Leading Change: Driving Health Outcomes

Engaging Stakeholders to Influence Managed Care Plans that Include Long-term Services and Supports

Panelists

- Jazmin Burns, LEND Clinical Psychology Postdoctoral Scholar Fellow, UC Davis Department of Psychiatry and Behavioral Sciences
- Merrill Friedman, Senior Director, Disability Policy Engagement, Anthem
- Dr. Ted Kastner, Commissioner, New York State Office for People with Developmental Disabilities
- Michael Monson, Senior Vice President, Medicaid & Complex Care, Centene

What is Managed LTSS?

- The delivery of long term services and supports through managed care programs.
- States contract with health plans.
- Health plans contract with medical and community based providers.

What are LTSS?

- Services or supports needed to perform routine daily activities.
- They include home and community based services.
- Examples: in-home care, housing supports, chore services, care coordination, home modifications, employment, respite.

Who Decides?

- States decide who will be enrolled in managed care.
- The federal government must approve the state approach.
- Sometimes courts decide, if challenges to the policy arise.

Why is this happening?

- State Medicaid budgets are growing.
- The demand for LTSS is growing.
- Spending on home and community based services is much higher for people with disabilities when compared to the aging population.

Why is this happening?

- To improve care coordination.
- Better access to community based services.
- Flexibility to be creative (transportation, technology, etc.).
- Better health outcomes.

Challenges for People with Disabilities

- Where is the disability voice?
- Can I get the services I need?
- Do health plans understand my needs?

