

Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities



*A report published by the American Network of Community Options and Resources
January 2019*

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About this Report

For nearly 50 years, the American Network of Community Options and Resources ([ancor.org](http://www.ancor.org)) has been a leading advocate for the critical role service providers play in enriching the lives of people with intellectual and developmental disabilities (I/DD). As a national nonprofit trade association, ANCOR represents 1,600+ organizations employing more than a half-million professionals who together serve more than a million individuals with I/DD. ANCOR also represents 55 state provider associations. Our mission is to advance the ability of our members to support people with I/DD to fully participate in their communities.

This report was prepared under ANCOR’s leadership and with the guidance of ANCOR’s Alternative Payment Model Workgroup by Vikki Wachino of Viaduct Consulting, LLC in conjunction with Molly O’Malley Watts of Watts Health Policy Consulting, LLC.

Executive Summary

Over the course of 2018, the American Network of Community Options Resources (ANCOR) identified and assessed alternative payment models (APMs) for Medicaid-funded services for people with intellectual and developmental disabilities (I/DD). ANCOR undertook this work recognizing that health care payment systems are moving toward paying for value, and that this movement offers the potential to increase efficiency, quality, and flexibility in service provision. However, the unique needs of individuals with I/DD and their families, the limited nature of approaches to APMs for long-term services and supports (LTSS) and I/DD services, and mixed experiences with transitions of LTSS to commercial, risk-bearing managed care organizations (MCOs) support the belief that any transitions into this area be undertaken thoughtfully and deliberately.

ANCOR reviewed research and analysis regarding alternative payment approaches in Medicaid, identified existing state APMs for I/DD services, and met with experts and representatives of national organizations who represent state officials responsible for oversight of Medicaid I/DD services. For purposes of this review, ANCOR defined any payment approach outside traditional fee-for-service (FFS) as an APM. Following a year of active discussion by ANCOR regarding current and future payment approaches to services for people with I/DD, ANCOR determined:

- **Community providers add significant value to the lives, health and well-being of people with I/DD and their families.** Community providers have, for example, played a leading role in advancing community integration and facilitating marked achievements in serving people at home and in communities rather than in large institutions. Over nearly forty years, Medicaid service delivery for long-term care has transformed from one that relied entirely on institutional care to one in which community services have become prevalent, particularly for people with I/DD. The capacity and skill of community providers is one factor among many that have contributed to this historic accomplishment, and will help drive needed additional progress in community integration.
- **Providers' expertise and experience should help drive I/DD delivery system reforms, including development of APMs.** As the health care system, including LTSS, moves toward incentivizing value over volume, community providers are prepared to leverage their skill and expertise to play a larger role in shaping delivery system reforms for the I/DD population. This work should leverage providers' expertise in providing both medical and non-medical services, and their longstanding experience addressing social determinants of health. These reforms should be developed in conjunction with individuals, self-advocates, and families, as well as states, plans, and others.
- **APMs have potential to strengthen quality and outcomes, but key challenges have not yet been addressed.** APMs can create opportunities to serve individuals with I/DD and their families as well or better than existing FFS models, and can incentivize greater quality and efficiency in service delivery. However, thus far few APMs for I/DD services have been developed. Most APM activity in Medicaid involves physical health services for populations that do not use LTSS. Key challenges in applying APM approaches to I/DD services include measuring quality and outcomes, risk adjustment, and design issues such as determining which entities hold risk.

- **APMs must advance broader policy objectives for I/DD services, including community integration, individual independence, and caregiver supports** Individuals, families, stakeholders, and the I/DD community as a whole have worked together to advance these objectives over many years. Payment and service delivery changes must, among other goals, assure individual independence, promote an individual's ability to achieve full community participation, respond to the unique needs of each individual, and support personal decision-making and self-determination. They must also continue to advance implementation of the Americans with Disabilities Act and the Olmstead decision.
- **Most APMs are relatively new, and have been developed incrementally.** In assessing alternative payment approaches, ANCOR reviewed ten APMs for I/DD services that operate in eight states. The majority of models were developed recently. With some exceptions, these models were implemented incrementally over time. Some were developed with significant stakeholder participation. These APMs involve different forms of risk-based payments, ranging from shared savings payments to providers to full-risk capitation through MCOs. The models generally involved integration of an array of Medicaid services. A few models facilitated investments in technology or flexibility in service provision.
- **The impact of these APMs on outcomes, cost, and quality of care for people with I/DD is not yet clear.** These models have not undergone extensive evaluation. Although measurement data is available on each of the models we reviewed, the measures used differ significantly and do not facilitate comprehensive assessment. Cost savings are difficult to achieve with services for the I/DD population, and should not be a primary motivating factor behind APM development.
- **It is also unclear to what extent the models are advancing key policy objectives for services for people with I/DD.** For example, some states use APMs or managed care as a tool to expand access to HCBS services. In the models we examined, some states with APMs reduced or removed waiting lists for services, although that change cannot necessarily be attributed to the existence of an APM. Other states established reducing waiting lists as a goal but have not yet achieved this goal. While some APMs facilitate investments in priority areas like supporting the direct service provider workforce, most do not.

Based upon its yearlong examination of APMs, ANCOR established **14 payment reform principles** (p. 8) to guide the development and assessment of new and emerging APMs for Medicaid I/DD services. It also established **13 recommendations** (p. 16) for current and future APMs for I/DD services. ANCOR proposes that the recommendations, principles, and policy analysis included in this report support state efforts in moving toward APMs for I/DD services.

These recommendations are designed to promote innovation in service delivery while avoiding disruption or placing individuals or their family members at risk. ANCOR's recommendations address the need for advances in measuring quality and outcomes for LTSS services, the desire to foster greater integration of services, and the need to support person-centered planning and individual choice. They also advocate for stakeholder engagement in developing new models, and strong, diverse governance structures in overseeing them.

