
HMA

HEALTH MANAGEMENT ASSOCIATES

*Current Landscape:
Managed Long-Term Services and Supports
for People with Intellectual
and Developmental Disabilities*

PREPARED FOR
AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES (ANCOR)



BY
SHARON LEWIS
RACHEL PATTERSON
MARCEY ALTER

JUNE 11, 2018

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

About Us

The American Network of Community Options and Resources (ANCOR) is a national trade association for disability service providers, representing over 1,400 private providers of disability community services for people with intellectual and developmental disabilities and 55 state provider associations. Collectively, ANCOR members support over a million individuals with disabilities with a workforce that's half a million strong.

ANCOR's mission is to advance the ability of our members in supporting people with intellectual and developmental disabilities to fully participate in their communities. www.ancor.org

Health Management Associates (HMA) is an independent national research and consulting firm founded in 1985, specializing in publicly financed healthcare. HMA provides technical assistance, research, decision support and expertise to government agencies, public and private providers, health systems, health plans, institutional investors, foundations and associations. With 22 offices and nearly 200 multidisciplinary consultants coast to coast, our team is always within client reach. For more information, visit www.healthmanagement.com.

Background and Acknowledgements

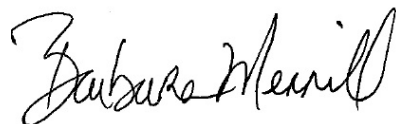
While the growth of Managed Long-Term Services and Supports (MLTSS) is well-documented, ANCOR has noted a scarcity of efforts focused on documenting and describing the MLTSS experience for systems supporting individuals with intellectual and developmental disabilities (I/DD). In response to growing concern among our members about this gap, ANCOR commissioned Health Management Associates (HMA) to develop a peer-reviewed whitepaper focused on a current factual review and description of the MLTSS experience for individuals with I/DD.

ANCOR is incredibly proud to publish the results of this effort. HMA's findings reflect and confirm what our provider members have shared over the years. As hoped, the resulting whitepaper provides guidance to all stakeholders on the program design and implementation features that are more likely to result in high quality, integrated supports that lead to positive outcomes for individuals with I/DD. We are particularly pleased to note that these findings are complementary to the best practices identified in the MLTSS Institute's recent report – [MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success](#).

We are extremely grateful to the entire HMA team including Sharon Lewis, Rachel Patterson, and Marcey Alter for their incredible work in exceeding our expectations within an aggressive timeline. We are also indebted to the twenty-seven ANCOR members – State Associations and providers – who contributed to this effort through extensive written questionnaires and follow-up. Lastly, we are thankful to the other state stakeholders who provided additional information and resources to assist in validating the information gathered through the process.

ANCOR is deeply committed to serving as a resource on this critical issue. This commitment is reflected in our participation as a key partner in the HCBS Business Acumen Grant. It is illustrated through ANCOR and ANCOR member contribution to the [June 2018 MACPAC report to Congress](#) and Chapter 3's coverage of MLTSS. It is reflected in our on-going investment in developing resources focused on raising awareness on the unique and key issues to consider when moving to integrated care approaches, including our [Principles of Managed Long-Term Services and Supports](#) and this whitepaper. And, finally, our commitment is strengthened in light of anticipated changes to MLTSS regulations and on-going media accounts, like the [Dallas Morning News Investigative Series Pain & Profit](#), that demonstrate the need for continued advocacy for MLTSS approaches that are built on careful planning, significant and ongoing stakeholder engagement, and a clear policy vision to advance integrated, quality home and community-based services over quick fixes or immediate cost savings.

Sincerely,



Barbara Merrill, Chief Executive Officer
ANCOR

Table of Contents

Executive Summary.....	1
Managed Long-term Services and Supports (MLTSS) for People with I/DD.....	2
States with Current MLTSS-I/DD Programs	8
Arizona	8
Michigan.....	10
Wisconsin	12
North Carolina.....	15
Kansas	19
Iowa.....	22
Tennessee	26
States with Emerging MLTSS-I/DD Efforts	29
New York.....	29
Arkansas.....	32
Texas	35
States to Watch.....	39
Conclusion.....	42

Executive Summary

While Medicaid Managed Care (MMC) programs have become prevalent in state health systems, serving over 54 million Americans in 45 states as of July 1, 2016,¹ implementation of Medicaid Managed Long-term Services and Supports (MLTSS) is a relatively recent trend, growing from fewer than eight states a decade ago to twenty states in 2016.² States are increasingly relying upon managed care approaches inclusive of long-term services and supports (LTSS) to support cost-effective and sustainable systems, to share financial risk and develop budget predictability, to foster innovative approaches to meeting complex needs, to encourage a focus upon value-based outcomes, and to help with the integration of physical, behavioral and home and community-based services.

However, the experience of managed care for people with intellectual and developmental disabilities (I/DD) is far more limited, as this population is often the last group to be enrolled in managed care for any Medicaid-funded healthcare, and LTSS for people with I/DD are frequently among the last services to be incorporated into managed care contracts. While the goals of care integration, improving quality and encouraging innovation are important to I/DD systems, there are only a few states who have fully embraced contracted MMC for all I/DD services, for several reasons as described in this report:

- Lack of potential cost savings in MLTSS-I/DD
- Limited MCO experience serving people with I/DD in MLTSS
- Limited state experience to set MLTSS-I/DD managed care rates
- Need for meaningful quality measures
- Lack of managed care experience among I/DD providers
- Unique role of I/DD case management and supports coordination
- Strong advocacy networks and relationships

As states deliberate their options for managing long-term services and supports and integrating care for people with I/DD, careful consideration of these issues is warranted. However, the most critical aspect of MLTSS-I/DD program development and implementation relates back to the state's goals and reasons for moving services to managed care. Recent experiences of states demonstrate that a focus primarily on cost savings, especially in the short-term, is unlikely to result in success, and may drive reductions in quality and/or service cuts that harm I/DD beneficiaries.

This report presents a high-level summary of the current landscape of Medicaid Managed LTSS for people with I/DD, with the intent of informing providers, advocates, policymakers and other stakeholders on the opportunities and challenges revealed by state experiences to date. States are presented in the order in which they began implementation of MLTSS programs for people with I/DD. Generally, the states with the longest-standing MLTSS-I/DD programs have built these programs through public entities and/or provider partnerships that have evolved over time. More recently, a few MLTSS programs are relying upon contracts with multi-state commercial health plans implementing MMC, such as in Kansas, Iowa and Tennessee. Finally, we present information about emerging or limited MLTSS efforts in other states, including emerging provider-led accountable care approaches.

¹Medicaid Managed Care Enrollment Report Summary Statistics. Centers for Medicare & Medicaid Services. www.medicaid.gov/medicaid/managed-care/enrollment/index.html

² Ibid.

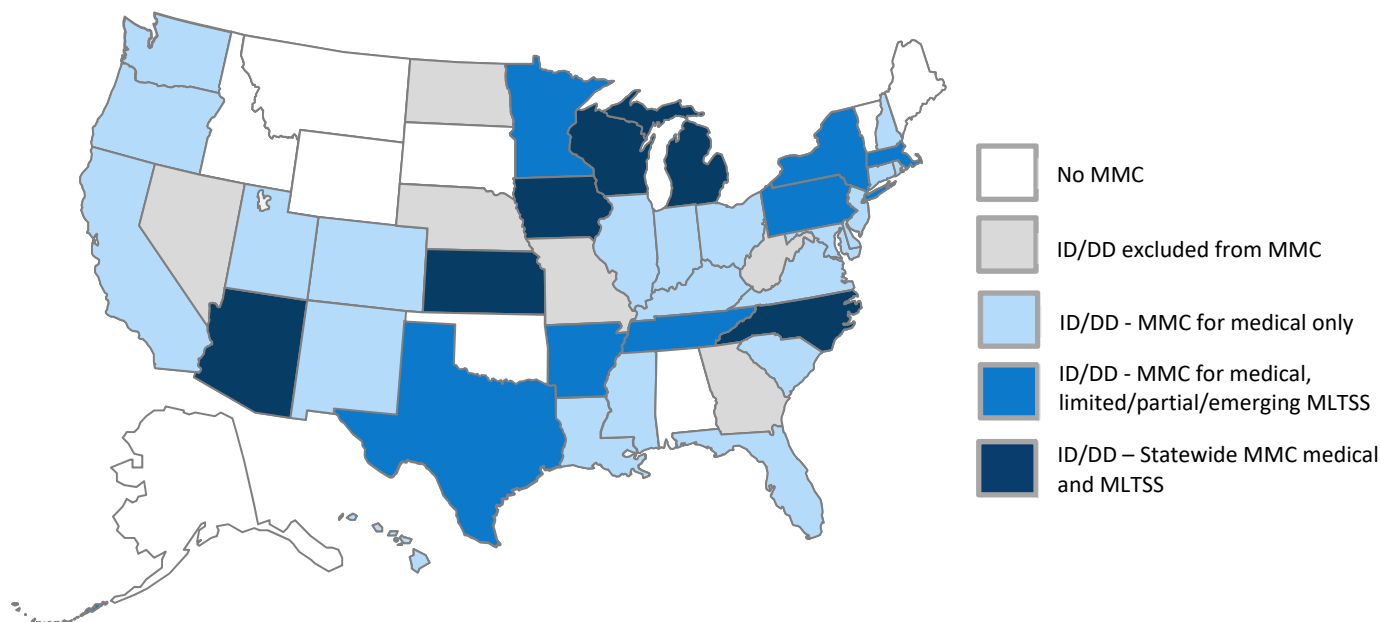
Managed Long-term Services and Supports for People with I/DD

Since the 1970's, Medicaid Managed Care (MMC) programs have proliferated across the nation. Originally, MMC was targeted at Medicaid state plan enrollees, children and very low-income adults, who received primarily traditional medical care services. Today, MMC has grown both in terms of populations served – to include people with disabilities and older adults – as well as in services offered, including LTSS. Most states contract with Managed Care Organizations (MCOs) or Accountable Care Organizations (ACOs) to operate the programs; some states employ Prepaid Inpatient Health Plans (PIHPs) or other managing entities.

Despite this growth, the experience of managed care for people with I/DD is limited, as they are often the last group to be enrolled in managed care, and their LTSS are frequently among the last services to be incorporated. According to the Kaiser Family Foundation, only eleven states fully include people with I/DD in mandatory state plan/medical care enrollment.³ Twenty more states have voluntary or varied enrollment, and eight states fully exclude people with I/DD from managed care.⁴

Most of the states that enroll people with I/DD in MMC continue to carve out LTSS. Further, the majority of states with Medicaid MLTSS programs for older adults and people with physical disabilities still exclude people with I/DD. This is reflected in expenditure data; in 2016, MLTSS for older adults and people with physical disabilities represented 24% of all Medicaid LTSS spending, while only 7% of LTSS for people with I/DD was expended through managed care.⁵

Medicaid Managed Care for People with I/DD, 2018



³ Gifford, Kathleen et al. "Medicaid Moving Ahead in Uncertain Times." *Kaiser Family Foundation*, October 2017, pg. 27. <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>.

⁴ Ibid.

⁵ Eiken, et al. "Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015," *Truven with the Centers for Medicare and Medicaid Services* (2017), p. 15. <https://www.medicaid.gov/medicaid/lts/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf>

Current MLTSS for People with I/DD

Of the 25 states identified by Truven Health Analytics as operating a MLTSS program in 2017, only ten states currently enroll people with I/DD in MLTSS, and most use an approach other than mandatory statewide programs contracted to commercial multi-state MCOs.

- Michigan and North Carolina operate their MLTSS program for individuals with I/DD through local county-based PIHPs, although both states are considering a move to MCOs.
- In Arizona, the state Division of Developmental Disabilities serves as the managing entity under a contract with the state Medicaid agency.
- In New York, people with I/DD can voluntarily enroll in the I/DD Fully Integrated Dual Advantage (FIDA-IDD) demonstration for individuals dually eligible for Medicare and Medicaid and the state is moving care management to provider-led care coordination organizations.
- Pennsylvania operates a small provider-led adult autism program in one area of the state under a risk-based contract, limited to 158 people.⁶
- While commercial MCOs manage contracts for medical care, for LTSS (for all populations), Wisconsin uses state-specific regional non-profit MCOs that grew out of county-based entities.
- Tennessee relies upon statewide commercial MCOs for MMC, but for people with I/DD the MLTSS program is only for new enrollees.
- Texas uses commercial MCOs across the state, but only the relatively few enrollees with I/DD in the Community First Choice program are enrolled in MLTSS, as well as children enrolled in the Medically Dependent Children Program.⁷
- **To date, only Kansas and Iowa have contracted with large national commercial managed care plans with mandatory enrollment statewide for nearly all beneficiaries with I/DD for all services, inclusive of Home and Community-Based Services (HCBS).**

Growth in MLTSS-I/DD: Slow and Incremental

State implementation of MLTSS for people with I/DD has been slower than adoption of MLTSS targeting other populations for several reasons.

- **Lack of potential cost savings in MLTSS-I/DD.** Medicaid funds the vast majority of I/DD services. There is very little private pay and virtually no commercial insurance coverage for HCBS, so most providers rely nearly exclusively on public program reimbursement. Many I/DD providers are non-profit organizations that depend on fundraising contributions and development activities to ensure solvency. Medicaid payments for HCBS for people with I/DD have historically been reimbursed at a level that many providers believe to be below their actual costs.^{8,9} Direct support labor comprises the vast majority of Medicaid HCBS expenditures for people with I/DD, with approximately 1.3 million direct support professionals (DSPs) supporting people with I/DD

⁶ "Adult Community Autism Program" *Pennsylvania Department of Human Services*.

<http://www.dhs.pa.gov/citizens/autismservices/adultcommunityautismprogramacap/>

⁷ In early 2018, Texas issued an RFP for their STAR +PLUS MLTSS program that indicated the state may choose to enroll people with I/DD in the future. To date, the state has not indicated whether or not LTSS services for people with I/DD will be included in the new contracts.

⁸ Testimony by Natalie Wood, Senior Policy Analyst, The Bell Policy Center, to the Medicaid Provider Rate Review Advisory Committee, March 17, 2017.

⁹ Colorado Department of Health Care Policy and Finance, "2017 Medicaid Provider Rate Review Analysis Report: Home- and Community-Based Services (HCBS) Waivers" May 1, 2017, p. 16.

<https://www.colorado.gov/pacific/sites/default/files/2017%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report%20-%20HCBS%20Waivers.pdf>

enrolled in state agency services.¹⁰ Typical wages for DSPs are near the minimum wage; the average DSP wage is \$10.72/hour.¹¹ In addition, services for people with I/DD are largely rebalanced from institutions, further reducing the opportunity for cost savings. Nationally, 75% of Medicaid LTSS spending for people with I/DD is in community-based settings,¹² and in states that have already largely or fully transitioned their system from institutional to community-based services, there may be little or no cost savings to be realized.

