manatt.com

Olga Deshchenko
Consultant, Manatt Health Strategies
212.704.1988
ODeshchenko@manatt.com
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