Introduction

The health care system, including Medicaid, is increasingly moving toward financing health care services to reward greater value and quality. A recent 2018 50-state survey by the Kaiser Family Foundation identified quality, value, and outcomes initiatives as key areas of focus for Medicaid now and in the coming years.¹ This generally means modifying or moving away from FFS payments, which pay for the delivery of specific services, and toward payments that pay incentives for specific improvements, quality goals, and outcomes. APMs can include risk-based or capitation payments. Most recent APM initiatives in Medicaid have focused on physical/acute health care services, and increasingly extend to behavioral health and LTSS. Outcomes are easier to define and measure for physical health care than they are for LTSS given the episodic nature of the services.

By rewarding quality and value, APMs can create opportunities to serve individuals and their families better and to incentivize greater efficiency in service provision. APMs can create flexibility in payment to advance quality and/or specific outcomes rather than incentivizing the number of services provided or being tied to specific administrative processes, such as billing increments.

Defining Key Terms

This report uses the following terms:

- **Alternative Payment Models (APMs)** are strategies that change the way Medicaid providers are paid, moving away from FFS payments to methods of payment that incentivize value. APMs can be implemented in different delivery systems, including FFS Medicaid programs and in Medicaid managed care.²
- **Value-Based Payment (VBP)** models are payment models in which a state Medicaid program holds a provider or a managed care organization accountable for the costs and quality of care they provide or pay for.³
- **Fee-for Service (FFS)** models are those in which payments are made for a service or unit of service that is delivered, and where payments vary based on unit of service.⁴ Fee-for-service includes payments that are made based on time-based billing increments during which the services are provided (monthly, daily, hourly, or half hourly rates).
- **Capitation** is a payment model in which payments are made based on the numbers of people enrolled or served in the expectation that services are provided rather than being based on the specific services that are delivered.⁵
- **Managed Long-Term Services and Supports (MLTSS)** programs are arrangements wherein states contract with managed care plans to deliver LTSS either as a stand-alone benefit, or as part of a comprehensive package of physical and behavioral and LTSS. These programs are generally capitated. MLTSS is not an APM, but APMs and VBPs can be integrated into MLTSS.

History of ANCOR's APM Workgroup

In December 2017, ANCOR convened a workgroup to identify and assess APMs for people with I/DD, which led the work reflected in this report. The workgroup, which represents a cross-section of ANCOR membership, was tasked to identify current and potential financing models that move beyond the FFS system. Specifically, ANCOR's charge was to identify, assess, and recommend potential opportunities to advance innovative payment and delivery models to improve the quality of care for people with I/DD and strengthen providers' role in serving these individuals. ANCOR identified and assessed approaches that tie payments to performance, value and outcomes, as well as those that allow for shared savings, cost incentives, shared risk, and flexibility, including through capitated payments or global payments to providers.

Over the past year, ANCOR engaged with the Centers for Medicare and Medicaid Services (CMS) and industry leaders including the Council on Quality and Leadership (CQL), the National Association of Medicaid Directors (NAMD), the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and the National Association of States United for Aging and Disabilities (NASUAD). ANCOR reviewed existing analysis and evidence on approaches to VBP for health care services and LTSS, as well as other recent delivery system changes, including the rapid movement by many states toward MLTSS programs. Additionally, ANCOR conducted two member surveys. The first identified the value that community providers bring to the provision of I/DD services. The second, more targeted survey, identified and assessed existing APMs for I/DD services from the standpoint of providers. The ANCOR APM workgroup spent considerable time reviewing existing APMs. We focused in particular on approaches in Pennsylvania and Arkansas, drawing on the expertise of ANCOR members in those states. ANCOR proposes that this work, and the principles and recommendations put forth in this report, support efforts in individual states to develop new and stronger APMs for I/DD services.

APMs Should Align with Consensus Goals for I/DD Services

ANCOR and its member providers support the broad goals for I/DD services that stakeholders, individuals, families, providers, and the larger I/DD community have agreed upon and have been working toward for decades. ANCOR based the development of the principles and recommendations offered later in this report on the assumption that any APMs should advance these consensus goals. Specifically, payment reforms should:

- Assure that individuals with I/DD are treated with dignity and respect and that services and supports are responsive to the diverse needs and perspectives of each individual served.

Key Messages from ANCOR's Discussions with State & Industry Leaders

- There is a need to better articulate the role, value, and importance of I/DD services to elected officials, policy-makers and payers.
- Opportunities to advance innovation in I/DD service delivery compete for the attention of state officials with other Medicaid priorities, including managing budget and cost growth, responding to the opioid crisis, and implementing Medicaid expansion.
- Applying APMs to I/DD is in its early stages, and key questions like outcomes, return on investment, and the role of workforce and technology need to be addressed.
- State interest in MLTSS programs is likely to grow, despite recent concerns related to transitions to MLTSS programs in some states.

- Ensure the ability of individuals to access an adequate and quality workforce.
- Promote each individual's ability to be valued, fully participating members of the community and to engage in meaningful and relevant activities in all aspects of life.
- Assure that each person has the opportunity to live, work, learn and socialize in integrated settings.
- Promote self-determination, personal decision making, and personal engagement, including the option of self-directed services; to fully support person-centered planning and individual choice.
- Assure each individual's safety and security within the context of the dignity of risk, autonomy and choice.
- Continue to advance progress toward full implementation of the Americans with Disabilities Act, the Supreme Court's Olmstead decision and CMS's Home and Community-Based Settings regulation.

