FEBRUARY 3, 2012
VOL 1 NO 1

NASDDDS

ManagedCareTrackingReport

Changes in I/DD Systems

Tracking Change

by Nancy Thaler, NASDDDS Executive Director

For the 42 years I have been in the field of developmental disabilities, we have been talking about change — Change is coming. Change is happening. We need to change how we are doing business. The only thing constant is change.

Well, we have some big change agendas now!

Baby boomers are joining the roles of Medicare and Social Security at the rate of 10,000 a day! Twenty years from now, 20 percent of the population will be over 65. This reality is driving both political parties to forge proposals to change Medicare dramatically. Means testing, privatization, and limiting the benefit are concepts both parties and the president are entertaining. The country cannot afford the cost trajectory for the Medicare program — so Medicare is going to change.

Medicaid is Going to Change. President Obama, Republicans, and Democrats have all advanced plans which included *savings* and *reforms* to Medicaid. Republicans have called for $185 billion in cuts to Medicaid and block granting the program. The President called for significant cuts to Medicaid beginning with $34 billion in cuts in his February 2011 budget release for 2012 and $21.2 billion (nearly $15 billion in a blended Medicaid/CHIPRA rate) in his September 2011 proposal during the joint committee deliberations. Make no mistake, Medicaid, as we know it is going to change, most likely after the 2012 election.

The State Stampede to Reform Medicaid through Managed Care. Managed care is a proven method for improving the quality of care and controlling costs. While the introduction of managed care in Medicaid in the 1990s frightened many, today the majority of Medicaid beneficiaries are in managed care for their acute care services with little criticism about quality and access.

States are now turning to managed care to control long-term care costs. In 2009, six states had some form of capitated managed long-term care. According to NASUAD's 2011 survey, 50 percent of the states are operating or exploring managed long-term care programs. Arizona, Michigan, and Wisconsin were early adopters. North Carolina is in the midst of a state-wide roll out for behavioral health and developmental disabilities. New York has a proposal into CMS to develop an 1115 demonstration waiver for people with developmental

disabilities. Other states have proposals to serve all populations in managed care. As one CMS official said, "there is a state stampede to do managed care."

The Federal Initiative to Reform Services to the Medicare/Medicaid 'Dual Eligibles'. Congress and the administration are focused on the dual eligible population because they are the most expensive participants in both Medicare and Medicaid: They comprise 21 percent of the Medicare population but 36 percent of Medicare spending and 15 percent of the Medicaid population but 39 percent of Medicaid spending (Kaiser 2007).

The health care reform legislation created the Federal Coordinated Health Care Office whose mission is to make sure dual eligible beneficiaries have full access to seamless, high-quality health care and to make the system as cost-effective as possible. The new coordination office has considerable authority to waive federal rules in order to support demonstrations in states to manage this population more effectively. To date 15 states have each received $1M in grant funds to develop demonstrations and an additional 23 states have submitted letters of interest. **The direction to states is that all populations and all services must be included in the dual-eligible demonstrations.**

While data is still hard to come by, many states estimate that somewhere between 40 percent to 60 percent of people in their state I/DD program are dual eligibles.

States Changing What Services They Provide. For some time state I/DD directors have been witnessing no growth or slower growth in funding even as waiting lists grow and concluding that traditional models of service are not only unsustainable but for many are undesirable.

Twenty-four hour residential arrangements and services to adults that do not lead to employment and are giving way to an emphasis on real work for real pay, increased support to families, and exploration of relationship-based alternatives to 24-hour residential services. The University of Minnesota has been documenting a constant growth in the percentage of people with I/DD getting services while living with their families over the past 20 years. Today it is approaching 58 percent (this does not include people on the waiting list) with at least six states reporting more than 70 percent living with their families.

In addition to changing service models, a number of states are implementing individual allocation strategies to both control the use of resources and provide consumers with far more personal control over how resources are used.

And now, the development of electronic monitoring technology that is non-invasive and supports increased independence is opening new avenues to reduce costs while improving services.

Integrating Change Agendas to Get the Best Results. Change is happening at multiple levels.

States are looking to: (1) change their service paradigm from one that is facility based to one that is community, employment and family based; (2) change the management and reimbursement structures of state Medicaid systems; while also (3) building self-direction, choice, and quality management into the program; and (4) running parallel to these efforts is the federal push to reconfigure services to the dual eligible population. The coordination and integration of these change agendas has the potential to significantly improve the lives of people with I/DD and their families while building a system that has long-term sustainability.

