CFHS

Managed Care Bootcamp:

The basics and beyond for IDD Providers

Presented by:
Jodi Fenner, Senior Advisor, CFHS

www.consultingfhs.com

Topics for Today

- Introduction to Traditional Managed Care
- IDD Managed Care Landscape
- Other Program Considerations
  - Community Investment Approach
  - In Lieu of Services
  - Engagement Opportunities with State and MCO Partners

Experience working with Managed Care Organizations?

What is Managed Care?

"Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services."

https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html

States may include all Medicaid services or may limit to select populations or programs under the federal authorities:

- State Plan (Section 1932(a))
- HCBS Waivers (Section 1915 (a) and (b)
- Demonstration Waivers (Section 1115)

Managed Care entity types:

- Managed Care Organizations (MCOs)
- Primary Care Case Management (PCCM)
- Prepaid Inpatient Health Plan (PIHP)
- Prepaid Ambulatory Health Plan (PAHP)

As of 2021, **48 states** used some type of managed care within their Medicaid programs, with approximately **72%** of Medicaid members enrolled in **comprehensive managed care** across 41 states as of 2022.

Why did they do it that way? Understanding managed care. https://medicaiddirectors.org/resource/understanding-managed-care/; Issue brief (1/22/2024)

CFHS

Managed Care or Managed Funding?

- Value Based Care Focus is on quality outcomes through integrated care over the lifespan
- Rising prevalence of I/DD/autism along with complexity and cost of care has payers looking for solutions = Managed Care
- Payers want low cost of care and pp spending, less use of UCs and ERs, and consumer satisfaction
- Beacon Health Options Autism Solutions division, CareSource, and Magellan are just a few MCOs that manage IDD/autism
- Care coordination is key to managing specialized service costs for fit into the payer care continuum
- Payers looking for performance data where no benchmarks currently exist
- Aging at home services on the rise with I/DD focus

Managed Care Requirements for States:

May mandate that recipients enroll in managed care, as well as automate enrollment	But	Must contract with 2 or more MCOs to provide choice to recipients (with limited exceptions)
May set capitation rates, or may require payors to submit cost proposals	But	Capitation rates must be based on generally accepted actuarial principals and practices
Must report Medicaid Loss Ratios, which identify the % of expenditures for medical purposes versus administrative costs	And	May set minimum MLR standards of 85 % or higher to promote high quality of care and appropriate service delivery May allow expenditures for quality programs and social supports to be considered as medical spend (under Community Investments and/or In Lieu of Services approaches)
Must define services, settings, and populations covered within the managed care contracts	And	May allow managed care organizations to include additional services as administrative costs, as well as allow them to cover services or settings that are in lieu of services or settings covered under the State Plan (which count as medical spend)

National Managed Care Organizations are Complex

- State Health Plans
- Enterprise Resources
- Diversified Business & Partners

- Health Plans are individual entities and must be licensed in the state where they operate, but typically report to a national MCO parent entity and share enterprise resources
- Enterprise Resources may be separate legal entities/diversified businesses, be part of the national parent entity, or exist within the State Health Plans - but states can dictate local accountability and/or legal and physical presence for any MCO function
- MCOs may invest in diversified businesses and/or enter into partnerships to provide direct services to members, such as:
  - Pharmacy Benefit Organizations
  - Provider Organizations (including behavioral health entities, hospitals, physician groups, LTSS providers, etc.)
  - Technology Organizations

Care and Case Management

- Care Management refers to the whole-person integrated care and planning for the member; Case Management refers to coordinating a limited scope of services, such as a waiver targeted case manager or a case management team that supports members with complex intermittent needs
- MCOs may do Care and Case Management internally and/or contract with external organizations/providers, BUT must ensure conflict-free care management and retain accountability
- Care Management teams may report to a Medical Director or may be independent, but typically have dual accountability through the Medical Director and local Health Plan leadership
- Unless required by the contract, the majority of members are not enrolled in dedicated Care Management, but a member can request Care Management at any time
- MCOs have an array of Disease/Condition Management programs for individuals to access services without having to be enrolled in Care Management
- MCOs use predictive analytics to risk stratify members to maximize care management resources and ensure members with complex needs are proactively offered/assigned to Care Management

Care and Case Management (cont.)