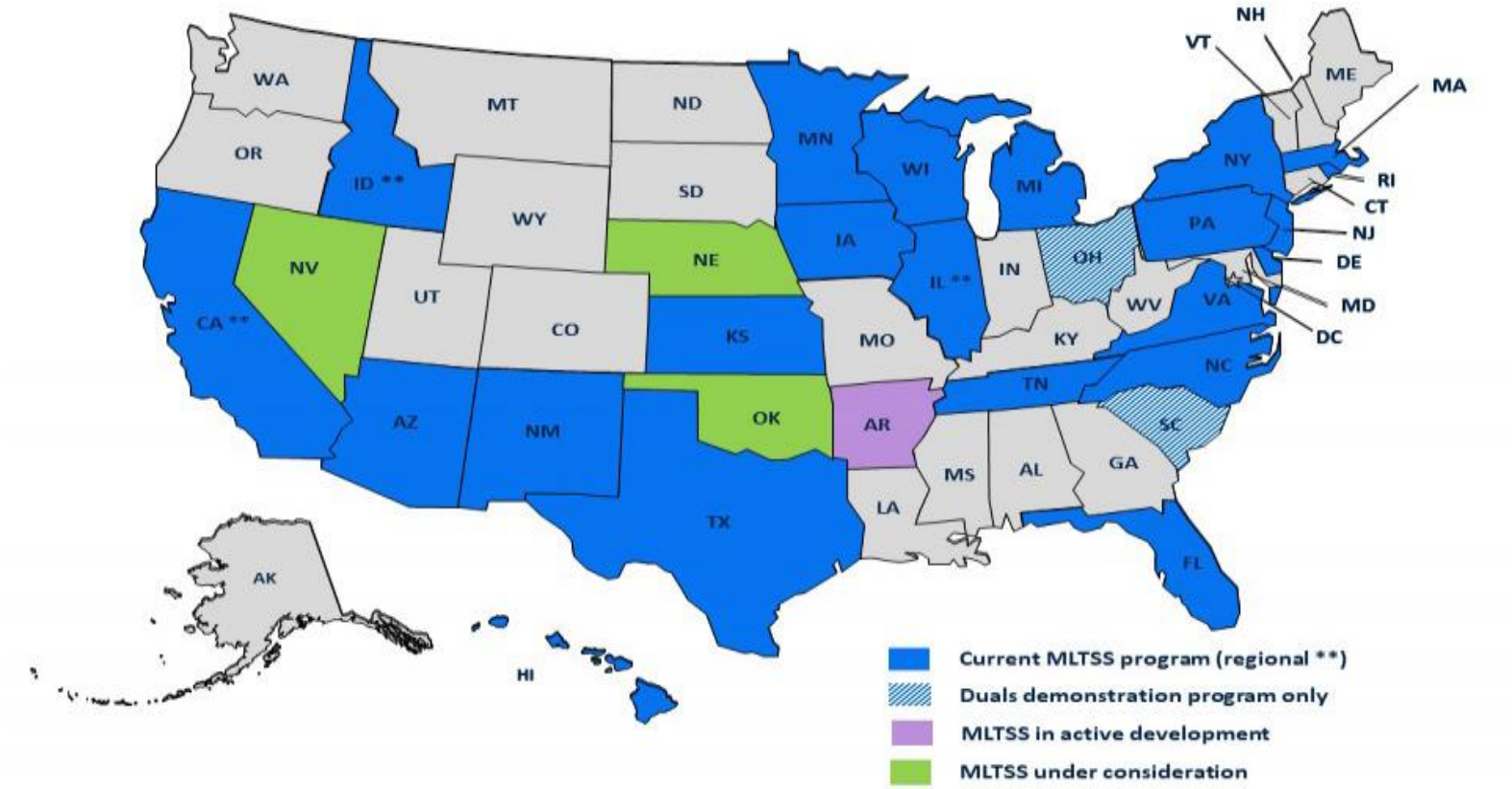
Challenges for Health Plans

- Balancing the expectations of its customers: the state and enrollees.
- Managing costs and quality.
- Every state has different rules and programs.
- Understanding the data: what is the disability experience in MLTSS?

Challenges for Both

- Environmental context:
  - Political decisions, both state and federal.
  - Direct care workforce shortages.
  - Other factors that are uncontrollable (e.g. the economy).

Where are we Now?



http://www.advancingstates.org/initiatives/managed-long-term-services-and-supports/mltss-map

Where are we Now?

- 24 states operate MLTSS programs for complex Medicaid populations.
- Up from 8 states in 2004.
- The number of new states has slowed, but some are actively considering MLTSS.

What's Next?

- How should MLTSS plans evolve?
- What have we learned that should inform future states?
- How can people with disabilities and the people and organizations that support them have a voice in that future?

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Managed Long-Term Services and Supports (MLTSS): A Clinician's Perspective

Jazmin Burns, PsyD

Clinical Psychology LEND Postdoctoral Scholar Fellow

November 19, 2019

A Little About Me

Been part of UC Davis Health since 2012

Have also worked briefly at the Veterans' Affairs Medical Center (VAMC) in Mather, CA as well as Sacramento County

Have family members and a spouse with disabilities

Been working with Medi-Cal recipients for a number of years

Passions: working with low-resourced families, neurodevelopmental disabilities, trauma-informed care, advocacy & policy, and psychological assessments

Challenge 1: Engaging Families with Limited Resources

- Multiple stressors
- Competing priorities (basic needs)
- Limited understanding of/or trust in a complex system
- Time
- Resources and advocacy skills

Challenge 2: Service Access

- Qualifying diagnosis varies by agency
- Long wait-list for qualified providers
- Limited diversity in providers
- Transportation and other resource limitations
- Rural areas with no providers

Challenge 3: Access to mental health and behavioral services

- Medi-Cal patients often slip through the cracks if they have a dual mental health (MH) and neurodevelopmental disability (NDD)
  - Limited integration between MH and NDD agencies
- Challenges with reimbursement for behavioral health services

Innovation 1: Care Coordination Support

- Family navigator services
  - Peer coaching and Family specialist care
- EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)

Innovation 2: Telehealth

- Community Early Start Denver Model (C-ESDM) -- This method is helping us more successfully reach families in rural and urban low-resourced areas
- Northern Valley Indian Health
- Autism ECHO