- **Limited MCO experience serving people with I/DD in MLTSS.** Commercial health plans accustomed to serving other Medicaid populations can find working with the I/DD community challenging, requiring thoughtful engagement, unique services and specific approaches. When states incorporate LTSS into existing managed care programs, MCOs frequently face a steep learning curve. MCOs' clinical orientation and experience with MLTSS for other populations often does not provide the depth of knowledge and understanding about I/DD home and community-based services. The longevity and intensity of services for people with I/DD is different than aging; people with I/DD are often involved with publicly-funded services for multiple decades, cradle to grave, and many rely on daily supports. Medicaid-funded I/DD services include a wide range of services specific to the population -- for example, employment services, residential homes, community inclusion activities, intensive behavioral supports, family caregiver services (at all ages), self-advocacy and more. These services are often different from the LTSS most frequently purchased for people with physical disabilities and older adults (nursing facility care, personal attendant care, home health services). Just as I/DD providers are unaccustomed to contracting with MCOs, many MCOs are also unaccustomed to the level of engagement and support providers, families, and people with I/DD expect and need over many years – and some struggle to develop “disability cultural competency” within their organizations.
- **Lack of state experience to set MLTSS-I/DD rates.** HCBS for people with I/DD is frequently delivered by small, community-based organizations; states currently pay these I/DD providers in a variety of ways. There is substantial diversity in how I/DD rates are set, structured and billed, including adjustments for acuity or intensity of medical or behavioral needs; individualized budgeting; prioritization in rates to support preferred HCBS outcomes; units ranging from 15-minute increments to hourly, daily or monthly rates; milestone payments for specific goals; or bundled contracts for certain kinds of care. States typically do not collect, maintain and analyze the detailed level of information on utilization, encounters and outcomes tied to beneficiaries' clinical and functional assessment data that would allow for risk adjustment and establishment of actuarially-sound rates in a managed care program in the same way medical data is used to determine rates for other populations. This makes it challenging for states to set adequate and actuarially-sound capitation rates for MCOs, especially early in the process, which can complicate

¹⁰ Ibid, p. 14.

¹¹ President's Committee for People with Intellectual Disabilities 2017 Report to the President, “America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy,” p. 8.

https://www.acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF

¹² Eiken, et al. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015,” *Truven with the Centers for Medicare and Medicaid Services* (2017), <https://www.medicare.gov/medicaid/lts/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf>

managed care implementation if the state is expecting to garner immediate savings on MLTSS for people with I/DD.

- **Need for meaningful quality measures.** Transitions to alternative payment models and value-based payments are increasingly a component of managed care. However, such payment models rely on robust and reliable quality measures that accurately reflect the outcomes of service. In the health system, data such as rates of infection, diabetes, or post-acute hospitalizations may demonstrate quality of care; however, when goals for services relate to independent living, employment, or community participation, valid and reliable metrics are far more challenging to identify. I/DD stakeholders fear a return to a “medical model” of services if measurement of quality of care relies primarily upon clinical outcomes and does not incorporate a broader definition of quality. Quality outcome measures in HCBS, and specifically for services for people with I/DD, are not widely agreed upon, nor are they easily defined. Many states currently rely on a combination of claims information, consumer experience data and systemic information, e.g., rebalancing, rates of employment, community integration, as well as process and output measures. Evidence-based outcome measurement for HCBS is still evolving, and many potential or proposed quality metrics may not be available through administrative data sets, requiring additional data collection and analysis.
- **Lack of managed care experience among I/DD providers.** Many HCBS providers for people with I/DD are small, community-based organizations that rely almost exclusively on Medicaid and other public funding for reimbursement. Unlike other LTSS providers such as home health agencies or assisted living centers, there is no payer mix. Many of these organizations have only contracted with state or county agencies and are not accustomed to working with other health care payers. They are likely to need significant support to develop the business acumen to interface with an MCO’s claims, billing, data collection, quality oversight, management systems, and other business and administrative processes; many I/DD providers lack the IT infrastructure needed in the managed care environment. Additionally, most I/DD providers are unlikely to have substantial financial resources or reserves to address cash flow issues as reimbursement models change, or to accept risk-sharing agreements that are increasingly common in managed care.
- **Unique role of I/DD case management and supports coordination.** Case management and supports coordination (sometimes referred to as service coordination, care management, or care coordination) for people with I/DD is often a much more significant and involved role than for many other populations. Individuals with I/DD and families often form personal relationships with their support coordinators, who frequently serve as system navigators and advocates for the beneficiaries on their caseload as much as they support assessment, person-centered planning, service authorization and utilization management. When MCOs become responsible for all aspects of case management and related coordination activities, this can disrupt trusted relationships and may change the nature and function of supports coordination. Additionally, depending upon state program design and enrollment rules, case managers may play a critical role in enrollment and roll-out as states transition from fee-for-service LTSS to managed LTSS, given their trusted relationships with enrollees.

- **Strong advocacy networks and relationships.** I/DD advocacy networks include family members, providers, professionals, and people with I/DD themselves. The community is strong in its ability to share information, mobilize advocates and learn about experiences in other states. They often engage with state legislatures and can readily activate grassroots advocates -- having fought hard for funding and services, they may be resistant to change. People with I/DD, families and providers are often deeply personally and emotionally involved, and are frequently skeptical of managed care, especially when the planned transition is focused on cost savings.

States' deliberation of options and structures for managing LTSS and integrating care for people with I/DD warrants careful consideration of these issues. Exploration of various pathways and models of integrated or managed care, thoughtful planning, responsive and flexible implementation efforts, and meaningful ongoing stakeholder engagement will improve any resulting program and the likelihood of success.

However, the most critical aspect of MLTSS-I/DD program development and implementation relates back to the state's goals and reasons for moving these services to managed care. Recent experiences of states demonstrate that a focus primarily on cost savings, especially in the short-term, is unlikely to result in success, and may drive reductions in quality and/or service cuts that harm beneficiaries. Due to the nature of the services and the reliance primarily on a low wage workforce, as well as the fact that most states' I/DD systems are largely rebalanced away from institutional care, MLTSS-I/DD savings targets are extremely limited. This is compounded by the fact that states implementing managed care for people with I/DD have rarely included all intermediate care facilities (ICFs) in managed care despite the potential cost savings in states still needing to rebalance away from ICFs.

Additionally, there is little evidence that states have been able to identify data-driven opportunities to improve care while reducing costs of services for people with I/DD in the same manner as other populations. For example, some state MLTSS programs have been successful in reducing nursing facility admissions and/or costly hospital stays for older adults, people with physical disabilities and/or people with specific chronic conditions.¹³ However, there seems to be little evidence of public data showing specific improvements in I/DD long-term services delivered through managed care that reduce particular high cost drivers and address quality of care issues for people with I/DD.

Recently, some states have contracted for managed care, including MLTSS, with a nearly singular focus on cost containment. Programs in Kansas and Iowa have sought to control not only future cost growth and budget predictability, but also projected significant savings very early in their managed care implementation.¹⁴ These states present very different outcome scenarios to date, including reported reductions in services and significant implementation challenges.¹⁵ In Kansas, recent reports indicate that state auditors are unable to come to conclusions regarding the program, due to lack of data

¹³ NASUAD and CHCS, "Demonstrating the Value of MLTSS Programs", p. 11. <https://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf>

¹⁴ Kansas Health Institute, "Issue Brief: KanCare—MCO Contracts Aim to Achieve Savings and Quality Improvement" <http://www.khi.org/policy/article/issue-brief-kancare-managed-care-contracts-aim-ach>

¹⁵ Interview with Chad VonAhnen, Executive Director, Johnson County Developmental Supports and Tim Wood, Executive Director, Interhab, April 11, 2018.

integrity and reliability.¹⁶ In Iowa, nearly all aspects of the service delivery system – including MCOs¹⁷ and providers¹⁸ – have reported substantial financial losses, and those receiving services and advocacy groups have indicated that many people have experienced a harmful reduction in services.^{19 20}

By contrast, states that have pursued managed care programs for reasons other than just cost efficiencies have seen less volatility in the service delivery system and program design that more closely reflects stakeholder input. While not without their challenges, in states focused on using managed care to address waiting lists, improve quality, address program goals and/or leverage the power of MCOs to undertake a paradigm shift toward truly integrated services inclusive of physical, behavioral and HCB services, stakeholders report far fewer challenges.

For example, Wisconsin undertook MLTSS with the explicit goals of ending the waiting list, improving access and choice, increasing quality, and achieving cost efficiencies.²¹ As counties have transitioned into MLTSS (known as Family Care) they have closed out waiting lists; the state's current small waiting list will be fully eliminated in 2021 when the last county in Wisconsin completes its transition.

Similarly, Tennessee created their Employment and Community-First (ECF) CHOICES program to address waiting lists, encourage more employment-focused and integrated community services, and improve quality. Tennessee's legacy 1915(c) waivers continue to operate and ECF enrollment is open to those on the waiting list or anyone currently in a 1915(c) waiver that wishes to join. ECF services are oriented toward integrated community employment and integrated community services and supports. Under the contracts, case managers are required to undergo extensive training on the concepts of community integrated services, and payment structures are designed to incentivize both MCOs and providers to promote integrated services, including fading the level of support as individuals gain skills.

As states consider MLTSS and integrated care models for people with I/DD, there is significant opportunity to learn from current and recent implementation efforts; this report offers a glimpse at state experiences to date.

¹⁶ Marso, Andy. "Kansas' Medicaid Data Is So Bad, Analysts Can't Even Tell If It's Working." *Governing*. May 11, 2018. <http://www.governing.com/topics/health-human-services/gov-kancare-data-is-so-bad.html>. Accessed May 25, 2018.

¹⁷ Iowa Medicaid Enterprise, "IA Health Link: Managed Care Annual Performance Report, (July 2016 – June 2017), January 3, 2018, pg. 86. https://dhs.iowa.gov/sites/default/files/7.2017_6.2017-Managed-Care-Annual-Performance-Report.pdf.

¹⁸ Interview with Shelly Chandler, CEO, Iowa Association of Community Providers, April 6, 2018.

¹⁹ Interview with Chris Sparks, Executive Director, Exceptional Persons and Shelly Chandler, CEO, Iowa Association of Community Providers April 6, 2018.

²⁰ "If the MCO's (sic) deny or reduce your services, let us know." *Disability Rights Iowa*. <https://disabilityrightsowa.org/special-announcements/>

²¹ "Family Care." Wisconsin Department of Health Services; <https://www.dhs.wisconsin.gov/familycare/index.htm>

States with Current MLTSS-I/DD Programs

ARIZONA	
Name	Arizona Long-Term Care System
Authority	1115
Managing Entity	Division of Developmental Disabilities
Population	I/DD
Start Date	1988

History and Structure

Arizona was the last state in the union to participate in the Medicaid program, joining in 1982. From that date, Arizona’s Medicaid program – the Arizona Health Care Cost Containment System (AHCCCS) – has operated entirely under an 1115 Waiver and provided services through managed care. In 1988, Arizona established the Arizona Long-Term Care System (ALTCS) for the management of LTSS. ALTCS delegates the management of LTSS for people with I/DD to the Arizona Division of Developmental Disabilities (DDD). Through a contract with AHCCCS, DDD serves as the managing entity under a capitated rate for LTSS, primary and acute care for people with I/DD.

Enrollment is mandatory and all LTSS for people with I/DD in Medicaid are covered under the DDD contract. People with I/DD receive behavioral health services through Arizona’s mainstream behavioral health service system, the Regional Behavioral Health Authorities (RBHAs). In the 2017-2018 contract, DDD received a monthly capitation rate of \$3,638.21.²² Arizona still maintains a small waiting list of a little over 200 people at last reporting.²³ Case management is performed by DDD employees.

Goals/Rationale for Managed Care

According to interviewees, Arizona undertook MLTSS to improve coordination of care, focus on HCBS,²⁴ and avoid creating a lengthy waiting list.²⁵ This focus along with Arizona’s history of relying primarily on state dollars – given their late entry into Medicaid – has resulted in avoiding the traditional institutional bias of the Medicaid program. Most significantly, Arizona’s developmental disabilities service system has focused almost solely on HCBS, and particularly emphasized serving individuals in family homes. As a result, in 2015, 96.6% of all Medicaid LTSS dollars for people with I/DD were delivered in home and community-based settings.²⁶

Enrollment Data

DDD serves approximately 36,000 members.²⁷ Arizona’s historic service delivery system has been largely oriented toward HCBS and has maintained that focus. In 2008 (the first year for which data are

²² Arizona Health Care Cost Containment System, “Contract Year Ending 2018 ALTCS DES/DDD Capitation Rate Certification.” April 2017. https://www.azahcccs.gov/PlansProviders/Downloads/CapitationRates/ALTCS-DDD/ActuarialCertification7_1_2017.pdf

²³ Residential Information Systems Project, “RISP Profile FY 2016 Arizona,” <https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Arizona-RISP-2016.pdf>

²⁴ Email from Traci Gruenberger, Executive Director, Mosaic - Arizona, April 6, 2018.

²⁵ Interview with Gale Bohling, Director of Government Relations, Res Care, April 9, 2018.

²⁶ Eiken, et al. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015,” *Truven with the Centers for Medicare and Medicaid Services* (2017), p. 101. <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-expenditures-fy2015-final.pdf>.

²⁷ Division of Developmental Disabilities, “Strategic Plan 2016-2020,” pg. 3. <https://des.az.gov/sites/default/files/media/Strategic-Plan-Booklet.pdf>

available), Arizona reported 95.8% of Medicaid LTSS expenditures for people with I/DD were provided in the home and community.²⁸ In 2015, that figure was 96.6%.

Experiences and Results

Arizona’s unique structure has meant that the challenges reported by Arizona providers are typical of those interfacing with a state agency, not an MCO. Providers report low reimbursement rates, little or no rate growth, and challenges with an administration that sets rates below cost.²⁹ Providers with experience interfacing with DDD and with the private MCOs operating MLTSS for other populations in the state note that working with DDD remains largely relationship based, resembling I/DD community relationships in other states; by contrast, working with MCOs is instead business- and operations-based. MCO staff frequently have shorter tenure, compared to DDD staff, and the leadership at DDD has a big impact on the relationship with providers. Providers also report less communication with the MCOs than with DDD,³⁰ and fewer problems with claims denials.³¹

Interviewees also report that the early integration of acute and LTSS under one managing entity has improved coordination and contributed to the stability of the system. Arizona has been able to contain a very small waiting list, and a relatively low state fiscal effort due to their focus on home-based services. Interviewees report that the remaining waiting list is due primarily to individuals unable to find providers, rather than lack of authorization for services from the state.³²

Key Indicators

Indicator	Arizona	National Average
Waiting List (RISP, 2014)	211	N/A
Statewide Staff Turnover (NCI), 2016	49.3%	45.5%
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	96.6%	76.0%
Gets Needed Services (NCI, 2014-2015)	81%	82%
Would Like to Live Somewhere Else (NCI, 2013-2014)	11%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	20%	18.6%
Proportion of people with I/DD in Poor Health, (NCI, 2015-2016)	5%	4%
State Fiscal Effort (State of the States, 2015)	\$3.77	\$4.30

²⁸ Wenslow, et al. “Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014.” *Truven Health Analytics with the Centers for Medicare and Medicaid Services*, pg. 57.

<https://www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf>.

²⁹ Department of Economic Security, “Rate Book” January 2018. <https://des.az.gov/sites/default/files/media/RateBook-Schedules-January-1-2018-Updated.pdf>

³⁰ Interview with Gale Bohling, Director of Government Relations, ResCare, April 9, 2018.

³¹ Email from Traci Gruenberger, Executive Director, Mosaic - Arizona, April 6, 2018.

³² Ibid.

MICHIGAN	
Name	Managed Specialty Services and Supports
Authority	1915(b)/(c)
Managing Entity	Local PIHPs
Population	I/DD and BH
Start Date	1998

History and Structure

In 1998, Michigan implemented a managed specialty services program for people with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders through county-based Community Mental Health Services Programs (CMHSPs). In 2002, the state implemented a new method for the selection of organizations to manage specialty services through Prepaid Inpatient Health Plans (PIHPs). This managed care structure is offered through the 1915(b) Managed Specialty Services and Supports Waiver and 1915(c) Habilitation Supports Waiver.

Michigan has no public or private ICFs; its last public ICF expenditures were in 2012. Case Management for behavioral health services and supports coordination for I/DD services are provided through the CMHSPs or contracted out to the private sector.

