Medicaid Managed Long Term Services and Supports for People with Intellectual and Developmental Disabilities

Kansas Department of Aging and Disability Services

Part 2 of 2

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Managed LTSS Care in I/DD

In Managed Care

- Arizona 1115
- Michigan b/c
- Wisconsin b/c
- Texas – to pilot I/DD 1115
- North Carolina- b/c going 1115
- New York – b/c
- Kansas - 1115
- California except people in HCBS Waiver

In Planning Stages

- Kentucky - discussion
- Georgia - discussion
- Louisiana - planning
- New Jersey - delayed
- Florida – legislative exploration
- Hawaii - discussion
- Illinois – in phase 3

Managed Care – Why the Resistance?

Families Built DD Systems over 50 years

- 1950s & 60s - State programs and State Statues
- 1970s Right to Education
- 1980s Deinstitutionalization litigation
- 1990s Medicaid HCBS

Service System

HCBS Waiver
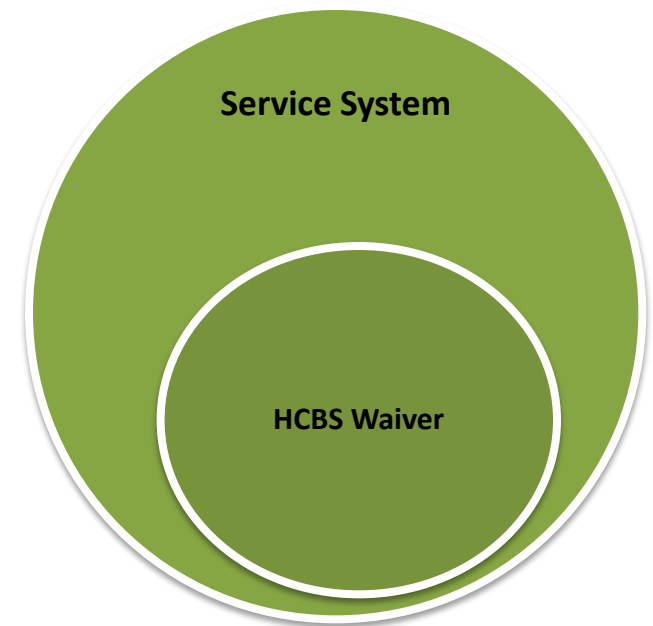
Families Are Skeptical About Replacing the Current System

➢ **State DD Director** - high level executive branch

➢ **Families are valued stakeholders**

➢ **Single point of entry** – in a community based entity

➢ **Service coordinator** to assess needs, create a person-centered plan and monitory service delivery

➢ **Services** - Early Intervention for infants; Family Supports; Adult Services in and out of home including employment; emergency/crisis services

➢ **Provider network** almost exclusively non profits, started by families and faith based organizations; families sit on the boards and fund raise.

➢ **Oversight** through licensing, certification and monitoring of providers

It is a System of Relationships
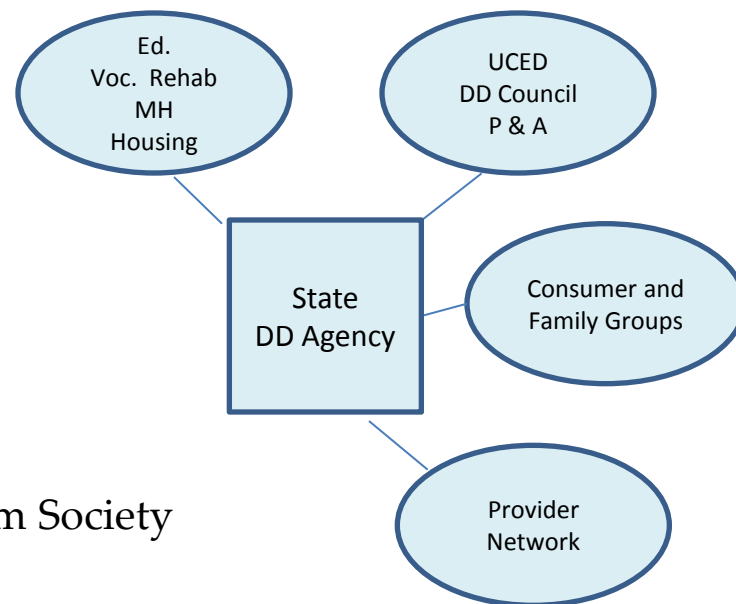
- **Interagency agreements with**
  - Education to transition students to adult life
  - Voc. Rehab
  - Mental Health
  - Housing