- Care Management teams may include:
  - Licensed Care Coordinators, such as nurses, social workers, physical and behavioral health professionals
  - Medical Specialists usually support via a “pod” approach at a local or regional level and include roles such as: physicians, psychiatrists, psychologists, gerontologists, and pediatricians)
  - Other Specialists, such as: community health workers, housing and employment specialists, health equity specialists, caregiver liaisons, and Medicare coordinators
  - Non-licensed Case Managers (typically in LTSS and IDD programs, with some education and training requirements)
  - Other non-licensed staff (outreach specialists, support staff, etc.)
- Centers of Excellence
  - Most MCOs managing LTSS programs have a national team of subject matter experts to support local health plans

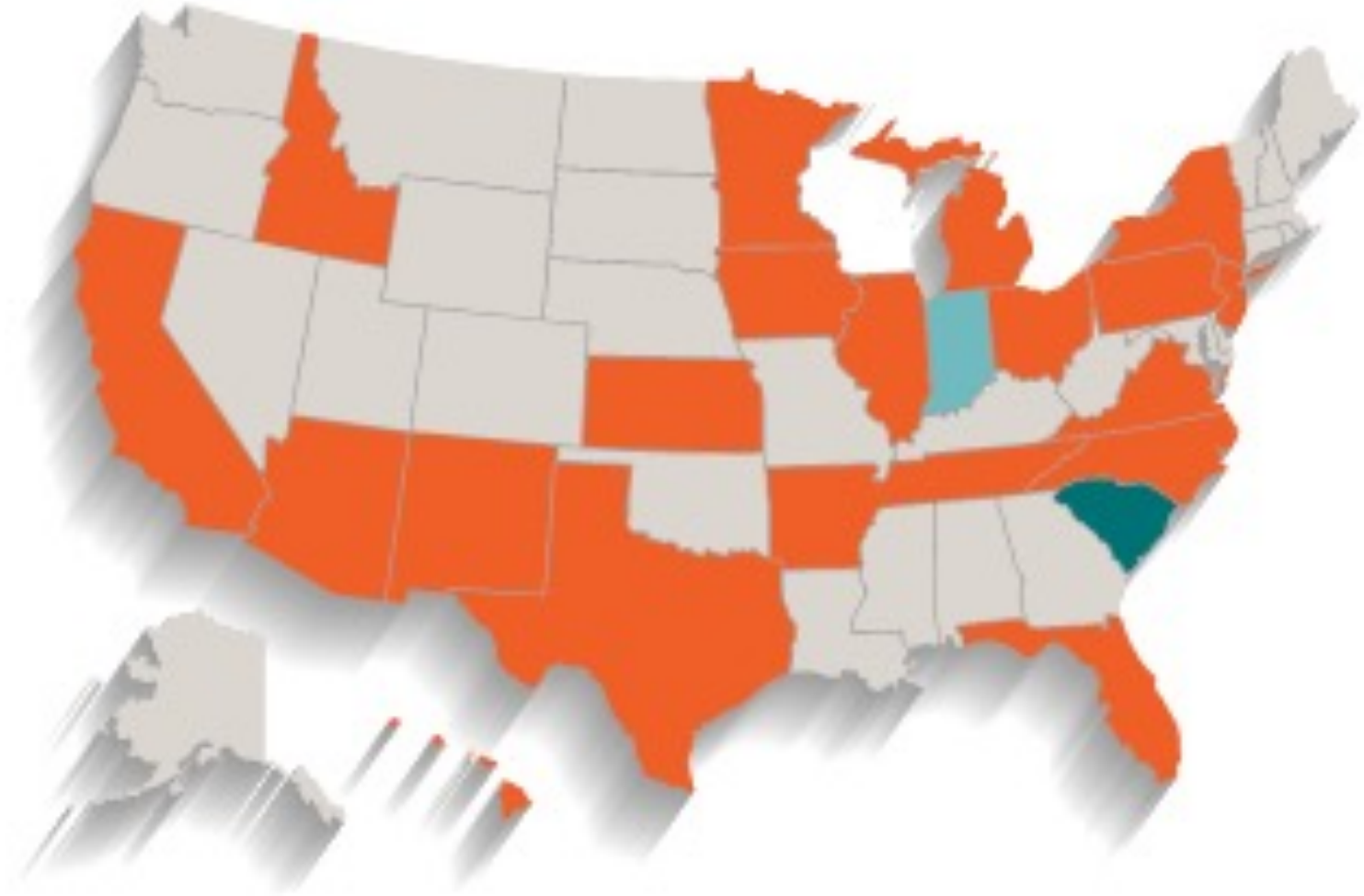
Provider Supports and Services - Generally