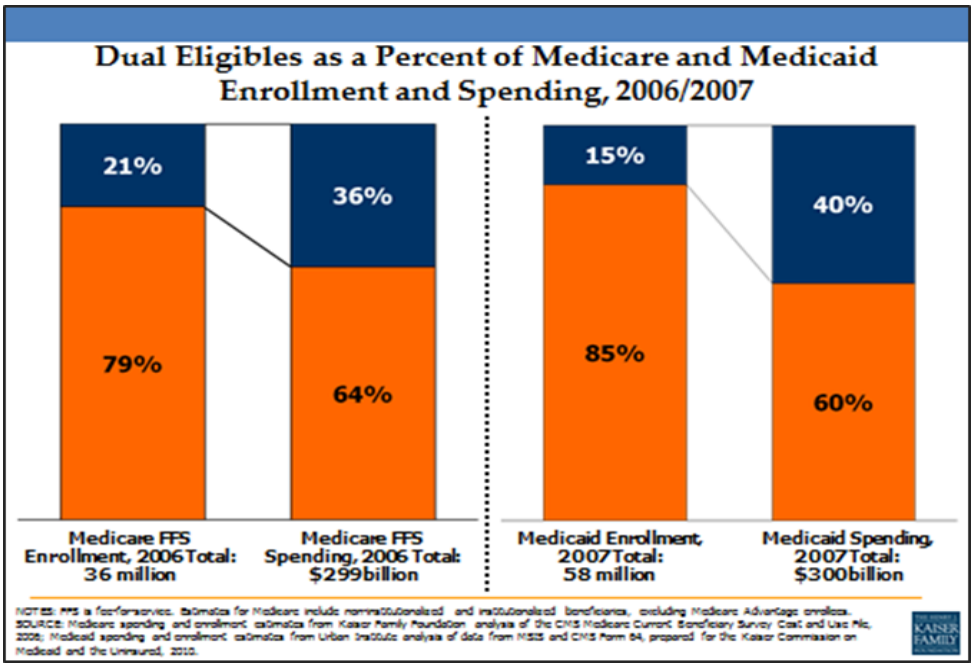
During 2012, NASDDDS will be reporting on these change initiatives at both the state and federal level through a supplemental bi-monthly report — NASDDDS *ManagedCareTrackingReport-Changes in I/DD Systems*. This publication will include information on federal initiatives and actions in states to implement managed care approaches for long-term supports for people with I/DD.

We welcome your feedback and suggestions to make this report as useful as possible to everyone.

Nancy

All Eyes on the Dual Eligibles!

According to the Kaiser Commission on Medicaid and the Uninsured, nearly nine million people, including 5.5 million low-income seniors and 3.4 million people with disabilities under age 65, are eligible for and enrolled in both the Medicare and Medicaid programs. These dual eligibles are attracting a great deal of attention inside the beltway in part because dual eligibles utilize a disproportionate percentage of resources as compared to their percentage of the population, which leads federal legislators and policy makers to perceive an opportunity to find cost savings through better coordination of the two programs through which dual eligible receive the bulk of their health care and long-term services and supports (LTSS).



Significant Percentage of People with I/DD are Dual Eligible. These federal policy initiatives have significant potential ramifications for state service systems for individuals with intellectual and developmental disabilities (I/DD). Estimates of the percentage of duals that are individuals with I/DD vary from 5 percent to 18 percent. However, although exact numbers are not known, most states who are able to make estimates report that 50-60 percent of the individuals they serve with I/DD are dual eligible. This is because an adult whose lifelong disability began before age 22 may be eligible for disabled adult children (DAC) benefits through the Social Security program if a parent eligible for social security is deceased or starts receiving retirement or disability benefits. This combination — individuals with I/DD constituting a relatively small percentage of dual eligible, while dual eligibles make up approximately half of the individuals in the I/DD service system — suggests that state I/DD agencies and other stakeholders need to pay close attention to activity in their states spurred by these federal initiatives to ensure that the interests of the individuals they serve are not adversely affected by unintended consequences of significant changes to the service delivery system for dual eligibles.

15 States Awarded $1M for Demonstrations to Integrate Care for Dual Eligible Individuals

CMS' has awarded grants of $1M to 15 states to "identify and validate delivery system and payment coordination models that can be tested and replicated in other states." The ACA authorizes CMS to "provide funding and technical assistance to states to develop person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for dual eligible individuals."