The Value Proposition of Community Providers

Community providers add significant value to the lives, health and well-being of people with I/DD and their families. In many cases, providers develop trust and lifelong relationships with individuals and their families. The length and strength of these relationships helps provide stability in type and quality of care over the course of peoples' lives. Providers support individuals with I/DD to work toward and achieve important life goals, including participating in their communities, developing personal relationships, and empowering individuals to make key life choices. One key to this is offering an array of services, including employment supports, community integration, self-direction and transportation, that support an individual's independence and well-being.

Community services underpin the historic national progress in shifting services for people with I/DD from institutional care to home and community-based services (HCBS). For over five decades, community providers have helped people move from institutions to home, family and community settings. As a result, an entire generation of individuals has had the opportunity to avoid living in large state-run institutions. Advancing additional progress toward full community integration remains a key goal of community providers.

As public and private payers steer the health care system toward more integrated models of care and toward linking payments to outcomes, quality, and value, the goals of community integration, supporting life goals and individual decision-making need to be paramount. Community providers' expertise in delivering HCBS, including both medical services and nonmedical interventions that address social determinants of health, such as helping people find jobs, social support networks, and stable housing, will be key to achieving these goals. Similarly, providers offer experience managing and addressing the challenges facing the direct service professional workforce. Maintaining and ideally advancing this workforce will underpin efforts to achieve quality and value in HCBS services.

As states work to design and implement value-driven models in Medicaid, including in the context of MLTSS, community providers of I/DD services, who are experts in serving people with I/DD, should be actively engaged in the policy development process. Further, providers should closely monitor the impact of these changes on their organizations and the people they serve.

ANCOR's Key Principles to Guide New Payment Models

ANCOR developed a set of principles for payment reforms for I/DD services that reflect providers' experience serving the I/DD population, and advance quality, value, and cost-effectiveness of service provision. These principles informed the development of the 13 recommendations made at the conclusion of this report. They also establish a standard for assessing future APMs as they are developed.

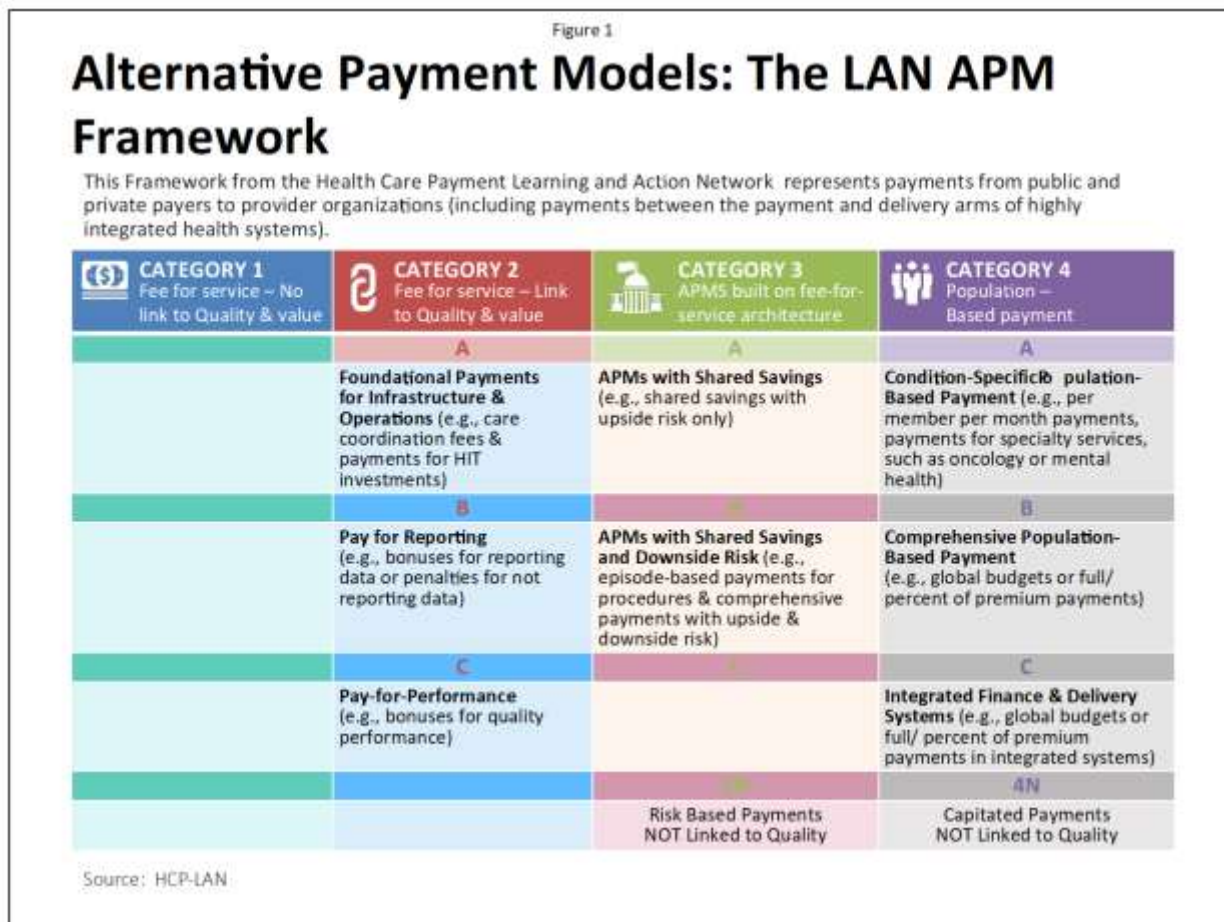
Community Providers' Principles for Payment Reforms

Community providers have been and will continue to be central to advancing state and national goals of promoting community integration and individual independence. Payment reforms should support providers' role in service provision, and take into account the complex array of services and the unique challenges associated with community-based services. Payment reforms should:

