

Enrolling Individuals with Intellectual/Developmental Disabilities in Managed Care: A Strategy for Strengthening Long-Term Services and Supports

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Traditionally, certain high-need populations, such as individuals with intellectual/developmental disabilities (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 could not 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, while ensuring the consumer experience and services are maintained.¹ Some states have transitioned long-term services and supports (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 as a first step toward transitioning this population to managed care. 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 Americans 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 \$154 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 LTSS reform 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.



► Implementation Mechanisms

States have used varying methods to improve integration for I/DD populations. Under the managed care approach, Arizona designated the Arizona Department of Economic Security, Division of Developmental Services to manage all Medicaid managed long-term services and supports (MLTSS) for individuals with I/DD under a single agency.² New York operates the only financial alignment demonstration in the country for this population, Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), which integrates both Medicaid and Medicare services and covers acute, long-term care, and habilitation services. In 2017, New York also submitted to CMS a proposal to begin the transition of the I/DD population into managed care through a concurrent 1915(c) waiver.³ The State received federal approval to expand its Medicaid health home model to serve individuals with I/DD through Care Coordination Organizations that began operating on July 1, 2018. As the initial phase of New York's I/DD managed care transition, the state intends to use this model to strengthen care coordination for the I/DD population under a single comprehensive plan.⁴ 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.⁵

► Results to Date

With years of successful integration of additional services for individuals with I/DD into its MLTSS program, Arizona has never had a waitlist for services, and has reported both high client satisfaction and strong performance on health, welfare, and consumer experience metrics.⁶ New York reports over 20,000 individuals with I/DD are voluntarily enrolled in Medicaid managed care for their acute care benefits, while its FIDA-IDD demonstration has close to 1,100 enrollees. These two initiatives represent the initiation of the state's long-term transition to fully integrated provision of services for individuals with I/DD under a comprehensive Medicaid managed care structure.⁷ 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.⁸

► Key Lessons

States with experience in integrating 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 can increase 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.⁹

- **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. 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) to scale their infrastructure and care coordination capabilities effectively. In addition, states might consider a regional rollout 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.¹⁰ New York recommended electronically connecting health plans with providers, beneficiaries, and their families to improve data sharing 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 Creates a Pathway to Managed Care for I/DD Populations. The New York State Department of Health requested CMS authorization for a specialized managed care model for I/DD populations to operate concurrently with the 1915(c) waiver authority for habilitation services. This model creates a pathway to managed care for I/DD populations via two steps: (1) creating care coordination organizations (CCOs) for care management services; and (2) transitioning to managed care over time. By integrating primary care, behavioral health, social support services, and LTSS under the CCOs, the state seeks to improve care coordination for this population. The 1115 waiver amendment will give New York will begin with voluntary enrollment opportunities and ultimately seek the authority to move the I/DD population to mandatory managed care, which is the state's long-term goal. Today, over 20,000 individuals with I/DD are voluntarily enrolled in the managed care system for their acute care benefits and 1,100 dually eligible beneficiaries with I/DD are enrolled in the FIDA-IDDD demonstration for their integrated Medicaid and Medicare services. The state also operates a specialized PACE program that serves senior beneficiaries with and without I/DD.



The New York Office for People with Developmental Disabilities (OPWDD) established the CCOs under the state’s existing health home authority.¹¹ These CCOs (or health homes) must demonstrate in their application that their governance structure and leadership has experience providing or coordinating developmental disability, health, and LTSS for individuals with I/DD.¹² The CCOs launched in July 2018 with beneficiary enrollment on a voluntary basis. This model provides a person-centered approach to service planning and promotes the delivery of integrated care that supports the needs of individuals with I/DD. It is expected that, over time, CCOs or existing providers of I/DD services will: (1) form managed care plans, which will be called “Specialized I/DD Plans”; or (2) enter into agreements with existing mainstream Medicaid managed care plans to manage the I/DD benefits provided to individuals with I/DD. OPWDD seeks to meet beneficiaries’ and their families’ care needs in the most comprehensive way possible, promoting the achievement of quality outcomes and improvement across the service delivery system.¹³

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. October 2014. Available at: http://www.bailit-health.com/publications/010515_bhp_rwjf_approaches_integration_services.pdf.

² *Ibid.*

³ New York State Department of Health. “Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115 Waiver Transition”. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm.

⁴ Case study update from New York, September 10, 2018.

⁵ Interview with New York, October 18, 2017.

⁶ B. Hogan, et al., op. cit.

⁷ Case study update from New York.

⁸ 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>.

⁹ 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>.

¹⁰ B. Hogan, et al., op. cit.

¹¹ 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.

¹² “Care Coordination Organization/Health Home (CCO/HH) Application to Serve Individuals with Intellectual and/or Developmental Disabilities.” New York State Department of Health. October 6, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf

¹³ Case study update from New York.