The states selected to receive design contracts are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. After federal review of the proposals, CMS will "work with states to implement the plans that hold the most promise."

The states selected fulfilled two criteria specifically articulated on the CMS:

1) they "met the goal of aligning the full-range of Medicare and Medicaid primary care, acute care, behavioral health, and long-term supports and services" and
2) "demonstrated a medium to high level of readiness, to ensure timely implementation."

In other words, these states committed to including dual eligibles from all populations, including the I/DD population, in their model, and convinced CMS that they could ramp up their new model quickly. Although CMS anticipates that some of the fifteen states will begin with demonstrations that only involve select populations or areas, the Request for Proposals (RFP) includes a requirement that the state's model include a "description of plans to expand to other populations and/or service areas if the model is focused on a subset of dual eligibles or is less than statewide."

The key elements required in the demonstration proposal make it clear that CMS expects states to explore managed care arrangements. These include:

- a "description of proposed delivery system/programmatic elements, including: benefit design; geographic service area; enrollment method; and provider network/capacity;"

- a "description of proposed payment reform, including payment type," and offers examples such as "full-risk capitation, partial cap, administrative PMPM";
- a "description of how the proposed model fits with: (a) current Medicaid waivers and/or state plan services available to this population; (b) existing managed long-term care programs; (c) existing integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs; and (d) other health reform efforts underway in the state."

The RFP contains quality requirements for the demonstration model, calling for a description of "key performance metrics, including how these data will be used to continuously improve access, quality, satisfaction, and efficiency as well as how they will fit within existing Medicaid and Medicare performance and quality measures," as well as a "description of proposed evaluation design, including key metrics that could be used to examine the model's quality and cost outcomes for the target population, beneficiary experience, access to care, etc." CMS has not offered any specific quality measures for states to incorporate. Agency officials have referenced the National Quality Forum (NQF) as a source for such measures; however, none of NQF's 400-some approved quality measures address LTSS.

The Innovation Center will approve qualifying states that collectively serve up to 1 to 2 million dual eligibles, and those states will have an option to pursue either or both of these financial alignment models. Demonstrations under this program would be limited to no more than three years, and will include a rigorous evaluation, the results of which "will help inform the potential for future program changes." Meaningful engagement with stakeholders and ensuring beneficiary protections will be a crucial part of developing and testing these models. CMS is in the process of establishing a technical assistance resource center to aid interested states in working through the process of developing a state initiative and meeting the necessary standards and conditions.

FMI

The CMS web page on state demonstrations is available at www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp.

Medicare Data Available to States

The Department of Health and Human Services also announced a new process that provides faster state access to Medicare data to support care coordination. With Medicare data, states can identify high risk and high cost individuals, determine their primary health risks, and provide comprehensive individual client profiles to its care management contractor to tailor interventions. States whose requests are approved will be able to combine Medicare Parts A and B claims and Medicare Part D Prescription Drug Event (PDE) data and link to the state's Medicaid data for "whole-person analysis of the dual eligible experience." States may also request Medicare eligibility and enrollment data on their dual eligible beneficiaries. CMS is now making available to states more timely "non-final action" (i.e., subject to subsequent adjustment) Medicare Part D PDE data for the specific purpose of supporting care coordination activities that have the potential to improve care for dual eligible beneficiaries at the individual level. These data will be made available at no cost to states.

FMI

For more information on Medicare data-sharing, go to www.cms.gov/CMCSBulletins/downloads/Coordinated-Care-Info-Bulletin.pdf.

New Financial Models for Dual Eligible Integration Projects

Thirty-eight states have expressed interest to CMS in pursuing alternative financing arrangements for services to dual eligibles in response to a State Medicaid Directors' Letter (SMD Letter) describing opportunities to test two new financial models designed to help states improve quality and share in the lower costs that result from better coordination of care for individuals enrolled in Medicare and Medicaid. The SMD Letter outlines "two models for states pursuing integration of primary, acute, behavioral health, and long-term services and supports for their full benefit Medicare-Medicaid enrollees."