1. Promote continuity and stability of services, reflecting that many individuals with I/DD have needs that span their lifetimes and that services are in many cases provided on a 24/7 basis by agencies, paid caregivers, and/or family caregivers.
2. Promote maximum flexibility and utilization of risk sharing and sharing of cost savings mechanisms.
3. Assure continued access to services, and, where possible, expand access to individuals on waiting lists.
4. Assure payment rates fund adequate direct support compensation to attract and retain a stable, skilled, qualified workforce.
5. Achieve a high level of quality and outcomes, including outcomes that are not medical in nature (such as independence, equality of opportunity, and economic self-sufficiency).
6. Promote a full range of services and supports needed to address the diverse needs of people with disabilities (including services such as competitive employment).
7. Promote coordination of physical health services with LTSS and behavioral health.
8. Support self-direction for any individual/family who opts to self-direct.
9. Reduce system complexity and administrative burdens.
10. Promote provider autonomy in the delivery of services.
11. Promote the use of technology where it is an efficient and effective means of supporting quality service delivery and delivering quality and outcomes for individuals.
12. Assure high levels of accountability and transparency to providers, individuals and governments and assure effective and efficient use of resources.
13. Provide payments based on actuarially sound rates.
14. Promote development of direct support workforce to bolster I/DD service provision.

Applying Alternative Payment Models to I/DD Service Provision

ANCOR reviewed literature on APM approaches in Medicaid for physical and acute care services, as well as for LTSS. It also reviewed recent literature on the development of APMs in HCBS, and the initial experience of community providers across the country in paying for quality and outcomes.



ANCOR paid particular attention to the APM framework established by the Health Care Payment Learning and Action Network (HCP LAN). The HCP LAN outlines payment models for transforming the health care system from a volume-based system, reliant on FFS payments to providers, to one that focuses on person-centered care and pays providers for quality care and the achievement of health outcomes. The LAN framework establishes categories of APMs based on different levels of provider financial risk, and consistent technology with which to describe the different models (Figure 1).⁶ LAN’s more advanced APM models, categories three and four, include risk-based and capitated payments that promote quality, coordination, and include safeguards that promote accountability.⁷

Challenges and Limitations in Applying APMs to I/DD Services

The literature regarding APMs for HCBS is still emerging, and analysis of payment models specific to I/DD services is extremely limited. For that reason, ANCOR considered how to apply existing APMs, which have generally been applied to physical and acute care services, to I/DD services.

One significant issue in moving to VBP is how to measure quality and outcomes. Quality measurement in HCBS is an evolving and growing field. Several entities have advanced approaches over the past 10 years, including the National Quality Forum quality measurement framework, the National Core Indicators survey, the Council on Quality Leadership (CQL) Personal Outcome Measures, HCBS CAHPS measures of consumer satisfaction, AHRQ's HCBS quality measurement framework, and Testing Experience and Functional Tools grants.⁸ CMS' Medicaid Innovation Accelerator Program (IAP) provides technical assistance for states interested in developing VBP approaches, including APMs and comprehensive MLTSS.⁹ However, the current set of quality and outcome measures, specifically for services for people with I/DD, is not widely agreed upon, and the field is still evolving to measure and incentivize aspects of community services that go beyond medical care to measure goals like independence and individual choice. In addition, these measures are not easily defined. Many states currently rely on a combination of claims information, consumer experience data and systemic information (e.g. rebalancing, rates of employment, community integration, process/output measures).¹⁰

As quality measures evolve, some organizations and providers are relying on the CQL accreditation process.¹¹ CQL provides accreditation and related services to human service organizations. Accreditation facilitates individuals with developmental disabilities selecting their own personal outcome measures, including measures that promote community integration and facilitate personal goal setting and choices. It also reviews provider safety, promotion of individual rights, dignity and respect, and staff resources. This and similar accreditation processes can potentially be used to support the development of APMs for I/DD services.

Beyond quality measures, there are significant design and development issues that need to be addressed in order for value-based payments, particularly those that are risk-based, to be effectively employed in HCBS services. Defining services and beneficiary populations subject to payment mechanisms, deciding which entity or entities bear risk and are held accountable for performance, and appropriate risk adjustment are all key to the success of paying for value for this population. Provider data and reporting infrastructure needs to be built to support measurement and payment.¹² In addition, the implications of downside risk for providers, especially small providers, should be carefully assessed before being implemented.

Recent Growth in MLTSS

A growing number of states are moving away from traditional FFS payments toward MLTSS programs, many of which are provided by national commercial MCOs. The number of states implementing MLTSS programs grew from 8 states in 2004 to 24 states as of July 2018.¹³ Managed LTSS accounted for 23 percent of LTSS expenditures in FY 2016 compared to seven percent in FY 2012.¹⁴ States most often use MLTSS to serve older adults and people with physical disabilities, although the number of programs that include individuals with I/DD is slowly growing. As of July 2018, ten states enrolled people with I/DD in

MLTSS.¹⁵ States' primary goals for implementing MLTSS are generally to improve coordination, integration, and to manage cost growth.

A June 2018 whitepaper by ANCOR and Health Management Associates (HMA), "Current Landscape: Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities," found states have been slow to adapt MLTSS for people with I/DD for a variety of reasons, including: lack of potential cost savings; limited MCO experience serving people with I/DD in MLTSS; the need for meaningful quality measures; lack of state experience setting MLTSS-I/DD rates; lack of managed care experience among I/DD providers; the unique role of I/DD case management and supports coordination; and strong advocacy networks and relationships.¹⁶

To date, few studies have evaluated MLTSS programs' performance or whether MLTSS programs are meeting their intended goals. Limited baseline data and insufficient targeted LTSS quality measures have made evaluation difficult.¹⁷ As the size and scope of MLTSS programs expands to more populations, including individuals with I/DD, it will be important to closely monitor the impact of these delivery system changes on individuals and families, providers, and state Medicaid programs.