- **Partnership with and financial support of**
  - Parent Groups: Parent to Parent; ARC; Autism Society
  - Self-advocacy groups
  - Partners in Policy Making

- **Admin on I/DD (AIDD) Network –**
  - University Centers for Excellence in DD – training and research
  - Developmental Disability Councils- systems planning and service innovation
  - Protection and Advocacy – protection of rights

Ed. Voc. Rehab MH Housing

UCED DD Council P & A

State DD Agency

Consumer and Family Groups

Provider Network

It a System with Vision, Based on Shared Values Openly Promulgated as Policy

- Normalization ..1970s
- Least Restrictive…1970s
- Family Support…1970s
- Most Integrated…1980s
- Full inclusion….Current

- Self Determination…1992
- Individual Budgets…1990s

- Supported Employment…1990s
- Self –Advocacy…1990s

- Person Centered Practices…1990s
- Positive practice alternatives to behavior management

Families Are Skeptical About Controlling Costs

- No runaway budgets
    - Community services are not an entitlement
    - States manage within a limited appropriation
    - Enrollment is capped for each waiver
    - Individuals in many states have capped budgets
    - People with DD are not high users of hospitals or nursing homes
    - Thousands are on the waiting list

- The system has already rebalanced except in a few states

- **Saving money means cuts to services for people living with families – it always has in the past**

What's Important to Families

➢ Access to Service – Eliminating Waiting Lists

➢ Transitioning from school to adult life – a real job with needed supports

➢ Support for families that is flexible, meets their needs and is consumer/family directed

➢ Their sons and daughters having a good and happy life with friends, family, a valued role in the community

➢ What happens to their sons and daughters when they die? Who will be there for them?

What Families Need to Hear

- Vision and Values – there is a purpose beyond "coordinating care and reducing costs"

- The words
  - Support families
  - School to work transition
  - Competitive employment
  - Self-direction – control over services & budget
  - Small, innovative providers *(run by families)* in their community will continue

- Eliminate waiting lists

- Collaboration with consumer and family groups & associations….they will have a say the way they do now

IDD and Aging & Disabled are not the Same

- **Focus**
  - Aged – Comfort and quality in remaining years of life
  - IDD - "Getting a Life"

- **Length of Service**
  - Aged - 2 to 3 years
  - IDD - up to 60 years

- **Cost Savings**
  - Aged - State is liable for nursing home reimbursement which is provided on demand.
  - IDD - State financial liability is controlled because 1) there is no demand for ICFs/MRs; 2) HCBS has caps on enrollment; types, frequency and duration of services; and individual budget caps; 3) waiver cost effectiveness formula applies

- **MCO Financial Incentives**
  - Aged – to provide HCBS to avoid NH costs
  - IDD – no incentive to provide anything, particularly family support or employment: families will not ask for ICF/MR

IDD and Aging & Disabled are not the Same

- **Care Issues**
  - Aged – health care and ADLS needs primary
  - IDD - involvement in the community primary; services having little to do with health condition

- **Primary Services**
  - Aging - medical and personal assistance
  - IDD - habilitation, training, employment, family supports

- **Family Care Giving**
  - Aged – In the later years of life
  - IDD - Begins at birth and endures through a life time

- **Natural Supports**
  - Aged - have a lifetime of natural supports to rely on
  - IDD - need to build and maintain them throughout life

CMS Expectations of Managed Care Programs

1. Adequate Planning and Transition Strategies
2. Stakeholder Engagement
3. Enhanced provision of HCBS (ADA/Olmstead)
4. Alignment of Payment Structures with MLTSS Programmatic Goals
5. Support for Beneficiaries
6. Person-centered Processes
7. Comprehensive and Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