The two models are meant to address the financial misalignment between Medicare and Medicaid, which CMS describes as "a longstanding barrier to coordinating care for Medicare-Medicaid enrollees." The models are:

- Capitated Model: A state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. This model will "target aggregate savings through actuarially developed blended rates that will provide a new savings opportunity for both states and the federal government."
- Managed Fee-for-Service Model: A state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

The CMS Center for Medicare and Medicaid Innovation intends to test these models to determine whether they save money while preserving or enhancing the quality of care for Medicare-Medicaid enrollees. According to CMS officials, the 38 letters of intent represent varying levels of interest, and the agency expects some states to pursue these financing demonstrations vigorously, while others of the 38 may not ultimately participate.

FMI

Visit the CMS Financial Alignment Page www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp.

Technical Assistance Available to all Fifty States

CMS is also making technical assistance available to all states interested in improving services for dual eligible individuals. The Integrated Care Resource Center (ICRC) can assist states in "delivering coordinated health care to high-need, high-cost beneficiaries" through technical assistance to states at all levels of readiness to better serve beneficiaries, improve quality and reduce costs. CMS recently awarded a contract to Mathematica to lead the Integrated Care Resource Center.

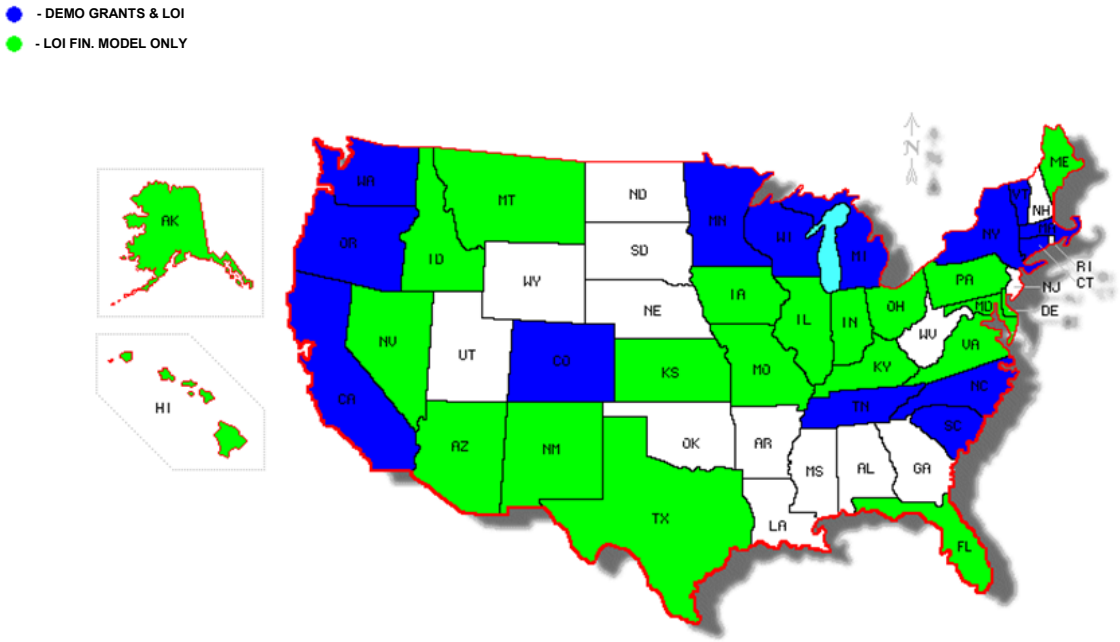
FMI

Assistance through the Integrated Care Resource Center is currently available at www.integratedcareresourcecenter.com.

Dual Eligible Changes - Coming Your Way

The following map outlines states awarded the 15 demonstration grants, all of which submitted Letters of Intent for Financial Alignment Models, and the additional states that sent Letters of Intent for the Financial Alignment Models only (no demonstration grant awarded.)

STATES W/ DEMO CONTRACTS & STATES W/LOI FOR FIN. ALIGN. MODELS



The 15 Demonstration Grants for Dual Eligibles-Changes for I/DD Planned in Many States

Depending on the administrative structure of state I/DD agencies, available data and state initiatives, there are varying levels of historical I/DD agency involvement in direct policy and planning for dually eligible individuals. Supporting people navigating coverage from Medicare Part A to long-term care and the more recent involvement in Part D coverage have both served to increase state I/DD agencies' knowledge significantly. Now, the focus on dual service integration has the potential for sweeping changes in state service delivery systems, including I/DD. People with I/DD could be "carved in" or "carved out" of current systems into another service delivery method or agency. Informed state leaders at the table will not only provide key policy direction, but will also assist stakeholders in navigating changes.