Profile of 10 APM Care Delivery Models

In August 2018, ANCOR conducted a survey of members in states with existing APMs for I/DD services. The survey was informed by ANCOR's payment reform principles and designed to identify the key elements of existing APMs, elicit community providers' perspectives on existing models, and identify similarities and differences across models. Where possible, we supplemented these ANCOR survey results with existing external research, and in particular ANCOR and HMA's June 2018 whitepaper on MLTSS for people with I/DD.¹⁸ ANCOR reviewed 10 APMs, which are summarized below, in the following eight states:

- Arizona
- Arkansas
- Kansas
- Michigan
- New York (3 models)
- Pennsylvania
- Tennessee
- Wisconsin

Arizona has operated a capitated, MLTSS program, the Arizona Long-Term Care System, since 1989 through a Section 1115 waiver demonstration.¹⁹ For individuals with I/DD, for whom enrollment is mandatory, the state Division of Developmental Disabilities (DDD) serves as the managing entity under a contract with the state Medicaid agency. Under the model, the DDD receives a monthly capitated rate for primary, acute, and LTSS for all individuals with I/DD. The model serves about 32,000 individuals with case management services provided by DDD staff. In 1989, Arizona undertook MLTSS to test delivery system models that coordinate care for acute and LTSS, and to avoid long waiting lists for HCBS services.²⁰ The Arizona model does not currently operate a waiting list for services – all eligible persons receive services.²¹ According to providers surveyed, the state has achieved savings through the bundling of LTSS and acute services under one entity, as well as by serving most people in the community as opposed to in an institutional setting. However, providers also noted that rates are below benchmark levels which in turn creates workforce and quality challenges.

Arkansas' Provider-led Arkansas Shared Savings Entity (PASSE) is a new provider-led model that serves certain individuals with I/DD and behavioral health needs, under Section 1915(b)/(c) waiver authority.²² Phase One of PASSE implementation began in January 2018, and Phase Two is scheduled to begin March 2019. Under the model, providers of specialty and medical services partner with managed care organizations to form new business organizations, the PASSEs, which are at least fifty-one percent provider owned. Once fully implemented, the PASSEs will serve about 7,500 people with I/DD and over 20,000 individuals with behavioral health needs.²³ The state plans to enroll individuals who are currently receiving services under the state's DD waiver and individuals who are on the waiting list for waiver services, as well as individuals who reside in private Intermediate Care Facilities. Enrollment is mandatory for selected individuals based upon assessed need. The premise of the PASSE model is that better case management and care coordination will minimize more costly acute services, such as emergency department visits, inpatient psychiatric stays, and hospitalizations. The global payment model includes both shared savings and incentive payments that are tied to reporting/achieving certain outcomes or quality measures. Under the model, both providers and MCOs share risk. In 2018, the stated goals of the model, according to providers surveyed, were to achieve savings over a five-year period and program sustainability, as well as to enhance case management services. Early implementation challenges reported by providers have centered on uneven enrollee attribution to PASSEs and concern over the speed at which implementation is occurring.

Kansas implemented a capitated managed care program called KanCare in 2014 that operates under Section 1115 waiver authority in conjunction with seven section 1915(c) waivers. The state contracts with national commercial plans to provide comprehensive services, including all LTSS, to individuals with I/DD for whom enrollment is mandatory. Nearly 9,000 individuals with I/DD were enrolled in KanCare in 2017.²⁴ In 2014, KanCare's stated goals included four elements: control Medicaid costs, improve quality of care, integrate and coordinate services, and serve as a reform model for other states.²⁵ Specifically for people with I/DD, KanCare also sought to eliminate the HCBS waiting list and improve employment outcomes.²⁶ Case managers in Kansas are employed by the MCOs to coordinate service delivery in conjunction with I/DD waiver case managers. The financial model includes incentive payments for achieving certain outcomes or quality measures. The state pays a capitated rate to the MCOs with a requirement that some services are paid FFS, such as waiver services for individuals with I/DD. Since implementation, providers have voiced concerns about what they perceive as low FFS rates for HCBS. Additionally, the size and speed of the transition to managed care in Kansas has resulted in reported reductions in services and significant implementation challenges.²⁷ Although the state planned to reduce its waiting list, the waiting list for I/DD services has grown from 2,414 in 2014 to 3,452 in 2016, and statewide employment outcomes have not been achieved.²⁸ Further, a recent legislative audit in Kansas determined that savings could not be attributed to the model.²⁹

Michigan operates a capitated, managed specialty services program for individuals with I/DD and serious mental illness (SMI) through local county-based Community Mental Health Services Programs (CMHSPs) that are managed through regional-based Prepaid Inpatient Health Plans (PIHPs). This managed care structure is authorized through the Section 1915(b) Managed Specialty Services and Supports Waiver and the Section 1915(c) Habilitation Supports waiver and enrollment is mandatory. The initial goals of the PIHP program were to enable people with I/DD to live and fully participate in their communities,³⁰ as well as to achieve program sustainability and cost-effectiveness.³¹ The PIHP model was implemented in 2002 after lengthy discussions with stakeholders, including public comments. The Michigan model emphasizes self-determination and person-centered planning where the person is

responsible for decisions regarding selection of individuals to assist in assessing needs such as family members and legal representatives, providers and supports coordinators. Under the model, care coordination is provided by a combination of support from the PIHPs, CMHSPs, provider networks and Medicaid health plans. Challenges reported by providers in the state include low provider rates and low direct support staff wages, although wages were recently increased modestly. Additionally, providers report the need for uniformity and consistency throughout the state regarding the scope of services available, rates, and contractual requirements. Looking ahead, Michigan has begun to explore implementing fully integrated, commercial managed care through pilot projects with a different funding mechanism from the current model and a greater focus on coordination of physical health, behavioral health and LTSS.