CMS Guidance to States Using 1115 Demonstrations or 1915 (b) Waivers for Managed Long Term Services and Supports Programs

2. Stakeholder Engagement

- At the beginning, families and people with I/DD need to hear how managed care will be adapted to
  - Deliver support services (not just acute services)

- During development
  - What we are looking to keep
  - What we are collectively looking to improve

- On going – How is it working: feedback, listening sessions, ongoing engagement

2. Stakeholder Engagement – cont.

- Transparency means
  - Sharing metrics/outcomes along the way. (EQRs can be hard to decipher)
  - Working together to identify population specific and MCO specific data to review & opportunities for improvement

- A seat at the table in policy development, not just review, for home and community based services enhancements

- Statewide groups are good; local groups with state involvement keep people involved and participating

- Fully engage existing ID/DD (& Mental Health) Expertise – acknowledge expertise- Will Be Different So Include Both- Ditto For Physical Disabilities

3. Most Integrated

- <u>Everybody</u> can live in the community.
  - In family homes with support
  - In their own homes
  - In shared living
  - Children and adults
  - Employment
  - Irrespective of medical or behavioral labels
    - People with trachs, g-tubes, suctioning, ventilators, medical frailty
    - People with behavioral reputations; criminal offenders

- Reduce use of nursing homes, ICFs, larger settings
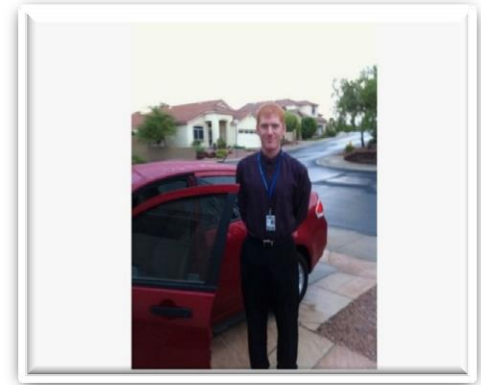
4. Aligning Payment Structures with Goals

- Capitation includes the ICFs, nursing homes (all congregate settings)

- Invest savings in waiting list and desired HCBS options (supporting families, employment, smaller settings)

- Capitation does not look solely at historical data, utilization, and regulatory changes: It looks at:
  - Desired policy changes, focuses on future, valued outcomes-more in home supports, crisis support to prevent out of home placement, employment, early intervention

4. Aligning Payment Structures with Goals cont.

- Rate setting- what components will be retained by the state vs. what the MCOs will have authority over?

- Network oversight to ensure that the rate structure supports desired outcomes – increase in home support, support families, employment

- Enforcement – consequences for not achieving outcomes

- Rate modeling to increase specific, desired services

5. Supporting Beneficiaries
Support Coordination in Managed Care

- More than the coordination of benefits, goods and services

- A person who:
  - Does not work for a provider (conflict free)
  - Develops a relationship with the person and family
  - Develops the individual plan with them
  - Conducts on-going oversight (checks in) to make sure services are delivered and are achieving outcomes
  - Is available for ad hoc problem solving

Assessment & Options Counseling
VS.
Conversation and Person-Centered Planning

Assessment & Options Counseling	Conversation & Person-Centered Planning
• Need is absolute: if X, then Y • Assessment leads to knowing what is needed • Based on presenting a list of services – leads to service assignment	• Need is situational & personal • The person defines what is needed • Based on removing barriers- leads to natural supports, community resources as well as services

6. Person-Centered Practices

- It is a process for both planning and service delivery, not an instrument or tool

- Person centered means conducting all activities from the person's point of view – what is important to them

- Balancing what others believe is important for the person against their right to self-determination

6. Person-Centered Practices Example

- The person wants to be a fireman.
  - Determine why. Status? Uniform? Excitement? Honor family history? Image of strength? They like the fire house?