The Medicaid funding for behavioral health and I/DD services is provided by the Michigan Department of Health and Human Services (MDHHS) to 10 PIHPs throughout the state. Three of the PIHPs are also structured as CMHSPs. The total number of CMHSPs is 46.

Goals/Rationale for Managed Care

Michigan has achieved significant I/DD service system milestones, including eliminating the waiting list and closing all public and private ICFs. However, these achievements occurred separate from the transition to a managed care model. The stated goals of the PIHP program were freedom, community, accountability, and efficiency.³³ The PIHP model was implemented after lengthy discussions with stakeholders, including public hearings and a formal comment process. Those working in the state at the time report that the goals were also to ensure sustainability, quality, and cost-effectiveness of the program with a focus on HCBS, without pursuing more significant privatization or engagement with traditional Medicaid health plans which are MCOs.³⁴

Enrollment Data

As of 2016, there were 45,371 recipients of LTSS with I/DD in Michigan enrolled in services.³⁵

Experiences and Results

Providers report both benefits and challenges of the regional PIHP system. Providers working in multiple counties across the state face significant variation in contract terms, quality assurance expectations, billing, and other procedures.³⁶ However, with MLTSS as part of a quasi-public system, beneficiary protections are stronger and the state has been able to implement a focus on self-determination and

³³ Michigan Department of Community Health, PHP Implementation Guide, p. 1

³⁴ Email from Robert Stein, General Counsel, Michigan Assisted Living Association, April 7, 2018.

³⁵ Residential Information Systems Project, "RISP Profile FY 2016 Michigan," <https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Michigan-RISP-2016.pdf>

³⁶ Email from Robert Stein, General Counsel, Michigan Assisted Living Association, April 7, 2018.

person-centered planning.³⁷ Challenges experienced across states include low provider rates and low DSP wages, likely precipitated by the fact that federal approval of actuarially sound PIHP rates has not typically resulted in higher rates for HCBS providers.³⁸

Interviewees also report that the state has continued progress in moving to integrated, community-based services. After closing all public and private ICFs, the state has continued its focus on transitioning from traditional group home models to reducing the size of settings and assisting individuals to own or lease their own homes.³⁹

Michigan MLTSS Moving Forward

Michigan has begun to explore implementing fully integrated MCO-based managed care, including MLTSS. Michigan’s 2017-2018 budget directs the Michigan Department of Health and Human Services to develop pilot projects for fully integrated behavioral health (including HCBS for people with I/DD) and physical health. These pilots are to be conducted through the Medicaid health plans that are currently providing acute and primary care services in the geographic regions selected for the pilots in collaboration with the CMHSPs.⁴⁰ These “298 pilots” are scheduled to begin in October of 2019 with the goal of ensuring greater integration of behavioral health, LTSS, and physical health services.⁴¹

Key Indicators

Indicator	Michigan	National Average
Waiting List (RISP, 2016)	0	N/A
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	100%	76%
Gets Needed Services (NCI, 2014-2015)	74%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	28%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	24%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2014-2015)	88%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	3%	3%
Routine Dental Exam in Past Year (NCI, 2015-2016)	74%	81%
State Fiscal Effort (State of the States, 2015)	\$3.71	\$4.30

³⁷ Email from Robert Stein, General Counsel, Michigan Assisted Living Association, April 6, 2018.

³⁸ Interview with Paul Gallagher, President/CEO, Genesis In-Home Care, April 9, 2018.

³⁹ Email from Robert Stein, General Counsel, Michigan Assisted Living Association, April 6, 2018.

⁴⁰ Michigan Act No. 107, Public Acts of 2017. July 14, 2017. <https://www.legislature.mi.gov/documents/2017-2018/publicact/pdf/2017-PA-0107.pdf>

⁴¹ Michigan Department of Health and Human Services, “Frequently Asked Questions About the Section 298 Initiative,” https://www.michigan.gov/documents/mdhhs/FAQ_about_the_Section_298_Initiative_616881_7.pdf

WISCONSIN	
Name	Family Care
Authority	1915(b)/(c)
Managing Entity	Regional Nonprofit MCOs for LTSS only
Population	I/DD, people with physical disabilities, older adults
Start Date	1998

History and Structure

Wisconsin began Family Care, its MLTSS program for older adults, people with physical disabilities, and people with I/DD, as a pilot program in 1998. Family Care is operated by county-based and regional nonprofit MCOs responsible only for LTSS. The Family Care MCOs grew out of their historic county-based system, from public entities, to quasi-public, to private nonprofit entities. While the managing entities have matured, the program has also expanded several times. In 2015, state legislation expanded Family Care statewide. Implementation has been gradual and done on a county-by-county basis; as a county transitions to MLTSS it becomes an “entitlement” county and the waiting list is eventually eliminated. The final county – Dane County, which includes the capital Madison – began enrollment on February 1, 2018 and officials expect the waiting list will be eliminated by 2021.

Today, Family Care MCOs operate regionally and most counties have two MCOs operating in their area.⁴² Enrollment is mandatory for individuals using HCBS, except for a self-directed carve-out, and optional for individuals living in nursing facilities. State operated ICFs are excluded. Wisconsin also employs large, multi-state MCOs to manage acute and primary care for individuals on Medicaid, including people with I/DD on a voluntary basis.⁴³ Those health services are not integrated with MLTSS except for people participating in the fully integrated Family Care Partnership program in some regions of the state.

The self-directed option that allows individuals to opt out of Family Care is known as the Include, Respect, I Self-Direct (IRIS) program. IRIS began in 2008⁴⁴ and is now available in all but one Wisconsin county. While self-directed services are available as part of Family Care, IRIS offers a full budget and employer-authority model, with beneficiaries working with an IRIS consultant and fiscal employer agent instead of a care manager to develop their person-centered plan and to identify, hire and manage provider staff.

Wisconsin also operates the Family Care Partnership MLTSS program in 15 counties, a fully integrated managed care model for older adults and people with physical disabilities as well as people who are eligible for both Medicare and Medicaid. MCOs in the partnership program are responsible for providing acute and primary care as well as MLTSS.

⁴² Wisconsin Department of Health Services. “Family Care Geographic Service Regions January 2018.” <https://www.dhs.wisconsin.gov/publications/p01790.pdf>

⁴³ Gifford, Kathleen et al. “Medicaid Moving Ahead in Uncertain Times.” *Kaiser Family Foundation*, October 2017, pg. 27. <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>.

⁴⁴ Wisconsin Department of Health Services. “Annual Report 2015 Long-Term Care in Motion: Wisconsin’s Long-Term Care Program” <https://www.dhs.wisconsin.gov/publications/p00318-2015.pdf>

Goals/Rationale for Managed Care

Family Care was created to address waitlists, decrease reliance on institutional settings, reduce costs, and improve efficiency of care delivery. Current goals for the Family Care program include encouraging choice, improving access to services, improving quality by focusing on both health and social outcomes, and creating a cost-effective system.⁴⁵

Enrollment Data

As of January 1, 2018, there were 21,373 people with I/DD enrolled in Family Care and 703 enrolled in Family Care Partnership, for a total of 22,076.⁴⁶ As of February 1, 2018 there were a total of 16,031 IRIS participants;⁴⁷ data to disaggregate the subpopulations in IRIS is not available.

As of the most recent state report in 2015, 66% percent of all LTSS users in Wisconsin lived at home, and 86% of enrollees said they were living in their preferred living situation.⁴⁸ In Family Care, 56% were living at home, 37% were living in another residential setting, and 7% were living in institutional settings; 31% of enrollees age 18-64 were working and 9% were working in integrated employment.⁴⁹ By comparison, for those with I/DD: 60% live at home with family and an additional 15% live on their own, for a total of 75% served in a non-disability specific setting.⁵⁰

Experiences and Results

Advocates in Wisconsin report both benefits and drawbacks of Wisconsin's incremental and county-based approach. Enrolling only a few counties at a time over an extended period means that the state has the capacity and resources to support the county in its transition, and providers and families can learn from counties that went before.

Providers report that state contracts with the MCOs do not include provider rate requirements, and providers must negotiate with each MCO for reimbursement rates, often even down to the individual beneficiary level. Providers also expressed frustration with the lack of transparency and potential inconsistencies in payment methodology statewide. However, some interviewees indicated improvements in timeliness of payment under Family Care relative to prior county-based reimbursement.⁵¹ To better address issues related to rate and payment, providers have advocated for moving to uniform contracts that limit rate decreases without an accompanying change in condition to no more than once in a 12-month period.⁵²

Providers report that rates have been relatively stagnant since 2011, exacerbating their concerns that the capitated rates paid to MCOs by the state do not adequately account for the breadth and depth of services needed by people with I/DD. As a result, providers voiced concerns with both the ability to

⁴⁵ <https://www.dhs.wisconsin.gov/familycare/index.htm>

⁴⁶ Ibid.

⁴⁷ Wisconsin Department of Health Services, "IRIS Enrollment by County as of April 1, 2018."

<https://www.dhs.wisconsin.gov/publications/p01759.pdf>

⁴⁸ Wisconsin Department of Health Services. "Annual Report 2015 Long-Term Care in Motion: Wisconsin's Long-Term Care Program," pg. 15.

<https://www.dhs.wisconsin.gov/publications/p00318-2015.pdf>.

⁴⁹ Ibid., p. 18.

⁵⁰ Residential Information Systems Project, "RISP Profile FY 2016 Wisconsin," <https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Wisconsin-RISP-2016.pdf>

⁵¹ Interview with Mark Hagan, Corporate Director of Public Policy, Bethesda Lutheran Communities; Anne Foerster, Director of Services for People with Special Needs & WI Operations, Volunteers of America; and Shelley Hansen-Blake, Executive Director - REM Wisconsin / REM North Dakota / IL MENTOR Community Services, April 26, 2018.

⁵² Interview with and subsequent information obtained from Anne Foerster, Director of Services for People with Special Needs & WI Operations, Volunteers of America and information obtained from Shelley Hansen-Blake, Executive Director - REM Wisconsin / REM North Dakota / IL MENTOR Community Services, April 26, 2018 and May 16-18, 2018.

achieve quality of life outcomes for individuals served and to ensure a sustainable, robust provider network within the current funding arrangement.⁵³

In March 2016, Governor Scott Walker proposed integrating MLTSS into the larger commercial MCOs but withdrew the plan after opposition from disability and aging advocates and the state legislature. Department of Health Services data showed that the fully integrated system would result in no net LTSS savings, and only a 1.7% reduction in physical health costs among a small proportion of LTSS users.⁵⁴

Key Indicators

Indicator	Wisconsin	National Average
Waiting List (RISP, 2016)	1,890*	N/A
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	88.5%	76.0%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	19%	18.6%
Proportion of people with I/DD in Poor Health (NCI, 2013-2014)	4%	3%
State Fiscal Effort (State of the States, 2015)	\$5.75	\$4.40

*waiting list expected to be eliminated by 2021.

⁵³ Questionnaires from Mark Hagan, Corporate Director of Public Policy, Bethesda Lutheran Communities; and Anne Foerster, Director of Services for People with Special Needs & WI Operations, Volunteers of America

⁵⁴ Wisconsin Long-Term Care Coalition, "Voices of Older Adults and People With Disabilities Were Heard," https://docs.wixstatic.com/ugd/2aa64e_fb6fbdf3986d40a7870c6675d65afd09.pdf

NORTH CAROLINA	
Name	North Carolina LMEs/MCOs
Authority	1915(b)(c)
Managing Entity	Local PIHPs
Population	I/DD and Behavioral Health (includes People with Mental Health and Substance Use Disorder Needs)
Start Date	2005 Pilot / 2013 Statewide Implementation Complete

History and Structure

North Carolina took a unique approach to managed care for individuals with I/DD by beginning with LTSS benefits. For individuals with I/DD enrolled in the Innovations Waiver or applicable state-funded services, their health care services are managed through North Carolina’s Medicaid Primary Care Case Management (PCCM) system under a fee-for-service (FFS) structure, while their behavioral health and intellectual/developmental disabilities (I/DD) services are covered through a limited benefit PIHP delivered by Local Management Entities-Managed Care Organizations (LMEs/MCOs).⁵⁵ Beginning with a 5-county pilot in 2005, North Carolina has utilized LMEs/MCOs to manage behavioral health and I/DD services through capitated arrangements.⁵⁶ In 2011, the North Carolina legislature enacted enabling language to move to statewide implementation of the LME/MCO model by 2013.⁵⁷ LMEs/MCOs are regionally-based quasi-governmental entities and Medicaid members receiving services through the Innovations Waiver, ICF-I/DD and applicable state-funded services are mandatorily enrolled in the LME/MCO in their region.⁵⁸

In 2015, legislation was passed to direct the NC Department of Health and Human Services (DHHS) to transition fully to a managed care structure for physical health in addition to I/DD and Behavioral Health. As contemplated in the legislation, the program is designed to utilize two managed care Prepaid Health Plan (PHP) models, one for up to three (3) Commercial Plans (CPs) to provide integrated physical, behavioral, and pharmacy services under statewide contracts⁵⁹, and a second for up to ten (10) Provider-Led Entities (PLEs) to provide integrated physical, behavioral, and pharmacy services under regional contracts.⁶⁰ In 2017, DHHS published a proposed program design to offer two different types of managed care offerings: Standard Plans (SPs) or Tailored Plans (TPs). Under the proposed design, both CPs and PLEs will be permitted to offer both plans, assuming they are able to meet the plan requirements.⁶¹ The SPs would be offered to the majority of beneficiaries (those with less significant needs) and would provide integrated physical, behavioral, and pharmacy services when managed care launches.⁶² TPs would focus on individuals with significant behavioral health needs, individuals with

⁵⁵ North Carolina’s Proposed Program Design for Medicaid Managed Care, North Carolina Department of Health and Human Services, August 2017, p. 22 - https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf

⁵⁶ CMS Managed Care Profiles for North Carolina, August 2014, p. 1, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/north-carolina-mcp.pdf>

⁵⁷ Session Law 2011-264, House Bill 916, <https://www.ncleg.net/Sessions/2011/Bills/House/PDF/H916v5.pdf>

⁵⁸ Disability Rights North Carolina, Managed Care Organizations (MCOs): The Basics and Emerging Issues, Disability Rights NC Conference 2015, Jennifer Bills and Lisa Nesbitt, www.disabilityrightsncc.org/system/files/MCOs%20and%20Medicaid%20Basics%20PowerPoint%20handout.pdf

⁵⁹ Session Law 2015-245, House Bill 372, Part I, Section 4(6)(a), <https://www.ncleg.net/enactedlegislation/sessionlaws/html/2015-2016/sl2015-245.html>

⁶⁰ Session Law 2015-245, House Bill 372, Part I, Section 4(6)(b), <https://www.ncleg.net/enactedlegislation/sessionlaws/html/2015-2016/sl2015-245.html>

⁶¹ Medicaid Managed Care Proposed Concept Paper, Behavioral Health and Intellectual/Developmental Disability Tailored Plan, North Carolina Department of Health and Human Services, November 9, 2017, p. 1.

⁶² Ibid.

I/DD, and TBI and provide specialized services targeted at their needs.⁶³ The proposed program design anticipates rolling out the Behavioral Health I/DD TPs in the second year of managed care implementation, with an impact on an estimated 85,000 enrollees.⁶⁴ LME/MCO contracts will be terminated concurrent with the BH I/DD TP rollout.⁶⁵ As noted in their concept paper, implementation of the proposed program design is contingent on action by the North Carolina General Assembly.⁶⁶

Goals/Rationale for Managed Care

With the introduction of the LMEs/MCOs, the state's aim was to advance high-value care, improve population health, engage and support providers, and promote predictable and sustainable costs. The stated goals of the current reform efforts do not stray far from the original goals. They are intended to move the state toward a more comprehensive model to achieve improved care coordination, establish a clearer point of accountability, improve population health, expand innovation, and experience greater cost management.