Requirements	Challenges	Options
States require **dedicated Provider Services** teams to provide support and education to providers to navigate the managed care systems	Providers still struggle with managing multiple processes, dashboards, and contracts in newer programs	States may require providers be assigned to a specific provider liaison and/or can require MCOs to have consistency in processes and forms
States may retain **credentialing**, centralize credentialing with an external organization, or delegate credentialing to the MCOs	Credentialing with multiple MCOs can be burdensome for providers	Where delegating credentialing, states may require consistency with processes and forms
States must set **network and access to care standards** to ensure provider capacity	Providers may exist geographically, but not have capacity to meet all appointment requests	MCOs may use single-case agreements for access to non-network providers; States may require investment in network capacity development
States require MCOs to meet the **cultural and accessibility** needs of members	Particularly in rural areas, providers may lack accessible equipment, disability experience, and face language or cultural barriers to supporting members	MCOs are creating Health Equity roles and actively supporting providers with training, equipment, and language and cultural resources; population-based reporting can be required to monitor health equity concerns

IDD Managed Care Landscape

Medicaid Managed Long Term Services & Support

State Adoption of Managed Long-Term Services and Supports Program as of January 2024



- No MLTSS Program
- Active MLTSS Program
- CMS Financial Alignment Initiative
- MLTSS Program in Active Implementation

Source:
State of Medicaid Managed Care Report: A Closer Look at Managed Long-Term Services and Supports

CFHS

What Might Change for IDD with MCOs:

- A more structured authorization/utilization process requiring data management
- Network credentialing after the honeymoon phase
- Technology push for data sharing, care coordination, and billing
- Technology and remote support may be more broadly reimbursable
- Care/Case Management Approaches
    - North Carolina created plans as firewalls between coordination and service delivery
    - South Dakota uses regional boundaries to determine which organizations can provide case management and services
    - Iowa used MCOs to bring case management in-house
- Larger providers will have more clout at the negotiating table

IDD Managed Care Landscape

- Per Advancing States' Medication Integration Tracker: 25 states have Managed LTSS programs; 5 of these states, plus one additional state, also have MLTSS Delivered through Section 1115 waivers
- While only 12 state have integrated IDD services into managed care
  - Most managed care states include individuals with IDD for purposes of managing physical and behavioral health
  - Many individuals with IDD access LTSS through other waivers (such as Family Support Waivers)
- The value proposition to transition IDD services to managed care often involves an increase in HCBS/LTSS services, with savings being achieved through institutional transitions/diversions and reduced acute physical and behavioral health costs. Additional benefits may be obtained through increased outcomes in areas such as community inclusion, employment, and member/caregiver experiences

IDD Managed Care Landscape (cont.)