- The person-centered plan developed explores:
  - Opportunities to visit the fire house
  - Opportunities to volunteer
  - Opportunities that include wearing a uniform
  - Joining a gym to increase physical strength

6. Person-Centered Practices Example

- The person needs to reduce weight (Types II Diabetes) but is not motivated.
  - Create opportunities for enjoyable physical exercise (get a dog to walk; start a dog walking business; volunteer with the park service (uniform and name badge and exercise)
  - Offer cooking classes that are appealing to the person
  - Education about diet
  - Counseling by nutritionist
  - Join Weight Watchers
  - ETC.

7. Comprehensive and Integrated Service Pkg. Example

Individual is self-abusing by hitting their head; is aggressive toward others; does not have speech.

Integrated Assessment:

1. **Medical** conditions that cause pain: sinus; migraine; broken bones; abdominal condition; medication side effects; dental pain;

1. **Behavioral Health:** sleep and mood charting; functional assessment; PSTD assessment;

1. **Social:** Abuse and/or neglect; loneliness; boredom

From the assessment, create an integrated intervention and positive plan.

7. Comprehensive and Integrated Service Pkg.

Transitioning Support between Services and Settings

– Focus on what assists people to stay in their home and community

– Having an active life and meaningful day for prevention

– Begin discharge planning immediately when a person enters the hospital

– Identify what prevents psychiatric hospitalization:
  • Crisis avoidance; positive behavioral supports; medication management; employment

Employment

Employment is a critical pathway to inclusion, independence and community living

Plans must increase access to employment - is it in the network plan?

Clinical guidelines should be person centered, easy to use, and highlight employment.

Supporting Family Caregivers

- Families should receive the assistance they need to effectively support and advocate on behalf of people with disabilities

- Managed care can expand in-home supports, assist in addressing the waiting list and families can be paid to provide care

Sustainability depend s on how well we support families and get people jobs.

8. Qualified Providers

- Basics are certification, licensing, background checks, credentialing (for clinical services), credentialing agencies

- Basics are not enough – providers need training in I/DD, supporting families and the value base of the services

- Keeping small providers and the rich network of HCBS agencies known in the I/DD community

8. Qualified Providers – cont.

- Provider agencies not traditionally in managed care may need training in billing, encounters, coding & other insurance based knowledge. Hold learning sessions, hotlines, T.A. and develop manuals

- Assure the training of non-certified direct support professionals; establish a core curriculum.

- MCO staff and enrolled providers need training on person centered processes, I/DD, self direction.

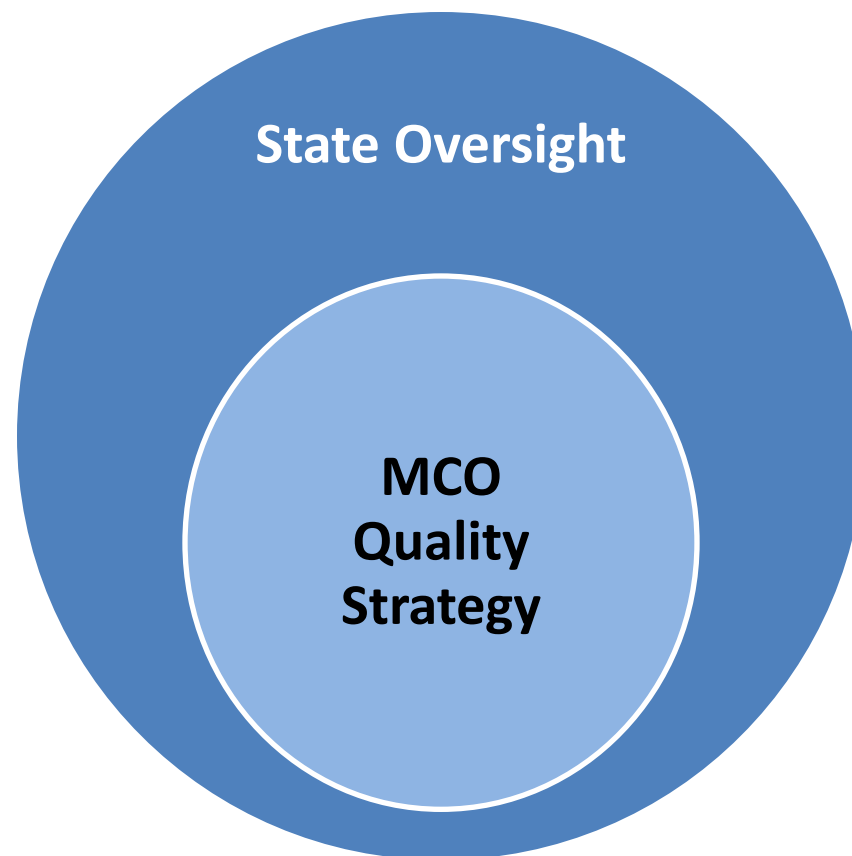- Involve people with disabilities and families as trainers.