North Carolina stakeholders interviewed agreed with the goals of the initial LME/MCO reform and believed most have been accomplished, such as improved budget predictability, a flattened Medicaid cost curve, and addressing service gaps through provider network development. Stakeholders noted that the system experienced a learning curve in moving toward achieving these goals that resulted in some initial system disruption and instability due to the significant culture change. Additionally, with the introduction of ten LMEs/MCOs, there was an initial loss in system standardization resulting in some increase in administrative burdens, inconsistency in payments, and challenges related to navigating multiple IT systems.⁶⁷ Stakeholders indicate that much of this initial instability has been mitigated with experience and LME/MCO consolidations.

Stakeholders believe there is value in moving toward a whole person integrated health approach with current reform efforts. However, there is concern that, despite the system being more managed-care ready, there will be disruption and instability as up to fifteen (15) new managed care entities are introduced to the system. This is of particular concern in contemplating the state's ability to successfully achieve their key goals and objectives for their transformation efforts, especially in ensuring an effective transition to managed care for beneficiaries and providers.⁶⁸

Enrollment

North Carolina's LME/MCO Annual Statistics and Admission Report for Fiscal Year 2017 reflect increases over the last three fiscal years in total LME-MCO members served (12.8%).⁶⁹ The LME-MCOs served a total of 321,511 persons⁷⁰ during fiscal year 2017 of which 18,007 were individuals with I/DD.⁷¹ Concurrently, an annual decrease in new enrollees with I/DD was noted from 1,219 in FY2013 to 758 in FY2017, including a 17.9% decrease from FY2016 to FY2017.⁷²

⁶³ Ibid.

⁶⁴ North Carolina's Proposed Program Design for Medicaid Managed Care, North Carolina Department of Health and Human Services, August 2017, p. 21, figure 5, https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf

⁶⁵ Ibid.

⁶⁶ Medicaid Managed Care Proposed Concept Paper, Behavioral Health and Intellectual/Developmental Disability Tailored Plan, North Carolina Department of Health and Human Services, November 9, 2017, p. 1

⁶⁷ Interview with Bob Hedrick, Executive Director, NC Providers Council and Jeanne Duncan, CEO, RHA Health Services and Affiliated Companies, April 12, 2018

⁶⁸ North Carolina's Proposed Program Design for Medicaid Managed Care, North Carolina Department of Health and Human Services, August 2017, p. 6

⁶⁹ North Carolina LME-MCOs Annual Statistics and Admission Report, Fiscal Year 2017, p. 1, <https://files.nc.gov/ncdhhs/documents/files/2017%20LME%20Annual%20Report.pdf>

⁷⁰ Ibid. at 4.

⁷¹ Ibid. at 6.

⁷² Ibid. at 3A.

Case Management

Prior to implementing LMEs/MCOs, case management was provided under the Community Alternatives Program for Individuals with I/DD HCBS Waiver (the predecessor to the current Innovations Waiver). Under the current managed care structure, care coordination is provided directly through the LMEs/MCOs.⁷³ With the shift to care coordination by the LMEs/MCOs, some stakeholders have voiced concern that there was no longer the same level of support especially for individuals with complex medical and behavioral needs, that there is an over-reliance on parents and guardians, and that combined this results in a barrier to community-based support.⁷⁴

Experiences and Results

Providers interviewed about system outcomes indicated there has been some development of co-location models, increased communication between physical health and MH/I/DD/SUD, and coordination of community clinical care with hospitals. There have also been increases in the use of evidence-based models that promote employment for behavioral health and I/DD populations.

Quarterly LMEs/MCO contract performance reports include treatment outcome metrics which are process- and time-oriented. LMEs/MCOs are to report on measures including prevention and early intervention, timely access to care, penetration rates, initiation and engagement in services, crisis and inpatient services, and continuity of care. Measures specific to individuals with I/DD include ensuring needs assessments are current, completion of National Core Indicators consents and pre-surveys, and NC-START/crisis respite use data.⁷⁵

Interviewees noted recent use of the most basic pay for performance activities from the LMEs/MCOs, though heavily concentrated on MH/SUD metrics. They anticipated the introduction of more outcome measures this year that would be more directed to I/DD, including some institution-to-home transition outcomes. Value-Based Purchasing (VBP) is scheduled to be included in the new contracts with PHPs to ensure that payments to providers are increasingly focused on population health, appropriateness of care, and other measures of value, rather than on a fee-for-service basis. Under the proposed approach, the PHPs will have latitude to develop and lead innovative strategies through VBP arrangements and will be incentivized for making measurable improvements.

In terms of challenges, litigation brought by Disability Rights North Carolina last year points to potential stakeholder concerns.⁷⁶ In its complaint, Disability Rights NC asserts that due to “systemic flaws in the design, funding, implementation, and administration of the [state’s] health and human services system” North Carolina citizens with I/DD are at higher risk of being institutionalized.⁷⁷ Among the challenges associated with the Innovations Waiver and/or LMEs/MCOs, plaintiffs cite financial incentives for service reductions, transitioning case management/care coordination to LMEs/MCOs, inadequate provider networks, funding reductions related to the use of an assessment-based resource allocation methodology, misapplication of the medical necessity standard, and an ineffective appeals process.⁷⁸

⁷³ Disability Rights North Carolina, Managed Care Organizations (MCOs): The Basics and Emerging Issues, Disability Rights NC Conference 2015, Jennifer Bills and Lisa Nesbitt, Slide 12

⁷⁴ Complaint at 13, Shannon r., et. al. v. State of North Carolina, May 24, 2017, http://www.disabilityrightsncc.org/sites/default/files/Complaint_SamanthaR.docx

⁷⁵ These measures are referenced in the SFY 2018 Performance Contract with Local Management Entities - Managed Care Organizations, Report/Data Submission Requirements, First Quarter Report, July 1, 2017 - September 30, 2017, at 29 -30.

<https://files.nc.gov/ncdhhs/documents/files/SFY18%20Q1%20DHHS-LME-MCO%20Performance%20Contract%20Report.pdf>

The link embedded in this First Quarter Report to reports on these measures was broken and according to the state DHHS contact are no longer posted publicly.

⁷⁶ Complaint, Shannon r., et. al. v. State of North Carolina, May 24, 2017,

http://www.disabilityrightsncc.org/sites/default/files/Complaint_SamanthaR.docx

⁷⁷ Ibid. at 5 – 6.

⁷⁸ Ibid.

Lastly, several newspaper outlets including the Winston-Salem Journal⁷⁹ reported upheaval related to Cardinal Innovations, the state’s largest LME/MCO, which was found to have mismanaged funds. After repeated audit findings suggesting concern, the state took over operations for several months and put Cardinal on a Corrective Action Plan. Using authority provided in state law, the Secretary of DHHS removed the CEO, several managers resigned, and a new Board of Directors was appointed. While creating some upheaval in the system, the experience demonstrates why building the appropriate infrastructure, including tools for the state to adequately monitor vendors/contractors and hold them accountable is so important.

Key Indicators

Indicator	North Carolina	National Average
Waiting List (RISP, 2016)	10,687	N/A
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2012)	56.9%	76%
Gets Needed Services (NCI, 2014-2015)	70%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	28%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	15%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2015-2016)	86%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	2%	3%
Routine Dental Exam in Past Year (NCI, 2015-2016)	85%	81%
State Fiscal Effort (State of the States, FY15)	\$4.66	\$4.30

⁷⁹ http://www.journalnow.com/news/elections/local/nc-health-secretary-orders-management-takeover-at-cardinal-innovations/article_1e6c09fd-4a0d-5259-8ab0-3b44047144f8.html

KANSAS	
Name	KanCare
Authority	1115
Managing Entity	Multi-state Commercial MCOs
Population	All
Start Date	2013, I/DD in 2014

History and Structure

Kansas implemented a fully capitated, MCO-based, state-wide managed care system in 2013 called KanCare, with enrollment of people with I/DD delayed until early 2014. KanCare operates under an 1115 waiver with seven 1915(c) waivers operating concurrently. All Medicaid services except for state institutions are included. Enrollment is mandatory for all Medicaid beneficiaries, except for Native American tribes which can elect to remain in fee for service. Kansas’ stated goals included: controlling Medicaid costs, improving the quality of care, providing integration and coordination of care, establishing long-lasting reforms to sustain health improvements, and providing a model for other states.⁸⁰

For people with I/DD, Kansas’ stated goals included improved access to health care and elimination of the waiting list, as well as improving employment outcomes. Local reports show a significant focus on cost. For instance, the Kansas Health Institute reported that then-Governor Brownback estimated \$1 billion in Medicaid savings over five years without reducing eligibility, covered services, or provider payment rates.⁸¹

In moving to managed care, Kansas undertook some provisions important to I/DD stakeholders. First, Kansas did not fully transition case management services to the MCOs. Rather, eligibility and assessment functions continue to be administered by local Community Developmental Disabilities Organizations and targeted case management is provided by I/DD providers. The targeted case manager then coordinates with the MCO-based care coordinator to develop the person-centered plan. Additionally, Kansas initially established a payment floor for LTSS providers, requiring MCOs to pay at least the Medicaid fee-for-service rates.⁸²

Enrollment Data

At the end of 2017, there were 8,954 people on the Kansas I/DD Waiver enrolled in KanCare.

Experiences and Results

Implementation of KanCare has raised concerns among disability advocates, both locally and across the nation. In 2013, the National Council on Disability (NCD) held a meeting in the state to hear about KanCare implementation. People with physical disabilities and older adults who had already been enrolled in KanCare attended the meeting and reported service cuts and significant concerns with the implementation. In December 2013, NCD recommended to CMS that enrollment of people with I/DD be

⁸⁰ Leavitt Partners, “Review of KanCare: Quality and Access to Care.” January 2018. <http://www.kamhp.org/news-resources/news/kamhp-2018-report-review-of-kancare-quality-and-access-to-care/view>

⁸¹ Marso, Andy. “Report: KanCare delivered on cost, not quality of care.” *Kansas Health Institute*. November 17, 2016. <http://www.khi.org/news/article/report-kancare-delivered-on-cost-not-quality-of-care>

⁸² Contract between Kansas Department of Health and Environment and Amerigroup Kansas, Inc. for Managed Care for Medicaid and CHIP Program (KanCare), p. 107. <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award>

delayed by another year (people with I/DD had already been excluded during the first year of implementation).⁸³

Providers in Kansas report that while they are making some progress in working with MCOs, the program has not achieved the stated goals for people with I/DD. Compared to the state’s goals, statewide employment outcome improvements have not been achieved and waiting lists have grown.

Percentage of people served in integrated employment. ⁸⁴							
2008	2009	2010	2011	2012	2013	2014	2015
19%	18%	15%	15%	15%	13%	14%	14%

Kansas has seen a slight decrease in people living in public ICFs.⁸⁵

Setting	2012	2013	2014	2015	2016
Public ICF/IDD	350	344	337	328	322

Waiting lists have increased.^{86, 87}

People with ID/DD	2014	2015	2016
Waiting for Medicaid Waiver	2,995	3,392	3,387

More recent data from the state notes that the ID/DD waiting list for services grew to 3,550 as of December 31, 2016.⁸⁸

In January 2017, CMS denied Kansas’ request to renew their 1115 waiver citing lack of compliance with federal requirements and significant numbers of complaints and concerns from beneficiaries, providers, and advocates.⁸⁹ CMS issued a corrective action plan regarding deficiencies in the state’s actions regarding: oversight of LTSS network adequacy, stakeholder engagement, LTSS ombudsman staffing capacity, compliance with person-centered planning requirements (including that participants receive services consistent with the plan), and HCBS critical incident reviews or monitoring of the use of restraints and seclusion.

A report from Leavitt Partners cites continuing concerns with the provision of HCBS. They note that while state data shows that it is meeting its commitments to reducing institutionalization and supporting people to live in the community, the reported provider experience does not match this

⁸³ National Council on Disability, “NCD Letter to CMS about Amendment to KanCare Medicaid Section 1115.” December 13, 2013. <https://ncd.gov/publications/2013/12132013>

⁸⁴ “Kansas” *StateData.info*. <https://www.statedata.info/bbstates/Kansas.pdf>

⁸⁵ Kansas Department of Health and Environment, “Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.16.” pg. 17. <http://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms---3-31-17---final.pdf?sfvrsn=14>.

⁸⁶ Residential Information Systems Project, “RISP Profile FY 2016 Kansas,” <https://risp.umn.edu/sites/risp.umn.edu/files/2018-03/Kansas-RISP-2016.pdf>

⁸⁷ Kansas Department of Health and Environment, “Quarterly Report to CMS Regarding Operation of the 1115 Waiver Demonstration Program – Quarter Ending 9.30.17.” Pg. 32. <http://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/2017/kancare-quarterly-report-to-cms---qe-9-30-17.pdf?sfvrsn=4>

⁸⁸ Kansas Department of Health and Environment, “Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.16.” pg. 17. <http://www.kancare.ks.gov/docs/default-source/policies-and-reports/annual-and-quarterly-reports/annual/kancare-annual-report-to-cms---3-31-17---final.pdf?sfvrsn=14>.

⁸⁹ Letter from James Scott, Associate Regional Administrator for Medicaid and Children’s Health to Jonathan Shorman, Reporter, Topeka Capital-Journal. January 27, 2017. <https://hcfgrc.org/wp-content/uploads/2017/02/CMS-KanCare-letters.pdf>

claim.⁹⁰ Recent media reports have shown that state audits are unable to come to conclusions regarding the program, due to lack of data integrity and reliability.⁹¹ Consistent with providers’ perspectives, a new report notes that a recent audit of KanCare found that “the state’s data is so bad, there’s no way to know [whether KanCare is working]”⁹² and that auditors noted that “data reliability issues entirely prevented [them] from evaluating KanCare’s effect on beneficiaries’ health outcomes.”⁹³

Since January 2017, CMS granted Kansas a temporary extension of the program, and in December 2017, Kansas submitted an 1115 waiver renewal titled KanCare 2.0.⁹⁴ On November 2, 2017 Kansas issued the KanCare 2.0 RFP based on the proposed 1115, even though it had not yet been approved.

In early 2018, a bipartisan group of state legislators began raising concerns about the implementation of KanCare 2.0, including the Republican Senate President and Majority Leader.⁹⁵ On January 24, 2018, the Governor announced the halt of KanCare 2.0.⁹⁶ According to a press release from the Governor’s office, the state will either extend contracts of the three current MCOs for three years or evaluate the proposals received and award contracts without implementing the elements that raised the most concerns. Kansas’ 1115 waiver is still pending with CMS.⁹⁷ As of the date of this report, no public announcement has been made on the disposition of KanCare 2.0.

Key Indicators

Indicator	Kansas	National Average
Waiting List (RISP, 2016)	3,161	N/A
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	81.6%	76.0%
Gets Needed Services (NCI, 2014-2015)	94%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	26%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	14%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2014-2015)	90%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	6%	4%
Routine Dental Exam in Past Year (NCI, 2015-2016)	80%	81%
State Fiscal Effort (State of the States, 2015)	\$3.89	\$4.30

⁹⁰ Leavitt Partners, “Understanding KanCare’s Challenges.” November 2016. Slide 55.

http://www.khi.org/assets/uploads/news/14677/understanding_kancare_full_final_report_nov_2016.pdf.

⁹¹ Marso, Andy. “Kansas’ Medicaid Data Is So Bad, Analysts Can’t Even Tell If It’s Working.” *Governing*. May 11, 2018.

<http://www.governing.com/topics/health-human-services/gov-kancare-data-is-so-bad.html>. Accessed May 25, 2018.

⁹² <http://www.governing.com/topics/health-human-services/gov-kancare-data-is-so-bad.html>

⁹³ Ibid.

