ANCOR's Funding Reform Checklist

A guide for dialogue with state officials in states proposing a capitated payment structure for long-term services and supports

ANCOR plays a key national role as a policy and practice expert for providing long-term community supports and services that ensure full citizenship and engaged community participation for people with disabilities of all ages. A majority of states are presently seeking integrated finance strategies (including capitation) in response to extensive Medicaid reform efforts nationally and by the states.

People with disabilities, long carved out of such efforts, are now being included in state proposals. These cost-containment efforts are being directed to supports and services for people with disabilities, people who are aging and individuals who are dually eligible for both Medicare and Medicaid. States are increasingly attempting to integrate services for physical health, behavioral health and developmental disability long-term services and supports (LTSS). LTSS are being fully included and integrated into states' proposed 1115 research and demonstration waivers or combined 1915 (b) freedom of choice and 1915 (c) home and community-based services waivers.

Individuals with disabilities should receive LTSS that improve quality of life and produce valued outcomes. As states propose fundamental shifts and dramatic changes to the way LTSS are funded, this checklist can be a useful tool in guiding the dialogue between states and stakeholders.

I. Stakeholder Engagement

1. There should be multiple opportunities for stakeholder engagement throughout the process, from concept development to waiver and contract specifications to evaluation and oversight.
2. The process should be transparent, with written documentation of input and responses.
3. Stakeholders should be included in dialogue with the Center for Medicare and Medicaid Services (CMS) as necessary and appropriate.

II. Mission, Vision, and Guiding Principles

1. The process must be driven by the development and communication of a clear mission, vision and guiding principles for the long-term services and supports system for individuals with disabilities, families and providers.

2. It must recognize the value of individuals with disabilities and families, as well as assure everyone is treated with dignity and respect.
3. It must acknowledge all stakeholders as full partners with the state.
4. It must be performance and outcome-oriented.
5. It should include a no-wrong-door solution.

III. Core Values to Consider

1. The foundation of LTSS should be based on principles of independent living and a psychosocial and recovery approach rather than a traditional *medical model*.
2. LTSS should result in an array of individually tailored services and supports, including a key role for assistive and environmental technologies and benefits counseling, rather than resulting in a continuum of care or beds and slots to be filled.
3. The array of LTSS options should be driven by a person-centered-planning approach rather than the needs of facilities.
4. The array of LTSS options should include a strong self-directed support option for anyone who opts to self-direct, including the ability to modify the level of support necessary to successfully self-direct.
5. There should be an ability to develop individual budgets for individuals supported.
6. The "Employment First" philosophy should be recognized and promoted.
7. The array of LTSS options should foster natural supports.

IV. Assessment and Rate Setting Methodology

1. The assessment and rate setting methodology should recognize the diversity of support needed within the populations.
2. The assessment and rate setting methodology should establish the application of a uniform assessment tool(s), provided by an entity independent of the provider or the managed care organization (MCO), to assure equity and to define levels of support as well as recognize a minimum of 5–7 risk adjusters (capitated rates).
3. The assessment and rate setting methodology should recognize geographic differentials within the state based upon elements such as wages, fringe benefits, housing and transportation.
4. The assessment and rate setting methodology should structure financial incentives to influence behavior to achieve valued outcomes consistent with mission, vision and guiding principles.
5. The assessment and rate setting methodology should recognize that needs change over time and assessments will be done as an individual's circumstances change.
6. The assessment and rate setting methodology should be built upon at least 2–3 years of Medicaid (and, as appropriate, Medicare) claims data, including acute, behavioral health and ***LTSS claims***, as available and appropriate. Emphasis should note that acute and behavioral health claims data should ***not*** be used to determine costs of LTSS as those supports are not medically based. LTSS data needs to be established and tracked over time relying upon LTSS claims (realizing there is limited data) as a baseline and then incorporating costs as determined through person-centered planning.

V. Performance Measures and Metrics

1. Performance measures and metrics must be explicit in the state purchasing specifications and contract language. The requirements and accountability for services and supports must be executed through the contract between the state and the MCO.
2. Outcome measures must be articulated that are non-clinical in nature and are focused on LTSS (in addition to acute and behavioral health).
3. Performance measures and metrics should incorporate independence, productivity, integration, inclusion and self-direction into all RFPs and contracts.
4. Performance measures and metrics should incorporate equality of opportunity, independent living, economic self-sufficiency and full participation as defined in the Americans with Disabilities Act (ADA).
5. Performance measures and metrics should incorporate the *integration mandate* of the ADA and the Olmstead Supreme Court decision.
6. Performance measures and metrics should establish benchmark data and articulate the definition of quality including requiring continuous quality improvement for non-clinical outcomes.
7. Performance measures and metrics should define the roles of all external quality reviews that will be required including primary, acute and LTSS; which organizations will be used; and what the frequency of reviews will be.
8. Performance measures and metrics should articulate an accreditation process if applicable, including what will be required or encouraged (such as CQL, CARF or others).