9. Participant Protections
Rights and Responsibilities

- MCO responsibilities focus on dignity, respect, privacy, informed consent, due process, non discrimination, choice of network providers

- Member responsibilities focus on providing accurate information, follow plans and instructions, participate in mutually agreed upon plans and decision making

9. Participant Protections
Rights and Responsibilities

- There are more rights and protections to include:
  - Right to most integrated settings
  - Fair compensation for labor
  - Right to own property
  - Right to date
  - Freedom from abuse and neglect
  - Right to presumptive competency
  - Right to be free from excessive medications
  - Right to contact Human Rights Committees
  - Rights specific to residential services

10. Quality

OUTLINE OF THE STATE'S ROLE

❖ State staff with expertise in I/DD as well as managed care

❖ Ensuring that people with disabilities and families have access to information about the plans and a problem resolution process

❖ Ensuring that statutes, rules, policies-everything that stakeholders developed over the decades are followed?

❖ Conducting oversight and imposing corrective actions

❖ Public reporting on the performance of MCOs

❖ Staying engaged with stakeholders

Outline OF the State's Role, Cont.

❖ **Managing & overseeing the MCOs**

- Establishing contract requirements and performance standards

- Requiring Performance Improvement Projects including mandatory projects such as employment, supporting families

- Developing policies, manuals, clinical practice guidelines supportive of HCBS services outlining expectations, and State oversight. If functions are delegated, need state review and approval process.

- Measuring access to services, health and safety, increase in community living, decrease in large residential services and institutions

- Review MCO quality management systems

Outline of the State's Role, Cont.

❖ **Managing & overseeing the MCOs**

- Monitoring feedback from program participants through complaint systems, hotlines, consumer surveys & outreach sessions with stakeholders

- Operational and financial reviews

- Enhanced expectations increase innovation & build capacity in lifespan supports.

- Network plan approval and oversight

- Review outcomes data: increase in community living, decrease in large residential services and institutions reported quarterly

A Sample of Things to Look For in the Contract

- A requirement to do a person centered plan for LTSS- including the person, their family and others important to the person- check out the values and mission in other states' contracts

- Basis for service approval/denials

- The inclusion of services that are valued e.g.
  - Employment
  - Family support

- Requirements for school to work transition

- Fiscal incentives balanced with consumer protections

Quality

- Comprehensive

  - Incident management
    - Reporting; monitoring; trending individuals, providers and MCOs

  - Evaluate Support Coordination

  - Participant Feedback

  - Utilization – who is receiving supports and where, underserved, targeted areas?