- Challenges to IDD Managed Care transition:
  - A large percentage of adults with IDD receive the bulk of their medical care through Medicare, which eliminates most of the financial benefits of integration when compared to the program intricacies
  - Some state IDD programs are managed at a county level, or otherwise siloed, which makes it difficult from a process and political perspective
  - States are hesitant to transition 1915(c) waiver programs due to their waiver management and reporting requirements, while transition for 1115 and 1915 (i) and (k) programs appear more seamless
  - Transition may be impacted by state employee considerations, such as union rules and retirement impacts to program staff
  - Rate setting has always been challenging, but statistical anomalies due to Public Health Emergency activities have heightened rate concerns
  - Individuals, caregivers, state teams, providers and other stakeholders remain distrustful of managed care experience and program capabilities
  - Many IDD programs continue to document manually, and transition to managed care does cause some additional administrative burdens in early years of implementation

Requirements	Challenges	Options
States must contract with **multiple MCOs** to ensure member choice	IDD providers, typically accustomed to billing ONE entity, must bill multiple MCOs due to the member choice requirement	States can enhance provider services staffing requirements and encourage consistency in MCO forms and processes
States may retain **credentialing**, centralize credentialing with an external organization, or delegate credentialing to the MCOs	Credentialing for IDD waiver providers is much more intense and lengthy than that for individual licensed clinicians and facilities, as licensure is usually based on education and testing requirements and typically handled by state boards	Most states that have carved IDD services into managed care have retained their central credentialing programs; alternatives would be to utilize external organizational credentials such as CQL and CARF
MCOs must process complete **claims with encounters documentation**, and most utilize electronic billing systems	IDD providers have limited staff and technical resources to support new billing and administrative requirements, as well as limited resources to absorb impacts from payment delays	States can require program-specific provider relations staffing, as well as processes and standards to ensure claims with errors are promptly addressed to avoid payment delays
States must set **network and access to care standards** to ensure provider capacity	IDD providers are experiencing unprecedented workforce challenges, and most states lack sufficient providers to meet the needs of members with disabilities	States can require MCOs to invest in workforce development and network capacity growth via Community Investments and/or quality programs
States must set **service initiation standards** for waiver recipients to ensure timely access to care	In addition to workforce challenges, most states lack systems to track provider capacity across multiple MCOs, which can delay delivery of IDD services	Similar to centralized credentialling, states may adopt an IDD systems capacity tracking system or require the MCOs to collectively address; states may incentivize or penalize MCOs for priority outcomes
States are required to comply with **the Final Rule** in relation to provider settings, person-centered practices, and member rights	Rule interpretation has been inconsistent since adoption in 2016, and members living in the same location may have different MCOs – both causing administrative burdens for provider staff	States must set clear standards for MCOs to follow for compliance reviews (some are requiring Care Management approach, while others expect provider relations teams to address); effort should be made to inform and simplify providers on expectations and processes
States must require MCOs to deliver **conflict-free care management**, regardless of whether the MCO handles Care Management internally or utilizes external providers and partners	States continue to struggle with conflict-free care management, including several under CMS corrective action plans; where IDD providers still provide care or case management to the people they support, states are finding it difficult to separate that function while also retaining adequate financial stability for providers within current rate structures; CMS is much more strict now on eliminating duplication in care management	States and MCOs must collaborate with providers on solutions that may include: creation of separate entities outside of provider reporting structures for care managers

Emerging Federal Regulations Impact Managed Care Expansion for IDD Programs

- HCBS Settings Rule (not new, but still an ongoing challenge)
- Payment Transparency and Adequacy
  - 80% requirement for funds to flow to the direct care workforce
  - Payment transparency across service and provider types
- Waiting List Management and Transparency
- Critical Incident Reporting
- Service Initiation Transparency
- HCBS Quality Measures
- Medicare/Medicaid Duals Alignment

Community Investments

Community Investment Approach

Under 45 CFR §158.150 –Activities that Improve Health Care Quality, states may:

- Allow managed care entities to account for non-benefit spending as medical costs instead of administrative costs for purposes of Medicaid Loss Ratio (MLR)
- Take advantage of the specialty national expertise and resources that most managed care organizations have acquired to deliver localized solutions
- States can set priorities and direct/approve proposed initiative spending
- Address community capacity and quality challenges impacting health equity for people with disabilities
- Impact HCBS or other programs not “carved-in”