New York has three different emerging payment models for Medicaid services for people with I/DD. The Fully Integrated Dual Advantage (FIDA-IDD) demonstration for individuals dually eligible for Medicare and Medicaid launched in 2016.³² This voluntary enrollment model integrates Medicare and Medicaid benefits in a single health plan and includes an interdisciplinary team that is responsible for the coordination of medical, behavioral, LTSS, and social needs. Currently, 764 people are enrolled in the model.³³ In a separate APM model in New York, the Shared Savings Pilot program, developmental disability providers contract with an MCO (owned by DD providers) on a fee-for-service basis to share potential savings achieved from emergency department and hospitalization reductions. Launched in 2018, fewer than one hundred individuals with I/DD are currently enrolled in the program. Under this model, MCO care managers work across all settings to coordinate service delivery. Providers described flexibility in service provision as a strength of the model. Early challenges involved working across two regulatory entities – the state and MCO. Finally, a third model in New York uses Section 1115 waiver authority to serve individuals with I/DD using Health Home/Care Coordination Organizations (HH/CCOs). Implementation began in July 2018. The HH/CCOs, which are controlled by a minimum of 51 percent nonprofit I/DD providers, will receive a capitated rate in exchange for providing care coordination across all service settings (acute, behavioral health, and HCBS), while authorization and utilization will still be overseen by the state agency.³⁴ The state identified several goals of the waiver including establishing a more person-centered system, improving care coordination and service planning, enhancing access to HCBS, and establishing budget transparency.³⁵ Enrollment for participants is voluntary until 2021 at which point all waiver participants are required to enroll.³⁶

Pennsylvania operates a small provider-led adult autism program under PIHP authority called the Adult Community Autism Program (ACAP). Launched in 2009, the model was based on PACE and developed by a planning taskforce that involved over two hundred families and self advocates. The program currently serves 165 individuals, on a voluntary enrollment basis, in four counties. The ACAP program is operated by Keystone Autism Services, a subsidiary non-profit corporation of Keystone Human Services. The financial model consists of a capitated payment where Keystone Human Services is paid on a per member per month basis for each individual. Keystone is then responsible for the coordination of comprehensive services including physical, behavioral, and LTSS. Keystone functions as the MCO and develops individual service plans through its internal case management function. The goals of ACAP are to increase a person's ability to care for themselves, decrease family/caregiver stress, increase quality of life, and provide access to specialized services that support participants over their lifespan.³⁷ Providers cite flexibility in service provision and staffing as strengths of the model. Individual service plans are developed internally and can be adjusted quickly as an individual's needs change. Quality measures focus on the impact of services on peoples' quality of life. Outcomes data collected by Keystone

demonstrates more than half of the individuals enrolled eventually procure jobs with compensation at market levels, high satisfaction among members, and increased access to and utilization of physical healthcare.³⁸ Keystone also reported that the model has generated savings. Any excess of three percent of revenue is considered savings and is then typically reinvested to fund expanded services.

Tennessee's ECF Waiver Tied to a Comprehensive Workforce Approach

As it implemented its ECF program, Tennessee developed a workforce development strategy. It provides competency-based training and a career ladder for direct service workers, provides infrastructure support for providers to establish reporting capacity, and offers technical assistance. Over time, it will provide financial incentives for achieving workforce goals and performance improvement activities.

Tennessee's Employment and Community First (ECF) CHOICES program uses Section 1115 waiver authority to provide an integrated, comprehensive service package of physical, behavioral, and LTSS to certain individuals with I/DD. In 2010, Tennessee implemented CHOICES, an MLTSS program for seniors and people with physical disabilities, but only recently added managed care for individuals with I/DD in 2016 under ECF CHOICES. Enrollment in ECF CHOICES is mandatory for all new HCBS applicants. Tennessee's Section 1915(c) waivers for individuals with I/DD continue to operate (though closed to future enrollment), while ECF enrollment is open to those on the waiting list or anyone currently in a 1915(c) waiver who elects to enroll. In 2018, over 2,300 individuals were enrolled in the ECF CHOICES waiver.³⁹

The initial stated goals of the Tennessee model were to serve more people, including those on the I/DD waiting list for services,⁴⁰ to promote integrated, competitive employment and community integration, and to improve quality.⁴¹ The MCOs provide case management services, and the state requires that all ECF providers have experience in integrated employment services and person-centered practices for people with I/DD. Under Tennessee's model, capitation payments incentivize both MCOs and providers to promote integrated services, including fading the level of support over time.⁴² Tennessee also advances comprehensive workforce development goals, which are incentivized with payment incentives.⁴³ Tennessee's model ties payments to specific tasks and employment outcomes.⁴⁴ Quality measures include an Individual Experience Assessment survey as well as numerous other quality assurance and performance improvement activities.⁴⁵