  - Review and trend grievances, complaints, appeals, claims, provider monitoring, incidents, quality of care concerns, outcomes, PIPS, and compliance data
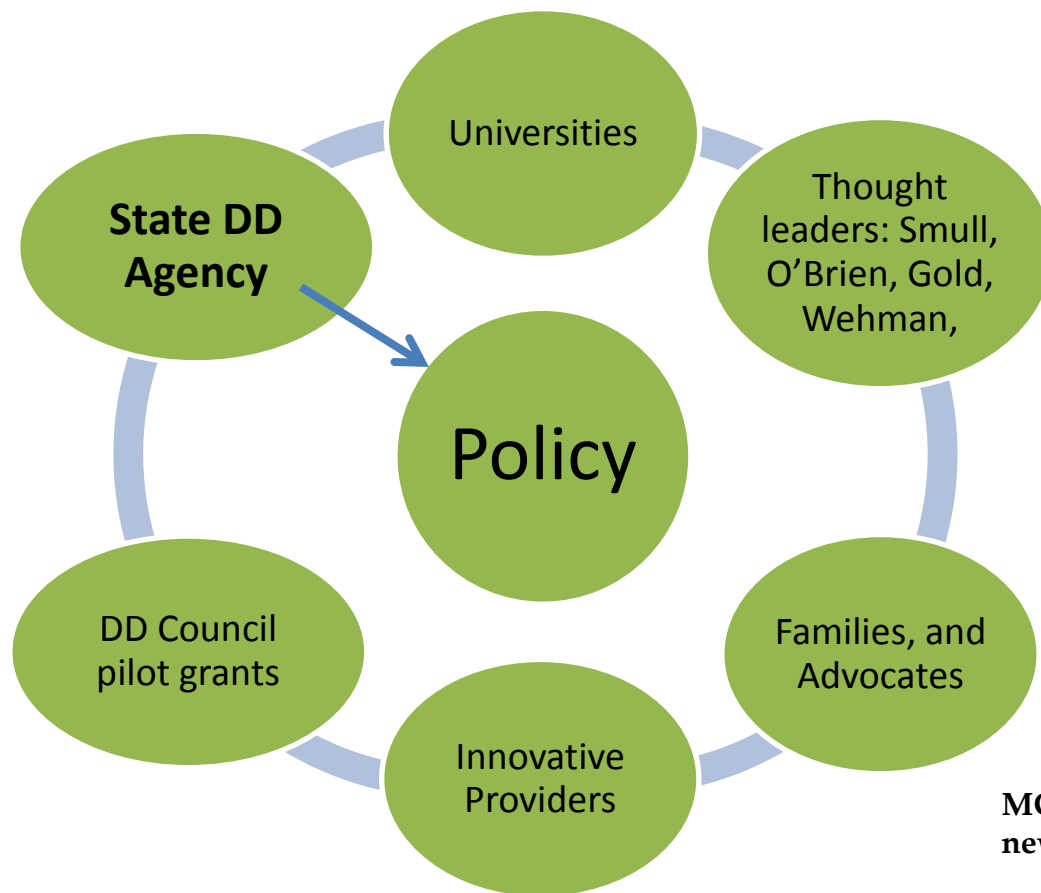
The oversight of the MCOs quality by the State is as important as the MCO's system

Innovation

Wherefore Art Thou?