CMS Inclusion/Exclusion Examples

Included	Excluded
• Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives • Quality reporting and documentation of care in non-electronic format • Accreditation fees directly related to quality-of-care activities • Patient-centered education and counseling • Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements • Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors • Health information technology to support these activities	• Those that are designed primarily to control or contain costs • Establishing or maintaining a claims adjudication system • Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services • Provider credentialing • Marketing expenses • Costs associated with calculating and administering individual enrollee or employee incentives • Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from premium revenue

Tools for Sustainability

Existing Benefit Enhancement

- Current Benefit/Billing Code
- Enhanced Rate and/or VBP Approach

In Lieu of Service

- Cost effective substitute for covered service
- 42 CFR 438.3

State Plan or Waiver Amendment

- Options within 1915 (c) and 1115
- CMS Technical Assistance to Manage Scope

Arkansas Community Investments Success

Providers challenged with supporting individuals with complex behavioral health and developmental disabilities, particularly with navigating the siloed systems of care

MCO collaborated with partner from another market, Benchmark Human Services, and local provider partners to adapt and create an interdisciplinary model for staff/caregiver crisis training and coaching, intensive wraparound resources and support coordination, specialized clinical resource, and transition supports

State approved model to be funded as a pilot through MCO Community Investments; Model implemented for pilot period with great outcomes

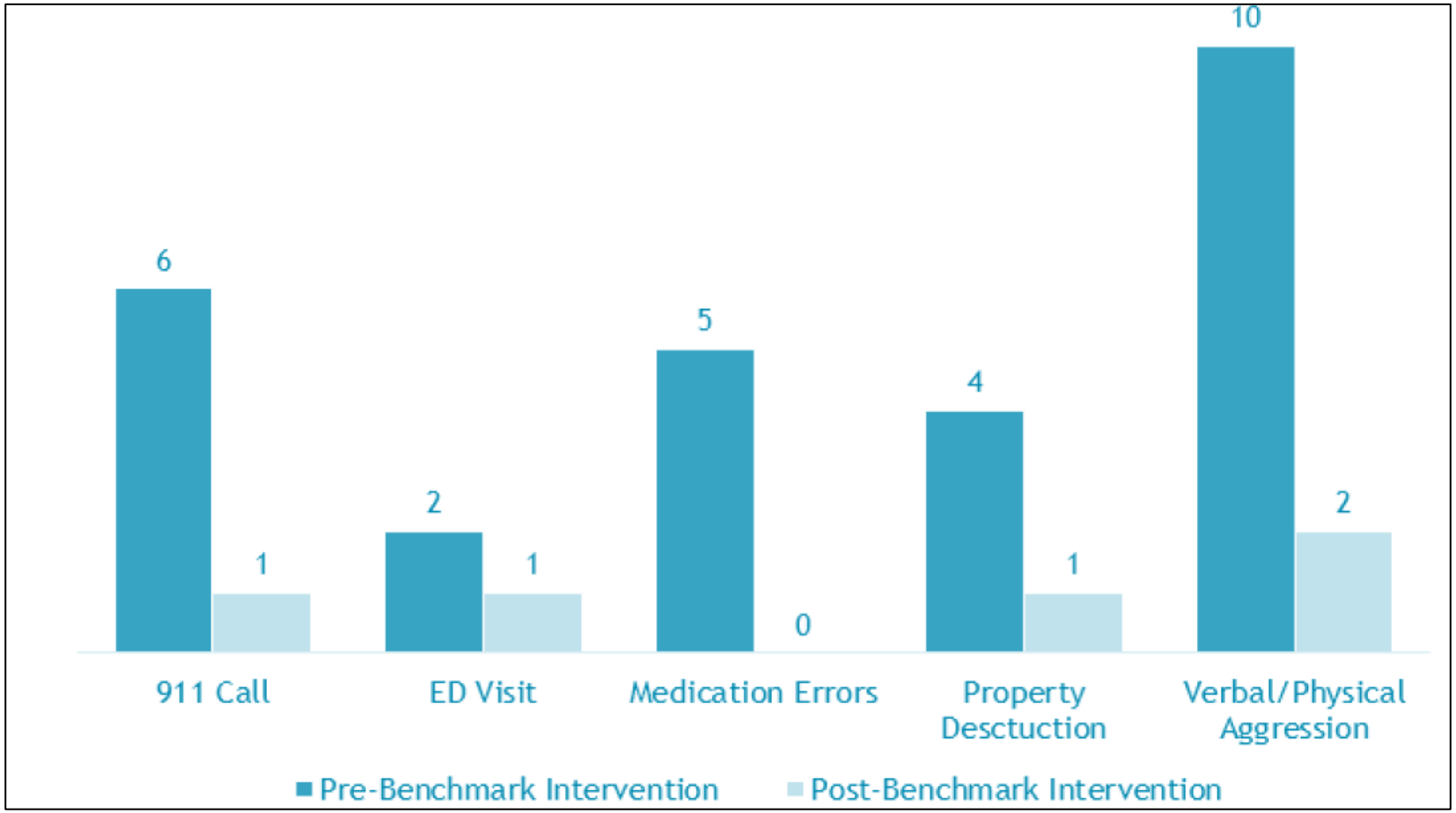
State agreed to continue the program and adopted a new HCBS provider type (Community Support System Provider, CSSP) an included the new service model as a standard waiver service to ensure sustainability