The 15 state demonstration proposals have foundational similarities, with state specifics on target populations, service delivery models, enrollment procedures, benefit packages and financing arrangements. The proposals are subject to change as states move forward, working through their planning and design processes.

The following summarizes the demonstration grants, provides links to state websites specific to the demonstrations where available, and highlights selected state websites in which people with intellectual and developmental disabilities are specifically mentioned as part of the Dual Eligible Demonstration Grants:

CALIFORNIA
The initial demonstration proposal outlines all full dual eligible in four pilot areas, with plans to expand. It would explore coordination with or coverage for behavioral health (including specialty MH and DD waiver services.) A Request for Solicitations issued on January 16, 2012 for indicates no beneficiaries will be excluded based on specific diagnostic categories and sites would be responsible for beneficiaries with developmental disabilities; however, HCBS services through Department of Developmental Services will be carved out. The Department of Health Care Services' comprehensive website for the demonstration can be found at www.dhcs.ca.gov/provgovpart/Pages/DualIntegrationDemonstration.aspx.

COLORADO
Colorado's initial proposal expects participation of at least 30,000 dual eligibles statewide; with a special focus on those with mental health needs. Colorado's website for the Dual Eligible Demonstration Proposal has multiple links to resources, including a workgroup for developmental disabilities is available at www.colorado.gov/cs/Satellite/HCPF/HCPF/1251610502140.

CONNECTICUT
Connecticut's proposal describes a phased-in approach that will offer participation initially to all dual eligibles ages 65 and over. Beginning in the third year of implementation, Connecticut would expand eligibility to dual eligibles under 65 and older dual eligibles with disabilities. See Connecticut's proposal to CMS at www.ct.gov/dss/lib/dss/pdfs/CT_ResponsetoCMS_Solicitation_RFP-CMS-2011-0009-2-1-11.pdf.

MASSACHUSETTS
Massachusetts' initial demonstration proposal includes all full benefit duals ages 21-64 statewide. As subgroup mentioned would be individuals with behavioral health needs; experience would inform potential improvements for the elderly and MassHealth only enrollees. The Massachusetts Dual Demonstration website, with meetings announcements, minutes, presentations, and updates can be found at www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/.

MICHIGAN
Michigan's submitted proposal target all duals by April 2012, with expansion plans statewide following a phased in implementation plan. People with I/DD are specifically mentioned in the Request for Information. A number of informative documents can be found on the state's Dual Eligible Demonstration Grant website at www.michigan.gov/mdch/0,4612,7-132-2939_2939_2939-259203--,00.html.

MINNESOTA
Minnesota's submitted proposal would target all full benefit dual eligibles, fully integrated for seniors, with a potential for separate plans for people with disabilities. Minnesota has a webpage dedicated to the dual eligible demonstration initiatives: www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573.

NEW YORK
New York's target population is to be determined based on data analysis and stakeholder input. One option includes managed care for people with I/DD, stating an interest to develop and pilot special care coordination or managed care to provide medical and LTC for duals with DD, with emphasis on primary and preventative care.

NORTH CAROLINA
North Carolina's demonstration proposal would target all dual eligible individuals statewide. The state has a comprehensive website dedicated to the initiative which can be found at www.communitycarenc.org/emerging-initiatives/dual-eligible-initiative/.

OKLAHOMA
Oklahoma's proposal describes an initial pilot for all duals, with an emphasis on those with behavioral needs in the new state plan, and those in need of a nursing home level of care in PACE expansion. The statewide link is at www.okhca.org/providers.aspx?id=13291.

OREGON
Oregon's submitted proposal would target full benefit duals statewide, with key subpopulations including people with mental illness and those who receive LTC services. The following links include minutes outlining the proposal and the state health authority website: www.health.oregon.gov/OHA/OHPB/health-reform/docs/2011-1019-materials-med.pdf?ga=t and www.health.oregon.gov.

SOUTH CAROLINA
The South Carolina Department of Health of Human Services has a comprehensive website for the dual eligible demonstration initiative materials, minutes and updates. The dual eligible demonstration as submitted would target those with a behavioral health diagnosis; HCBS waiver participants could enroll in demonstration. There is a pilot/phase in period. See msp.scdhhs.gov/scdue/content/resources for resources and www2.scdhhs.gov/organizations/south-carolina-dual-eligible-demonstration-project-sc-due for the South Carolina Dual Eligible Demonstration Project.