⁹⁴ Kansas Department of Health and Environment, “KanCare Renewal,” <http://www.kancare.ks.gov/about-kancare/kancare-renewal>

⁹⁵ McLean, Jim. “Republican Opposition to KanCare .20 Echoing Democratic Gripes on Privatized Medicaid” KCUR. January 16, 2018.

<http://kcur.org/post/republican-opposition-kancare-20-echoing-democratic-gripes-privatized-medicare-stream/0>

⁹⁶ Dulle, Brian. “Kansas governor announces plans to stop KanCare 2.0.” January 24, 2018. <http://ksnt.com/2018/01/24/kansas-governor-announces-plans-to-stop-kancare-2-0/>

⁹⁷ Governor Colyer was sworn in on January 31, 2018, and Brownback administration archives are not available. The Brownback press release is available here: http://www.kha-net.org/advocacy/kansaslegislature/advocacydownloads/gov-sam-brownback-announces-plans-to-stop-kancare-20-press-release_145130.aspx

IOWA	
Name	IA Health Link
Authority	1915(b)/(c)
Managing Entity	Multi-state commercial MCOs
Population	All
Start Date	2016

History and Structure

Iowa began pursuing Medicaid managed care through their Medicaid Modernization initiative led by then-Governor Terry Branstad in 2015. In 2016, Iowa implemented Iowa Health Link – a statewide, fully integrated, mandatory managed care program for all services (inclusive of LTSS) and all populations, including people with I/DD. Iowa implemented managed care under a 1915(b) authority and contracts with multi-state national for-profit MCOs.

Goals/Rationale for Managed Care

The Iowa Health Link initiative’s stated goals included improved quality and access, accountability for outcomes, and predictable and sustainable Medicaid budgets.⁹⁸ Presentations from the state focused heavily on budget aspects and cost control, noting that Medicaid costs had grown 73% since 2003.⁹⁹ The state pursued aggressive savings targets, projecting \$53.1 million in savings in the first six months of operations.¹⁰⁰

Iowa also included goals to rebalance the LTSS system from institutional to community-based services. MCO contracts describe the use of an HCBS-institutional blended rate to encourage rebalancing and lays out the expectation that MCOs will manage services to reduce capacity in State Resource Centers by 12 beds a year.¹⁰¹

Stakeholders interviewed report that they agree with the goals of improving quality and controlling costs through quality and coordinated care. They had been proud of the progress Iowa had made toward community-based services and employment outcomes. However, they also report that the singular focus on cost savings and lack of stakeholder engagement in system design have halted, if not eroded, progress and harmed the I/DD service system.¹⁰²

Enrollment Data

According to state annual reports, there were 36,825 people enrolled in MLTSS in 2016 and 37,664 enrolled in 2017. In 2016 63.2% of enrollees received services in the community;¹⁰³ in 2017 that figure grew slightly to 63.6%. In both years, AmeriHealth Caritas had the vast majority of LTSS enrollees, in general, and those living in the community, more specifically. In 2017, AmeriHealth Caritas had 62% of

⁹⁸ Iowa Department of Human Services, “Medicaid Modernization: Iowa High Quality Health Care Initiative.” March 18, 2015. Slide 10. https://dhs.iowa.gov/sites/default/files/IME_ModernizationPresentation_031815.pdf.

⁹⁹ Ibid, slide 3.

¹⁰⁰ Ibid, slide 12.

¹⁰¹ Department of Iowa Human Services, MCO Contract-MED-16-019. Pg. 36, 105.

https://dhs.iowa.gov/sites/default/files/AmeriHealth_Iowa_Contract.pdf

¹⁰² Interview with Shelly Chandler, CEO, Iowa Association of Community Providers, April 6, 2018.

¹⁰³ Letter from Sally Titus, Deputy Director of Iowa Department of Human Services to Senate Human Resources, House of Representatives Human Resources, and Joint Appropriations Committee on Health and Human Services. December 15, 2016.

https://dhs.iowa.gov/sites/default/files/MCO_Annual_Report_Final_12-15-16.pdf, p. 14.

all LTSS enrollees, 74% whom lived in the community. By contrast, 46% and 47% of Amerigroup and UnitedHealthcare enrollees, respectively, were living in the community in 2017.¹⁰⁴ State reports do not disaggregate I/DD populations from others receiving LTSS.

Case Management

Iowa's case management structure has evolved during implementation of the program. Originally, Iowa allowed MCOs to propose offering internal MCO case management or to contract with existing case management structures, such as counties, AAAs, and non-profits.¹⁰⁵ Two of three MCOs implemented internal case management, hiring many of the existing case managers from the field onto their own teams, while the third (AmeriHealth Caritas) established contracts with existing case management entities. Prior to roll-out, Iowa changed course to try to smooth the transition, and instead required MCOs to contract with existing case management entities for the first year of the contract before allowing the full transition of all members to MCO-based care management. Because current LTSS enrollees were likely to have trusted relationships and relied upon their existing case managers for advice during the enrollment process, even with some firewall protections there was little "conflict-free" enrollment counseling which likely contributed to the disproportionate enrollment; AmeriHealth enrolled the majority of LTSS users (see more below), and all three plans suffered from the disparate enrollment relative to actuarial projections.

Experiences and Results

MCOs, providers, and beneficiaries all report that the transition to managed care has been rough. The three participating MCOs all reported significant losses with medical loss ratios above 100% in most quarters through SFY2017.¹⁰⁶ In official documents, Amerigroup called attention to the "catastrophic experience" the Medicaid program was facing in Iowa;¹⁰⁷ UnitedHealthcare similarly called it "drastically underfunded."¹⁰⁸ AmeriHealth Caritas decided in late 2017 to exit the market, in large part due to the significant losses they incurred.¹⁰⁹

In June 2017, Disability Rights Iowa and the National Health Law Program filed a class action lawsuit against the state of Iowa on behalf six Iowans with disabilities, who claim that the implementation of MLTSS has resulted in arbitrary reductions in service hours, budgets, and provider payment for HCBS.¹¹⁰ The lawsuit has since been dismissed, largely due to the exit of AmeriHealth Caritas.¹¹¹ Multiple media outlets have reported cuts to services and, in one case, the death of a beneficiary after changes in

¹⁰⁴ Iowa Medicaid Enterprise, "Managed Care Annual Performance Report (July 2016-June 2017)." January 2018. Pg. 14-15.

https://dhs.iowa.gov/sites/default/files/Annualreport2017_Final.pdf

¹⁰⁵ Iowa Department of Human Services, "Iowa's Medicaid Program Updates and Transition." Slide 38.

https://dhs.iowa.gov/sites/default/files/Annual_Training_2015_Slides_Final_091115.pdf.

¹⁰⁶ Iowa Medicaid Enterprise, "Managed Care Annual Performance Report (July 2016-June 2017)." January 2018. Pg. 14-15.

https://dhs.iowa.gov/sites/default/files/Annualreport2017_Final.pdf

¹⁰⁷ Letter from Cynthia M. McDonald, Plan President Amerigroup Iowa to Charles M. Palmer, Director, Iowa Department of Human Services. November 10, 2016. <https://www.scribd.com/document/334801403/Amerigroup-Letter>

¹⁰⁸ Letter from Kimberly S. Folz, CEO, United Healthcare Community Plan of Iowa to Mikki Stier, Iowa Medicaid Director. November 18, 2016.

<https://www.scribd.com/document/334801434/UnitedHealthcare-Letter>

¹⁰⁹ Boyd, N. "AmeriHealth Caritas Announces Departure." KASA Practice Solutions Blog, October 31, 2017 <http://kasa-solutions.com/amerihealth-caritas-withdraws-iowa-medicaid/>

¹¹⁰ "Iowans Challenge State's Termination of Critical Health Care Services." Disability Rights Iowa. June 13, 2017.

<https://disabilityrightsiowa.org/wp-content/uploads/Press-Release-Managed-Care-June-2017.pdf>

¹¹¹ "Managed Care Class Action Lawsuit." Disability Rights Iowa. <http://disabilityrightsiowa.org/resources/managed-care/managed-care-class-action-lawsuit/>.

services.¹¹² These include [Care denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals](#),¹¹³ a special report from the Des Moines Register.

Providers have reported substantial operational challenges that threaten their ability to remain in business. Most significantly, those interviewed noted that in developing the rate minimums, the Iowa Department of Human Services used rate data from 2014, which resulted in underfunding.¹¹⁴ While MCOs were permitted to establish rates above the minimums, according to providers, AmeriHealth Caritas was the only MCO to do so. This appears to be confirmed by Iowa's most recent annual report showing significantly higher average aggregate per member per month cost for AmeriHealth Caritas than Amerigroup or UnitedHealthcare and likely contributed to their ultimate exit.¹¹⁵

In October of 2017, Iowa announced the exit of AmeriHealth Caritas, the largest (by enrollment) of the three MCOs serving the Iowa managed care market, effective December 1, 2017,¹¹⁶ and issued a new RFP to replace this MCO, for implementation on July 1, 2018. The new RFP continued to include coverage for the same populations and services, including MLTSS for people with I/DD. On May 22, 2018, the state announced it will award the replacement contract to Centene's Iowa Total Care Plan to begin coverage July 1, 2019.¹¹⁷

The exit of AmeriHealth Caritas caused significant disruption. In their October announcement, the state also noted that all AmeriHealth Caritas enrollees would be auto-enrolled into UnitedHealthcare, unless they opted into Amerigroup, the only other remaining MCO in the state. However, on November 21, 2017 Amerigroup announced that they did not have the capacity to take on the new members.¹¹⁸ A week later, the state announced that those enrollees who had tried to opt into Amerigroup by November 16, 2017 would receive fee-for-service coverage until Amerigroup could enroll them, affecting an estimated 10,121 members.¹¹⁹ On February 2, 2018 the Des Moines Register reported that Amerigroup would begin enrolling those members with enrollment beginning on March 1, 2018. Enrollees who had been served by United Healthcare (and were not under fee-for-service) can not switch to Amerigroup until the next open enrollment, unless they had "good cause" to disenroll from United Healthcare.¹²⁰

Providers report that problems with billing and payment have been an issue for all three (now two) MCOs. As an example, some providers reported that recently they've noted receipt of only 30%

¹¹² Clayworth, Jason. "A Medicaid patient lost the care he'd received for 20 years. 3 months later, he was dead." *Des Moines Register*. August 12, 2017. <https://www.desmoinesregister.com/story/news/investigations/2017/08/13/medicaid-patient-lost-care-hed-received-20-years-3-months-later-he-dead/488367001/>

¹¹³ <http://features.desmoinesregister.com/news/medicaid-denials/>

¹¹⁴ Email from Shelly Chandler, CEO, Iowa Association of Community Providers, April 2, 2018.

¹¹⁵ Iowa Medicaid Enterprise, "Managed Care Annual Performance Report (July 2016-June 2017)." January 2018. Pg. 23. https://dhs.iowa.gov/sites/default/files/Annualreport2017_Final.pdf.

¹¹⁶ Leys, Tony. "DHS waited 30 days to disclose AmeriHealth's possible exit from Iowa's Medicaid program." *Des Moines Register*. November 8, 2017. <https://www.desmoinesregister.com/story/news/health/2017/11/08/dhs-waited-30-days-disclose-amerihealths-possible-exit-iowas-medicaid-program/846332001/>

¹¹⁷ Leys, Tony. "Centene to replace AmeriHealth in managing Iowa's Medicaid program." *Des Moines Register*. May 21, 2018. Accessed at <https://www.desmoinesregister.com/story/news/health/2018/05/21/centene-replace-amerihealth-iowa-medicaid-manager/630758002/>

¹¹⁸ Clayworth, Jason. "215,000 Iowans left with 1 Medicaid choice after provider says it can't take more patients." *Des Moines Register*. November 21, 2017. <https://www.desmoinesregister.com/story/news/health/2017/11/21/215-000-iowans-have-1-choice-medicaid-after-provider-says-cant-take-more-patients/886335001/>

¹¹⁹ Leys, Tony "State to resume handling of 10,000 Iowa Medicaid members being dropped by AmeriHealth." *Des Moines Register*. November 27, 2017. <https://www.desmoinesregister.com/story/news/health/2017/11/27/iowa-medicaid-program-resume-direct-oversight-10000-members/899434001/>

¹²⁰ "IA Health Link Members Regain Choice." Iowa Department of Human Services. https://dhs.iowa.gov/iahealthlink/faqs/IAHealthLink_Members_Regain_Choice

reimbursement for billings related to Habilitation. In offering one possible explanation for the discrepancy, UnitedHealthcare reported that a “glitch” in the system had accidentally labeled the providers as out of network. UnitedHealthcare has announced it will retroactively reimburse providers in 30-45 days, a payment lag many providers will be unable to withstand.¹²¹ These billing issues are so endemic that the provider community has begun asking, “what will be the billing challenge of the month?” The Iowa Association of Community Providers reports that many providers have gone out of business or faced significant funding challenges due to low rates, reductions in authorized services, and payment lags.¹²²

Medicaid beneficiaries and advocates in Iowa have also spoken up about the transition to managed care. Public comments to Iowa’s Medical Assistance Advisory Council show problems with HCBS, consumer-direction, and case management as a consistent theme.¹²³ Providers reported concerns with low reimbursement rates, reductions in services, and statements from families fearful of long-time providers going out of business. Most importantly, interviewees in Iowa emphasized that Iowa has lost ground on its efforts to improve community integrated services, including employment.

Key Indicators

Iowa’s MMC program is so new that outcome data is somewhat limited. The Indicator chart below provides context data for Iowa’s performance before the implementation of IA Health Link, and the tables that follow provide some recent systemic perspective. Of note, after a brief decline, waiver waiting lists have risen above previous levels and rebalancing targets have not materialized in any change.¹²⁴

Indicator	Iowa	National Average
Waiting List (Iowa Department of Human Services, 2018) ¹²⁵	2,958	N/A
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	62.2%	76.0%
Community-Based LTSS Enrollment in Managed Care (Iowa Department of Human Services, 2017) ¹²⁶	62.3%	N/A
Percentage of people with I/DD in Integrated Employment (IA Health Link, Managed Care Organization Report, Performance Data, SFY2018, Q1 and Q2)	15.3% ¹²⁷	18.6%
State Fiscal Effort (State of the States, 2015)	\$6.88	\$4.30

¹²¹ Interview with Chris Sparks, Executive Director, Exceptional Persons, April 6, 2018.

¹²² Interview with Shelly Chandler, CEO, Iowa Association of Community Providers, April 6, 2018

¹²³ Iowa Medical Assistance Advisory Council. https://dhs.iowa.gov/sites/default/files/MATERIALS_PACKET_MAAC_FULL_COUNCIL_11-07-2017.pdf,

¹²⁴ Iowa Department of Human Services, “Medicaid Managed Care Quarterly Reports.” <https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports>. Accessed May 25, 2018.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Percentage calculated based on total number of members with I/DD in individual jobs divided by the total number of members with I/DD who had an assigned community-based case manager.

TENNESSEE	
Name	Employment and Community First CHOICES
Authority	1115
Managing Entity	Multi-state Commercial MCOs
Population	I/DD
Start Date	2016

History and Structure

Tennessee has a long history of managed care and MLTSS. Particularly noteworthy is its incremental approach beginning with the initial implementation of TennCare – Tennessee’s Medicaid program – in 1994, the state’s mental health service system moving to complete managed care in the mid 90’s, and the addition of CHOICES – it’s MLTSS program for older adults and people with physical disabilities – in 2010. Most recently, the implementation of Employment and Community First (ECF) CHOICES – its first foray into managed care for I/DD services – started in 2016. TennCare operates under an 1115 waiver and employs large multi-state MCOs.