BENCHMARK
HUMAN SERVICES

CFHS

Arkansas Community Investments Success (cont.)

Targeted Outcome: Crisis Recidivism

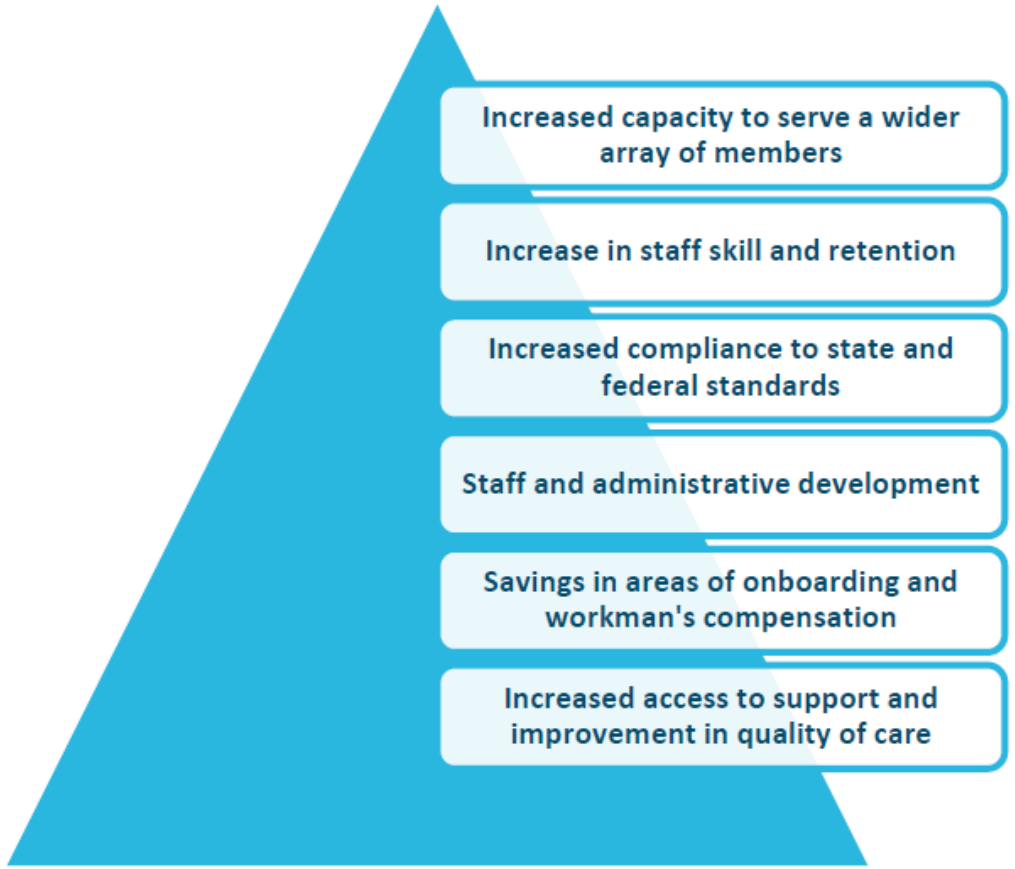


BENCHMARK HUMAN SERVICES

CFHS

Arkansas Community Investments Success (cont.)

Systemic Benefits



BENCHMARK
HUMAN SERVICES

CFHS

How to Succeed with Community Investments

Opportunities

- Do you have an innovative idea to address workforce shortages or enhance capacity?
- Is there a particular population you support where you think you could help improve health and social outcomes?
- Would you and your fellow IDD providers benefit from system uniformity in technology, training, or credentialing?
- Are there emerging technologies that would help you more efficiently or effectively support people with IDD?

Approaches

- Connect with your state agencies to ensure IDD system needs are considered (even if IDD is not carved in).
- Craft proposals that can be implemented with minimal health plan support.
- Where possible, partner across the state with other providers and CBOs.
- Connect with your MCOs with proposals.
- Be sure you have a path to sustainability vs. a one-time impact.

In Lieu of Services

We could support more members with complex needs if only we had….

- ✓ Internal behavior supports staff
- ✓ Transitional staffing supports
- ✓ Extra resources during the transition period
- ✓ Home-based technologies
- ✓ Emergency respite
- ✓ Caregiver assessments and supports
- ✓ Specialized mobile crisis services
- ✓ Crisis stabilization units
- ✓ Community-based wrap-around services
- ✓ Intensive outpatient programs
- ✓ Wearable technologies to indicate behavior escalation
- ✓ Adult dental services
- ✓ Housing deposits and navigation
- ✓ In-home nursing care