Wisconsin began its Family Care program for individuals with I/DD (and older adults and people with physical disabilities) as a pilot program in 1998 and grew incrementally on a county-by-county basis until state legislation approved statewide expansion in 2015.⁴⁶ Enrollment is mandatory for individuals using HCBS, except for a self-directed carve-out, and optional for individuals living in a nursing facility. Family Care is operated by county-based and regional nonprofit MCOs responsible only for LTSS. Separately, Wisconsin relies on large, multi-state MCOs to manage acute care services for Medicaid beneficiaries, including people with I/DD on a voluntary basis.⁴⁷ As of October 2018, there were 22,652 individuals with I/DD enrolled in Family Care, under Section 1915(b)/(c) waiver authority.⁴⁸ Initially, Family Care in Wisconsin launched with goals of ending the waiting list, improving access and quality of services, and creating a cost effective long-term care system.⁴⁹ As of July 1, 2018, Family Care is available in all counties in Wisconsin,⁵⁰ and the state plans to eliminate its current waiting list by 2021.⁵¹ An early evaluation that the state commissioned of the Wisconsin Family Care pilot in five counties found cost savings relative to the prevailing FFS model.⁵² However, providers have expressed concern over what they described as relatively stagnant payment rates since 2001, which negatively impacts their ability to achieve quality of life outcomes and sustainable provider networks.⁵³

Key Themes & Attributes of the 10 APMs

The ten models we reviewed, which reflected programs operating in eight states, are diverse, including in size, scope, ownership, financing structure, and longevity. Although this report does not attempt to draw conclusions about these different models, ANCOR assessed these payment models against the payment reform principles that it established (described on page 6). Some models were strongly consistent with some of the principles, but no one model reflected them all.

The information ANCOR reviewed about the models supports a few observations:

Although there are a few longstanding approaches, most of the APMs for I/DD services that ANCOR reviewed are relatively new. Arizona, Wisconsin, and Michigan all have longstanding, statewide MLTSS programs for individuals with I/DD. In all three, public entities or nonprofits play a large role in governance and/or service delivery. The provider-led ACAP system in Pennsylvania is also longstanding, although it operates only in a few counties. The remaining models are more recent. Kansas' movement to commercial MCOs took place in 2014; Tennessee's approach to MLTSS for I/DD began in 2016, as did the earliest of the three models in New York. Arkansas' PASSE model is currently being implemented.

Some of these models were established through incremental, phased changes over time. Wisconsin's Family Care program was phased in county by county over time; Tennessee's ECF program was built on a Medicaid managed care program that had existed and been improved upon over time. New York's FIDA-IDD program and Pennsylvania's ACAP program are small; New York's remaining programs are pilots or being introduced incrementally. Similarly, Arkansas' transition to PASSE is taking place in phases. Kansas, in contrast, rapidly moved nearly its entire Medicaid program, including HCBS services, to managed care in 2014.

All APMs surveyed included risk-based models that are capitated, offer incentive payments or shared savings designed to incentivize specified outcomes. The degree of risk that providers assumed varied by model, ranging from full-risk in Pennsylvania's ACAP model to partial-risk in New York's FFS Shared Savings Pilot Program where reductions in emergency department visits and hospitalizations are subject to shared savings. In states with commercial MCOs, the MCOs receive full capitation, although they may pay providers with whom they contract on a fee-for-service basis.

Many models integrate a comprehensive set of Medicaid services across settings. Nearly all the models ANCOR reviewed integrated an array of acute and HCBS services, although they vary in the extent of the integration. The most integrated approach is New York's FIDA-IDD program, which is the only model we reviewed that fully aligns both Medicare and Medicaid benefits in a single health plan with an interdisciplinary team that coordinates medical, behavioral, LTSS, and social needs. At the other end of the integration spectrum, the Family Care model in Wisconsin provides only LTSS.⁵⁴

All survey respondents reported that their models measured outcomes, but measures varied and few reported achieving savings. The survey and relevant external research did not identify formal program evaluations of any of the models. Most of the APM models that we surveyed reported measuring outcomes of service. However, quality measures varied widely (e.g. quality of life, quality of provider performance, and employment outcomes), and there were few measures of beneficiary experience and outcomes for individuals with I/DD. Three models (AZ, PA & WI) reported having achieved savings.

Some of the states with APMs reported that they have expanded or plan to expand access to services for people on waiting lists. Arizona reported offering services to all who qualify for HCBS services in the state; it does not operate a waiting list for services. Wisconsin is planning to phase out its waiting list over time, and Tennessee has stated that its ECF program will address waiting lists. In Kansas, on the other hand, the waiting list has grown since the state implemented managed care. In each of these states, the presence or absence of a waiting list is not necessarily attributable to the payment model the state is using; many factors can influence access to and eligibility for HCBS.

Some of the models used financing flexibility to make investments in workforce; in other cases, wages remained a concern. Tennessee has included approaches to strengthening the HCBS workforce as an explicit part of its ECF program. According to a provider survey respondent, Pennsylvania's ACAP model pays a competitive wage and most direct support professionals (DSPs) have college degrees. However, in a vast majority of states, providers reported significant concerns with low DSP payment rates, consistent with national data that show low wage rates and recruitment challenges in the home care workforce.⁵⁵

Most of the APMs established a network that included all qualified providers, but providers reported concern about payment rates. According to the survey responses, each model ANCOR reviewed ensured that all qualified providers participated in plan or model networks, which can facilitate provider participation and continuity of experience for the individual. States can also support provider readiness and capacity to participate in APMs, which can vary significantly across HCBS providers, by making investments in data and technology, infrastructure, and education/technical assistance.⁵⁶ However, few survey respondents reported that provider payment rates were adequate in their model.

Stakeholder input into model development varied. The majority of survey respondents said that states had solicited stakeholder input in developing their APM, but approaches to stakeholder engagement and responsiveness to stakeholder feedback differed. Arizona and New York both require advisory committees that include members and families to provide input into the plan. Tennessee identifies specific I/DD organizations that the MCOs must include in their stakeholder engagement efforts.⁵⁷ Some providers who responded to the survey questioned whether stakeholder feedback had not been considered by states.

