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Integration Strategy 3: Enroll Individuals with I/DD in Managed Care

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Impetus for Strategy

Traditionally, certain high-need populations, such as individuals with I/DD, have been "carved out" of managed care, and remained in fee-for-service arrangements. In part, this has been due to significant concern from the I/DD community that the Medicaid managed care model cannot address the diverse clinical, functional, and employment support needs of this population. Specific concerns center on continuity of care and health plans' perceived lack of familiarity with the needs of this population. However, the rise in managed care in both Medicaid and Medicare, as well as states' recognition of challenges that the I/DD population faces in the fee-for-service environment, has prompted more states to carve in these populations and services to improve coordinated care delivery and contain costs. These efforts seek to improve community integration and reduce the fragmentation of care that individuals with I/DD experience across the complex medical and social services that Medicaid typically provides.

Strategy Description

States are taking a few different approaches to better integrate care for the I/DD population.[1] Some states have transitioned LTSS benefits into managed care, keeping physical and behavioral health services separate, as a starting point to move toward fully integrated managed care. Other states are creating care coordination entities that will be responsible for coordinating beneficiary care across funding streams. The most comprehensive approach underway at the state level is to move the I/DD population into fully integrated managed care, whereby a single health plan oversees and coordinates all services for this population, including LTSS, medical, behavioral health, and social services.

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million people to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than $140 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This integration strategy is part of a larger toolkit, ***Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment***, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.

To learn more and view the full toolkit, visit **www.chcs.org/ltss-toolkit**.

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Implementation Mechanisms

States have taken different approaches to improving integration for I/DD populations. Under the managed care approach, Arizona designated a Division of Developmental Services to manage all MLTSS for individuals with I/DD under a single agency.[2] New York operates the only duals demonstration in the country for this population, the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), which integrates both Medicaid and Medicare services and offers acute, long-term care, and habilitation services. New York also recently submitted an 1115 waiver for CMS approval that will improve care coordination for the I/DD population under state plan health home authority by integrating all 1915(c) habilitation services under a single comprehensive plan.[3] If successful, the state hopes to eventually move to mandatory managed care enrollment, and potentially include value-based payment arrangement requirements to improve care outcomes and reduce costs for this population.[4]

Results to Date

With years of successful integration of individuals with I/DD into its MLTSS program, Arizona has eliminated its waitlist for services, and reported both high client satisfaction and strong performance on health, welfare, and consumer experience metrics.[5] New York reports over 20,000 individuals with I/DD are voluntarily enrolled in Medicaid managed care for their acute care benefits. Its FIDA-IDD has close to 600 beneficiaries, and these two initiatives represent the state's long-term transition to fully integrated provision of services for individuals with I/DD under a comprehensive Medicaid managed care structure.[6] However, I/DD consumer advocates in some states that have moved or are considering moving to managed care report concerns with limited access to services. In Kansas, advocates submitted these concerns during public comment periods for the KanCare system, including the lack of engagement and communication with stakeholders during the program design process.[7]

Key Lessons

States with experience in integrating their I/DD populations into managed care reported three main recommendations to other states considering pursuing this path:

- **Promote stakeholder engagement and support.** The advocacy community has raised significant concerns with moving this population into managed care, driven in part by people's fear that they will lose access to much-needed services. Launching consumer advisory groups, arranging stakeholder meetings, and ensuring clear communication are some of the steps states have taken to improve the implementation process and engender stakeholder support. New York has developed carefully targeted messages during managed care transitions that focus on how a managed arrangement increases access to mental, physical, and specialty health services such as dental care, while there are gaps between these services under the current fee-for-service arrangement. Furthermore, states reported that using a case manager as a

single point of contact for beneficiaries and their families, in conjunction with integrated care teams, is helpful in establishing a clear line of communication and coordinating care for the beneficiary. Other states solicited input from community-based organizations and consumer advocates to shape MLTSS design for I/DD populations and to support development of a care continuum that meets their needs and enables a smooth implementation process.[8]