Even where IDD waiver services remain carved-out of managed care, IDD providers are burdened with the unintended impacts of emergency room visits, in-patient hospitalizations, and transitions to higher levels of care:

- Staff overtime
- Workers' compensation claims
- Staff turnover
- Missed days billed from inpatient stays
- Property destruction
- Transportation costs

In Lieu of Services (ILOS)

- Authorized by 42 CFR 438.3(e)(2)
- Must be determined to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan (i.e. hospital or intermediate care facility diversions)
- States can pre-approve ILOS or have processes for one-time approvals
- May not require individual to use an ILOS if they choose the State Plan service

ILOS Case Study: IDD Provider supports Gary, an individual with complex behavioral health and diabetes needs. Gary experienced over a dozen emergency room visits in 2021, as well as 2 inpatient stays lasting over a week – since discharge was delayed by adjustments to Gary's behavioral health medications and enhanced support needs when transitioning home.

Gary's IDD Provider is paid through the state DD division, not an MCO, but was impacted by increased staffing cost, transportation costs, and missed income for days Gary was in the emergency room or hospital. IDD provider approached MCO and indicated that they could reduce Gary's acute incidents using some wearable technologies and could reduce his hospital stays with temporary home-based wrap-around supports to supplement his waiver-funded staffing.

With state approval, the MCO could provide these additional resources as ILOS. This could be accomplished through an existing MCO provider or by credentialing the IDD Provider, depending upon state requirements.