ANCOR'S APM Recommendations

Based on our assessment of 10 existing APMs for I/DD services, a review of analyses and literature on alternate payment approaches, and discussion with key experts from CMS and organizations that represent state officials, ANCOR makes the following recommendations on APMs for individuals with I/DD:

- 1. Specific value-based payment approaches should be developed to incentivize the delivery of desired lifelong outcomes for people with I/DD.** Value-based payments can increase quality and efficiency. In contrast to FFS payments, APMs reward quality and value over volume. Cost savings are difficult to achieve with services for the I/DD population, and should not be a primary motivating factor behind APM development.

2. **To promote outcomes, efficiency, and flexibility in service delivery, models should move toward risk-based and/or global payments to providers at a measured pace and with robust risk adjustment.** Risk can encourage innovation, coordination, and efficiency better than existing FFS arrangements. But providers have small margins and low rates, and the consequences of inappropriate risk adjustment are significant for providers and people with I/DD.
3. **For APMs to be successful, significant advances in measuring quality and outcomes for people with I/DD are needed. In initial stages, tying value to measures used for CQL accreditation is an example of an approach to explore.** The success of APMs in meeting the needs of individuals with I/DD and promoting their health, independence, and well-being will depend on the measures of progress to which they are tied. However, currently quality measures exist to only a limited extent.
4. **APMs should maintain access to necessary services and promote continuity and stability for individuals, families, and providers.** People with I/DD are best served by providers who understand them as individuals and their families and make a long-term commitment to advancing their health, lifetime needs, and life goals (rather than entering and exiting the market frequently).
5. **APMs should foster integration of physical health, behavioral, and LTSS and support coordination of I/DD services led by providers/interdisciplinary care teams who have experience and expertise with individuals' needs.** People are better served when their services are coordinated; coordination also promotes efficiency in service delivery.
6. **APMs should reduce administrative burdens, administrative layers and promote flexibility in service provision while maintaining accountability and sound stewardship of public dollars.** Small timed increments for billing are burdensome, inefficient, and do not promote self-determination or provider accountability; layering intermediaries between the state as payer and providers can be inefficient.
7. **APMs should incentivize technology to promote a more efficient service delivery system and an adequate and sustainable workforce.** High rates of worker turnover are a barrier to the delivery of quality services. Savings that occur through the use of technology under APMs should be reinvested to promote recruitment and retention of DSPs, reduction of waiting lists, and further advances in technology at the payer, provider and individual level.
8. **APMs should promote person-centered planning and opportunities for individual choice and control in service provision, and accelerate progress toward greater community integration.** APMs should support key goals of individuals and their families. Provider resources and capacities can be deployed to promote self-direction.
9. **Payment models for LTSS should continue to move toward fostering independence, individual well-being, and community integration. They should encompass medical services but not impose a medical model.** The role of LTSS HCBS as social determinants of health needs to be analyzed and better understood. Although medical services are important for this population, the needs of and services for people with I/DD exceed the boundaries of a medical model.

10. **APMs should be overseen with a diverse governance model that actively involves individuals, families, providers, and state/county governments. Regardless of APM approach, a state oversight role remains important.** To support model success, safety and well-being, family involvement, and individual self-advocacy, governance is important.
11. **The transition to new models should not be rushed. Models should be developed with transparent, iterative processes. The consequences of moving too fast are significant, and range from placing individuals at risk and provider dislocation to undermining broader system goals for promoting community integration.** The speed of some recent managed care transitions has created significant disruption and compromised quality of care. CMS' LTSS transition principles may also inform the appropriate speed of transition for APMs.⁵⁸
12. **Models should be responsive to individuals' changing needs and ensure access to necessary LTSS services across the lifespan.** People with I/DD have LTSS needs resulting from a range of conditions and often require a lifetime of services. Their specific needs will evolve over time, as the population ages and as new health and public health challenges emerge. Evidenced-based best practices need to be studied and promulgated to result in better outcomes and a better experience of care for individuals.
13. **Efforts to further engage providers and other stakeholders in this process should continue.** Despite limited experience with APMs in LTSS, the number of APMs is likely to grow in the future. Community providers along with other stakeholders should be continuously engaged in the development and implementation of APMs.

ANCOR provides these recommendations to support the development of innovative payment models in states. ANCOR hopes that these recommendations and the report as a whole can help advance the efforts of a broad array of stakeholders to advance goals including community integration, the independence of individuals, support for families, and the development of a stable, quality workforce.

Notes

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³ Ibid.

⁴ Health Care Payment Learning and Action Network, “Alternative Payment Model Framework, Refreshed for 2017,” July 2017, <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf> and Center for Health Care Quality and Payment Reform, “The Payment Reform Glossary: Definitions and Explanations of the Terminology Used to Describe Methods of Paying for Health Care Services,” First edition, October 14, 2014, <http://www.chqpr.org/downloads/paymentreformglossary.pdf>.

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- ¹⁹ Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. Demonstrations must be budget neutral to the Federal government and are generally approved for an initial five-year period. For more information see: <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.
- ²⁰ S. Lewis, R. Patterson, M. Alter, “Current Landscape: Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities,” Health Management Associates for ANCOR, June 11, 2018, http://anchor.org/sites/default/files/anchor_mltss_report_-_final.pdf.
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- ²² Section 1915(c) waiver authority allows states to provide HCBS to beneficiaries who qualify for an institutional level of care and would be financially eligible for Medicaid if institutionalized. Under Section 1915(c) waivers, states can target services to particular populations and provide services that are not strictly medical in nature. Section 1915(b) allows CMS to waiver state compliance with certain provisions of federal Medicaid law, such as those that otherwise require benefits to be provided statewide, comparability of benefits among different Medicaid populations, and beneficiaries’ free choice of provider. States can implement a managed care delivery system for HCBS using waiver authority under 1915(b)/(c).
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