# Innovation In Managed Care - a Concern

Innovations

Individual Services Plans

Positive Behavioral Practices

Supported Employment

Person-Centered Practices

Self-determination

Applied Behavioral Analysis

Universities

State DD Agency

Thought leaders: Smull, O'Brien, Gold, Wehman,

Policy

DD Council pilot grants

Innovative Providers

Families, and Advocates

MCO provider lockouts will discourage new innovative providers

No private market therefore no private sector innovation
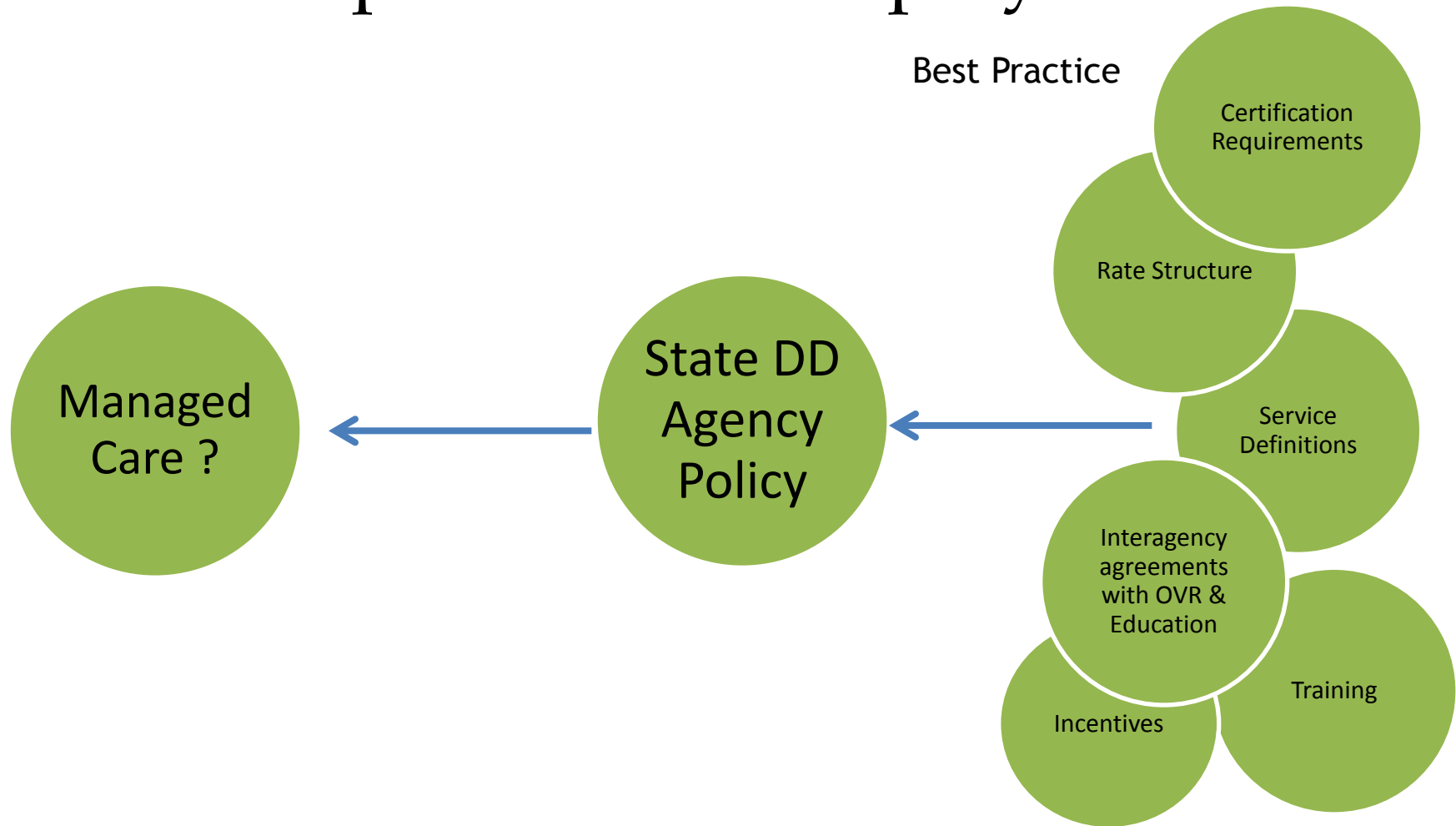
SELN and non-SELN State Comparison