Other Opportunities for IDD Provider and MCO Engagement

Engagement Opportunities with State and MCO Partners

Challenge	Opportunity
States are required to obtain CMS approval before moving State Plan or waiver services into managed care, which requires public notice and comment long before an RFP can be issued for procurement. MCOs invest millions of dollars into markets anticipated to issue RFPs within the next 2 year period.	IDD providers should engage individually and collectively with their state agencies and MCOs to ensure program design and investments are aligned with the needs of individuals with IDD and those who care for them (regardless of whether the IDD waiver services are carved into managed care).
Value-added Services: MCOs are being required to customize value-added services and benefits to individuals in fee-for-service IDD waiver programs and/or individuals with IDD on waiting lists.	IDD providers should share their insights with MCOs on what value-added services offer real value to individuals with IDD, as well as the processes to access such services for the members they support.
MCOs are required to provide whole-person, integrated care for physical and behavioral health, which is a common challenge for people with IDD, and failure to access quality care can drain resources for IDD providers trying to support people with IDD.	IDD Providers should work with individuals and their guardians so that their staff can connect directly with the MCO on their behalf when experiencing trouble with appointments or access to services (particularly where the waiver services are carved-out and they don't have access to the member's health dashboards, etc.). Many states also require the MCOs to share the individual's care plan with the IDD provider, which can be a helpful tool to collaborate with care management.

Engagement Opportunities with State and MCO Partners (cont.)

Challenge	Opportunity
Workforce Development: Every RFP for managed care services issued in the past 2 years has included requirements for MCOs to support workforce strategies and provider capacity development.	IDD providers should evaluate the data around the people they support, staffing hiring and retention models, service delivery alternatives, useful technologies, etc., and advocate with the state and MCOs to implement meaningful workforce development strategies.
MCOs are required to provide whole-person, integrated care for physical and behavioral health, which is a common challenge for people with IDD, and failure to access quality care can drain resources for IDD providers trying to support people with IDD.	IDD Providers should work with individuals and their guardians so that their staff can connect directly with the MCO on their behalf when experiencing trouble with appointments or access to services (particularly where the waiver services are carved-out and they don't have access to the member's health dashboards, etc.). Many states also require the MCOs to share the individual's care plan with the IDD provider, which can be a helpful tool to collaborate with care management.
Health Equity: MCOs are being required to adopt population-specific health equity strategies, with individuals with IDD being recognized as a population experiencing health disparities.	IDD Providers should connect with MCOs for support with training and tools (for IDD provider staff, but also training for the physicians and clinicians that serve the individuals they support). MCOs have also provided equipment and resources to increase remote supports and telemedicine in rural and underserved areas.

Engagement Opportunities with State and MCO Partners (cont.)

Challenge	Opportunity
2023 Proposed Rules: CMS has proposed new rules that require minimum staffing in long-term care facilities, mandates that at least 80% of Medicaid payments in a state for homemaker, home health aide, or personal care service be spent on compensation for direct care workers, and create new reporting requirements. While the intention of these rules is commendable, they could have unintended effects on workforce availability and increase administrative burden on small IDD providers.	IDD Providers should collaborate with their local and national associations to ensure that all new mandates are fully funded and implemented in a way that is not disruptive to service delivery. They should also request to be included in the interested parties advisory group that each state is required to create to review payment rates for direct care workers.
Members Dually Eligible for Medicare and Medicaid: MCOs are being required to align their Medicaid Care Management with an affiliated Medicare program to ensure more seamless coordination between programs – as well as generally coordinate better with Medicare entities overall. They are also required to provide training on duals' processes and issues to members, caregivers and their providers.	IDD Providers should familiarize themselves with the Medicare services available to the individuals they support, particularly as many Medicare entities are providing "extra" services and supports that may be helpful (similar to value-added services in Medicaid). They may also want to be familiar with the dual's coordination expectation, as historically that burden has fallen on the IDD provider and the individual and their guardian; so this offers an opportunity for administrative simplification in the future.

Contact CFHS for Support

1. Jodi.Fenner@ConsultingFHS.com
2. Connect on LinkedIn
3. www.ConsultingFHS.com
4. Resources for Provider Organizations

CFHS