- **Transition incrementally.** New York, in particular, emphasized the value of moving to managed care in a staged process. The state is using a multi-year transition period to move from voluntary to mandatory enrollment, as well as in implementing managed care regionally first rather than across the entire state. Furthermore, New York intends to continue maintaining fee-for-service provider rates for the initial phase of the transition to managed care to support access under the new system and also to prepare health plans and providers to implement the capitated payment model. By pursuing this transition in phases, New York has been successful in addressing some advocates concerns regarding the managed care model. Finally, New York recommended that other states build off their existing provider delivery system (i.e., health home authority in New York) in order to scale their infrastructure and care coordination capabilities effectively. In addition, states might consider a regional roll out plan as well.

- **Utilize data reporting and health information technology in a way that engages and connects individuals and their families to providers.** Implementing an electronic health record or other health information technology tools facilitates care coordination by capturing data in a single system to allow states to monitor and report on cost and quality metrics.[9] New York recommended connecting health plans with providers, beneficiaries, and their families electronically to improve data sharing abilities and care coordination. Compared to a paper documentation system, which can impede service delivery through inefficiencies and care gaps, this is generally an appealing change for providers and beneficiaries.

Case Study

New York's 1115 Waiver Creates Care Coordination Organizations to Integrate Primary Care, Behavioral Health, and Social Support Services with LTSS for the I/DD Population. The New York State Department of Health submitted a request to CMS for a section 1115 waiver amendment that would encompass all 1915(c) habilitation services, after experiencing a significant delay negotiating amendments to its 1915(c) waiver and realizing that it did not provide the flexibility necessary to implement the changes it was seeking for the I/DD population. The 18-month negotiation on the state's 1915(c) waiver amendment (ultimately resulting in the state's decision to request an 1115 waiver as identified above), as well as the state's desire to transition to a managed care delivery system, spurred a deeper look at the challenges individuals with I/DD face within the fee-for-service system and the need for a more holistic structure. The 1115 waiver amendment would give New York the authority to move the I/DD population to mandatory managed care, which is the state's long term goal and has been over the past eight years. Today, over 20,000 individuals with I/DD are voluntarily enrolled in the managed care system for their acute care benefits.

Through its existing health home authority, the New York Office for People with Developmental Disabilities' new five-year initiative will establish care coordination organizations to integrate primary care, behavioral health, community, social support, and long-term care services under a single comprehensive care plan, eventually transitioning this to managed care under 1115 waiver authority.[10] The state is currently reviewing care coordination organizations (or health home) applications, which must demonstrate a history of providing or coordinating developmental disability, health, and long-term care services to individuals with I/DD. Care coordination organizations are anticipated to launch in July 2018 on a voluntary enrollment basis.

ENDNOTES

[1] B. Hogan, K. Bazinsky, B. Waldman. "Approaches to the Integration of Services for Individuals with Intellectual and Other Developmental Disabilities (I/DD)." Bailit Health Purchasing. Available at: http://www.bailit-health.com/publications/010515_bhp_rwjf_approaches_integration_services.pdf.

[2] *Ibid.*

[3] Interview with New York, October 18, 2017.

[4] *Ibid.*

[5] B. Hogan, et al., op. cit.

[6] Interview with New York, October 18, 2017.

[7] D. Ranney. "Kansas with disabilities concerned about proposed KanCare changes". The Kansas Health Institute. December 15, 2014. Available at: http://www.khi.org/news/article/kansans-disabilities-concerned-about-proposed-kanc.

[8] The Kaiser Commission on Medicaid and the Uninsured. "People with Disabilities and Medicaid Managed Care: Key Issues to Consider." The Henry J. Kaiser Family Foundation, February 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf.

[9] B. Hogan, et al., op. cit.

[10] New York State Department of Health. "Frequently Asked Questions (FAQ), Care Coordination Organizations / Health Homes (CCO/HH)." July 28, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/frequently_asked_questions.pdf.