Tennessee further applied its incremental approach to the implementation of ECF CHOICES. The state undertook significant stakeholder engagement efforts to help guide the development and eventual implementation of the I/DD program. Second, rather than fully transitioning all current beneficiaries to MLTSS, Tennessee maintained the existing 1915(c) HCBS waiver for current participants (though closed future enrollments) and opened the ECF CHOICES program to those individuals on the waiting list and those on the 1915(c) who choose to switch. Enrollees in ECF are served by the same three MCOs that hold statewide TennCare contracts; their Medicaid primary, acute, behavioral, and LTSS are now fully integrated. State ICFs are not included in the contracts.

The MCOs provide Supports Coordination (case management). The state requires extensive support coordination training – more than any other state reviewed. These include an orientation to I/DD and the ECF program, employment, person-centered practices, and the *Supporting Families*¹²⁸ philosophy and approach.¹²⁹

Enrollment is broken into three groups, labeled 4-6 (Groups 1-3 refer to older or physically disabled enrollees in traditional CHOICES):

- Group 4: Essential Family Supports – supports for families caring for a person, primarily under the age of 21, designed to plan and prepare for transition to employment and integrated community living in adulthood. This group may also serve adults over age 21.
- Group 5: Essential Supports for Employment and Independent Living – supports adults age 21 and over to plan for and achieve employment and community living goals, including the transition from school to competitive integrated employment.
- Group 6: Comprehensive Supports for Employment and Community living – supports for adults age 21 and over who need more intensive supports to achieve employment and community living goals.

¹²⁸ Supporting Families is a project of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the University of Missouri Kansas City (UMKC). See <http://supportstofamilies.org/> and <http://www.lifecoursetools.com/>.

¹²⁹ TennCare CHOICES contract, Care Coordination, pg. 187-188.

Next year, Tennessee will create two new groups – 7 and 8 – designed to serve those individuals with even more intense needs.¹³⁰

Goals/Rationale for Managed Care

ECF CHOICES was implemented with clear policy and programmatic objectives in mind: to reduce the waiting list and leverage managed care to build a system oriented toward employment and community integration.

To support their employment goals, Tennessee instituted a required Employment Informed Choice process before traditional residential supports can be initiated. Individuals aged 16-62 seeking Community Integration Support Services and/or Independent Living Skills Training who are not employed or pursuing employment must first complete the Employment Informed Choice process. This process includes:

- Orientation to employment, self-employment, employment supports and work incentives
- Completion of Exploration services designed to experience various employment settings aligned to the individuals' interest, aptitudes, experiences, and skills
- A signed acknowledgement from the individual that he or she elects not to pursue employment¹³¹

Tennessee also implemented ambitious service initiation timelines and significant preferred provider standards. Within 10 business days of enrollment, the MCO must determine if any individual has an immediate need for HCBS, and authorize and initiate the services. Within 30 calendar days, the MCO, through the support coordinator, must complete a comprehensive needs assessment, develop the person-centered support plan, and authorize and initiate services as outlined in the person-centered support plan.¹³² Tennessee's preferred provider standards span a page and a half, including person-centered organization training, documented success in helping people with I/DD achieve employment, leadership in employment service delivery, and employing a Certified Work Incentive Coordinator.¹³³

Providers¹³⁴ and the state¹³⁵ have noted challenges with service initiation timelines. Providers report that, to meet timelines, service plans are frequently underdeveloped when transmitted to providers. At times, providers and service coordinators continue to develop plans and individual goals after services have first been initiated. The state has reported that the majority of delays in meeting timelines are initiated by the individual or family in order to have more time to develop their person-centered plan, interview and chose providers, and identify community living arrangements.

Tennessee has undertaken several fundamental reforms at once. In addition to transitioning the system toward managed care, Tennessee has implemented a paradigm shift in service structure, reducing the focus upon 24/7 residential services and prioritizing family supports, community integration, and competitive integrated employment. In addition, by using an incremental approach, Tennessee has continued to operate two service systems – the traditional 1915(c) services managed by the Department

¹³⁰ Interview with Dotty Bell, Director – Quality Assurance for TN and GA, RHA Health Services, April 20, 2018.

¹³¹ TennCare CHOICES Contract, Definitions, p. 19; Care Coordination, p. 131.

¹³² TennCare CHOICES Contract, Care Coordination, p. 131.

¹³³ Contract, p. 256-258

¹³⁴ Interview with Dotty Bell, Director – Quality Assurance for TN and GA, RHA Health Services and Robin Atwood, Executive Director, Tennessee Community Organizations, April 20, 1028

¹³⁵ Presentation: Service Initiation in Employment and Community First CHOICES, May 14, 2018

of Intellectual and Developmental Disabilities and the new MLTSS program managed by TennCare and the MCOs. Many providers find themselves operating both simultaneously, running separate business lines with different rules, standards, services, and billing procedures.

The higher training standards for ECF provider staff, as well as the relatively few ECF enrollees, continues to create challenges in recruiting and retaining provider staff. Designed to be highly person-centered and flexible, ECF services rarely fill a full-time equivalent of hours, and both providers and employees could not afford to have trained staff “engaged to wait.”¹³⁶ However, providers report they are learning to work through these issues, including through assigning staff to both ECF programs and traditional 1915(c) programs. Providers also report higher staff satisfaction and (anecdotally) lower turnover among staff providing ECF services.¹³⁷ However, this currently applies to providers operating in urban and suburban areas; rural providers are still facing challenges in staffing programs. The state has also undertaken efforts to address workforce turnover and quality.

MCOs operating in Tennessee have made efforts to streamline credentialing to ease transition burdens on providers. Providers report good support from the state and MCOs, and the state continues to engage with MCOs and providers to solve problems as they arise.

Enrollment

As of January 31, 2018, there were 2,355 individuals enrolled in the ECF CHOICES program. Of those, 91% who had been enrolled for 30 days or more were receiving services.¹³⁸

Experiences and Results

TennCare reports that they have made progress on their goals. Specifically, they note that 80% of individuals who participated in the Employment Exploration service decided to pursue employment, over 20% of working age enrollees are working in competitive integrated employment. Average wages are \$8.44/hour (above the Tennessee minimum wage of \$7.25), and average hours per work week are 16.5 hours.¹³⁹ These indicators are provided for reference on Tennessee’s past statewide performance. Changes due to the implementation of ECF CHOICES are not yet captured in data reporting.

Key Indicators

Indicator	Tennessee	National Average
Waiting List (RISP, 2016)	5,769	N/A
Staff Turnover (NCI, 2016)	51.1%	45.5%
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	75.9%	76.0%
Gets Needed Services (NCI, 2014-2015)	94%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	17%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	18%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2014-2015)	95%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	4%	4%
Routine Dental Exam in Past Year (NCI, 2015-2016)	89%	81%
State Fiscal Effort (State of the States, 2015)	\$3.62	\$4.30

¹³⁶ Presentation: Service Initiation in Employment and Community First CHOICES, May 14, 2017 (slide 5)

¹³⁷ Interview with Robin Atwood, Executive Director, Tennessee Community Organizations, April 20, 2018.

States with Emerging MLTSS-I/DD Activity

NEW YORK	
Name	Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115
Authority	1115
Managing Entity	Regional I/DD Health Home/Care Coordination Organizations
Population	People with intellectual and developmental disabilities
Start Date	2018
Name	Fully Integrated Duals Advantage for Individuals with Developmental Disabilities
Authority	1115 – Medicaid/Medicare Plan
Managing Entity	Local Provider-led Managed Care Organization
Population	People with intellectual and developmental disabilities eligible for Medicare and Medicaid
Start Date	2016

History and Structure

New York began its first foray managing LTSS for people with I/DD in 2011, with the state’s announcement of the intent to submit an 1115 waiver for people with developmental disabilities as described in a [concept paper](#)¹⁴⁰ published by NY Department of Health (DOH). The state was facing substantial challenges due to a federal investigation into longstanding state practices resulting in significant Medicaid overpayments in the developmental disabilities program^{141,142} (estimated to be over \$700 M per year in federal funds), resulting in pressure to reduce DD expenditures and improve management of the program. In 2013, the state entered into a [“Transformation Agreement”](#)¹⁴³ with CMS, reflecting special terms and conditions on their primary 1115 Partnership waiver, with explicit accountability and outcome requirements for DD services.

The 2011 People First Waiver proposal sought to establish “Developmental Disability Individual Support and Care Coordination Organizations” (DISCOs), entities to be paid through a capitated rate and licensed as PIHPs. Additionally, the state proposed a specialized managed care demonstration for people with I/DD eligible for both Medicaid and Medicare to provide fully-integrated care (FIDA-IDD). The NY Office for People with Developmental Disabilities (OPWDD) spent three years working on waiver design and implementing reforms such as design of a standardized functional assessment process, reducing the ICF census, and building community capacity through Balancing Incentive Program resources. Legislation followed in 2013 (NY PHL§4403-g), authorizing the establishment of the DISCOs, which were required to be “controlled” by non-profit I/DD providers, but also authorizing “mainstream” managed care plans to participate if they could meet the DISCO requirements. A letter of intent solicitation followed in 2013, attracting a wide range of entities including I/DD provider-led DISCOs, large multi-state MCOs, and local home health agencies – both non-profit and for-profit organizations – expressing interest, 37 in total.

In August 2014, the state published the DISCO application with the intent to award contracts in early 2015 and start enrolling individuals in fall of 2015. However, this next step never occurred, for multiple

¹⁴⁰ https://opwdd.ny.gov/sites/default/files/documents/concept_paper.pdf

¹⁴¹ U.S. House of Representatives, Committee on Oversight and Government Reform. “Billions of Federal Tax Dollars Wasted Annually by New York’s Medicaid Program.” February 2013. <http://docs.house.gov/meetings/go/go00/20130205/100224/hrpt-113-x.pdf>;

¹⁴² Letter from Daniel R. Levinson, Inspector General, to Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services. May 17, 2012. <https://oig.hhs.gov/oas/reports/region2/21101029.pdf>

¹⁴³ https://opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment

reasons including continuing stakeholder concerns. While the effort to establish specialty managed care plans through DISCOs stalled, the duals demo (FIDA-IDD) forged ahead, and was approved by CMS in November 2015, with enrollments beginning April 2016.

In January 2015, OPWDD leadership announced the formation of a “Transformation Panel,” a state workgroup that would help develop the priorities for a DD system redesign. The state started anew, with robust stakeholder engagement, and a year of meetings resulting in a [final set of recommendations](#),¹⁴⁴ including support for a managed care approach provided by “experienced entities with expertise in providing services to people with developmental disabilities” and support for “transitioning OPWDD services to managed care using an 1115 waiver to allow for maximum flexibility.”¹⁴⁵

Current implementation: Health Homes/Care Coordination Organizations

Starting in 2016, New York embarked on a revised effort to implement provider-led care coordination entities, taking a more incremental approach than the initial DISCOs. After substantial (and nearly continuous) stakeholder engagement, the state has moved forward with a state amendment to the NY DOH 1115 Waiver, bringing the I/DD population in under its own unique structure using “Health Home/Care Coordination Organizations” (HH/CCOs). Entities controlled by a minimum of 51% non-profit I/DD providers will provide care coordination across all benefits (medical/acute, behavioral health, HCBS) for a capitated rate, relying upon the Health Home model (which provides a 90% federal match for the care coordination for the first two years, per beneficiary). Service providers will no longer offer supports coordination/case management services; all the staff and resources for those functions will reside within the HH/CCOs by July 1, 2019. The care coordination rate for the first month of service ranges from \$950-\$1012; the monthly PMPM for care coordination ranges from \$317-\$637 after the first month, dependent upon acuity and geographical region. At this point, the HH/CCOs will bear no risk (beyond their own case management services); they are responsible for establishment of comprehensive person-centered service plans (“Life Plans”) that incorporate all healthcare and I/DD services, but authorization and utilization will still be overseen by the state agency, OPWDD.

Seven HH/CCO organizations were approved by OPWDD to begin implementation on July 1, 2018.¹⁴⁶ Nearly all providers have aligned with a CCO for purposes of transitioning the service coordinators, but networks are still being built. Enrollment for participants is “voluntary,” although because so many people with disabilities and families have expressed concerns about maintaining the service coordination relationships, and since the existing service coordinators will become employees of the HH/CCOs, it is expected that the majority of eligible members will enroll fairly quickly, by following their current service coordinator. The alternative for any beneficiary who does not enroll with a CCO is state-provided case management without care coordination. Enrollment remains voluntary through 2020 and becomes mandatory in 2021.

Goals/Rationale for Managed Care

OPWDD originally articulated four areas for reform: establishment of a person-centered system that would better meet individual needs, with a valid needs assessment, equitable resource allocation, and choices in plans, providers, and services; enhancing care coordination and service planning, including no wrong door access and comprehensive care integration with teams specifically able to meet the unique needs of people with DD; enhancing community-based services and reducing reliance on institutional

¹⁴⁴ <https://opwdd.ny.gov/sites/default/files/documents/TransformationPanelReport-RaisingExpectationsChangingLives.pdf>

¹⁴⁵ Office of People with Developmental Disabilities, “Raising expectations, Changing lives.”

<https://opwdd.ny.gov/sites/default/files/documents/TransformationPanelReport-RaisingExpectationsChangingLives.pdf>

¹⁴⁶ Office of People with Developmental Disabilities, “Care Coordination Organizations.”

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/CCOs

settings; and establishing transparent funding streams that support individual outcomes.¹⁴⁷ The state also made clear that the intent of the waiver was not “a Medicaid block grant to cap spending on individuals, a means to achieve budget reductions, or a means to restrict or expand eligibility.”¹⁴⁸

As the state rolls out the HH/CCOs, the focus is on care management integration, continuing “to provide the service coordination that people currently receive, but also include coordination of other services, such as health care, wellness, behavioral, and mental health services through a single individualized Life Plan, to replace the current Individualized Service Plan (ISP).”¹⁴⁹

Enrollment

There were 98,499¹⁵⁰ individuals with I/DD enrolled in OPWDD care management (both Medicaid Service Coordination and Care Plan Support Services) in 2016. The state anticipates that the majority of these individuals will enroll in HH/CCOs. As of December 2017, only 713 people had voluntarily enrolled in the FIDA-IDD (out of an estimated 20,000 eligible individuals.)¹⁵¹

Key Indicators

Indicator	NY	National Average
Waiting List (RISP)	0	N/A
Staff Turnover (2016 Staff Stability Survey Report, 2018)	31.2%	45.5%
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	73.4%	76%
Gets Needed Services (NCI, 2014-2015)	85%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	20%	26%
Percentage of people with I/DD in Integrated Employment (StateData: The National Report on Employment Services and Outcomes, 2016)	13%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2014-2015)	86%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	1%	4%
Routine Dental Exam in Past Year (NCI, 2015-2016)	91%	81%
State Fiscal Effort (State of the States, FY15)	\$9.06	\$4.30

¹⁴⁷ “Strengthening Services for the Future: An Introductory Presentation on the People First Waiver.” April/May 2012.

https://opwdd.ny.gov/sites/default/files/documents/Waiver_101_April_2012_final.pdf

¹⁴⁸ Ibid.