TENNESSEE
The Tennessee initial proposal targets all full dual eligible; discusses physical and behavioral health services and has consideration of other options. Tennessee's Proposal to CMS is available at www.familiesusa2.org/assets/pdfs/TN_Dual_Integration_Proposal.pdf.

VERMONT
Vermont's initial proposal would target all duals statewide. Vermont website on Dual Eligibles is located at humanservices.vermont.gov/dual-eligibles-project.

WASHINGTON
The state of Washington's demonstration proposal would target full benefit dual eligible individuals who are "categorically needy, aged, blind and disabled", with a phased in implementation (www.adsa.dshs.wa.gov/duals/).

WISCONSIN
The Wisconsin proposal as submitted would target duals who are elders and adults ages 18 and older with physical and developmental disabilities who require nursing home care. There are pilots and a phased in implementation proposed. The following is a link to a copy of the grant submission: www.dhs.wisconsin.gov/wipartnership/pace/grant-submission.pdf.

FMI
Summaries of all 15 State Design Contract Summaries can be found at www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp.

What's Next

The *ManagedCareTrackingReport* schedule will be determined by developments in the states and federal agencies.

ManagedCareTrackingReport - Changes in I/DD Systems

Published bi-monthly by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) as a supplement to *Community Services Reporter* and *Federal Perspectives*.

Writers/Editors
Barbara Brent, Director of State Policy
bbrent@nasddds.org

Dan Berland, Director of Federal Policy
dberland@nasddds.org

Layout, Design, and Distribution
katherine karol snyder, Director of Member Services
ksnyder@nasddds.org

Dual Eligible Demonstration Grants Summary Chart

State	Target Population	I/DD included/ mentioned	Service Considerations	Phase In
California	Full dual eligibles. Acute, w/LTSS added, depending on pilots	Yes, but with exceptions	Explore coordination w/ or coverage for MH, I/DD	Four pilot areas to start, with plans to expand statewide
Colorado	Full dual eligibles. Seeks to link acute, behavioral and LTSS	Not in proposal. Has DD workgroup		Phase in with anticipated statewide implementation
Connecticut	Initially to all dual eligibles ages 65 & over	Not specifically. DDS & others in documents	Initial focus on the elderly	Phase in starting with 20-30% >65. Year 3, expand to <65 & people with disabilities
Massachusetts	Full benefit duals ages 21-64 statewide w/acute, BH & community services	Mentioned, w/ exploration & exceptions	BH emphasis, seeks improvement for elderly & MassHealth	Statewide, with implementation planning
Michigan	All dual eligibles: acute, LTSS & BH	Yes, I/DD in RFI	Design phase plans for BH and LTC integration	Phase in approach
Minnesota	All full benefit dual eligibles statewide, SNPs highlighted	Mentioned in progress report	Some I/DD discussions	Statewide with phase in
New York	TBD. Several options outlined to include primary, acute and LTC	Potential pilot option/ I/DD managed care	Options outlined include primary, acute and LTC	
North Carolina	All dual eligibles	Uncertain. I/DD on LTC workgroup	Proposal varies, for people at home, nursing homes, etc.	Statewide
Oklahoma	Emphasis on behavioral health and duals in in new Accountable Care Organizations	Not indicated in proposal	High risk/high cost people PACE expansion nursing home LOC	Three geographical areas to start
Oregon	Full benefit duals; emphasis on behavioral health (BH)		Emphasis on BH; includes acute, LTSS, BH	Statewide
South Carolina	Emphasis on BH; including acute & LTSS		HCBS discussed	Pilot and phase in statewide
Tennessee	Full dual eligibles, physical & BH services		Duals w/nursing home LOC could access HCBS	
Vermont	All dual eligible managed care	Yes	Acute, long-term care, etc.	Statewide
Washington	Full benefit duals; phased in populations	Yes	Acute, long-term care, etc.	Phase in population and areas
Wisconsin	Duals who are elders & adults ages >18 older w/ physical and I/DD	Yes	Acute & LTSS managed care	Phase in, then statewide

Note to states: The state level implementation of demonstration grants changes quickly. What was proposed in the initial applications may have adjusted appreciably based on stakeholder input, data and other analyses. NASDDDS welcomes any corrections or additions to information provided in this publication. Please send your comments and corrections to bbrent@nasddds.org or dberland@nasddds.org.