Percent participating in integrated employment services, 2004 to 2010

Employment Services in SELN member states

Employment Services in Non-SELN member states
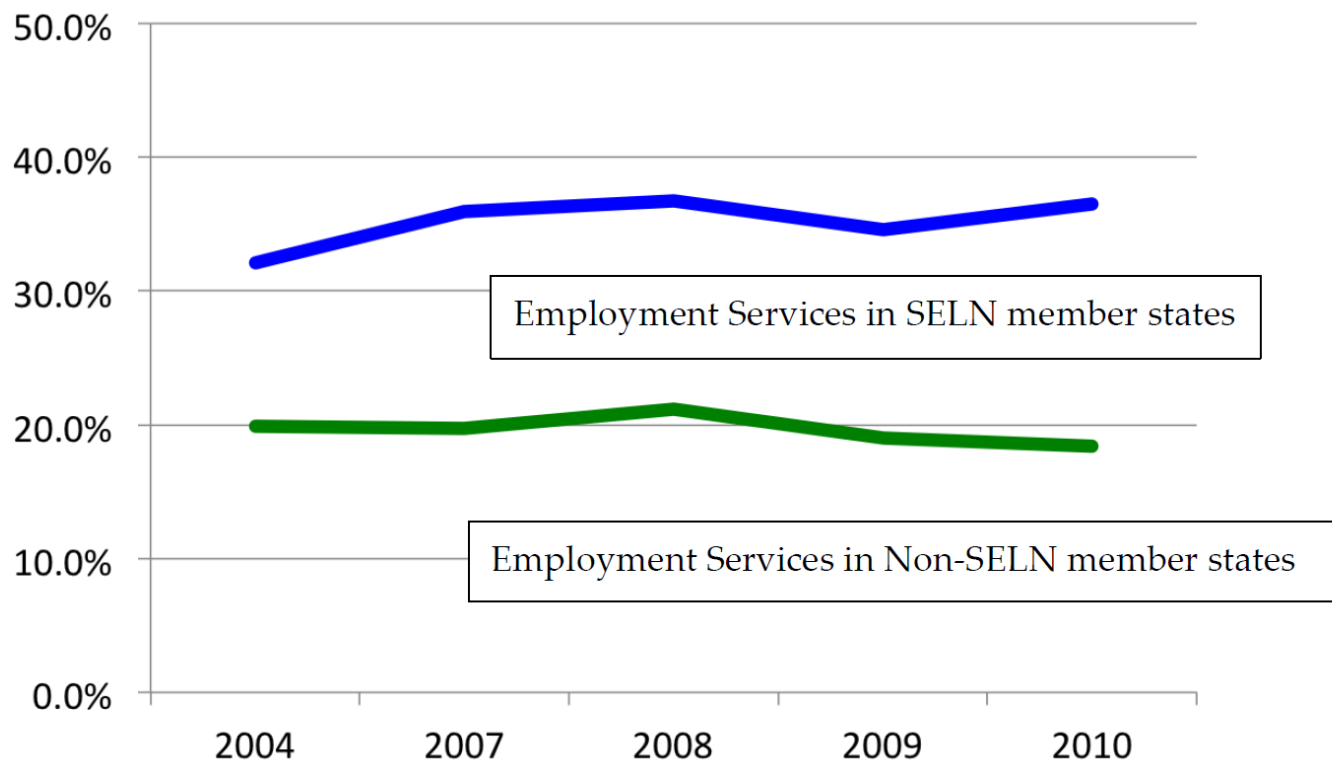
Chart reflects states with complete data between 2004-2010, SELN n=12 states, Non-SELN n=15 states.
[**Source: ICI National Survey of State IDD Agency Day and Employment Services 2010**, www.statedata.info]

Example – SELN Employment

Best Practice

- Certification Requirements
- Rate Structure
- Service Definitions
- Interagency agreements with OVR & Education
- Incentives
- Training

Managed Care ? ← State DD Agency Policy

Continuous Innovation

- Building a resilient community infrastructure
- Beware of "locking in" to set models
- Service designs & support strategies that enable people to get what they need not just what is available
- Policy must stimulate and support innovation
- Improving access
- Forging creative and productive partnerships
- Promoting the use of natural and community resources
- Remember how much innovation has come from people with disabilities, families and leadership already! Positive behavior support, supporting families, employment first, shared living – keep it going!

Measuring Progress

Managed care is more than a financing mechanism.
Defining quality outcomes for people with disabilities, seeking opportunities for integrating care, and supporting more people and their families in the community=
Progress.
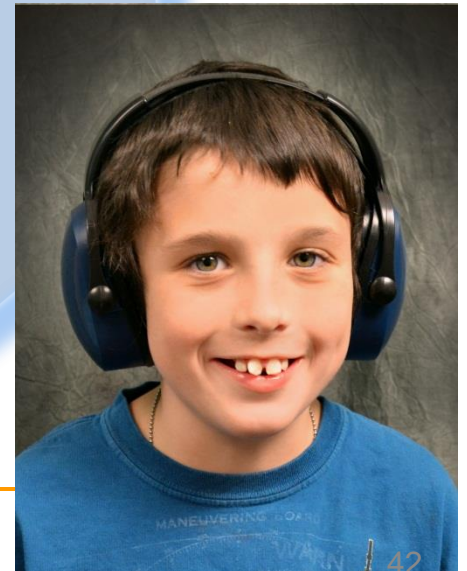
Thank You!
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