VI. Type of Waiver(s) Being Used and Other Medicaid Policies

1. If a 1915 (b) freedom of choice waiver, to what services and supports will it be applied? It must provide assurance for choice between at least two MCOs, choice of service coordinator, and choice of provider.
2. If a 1115 research and demonstration waiver, what are the Medicaid requirements the state is asking to be waived by CMS?
3. There must be a delineation of which federal regulations, including appropriate citations, will apply to the MCOs and to its provider networks.
4. There should be a discussion explaining the linkages to and potential impacts from other ACA efforts such as Health Homes, Community First Choice, Money Follows the Person, Section 1915 (I) HCBS state plan amendments, the State Health Exchange, and the Medicaid-Medicare “Dual Eligibles” initiatives.

VII. State Responsibility and State Regulations

1. There must be assurance that the state is ultimately responsible for services and quality and cannot delegate or contract this away to a third party.
2. State regulations must be modified to reduce process burden in exchange for performance outcome measures as the accountability standard.

3. State regulations should focus on the *what* and allow provider creativity on the *how* to accomplish the regulation (e.g., state regulation for six characteristics of a person-centered plan rather than 10–15 pages of detailed, step-by-step processes and methods for a person centered plan).
4. The state must provide basic safeguards to assure that individuals are safe and secure without compromising an individual's civil rights, choice, informed decision making and dignity of risk.
5. The state should encourage and support innovation.
6. The state should establish timely and transparent grievance and appeals processes for individuals and families, as well as providers (sub-contractors) with MCOs and with the state.
7. The state must assure active, independent oversight and monitoring and a robust evaluation of the MCOs and their provider networks.
8. The state must take the lead responsibility for continuing statewide Direct Support Professional (DSP) workforce development or apprenticeship initiatives.
9. The state should provide infrastructure support to enhance both self-advocacy and family support movements.

VIII Financial Risk between the State and the MCOs

1. The contract must define the amount of risk shared by the state with the MCO. It could be "full risk" to the MCO or could contain a "risk corridor" of a limited and/or shared risk between the state and the MCO.
2. The contract with the MCO should be conducted in a transparent process in which the MCO capitation rates and the provider rate-setting mechanisms are known.
3. The contract should define what portion of the risk, if any, will be shared with the provider network.
4. The contract should clearly designate which state agency is responsible to license the MCO and which state regulations will be applied (e.g. such as those for an HMO should be disclosed).
5. The contract should clearly articulate the amount or level of reserves that must be maintained by the MCO.
6. The contract should clearly articulate minimum loss ratios, stop loss factors, shared savings, etc.
7. The contract should clearly limit the percentage of revenue that can be used for administration and profit margins.
8. The contract should define the role of and relationship to community mental health centers and federally qualified health centers.

IX. Requirements for the MCOs

1. MCOs should be required to document staff knowledge and expertise in LTSS for children and adults with disabilities under the age of 65.
2. MCOs should have demonstrated experience in providing quality health care services and supports to children and adults with disabilities and chronic health conditions.
3. MCOs should have knowledge of evidence-based best practice in LTSS for persons with disabilities.

4. MCOs should have knowledge of and commitment to Title II of the ADA and the implementation of the Olmstead Supreme Court decision.
5. MCOs must demonstrate the existence of transparent and functional advisory boards that include meaningful and supported opportunities for people with disabilities and families to be at the table.

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

1. The HIT and/or the EHR system should be designed and implemented prior to the implementation of the capitated system.
2. The data system must include real time incident reports and issues impacting individual health, life and safety.
3. The HIT and/or the EHR system should define the data elements that will be required of the MCO.
4. The HIT and/or the EHR system should define the data elements that will be required of the provider networks.
5. The costs of the software and staff training for providers should be identified including whether or not they will be provided by the state and/or the MCO.
6. The costs for smart phones, laptop computers and/or notepads to be used by providers should be identified including whether or not they will be incurred by the state and/or the MCO.

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