Innovation 3: Community Partnerships

- Working with community providers – labs are teaming up with doctors in the Greater Sacramento area to improve early screenings for babies/infants who may have NDDs
- Education for providers, families, preschools about NDD screening

Innovation 4: Access to Mental Health Services

- Educating families and providers about MH screening in individuals with NDD, as well as about using mental diagnosis to access care (stating the MH diagnosis first, followed by NDD)
- Educating MH providers about NDD and strategies to support clients in clinical care

Engaging People with Disabilities

- Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program
  - Provides various opportunities for individuals across multiple fields with and without disabilities to learn about many different topics from policy and advocacy, NDDs, leadership, education, etc.

Story to Reflect On

- 4-year-old Sarah has parents who are considered low SES and struggle with mental health issues. Due to constant court issues, lack of trust in the health care system, and lack of follow-through on appointments, Sarah ends up not receiving proper care and continues to struggle emotionally, behaviorally, and socially.

Another Story

- 60-year-old single mother, Tammi, suffers a stroke, falls into a coma, and is hospitalized. Her 28-year-old daughter with severe autism symptoms is placed in a hospital room for eight months while health care workers attempt to figure if she has family able to care for her.

How should MLTSS plans evolve?

- Increase engagement with individuals with disabilities and help them recognize their medical rights and power
- Example: Supported Decision Making (SDM) and PREPARE Advance Health Care Directives

Other Suggestions

- Serving families holistically
- Systematic checking of program efficacy to see what we could be doing better
- Insurance companies playing a bigger role in connecting patients to food banks, housing supports, etc.

- Contact information:
  - Jazmin Burns, PsyD
  - Email: jlsheppard@ucdavis.edu

Resources

- Adults with Developmental Disabilities: A Comprehensive Approach to Medical Care (article by Clarissa Kripke, MD) - https://pdfs.semanticscholar.org/b8af/c6b92c35515b65efba17297b11380a08e92f.pdf

- California Department of Managed Healthcare - https://www.dmhc.ca.gov/

More Resources

- Health Passport Form - http://flfcic.fmhi.usf.edu/docs/FCIC_Health_Passport_Form_Typeable_English.pdf
- Office of Developmental Primary Care - https://odpc.ucsf.edu/training/best-practices-behavior-support/understanding-autism-aggression-and-self-injury-transcribed and https://odpc.ucsf.edu/supported-health-care-decision-making

More Resources

- PREPARE Advance Directive - https://prepareforyourcare.org/advance-directive-library
- Supported Decision Making - https://health.ucdavis.edu/mindinstitute/centers/cedd/sdm.html

Thank you

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Perspectives on MLTSS for Individuals With I/DD

Theodore Kastner MD, MS
Commissioner

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

About NYS OPWDD

- NYS OPWDD operates under an 1915C Waiver authority. We build services and supports for individuals with intellectual and developmental disabilities (I/DD) through an interdisciplinary team (IDT) and a care planning process undertaken by a Care Coordination Organization (CCO) resulting in a Life Plan.
- We do not (in general) fund Medicaid State Plan Services. However, we do co-operate some services (ICF/IDD, Article 16 Clinics, Crisis.)
- We support 140,000 Individuals and 350 agencies with a budget of about $8.0B. This includes 43,000 certified and non-certified residential opportunities. Revenues increase at 2% to 3% per year. Costs increase approximately 8% to 12% per year.

NYS OPWDD Is Moving To Managed Care

- 2011 Medicaid Redesign Team: Care Management for All
- 2013 DD Individual Support and Care Coordination Organizations or DISCOs
- 2014 Alliance for Integrated Care of New York – an I/DD focused ACO
- 2015 OPWDD Transformation Panel

Transformation Panel Recommendations

- Reinvest savings achieved through managed care in the OPWDD system.
- Identify additional/new funding to meet the administrative costs of managed care.
- Consider not including certified residential services.
- Evaluate care management before mandatory enrollment begins.
- Ensure that OPWDD services are coordinated by experienced entities.
- Ensure that the input of families and individuals guides any service changes considered and that reliable data is used.