¹⁴⁹ Office for People with Developmental Disabilities. “Care Coordination Organizations.”

https://opwdd.ny.gov/providers_staff/care_coordination_organizations

¹⁵⁰ Office for People with Developmental Disabilities, “Care Coordination Organization/Health Home Application to Serve Individuals with Intellectual and/or Developmental Disabilities.” October 6, 2017.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf

¹⁵¹ Medicaid and CHIP Payment and Access Commission, “State Profile for the Capitated Financial Alignment Demonstration,” <https://www.macpac.gov/wp-content/uploads/2016/07/NY-FIDA-IDD-Capitated-Financial-Alignment-Demonstration.pdf>

ARKANSAS

Name	Provider-led Arkansas Shared Savings Entity (PASSE)
Authority	1915(b)/(c)
Managing entity	Provider-led ACOs (must be 51% provider owned)
Population:	Community-based BH and I/DD
Start Date	Phase 1-January 2018; Phase 2-Scheduled for January 2019

History and Structure

In 2016, an Arkansas Legislative Task Force charged the Arkansas Department of Human Services (DHS) to examine potential reforms that would make Arkansas Medicaid programs sustainable. After examining the options, the state chose a hybrid model that would allow them to build on the foundation of existing successful provider-based organizations and merge them with established managed care companies. Act 775 was signed into law on March 31, 2017 and established a new business organization called Provider-Led Arkansas Shared Savings Entity (PASSE). These entities must maintain provider ownership of at least fifty-one percent (51%). With this implementation, Arkansas will become the first provider led/owned, integrated managed care model for people with I/DD in the country.

Beneficiaries are assigned to a PASSE based on an independent assessment that indicates they meet a Tier II or Tier III level of care, which demonstrates a need for intensive behavioral health or I/DD services. Individuals with Tier I assessment may opt in. Each PASSE must operate on a statewide basis and will be responsible for the full integrated care for all assigned beneficiaries. PASSE implementation is occurring in two phases; the first phase began January 15, 2018 and Phase Two is to begin January 2019, at which time DHS intends to make global per-person, per month (PMPM) payments.

Goals/Rationale for Managed Care

The key features of the PASSE model are to enhance case management and care coordination to proactively manage and improve members' health by coordinating all provider services, increase the array of services and number of service providers, and to ultimately minimize costlier acute services, such as emergency department visits, inpatient psychiatric stays, and hospitalizations. PASSEs will have the opportunity to participate in value-based initiatives to incentivize desired outcome measures.

The Legislative Task Force's charge also includes development of strategies to address Medicaid sustainability; Act 775 compelled the implementation of a Medicaid Redesign Initiative to, among other goals, control and reduce "excessive and unnecessary costs."¹⁵² To that end, providers have expressed concerns that savings are trying to be gained from a system with existing service gaps; that the only way to realize savings is through service cuts; and without the inclusion of institutional services in the system there is no way to save on highest-cost services to reinvest in community services.¹⁵³ Serious concerns were raised by providers about the likelihood that members who need higher-cost supports would be pushed out of the most integrated community settings, and into institutional and more segregated service settings.¹⁵⁴

¹⁵² Act 775 of the 91st Session of the Arkansas General Assembly; <http://www.arkleg.state.ar.us/assembly/2017/2017R/Acts/Act775.pdf>

¹⁵³ Questionnaire from Syard Evans, CEO, Arkansas Support Network, April 26, 2018

¹⁵⁴ Questionnaire from Harold T. Watts Jr., State Executive Director, Evergreen Life Services, Questionnaire, April 30, 2018.

Case Management

Case Management has historically been a covered service for the I/DD population through the waivers, but not for the BH population. In Phase One, care coordination is provided by the PASSE responsible for the coordination of care across multiple systems, while plan of care development and service authorization responsibilities are scattered across different entities in the behavioral health system and I/DD system respectively. Case management/care coordination (CM/CC) will transition fully to the PASSEs in Phase Two and will include plan of care development and service authorization.

Stakeholders expressed concern about CM/CC gaps, including the short-term challenges related to CM/CC staff moving to the PASSE organizations while providers still have CM/CC responsibilities until Phase Two is implemented, as well as the steep learning curve to shift to care coordination. Some providers have sufficient funding to maintain some case management resources in-house and fill those perceived gaps, but many do not.

One stakeholder indicated that the full range of CM/CC activities and expectations remains to be addressed, as the state has indicated that those policies have not yet been developed for Phase Two. It was also reported by stakeholders that the care coordination fee has been reduced and an annual plan development fee added. With the traditional CM/CC activities scattered across entities in the phased implementation process, and without the availability to review the CM/CC policies for Phase Two, providers expressed some trepidation about future implementation.

Enrollment Data

According to a projected enrollment table published June 2017, the state anticipated that nearly 28,000 people would be covered by the PASSEs; about 7,500 individuals with I/DD and over 20,000 individuals with behavioral health needs. Data furnished by the state reflects a total 9,998 members assigned across the four PASSEs as of April 15, 2018. The distribution among the PASSEs:

- Summit Community Care - 2,617 (26.18%)
- Arkansas Total Care - 1,580 (15.80%)
- Empower Health - 4,406 (44.07%)
- Forever Care - 1,395 (13.95%)

However, the state is prioritizing enrollment of members with behavioral health needs first with enrollment of individuals with I/DD second, and the attribution for people with I/DD may vary from these initial trends. While the state acknowledges a slow start relative to completion of assessments, 4,500 members were successfully assigned in April 2018 with a target of processing 4,500 assignments each month going forward until all initial assessments are complete. Members for whom eligibility had lapsed would not be included in the PMPM fee.¹⁵⁵ One interviewed provider referred to the challenges with assessments saying, “We have no consumers as of today that have been attributed to the PASSE as they are still waiting on assessment.”¹⁵⁶

Rebalancing

The state has announced that they expect to reduce and eventually eliminate the I/DD waiting list for the Community and Employment Supports HCBS waiver through the revenue generated by the 2.5 percent premium tax.¹⁵⁷ Act 775 requires that at least 50% of the receipts from the state’s “premium tax” go to I/DD services and to eliminating the waiting list.¹⁵⁸

¹⁵⁵ Robert Nix, Arkansas Department of Human Services, Medicaid Organized Care Plan Manager, May 1, 2018.

¹⁵⁶ Questionnaire from Harold T. Watts Jr., State Executive Director, Evergreen Life Services, Questionnaire, April 30, 2018.

¹⁵⁷ The Official Code of Arkansas requires hospital and medical service corporations to pay a 2.5% premium tax based on its net direct written premiums in compliance with the provisions of §26-57-601 et seq. as a tax for the privilege of transacting business in the state.

¹⁵⁸ Interview with Shane Spotts, Anthem, Inc. and Debbie Stehling, Friendship Community Care, Inc., April 15, 2018.

As of FY2015, Arkansas’ percentage of LTSS that is HCBS is 52.0% of total spending. The state increased its total HCBS expenditures from FY2012 to FY2015 by 28.9%, and concurrently decreased institutional LTSS spending by 3.37%. This slightly higher investment in HCBS provides a solid benchmark from which to follow how the implementation of the PASSE model might influence the balance.

Early Implementation

Issues related to PASSEs readiness, attribution of members to PASSEs, and the independent assessments have been reported in its preliminary stages.¹⁵⁹ Only three of the five licensed PASSEs had completed the necessary paperwork and processes to begin enrolling members by the February 1, 2018 deadline.¹⁶⁰ The attribution methodology adopted for the PASSEs was designed to align members with providers with whom they had an established relationship. The methodology uses member scoring based on three factors from 12 months of claims data: provider relationship history visits, specialty classification with weights by type of provider, and cost. With attribution distribution among the PASSEs ranging from as high as 44% in one and as low as 14% in another,¹⁶¹ the attribution algorithm has not proportionately assigned members to PASSEs thus far. The attribution is also being affected by the rate of completion of independent assessments, occurring at a slower pace than originally anticipated, as attribution is dependent upon the completion of the assessment.

Since PASSE attributions began, providers report concerns based on feedback that families have been told that their current primary care provider was not in their PASSE and as a result they would need to educate the primary care provider on the need to join the network or to find a different primary care provider. Providers also shared that the short transition timeline for Phase One causes concern that there will be negative consequences for beneficiaries as a result of the rapid timeframe for this transition. In addition, providers reported that the lack of specificity in information and policy related to Phase Two implementation also causes uncertainty and makes the implementation process challenging. The lack of a CMS-approved waiver and defined rate structure prior to implementation has raised concerns. Providers also worry that all of the assessments will not be completed in a timely manner that will allow the state to maintain the projected timeline.¹⁶²

Key Indicators

Indicator	Arkansas	National Average
Waiting List (RISP, 2016)	3,161	N/A
Staff Turnover (NCI, 2016)	DNF	45.5%
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)	53.1%	76%
Gets Needed Services (NCI, 2014-2015)	91%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)	39%	26%
Percentage of people with I/DD in Integrated Employment (StateData.info, 2015)	DNF	18.6%
Case Manager /Service Coordinator Helps Get What Individual Needs (NCI, 2015-2016)	94%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)	3%	3%
Routine Dental Exam in Past Year (NCI, 2015-2016)	87%	81%
State Fiscal Effort (State of the States, FY15)	\$5.28	\$4.30

¹⁵⁹ Comments by Paula Stone, Deputy Director, DMS, DHS, to Arkansas Health Care Payment Improvement Initiative Strategic Advisory Group, Minutes, March 7, 2018; <http://www.paymentinitiative.org/Websites/paymentinitiative/images/SAG%20Minutes%2003-07-2018.pdf>

¹⁶⁰ Ibid.

¹⁶¹ Robert Nix, Arkansas Department of Human Services, Medicaid Organized Care Plan Manager, May 1, 2018.

¹⁶² Questionnaire from Harold T. Watts Jr., State Executive Director, Evergreen Life Services, Questionnaire, April 30, 2018.

TEXAS

Name:	STAR+PLUS; Community First Choice
Authority:	1115; 1915(k)
Managing entity:	Multi-state Commercial MCOs
Population:	All for Medical/Acute Services
Start Date:	TBD for MLTSS-I/DD

History and Structure

STAR, established in 1993, is a Texas Medicaid managed care program in which the Texas Health and Human Services Commission (HHSC) contracts with MCOs to provide, arrange, and coordinate preventive, primary, and acute care with behavioral health and pharmacy services for pregnant women, newborns, children, and parents with limited income. In 1995, the Texas Legislature implemented the State of Texas Access Reform Plus (STAR+PLUS) program to combine acute care and long-term services and supports through a cost-neutral managed care system. STAR+PLUS is a capitated health maintenance organization (HMO) model for Medicaid clients with disabilities and dual eligible clients who have Medicaid and Medicare which integrates acute and long-term services and supports. STAR+PLUS was piloted in 1998 and now operates under an 1115 waiver. The STAR+PLUS HCBS program, also approved for the managed care delivery system, is designed to allow individuals who qualify for nursing facility care to receive LTSS to be able to live in the community. Beginning in September 2014, management and coordination of acute care services for certain Medicaid-eligible persons with I/DD were transitioned to managed care (STAR+PLUS). Most of the LTSS services offered via the community based ICF/IDD program and waivers are planned to be carved-in by September 2021 with the carve-in for the Texas Home Living (TxHmL) waiver to occur in 2020 and the carve-in for community-based ICF/IDD services and the Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), & Deaf Blind with Multiple Disabilities (DPMD) (TxHmL) waivers to occur in 2021.¹⁶³ The State Supported Living Centers (state operated ICF-IDD) are not included.

Since 2015, Texas has also provided personal attendant services through MCOs (authorized by a Community First Choice state plan option) to individuals with I/DD enrolled in STAR+PLUS and/or who are on the waiting list for a waiver. In January 2017, HHSC released an RFP to conduct a pilot demonstration for the delivery of I/DD HCBS services through managed care. Ultimately, the pilot was canceled due to issues with insurance code compliance for providers who were targeted to participate in the pilot, concerns about elements of the pilot which may not conform to the HCBS Settings Rule, and time constraints.¹⁶⁴

Care Management Structure

Service coordination, available to all members, is a main feature of the STAR+PLUS program and is staffed by the MCOs. It is a specialized case management service for program members who need or request it and emphasizes member and family involvement in service planning. Enrolled members of excluded waiver populations have their own case managers. STAR Service Coordinators are expected to

¹⁶³ Request for Proposals (RFP) for STAR+PLUS RFP No. HHS0000428, Texas Health and Human Services Commission, December 4, 2017, p. 18.

¹⁶⁴ Presentation by Joy Kearney, IDD Specialist, Medicaid and CHIP Services Department, Health and Human Services Commission, to the Intellectual and Developmental Disability System Redesign Advisory Committee, October 2, 2017, <http://texashhsc.swagit.com/play/10022017-602/>

coordinate with waiver case managers. Service Coordinators specifically must be subject matter experts or have internal access to such expertise in working with individuals with I/DD and the LTSS and medical services commonly necessary for I/DD populations.

Currently, Local I/DD Authorities provide case management functions such as functional assessment, PASRR assessments, person-centered service planning and service authorization. Providers report also conducting some aspects of case management, such as development of person-centered plans, but express concern about lack of acknowledgement or reimbursement for these activities.¹⁶⁵

Current Procurement

Proposals were due March 6, 2018 in response to a new procurement initiative for all the STAR Medicaid Managed Care Programs including STAR, STAR+PLUS, and CHIP, which served an estimated 2,996,000 members statewide. In addition to responsibility for providing most state plan services through an integrated model, the state has reserved the right to require the selected MCOs to also provide HCBS/LTSS waiver services for all the waiver populations including individuals with I/DD. In anticipation, the state has included select sets of expectations in the RFP to which applicants must respond in their proposals.

Inclusion of this requirement in the current procurement supports HHSC compliance with state statutes which require the commission to first determine the most appropriate integrated capitated managed care program delivery model for individuals with I/DD based on cost-effectiveness and experience and then transition those individuals supported in TxHML to that plan; second, based on that transition experience, to transition the remaining individuals receiving HCBS/LTSS served in other fee-for-services programs to the most appropriate integrated capitated managed care program delivery model.^{166,167} The targeted dates for these transitions as listed in the procurement are more aggressive than those listed in Texas Government Code. Given the recent departure of key personnel from the Health and Human Services Commission and the upcoming legislative session, it is possible that the implementation dates may be further adjusted.¹⁶⁸

Specific Expectations for Potential I/DD Services

Under the new procurement standards, MCOs will have to provide plans and policies that demonstrate their expertise in managing their network and operations for and services to members with I/DD including promoting quality of life and community inclusion goals, ensuring appropriate infrastructure resources are in place to support transitions (from inpatient to community or from one provider home to another), and offering consumer-directed care options. The RFP lays out expectations for MCOs to support competitive and community-integrated employment. The MCO must promulgate policies and deploy programs to ensure access to customized work options.

In addition to demonstrating their I/DD expertise across all levels of the organization, MCOs must evidence how they identify and address barriers to access for members with I/DD, how they will enhance access to services, and how they will exercise flexibility in the Medicaid program to ensure the health and safety of members. In the RFP, MCOs were asked to specifically address how they will incorporate and provide behavioral health best practices for members with I/DD. Additionally, MCOs

¹⁶⁵ Questionnaire Response from Richard A. Hernandez, Director of Government Relations, ResCare, Inc., April 12, 2018

¹⁶⁶ Texas Government Code 534.201(b) - <http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.534.htm> (see also, [I/DD System Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting) [https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting) <https://texasnhsc.org/play/01252018-635>)

¹⁶⁷ Texas Government Code 534.202(b) - <http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.534.htm> (see also, [I/DD System Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting) [https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting) <https://texasnhsc.org/play/01252018-635>)

¹⁶⁸ Comments, Stephaine Muth, HHSC Medicaid Director, [I/DD System Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting), Agenda Item 3 at 2:16 [https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign Advisory Committee, January 25, 2018 Meeting](https://www.legis.state.tx.us/committees/committees/I/DD_System_Redesign_Advisory_Committee_January_25_2018_Meeting) <https://texasnhsc.org/play/01252018-635>; HHSC commissioner leaves agency following increased heat on agency's contracts, Houston Chronicle, May 3, 2018, <https://www.chron.com/news/politics/texas/article/HHSC-commissioner-leaves-agency-following-12885845.php>

must have approaches in place to address provider network gaps and specifically when there is a lack of a network PCP with experience serving individuals with I/DD.