NYS Is Moving To I/DD Managed Care

- 2016 Partners Health Plan - an I/DD FIDA
- 2017 Specialized I/DD Plans - Provider Led or SIP-PLs
- 2018 I/DD Health Homes - Care Coordination Organizations
- 2018 Qualification Document for SIP-PLs with public comment
- 2019 Ongoing voluntary enrollment in mainstream managed care
- 2019 Medicaid Budget Concerns
- 2019 Project Evaluation of FIDA-I/DD
- 2019 Legislative Hearings on I/DD Managed Care

Impact of Three I/DD "Managed Care" Experiences in NYS

- Three operating models:
  - Medicaid State Plan in mainstream managed care plans
  - Provider-led shared savings arrangements using an ACO model;
  - Provider-led, all benefit, full risk, full capitation Medicare/Medicaid State Plan/HCBS demonstration under FIDA-I/DD authority. (A more traditional insurance model.)

What Have We Learned From Experiences?

- There is no major objection to enrollment in mainstream plans for Medicaid State Plan services. There is less enthusiasm with management of the Medicare benefit
- I/DD providers can manage the health care portion with improvements in quality and reductions in cost. There are greater challenges associated with the management of the HCBS benefit
- The insurance-based model of the FIDA-I/DD demonstration has maintained quality, has not reduced utilization (MLR 99%), and operates 10% above historical costs

What About The Affordable Care Act? Does the ACA Represent New Opportunities?

- Systems Transformation
  - Delivery System Redesign Incentive Payments
  - Balancing Incentive Payment
  - State Innovation Models (SIMs)
  - Children's Systems of Care
- Opened the door to new delivery models
  - Accountable Care Organizations, Health Homes
- Alternative Payment Models
  - Capitation, Bundled Payments, Shared Savings, Quality Incentives/Withholds

Consequences of The Affordable Care Act? Who is First in Line for Premium?

- Providers/Systems have more management capacity resulting from their ACO experience
- Providers want direct contracting relationships with payors that include risk (i.e. Medicaid ACOs)
- Providers/Systems are seeking opportunities to eliminate fiscal intermediaries
- MCOs are moving in the same space
  - Building/buying data analytics/AI
  - Selling TPA and ACO platforms

Managed Care Tools: How Can These Be Applied to State Systems?

- Credentialing/Network Restrictions/Preferred Providers
- Service Authorization
  - PA, Concurrent Review, Retroactive Review
- Medical Necessity Criteria
- Population Health/Acuity
- Data Analytics

  Hot spotting/Outliers

  Social Determinates of Health

What Are We Doing Now?

- Focus on CCO Roll-Out/Implementation
- Incremental Expansion of Managed Care
- Internal OPWDD Strategies (Use managed care tools):
  - Consider Tiered Waiver
  - Use Acuity Measures (CAS) to Manage Budget
  - Incorporate Acuity and Budget in Life Plan Development
  - Strengthen Data Collection and Analysis
  - Strengthen Service System
  - Explore Alternative Payment Models
  - Explore Alternative Provider-Led Delivery Models

Where Might This Take Us?

- Insurance-Based Model: Will full capitation, full risk contracting for MLTSS leave States without any new funds to support innovation or expansion? Could States be compelled to create waiting lists (Kansas)? What happens if MLTSS fails (ICS)? Who is the backstop?
- Alternative Payment Model: Will I/DD providers change their behavior in response to new financial incentives. Does this depend on where premium sits – MCO vs State?
- Either scenario: How will individuals/families be effected? How will current and future capacity and service options be effected? From where will innovation arise?

Questions/Discussion