The MCOs must develop detailed policies in support of providing covered services to members with I/DD that address how the MCO will promote quality of life, community-based services, and independence potential for I/DD members including promoting employment opportunities. Policies must also ensure members have the appropriate array of ongoing services and supports to sustain community-based care and sufficient temporary supports for stably transitioning back home after a hospitalization or institutionalization or relocating to a new Medicaid-approved community setting.

In describing their Service Coordination plan for I/DD LTSS, MCOs must address how service coordinators will support integrated housing placement and community residence stability for institutionalization avoidance; and how they will use innovative care coordination practices to provide continuity of care and prevent service disruption when I/DD LTSS is added or when a member is transitioning to managed care and between MCOs or between facility and community-based service settings. Service Coordinators must also be well-versed in consumer-direction and familiar with expectations for coordinating with Financial Management Services Agencies.

As of the writing of this report, the state has not announced awards for the re-procurement; all the information included here relates to the proposed requirements which may or may not ultimately be reflected in state contracts.

Enrollment Data

In state fiscal year 2015, an average of 39,042 individuals were actively enrolled in an I/DD waiver or community based ICF-IDD each month. In August 2015, there were 17,577 individuals enrolled in STAR+PLUS for acute care services who lived in a community-based ICF-IDD or who received services through an I/DD waiver. Of the 17,577 individuals with I/DD enrolled in STAR+PLUS, 504 were children age 21 and younger, and 17,187 were adults (age 21 years or older).¹⁶⁹

Experiences and Results

The state's goals for moving to managed care, including for the I/DD population are to improve outcomes, offer flexibility to providers and recipients, reduce the waiting list for services by being able to serve more eligible individuals, and reduce costs¹⁷⁰ to the state. Based on provider interviews, there appears to be consensus on the value of these goals. However, providers question whether moving I/DD waivers to full-risk managed care will best position the state to achieve these goals.

In particular, I/DD providers cited potential challenges related to an underinvestment in the system, a failure to address unresolved programmatic and administrative barriers, and inflexibility in the design to allow for unanticipated challenges.¹⁷¹ Examples of these challenges and barriers were also articulated by several stakeholders during twelve hours of testimony provided in a recent Texas House Committee on Human Services.¹⁷² Of note, the Chair of that Committee stated several times during the hearing that perhaps a 'pause' is needed on moving any further services or populations into managed care. More

¹⁶⁹ Annual Report on Implementation of Acute and Long-Term Services and Supports System Redesign for Individuals with Intellectual and Developmental Disabilities, Texas Health and Human Services Commission, November 2016

¹⁷⁰ S.B. 7 directed HHSC to implement the most cost-effective option for the delivery of basic attendant and habilitation services to individuals with disabilities and to maximize federal funding. Source: Texas Health and Human Services Commission, "Annual Report on Implementation of Acute and Long-Term Services and Supports System Redesign for Individuals with Intellectual and Developmental Disabilities", November 2016.

¹⁷¹ Interview with Angela King (Volunteers of America – TX), Sandy Frizzell Batton (Provider Community Alliance), Carole Smith (Private Providers Association of Texas), and Richard Hernandez (ResCare, Inc.), April 12, 2018

¹⁷² May 9th Texas House of Representatives Health Committee Meeting, http://tlchouse.granicus.com/MediaPlayer.php?view_id=40&clip_id=15114

specifically, he stated “there is growing consensus that we pull back on the [transition] dates and change dates and move forward with a strong pilot so we get it right.”¹⁷³

In addition, providers reflected on challenges experienced in the Community First Choice program when there was an attempt to “standardize” attendant care rates across waiver and between MCO and FFS.¹⁷⁴ Providers also pointed to existing activities working toward integration, primarily through the functional assessment and person-centered planning process. This is a good first step but requires appropriate funding to adequately address the individual’s medical and behavioral support needs. Lastly, moving to full-risk managed care, will likely exacerbate existing payment and prior authorization issues as that process is decentralized across multiple MCOs with individual processes and guidelines.

Rebalancing

Texas’ percentage of LTSS expenditures that are spent on HCBS as of FY2015 is 57.9%, up from 50.1% in FY2012.¹⁷⁵

The legislation that compelled the I/DD MLTSS pilot, S.B. 7 and H.B. 3523, required the pilot to, among other items, promote the placement of individuals in settings most appropriate to the individual’s needs and in the “least restrictive setting.”¹⁷⁶ This is echoed in the most recently released RFP for re-procurement of the STAR plan products. The state’s approach for holding the MCOs accountable for this and how related outcomes such as rebalancing will be tracked and measured will depend on the methods the state uses to fully roll out the inclusion of the waiver populations through the MCOs selected in the current procurement.

Key Indicators

Indicator		Texas	National Average
Waiting List (Legislative Budget Board Issue Brief, 2015)¹⁷⁷	Community Living Assistance and Support Services	54,084	N/A
	Deaf Blind w/Multiple Disabilities	221	
	Home and Community-Based Services Waiver	73,011	
	Texas Home Living Waiver	50,683	
Staff Turnover (2016 Staff Stability Survey Report, 2018)		47.4%	45.5%
Share of Medicaid I/DD LTSS Spending on HCBS (Truven, 2015)		51.4%	76%
Gets Needed Services (NCI, 2014-2015)		89%	82%
Would Like to Live Somewhere Else (NCI, 2014-2015)		25%	26%
Percentage of people with I/DD in Integrated Employment (StateData: The National Report on Employment Services and Outcomes, 2016)		9%	18.6%
Case Manager / Service Coordinator Helps Get What Individual Needs (NCI, 2014-2015)		87%	88%
Proportion of people with I/DD in Poor Health (NCI, 2015-2016)		4%	4%
Routine Dental Exam in Past Year (NCI, 2015-2016)		89%	81%
State Fiscal Effort (State of the States, FY15)		\$2.19	\$4.30

¹⁷³ Ibid.

¹⁷⁴ Interview with Angela King (Volunteers of America – TX), Sandy Frizzell Batton (Provider Community Alliance), Carole Smith (Private Providers Association of Texas), and Richard Hernandez (ResCare, Inc.), April 12, 2018

¹⁷⁵ Ibid.

¹⁷⁶ Annual Report on Implementation of Acute and Long-Term Services and Supports System Redesign for Individuals with Intellectual and Developmental Disabilities, Health and Human Services Commission November 2016, p. 19.

¹⁷⁷ http://www.lbb.state.tx.us/documents/publications/issue_briefs/3106_wait_list_interest_list.pdf, 2015

States to Watch

Several other states have considered the inclusion of people with I/DD in managed or integrated care models, have stated intentions to incorporate I/DD populations into managed care, and/or have pilots or limited implementation of such approaches.

Massachusetts

MassHealth introduced a new Accountable Care Organization (ACO) model health plan on March 1, 2018. The ACO is intended as a mechanism for enhancing person-centered care and care coordination as well as to align financial incentives. The ACO model uses Community Partners, experienced community-based LTSS and behavioral health organizations, to partner with ACOs and MCOs in coordinating and managing care for approximately 60,000 eligible members. Expected to launch in June 2018, LTSS Community Partners will address the social determinants of health and provide care coordination and navigation to Medicaid-only members with physical disabilities, brain injury, and intellectual or developmental disabilities living in the community (not in a nursing facility).¹⁷⁸

Minnesota

Building on its Integrated Health Partnership (IHP) demonstration, Minnesota created and is demonstrating an Accountable Health Model based on collaborative partnerships between community-based providers of medical and social services with a patient-centered medical home at the hub. Altair Accountable Community for Health is the first social service-initiated ACO in Minnesota, and believed to also be the first in the nation, built specifically for people with disabilities including individuals with I/DD. The program's goal is to enhance the physical health and psychosocial well-being of its members by focusing on population health, experience of care, and per capita cost. Altair aligns health and social services through intensive and complex coordination among the partners and for its members. Electronic data exchanges and data-sharing tools are integral to the design for quality measurement and outcome tracking. Altair targets about 6,600 people with disabilities in the six-county Twin Cities metropolitan area.¹⁷⁹

Nebraska

At the beginning of 2016, the NE Department of Health and Human Services released a concept paper on their guiding principles for long-term care redesign. A final long-term care redesign plan was published in August 2017 recommending the state move forward with incorporating long-term services and supports into the existing system. DHHS proposes a staggered implementation by enrolling individuals who are aging and/or have physical disabilities into the MLTSS program first (phase 1), followed by those with intellectual and/or developmental disabilities (phase 2) with a target date of January 1, 2021 for phase 2. DHHS's Division of Medicaid Long-Term Care is currently extending the dialogue with stakeholders to address a more comprehensive redesign plan for long-term care services in Nebraska. Meetings are scheduled monthly May-July 2018.¹⁸⁰

¹⁷⁸ PowerPoint presentation, "MassHealth Delivery System Restructuring" Open Meeting, March 2017 Boston, MA and Springfield, MA
<https://www.mass.gov/files/documents/2018/03/22/pcdi-fs-ltss-02-08-18.pdf>

¹⁷⁹ Sources: Altair presentation, untitled. 2018 ANCOR Conference, New Orleans, LA, April 15, 2018.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SLM_Home; [http://www.lutherservices.org/sites/default/files/Altair%20general%20overview%20GJK%20\(00000002\).pdf](http://www.lutherservices.org/sites/default/files/Altair%20general%20overview%20GJK%20(00000002).pdf)

¹⁸⁰ Sources: http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx; <http://www.nasud.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker/nebraska>

New Jersey

New Jersey's I/DD system has been evolving gradually toward a MLTSS structure consistent with other populations already in MLTSS. One of the dynamics forcing the gradual evolution is the historic payment mechanisms the state has used to pay providers of services in their Community Care Waiver, the comprehensive I/DD HCBS waiver. In 2017, the state began converting the I/DD payment system to fee-for-service, a necessary step before that state could move to MLTSS because under the old payment process, the state collected very little data about utilization that would be needed to set capitation rates. According to stakeholders, transition to MLTSS for this population is likely on the horizon, but there has been no proposed timeline issued by the state.

Oklahoma

The Oklahoma Health Care Authority (OHCA) released an RFP in November 2016 for SoonerHealth+, a fully capitated, statewide model of care coordination for Oklahoma Medicaid's aged, blind and disabled population. The targeted ABD populations were to be phased in with Medically Fragile waiver members and I/DD state plan only members to be enrolled in the first year, I/DD waiver members in the second year, and nursing facility residents in year 3. After conducting the procurement process, OHCA canceled the RFP in June 2017, a decision backed by the Governor who asked the agency to postpone for a year. A House Resolution was also passed asking OHCA to pause the process. Some stakeholders believed there was too much uncertainty in state funding and too many unanswered questions about the implementation plan. OHCA decided to cancel, rather than pause the demonstration, because they lacked the funds necessary to start up the program (estimated at \$52 million) while also maintaining the current Medicaid program.¹⁸¹

Pennsylvania

Pennsylvania created the Adult Community Autism Program (ACAP), one of the first programs in the nation for adults with autism. ACAP is a provider-led, full-risk managed care model authorized as a PIHP. The program is currently available in a limited number of counties with an enrollment cap of 158 and provides fully integrated services. Participants must have a diagnosis of Autism Spectrum Disorder with or without ID, be 21 years of age or older, meet functional criteria, and have active Medicaid eligibility. In carrying out the goals for member independence and community integration and belonging, Keystone Autism Services, the Provider-MCO for ACAP, assists individuals with their physical health, behavioral health, employment, social, recreational, educational, transportation, therapeutic and crisis needs. Keystone provides comprehensive assessment, service planning, and care coordination, manages most of the services internally, and contracts out for medical services. The holistic framework provides supports for families and caregivers as well. Early outcomes are positive with over 50% of members competitively employed and 25 members living independently. Additional results are that access to and utilization of physical healthcare has increased, cost efficiencies have been realized, and satisfaction is consistently high.

Virginia

The 2015 Virginia Appropriations Act directed inclusion of all remaining Medicaid populations and services into "cost-effective, managed and coordinated delivery systems"¹⁸² including people with I/DD. Virginia recently moved people with I/DD into its Medicaid managed care program for medical/acute

¹⁸¹ <http://www.okhca.org/> and <https://nondoc.com/2017/06/14/oklahoma-cancels-managed-medicaid-rfp/>; <http://newsok.com/article/5579215/oklahoma-senator-modernizing-health-care-can-improve-budgetary-stability>

¹⁸² <https://budget.lis.virginia.gov/item/2015/1/HB1400/Chapter/1/301/>, HB1400, item TTT. 4

care services, and launched MLTSS for aging and physical disability populations. The state has conducted some limited planning and discussion for including individuals with I/DD in MLTSS, however, enrollment will likely be delayed for at least another three years, until the state has collected more data and expenditure information under the recently established fee-for-service I/DD waivers.

Conclusion

While people with I/DD are still largely excluded from Medicaid MLTSS programs in most states, the number of states using managed and/or integrated care structures for people with I/DD is slowly growing. Researchers identified several trends in the review of states' experiences as viewed through the lens of community providers' perspectives, public data and reporting, and MCO contracts.

States with the longest running MLTSS-I/DD programs have been built locally, starting with public or quasi-public or nonprofit entities. Only recently have a few states adopted mandatory statewide MLTSS-I/DD using national commercial health plans, with many challenges. Likely in response to some of these challenges, states on the horizon of implementation have begun to further explore and test provider-led initiatives, accountable care organizations and other innovative approaches for managing I/DD services.

However, no matter the structure or managing entity, the most important determining factor in the impact of managed care implementation comes from the state's rationale and goals for pursuing managed care and the alignment of the program with those goals. In their contracts with MCOs, states set program parameters, implementation timelines, quality measures, capitation rates, case management structures, provider qualifications and other programmatic elements that drive the performance of the program and should address the state program and policy goals. States seeking comprehensive systems change consistent with I/DD best practices – e.g., those hoping to address issues such as waiting lists, rebalancing, employment outcomes, quality of services, community integration practices – are well-served when they work with stakeholders and MCOs to design programs with clear policy and program goals. In well executed programs, these priorities will be evident throughout managed care contracts, including in preferred provider networks, case management standards, service definitions, quality measures, reimbursement approaches, incentive options and other programmatic elements. On the other hand, states with an eye primarily on immediate cost containment are unlikely to be innovative in contract standards, but instead set capitation rates at levels that ensure savings on the part of the state, even if they are not enough to cover needed services.

States considering a move to MLTSS for people with I/DD should also assess whether they have adequate data and analysis to support the development of a sound capitation rate inclusive of all I/DD services. If services have historically been delivered and reimbursed in a manner that does not connect utilization and encounter data tied to clinical and functional assessment information, developing an actuarially sound rate will pose significant challenges, and some additional protections such as risk corridors or risk adjustment options may be necessary.

States seeking to use managed care to address long-term policy and program goals for people with I/DD may benefit from an incremental approach that helps ensure success. While this may have short term drawbacks, including the operation of dual systems for states and sometimes for providers, it also allows state agencies, MCOs and providers the opportunity to solve implementation problems as they arise, be it in a particular region, service, or population. Incremental implementation also allows providers, beneficiaries and families to adapt and provide feedback; states may also "grandfather" current enrollees into fee-for-service programs to minimize disruption.

While states are still exploring how best to implement managed care options for people with I/DD, learning from experience, and addressing both challenges and opportunities, states' experiences show that the decision to employ managed care for people with I/DD should not be made hastily or with the

expectation of quick fixes or immediate cost savings. Examples from states implementing MLTSS for people with I/DD show that successful programs are most likely to result from careful planning, significant and ongoing engagement with stakeholders, and a clear policy vision intended to advance the goals of integrated, quality home and community-based services.