
HMA

HEALTH MANAGEMENT ASSOCIATES

Stakeholder Review and Comment:

*Options for a Capitated or Non-capitated Pilot
to Serve Persons with Intellectual and
Developmental Disabilities*

STAKEHOLDER COMMENTS DUE JULY 1, 2010

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Introduction

States have begun to apply the principles of managed care to the delivery of long term care services, including services for people with intellectual and developmental disabilities (IDD). In most cases, the use of managed care principles was driven by states' need to develop a more fiscally sustainable approach to delivering services to people with IDD. As interest lists for IDD community services have continued to grow in some states, the potential for savings from managed care approaches and the possibility of translating those savings into increased access to IDD services has interested state policy makers.

There are significant challenges to implementing managed care for IDD services. People with IDD generally have long term support needs that are focused on daily, consistent habilitation. Given this, their service patterns tend to offer less obvious and less easily realized opportunities for savings than service patterns for people with more episodic patterns of care - such as people with mental illnesses or with acute medical care needs. In states that have implemented IDD managed care approaches, there is generally less certainty about the potential for savings from managing acute care services for people with IDD (hospital, physician services, etc.) and all of the IDD-specific approaches have limited managed care to IDD services only.

A handful of states have adopted managed care approaches for IDD services that appear to have met some key objectives, such as increasing access to services, allowing for more flexibility in services offered, and helping to "rebalance" the states' IDD service system toward a greater use of home and community based services. While managed care is still a relatively new and somewhat experimental approach for IDD services, there are some state examples which suggest that the principles of managed care can be harnessed to improve services for people with IDD.

States considering applying managed care approaches to the persons with IDD can pursue either capitated or non-capitated approaches. The basic difference between these approaches is the assumption of financial risk on the part of the entity responsible for managing services. Non-capitated models may pose less of a concern that the managing entity will have an incentive to underserve consumers. However, non-capitated models offer less budget certainty and less potential for service improvements via increased service flexibility. One of the potential benefits of pursuing a capitated (e.g. risk-based) payment approach is that it can provide greater flexibility in arranging and coordinating services to meet the needs of the individual member. Under a capitated payment structure using a combination of Medicaid waivers, health plans can substitute services and/or provide enhanced services based upon the individual needs of the member that may extend beyond the current covered services. This may lead to overall lower costs of care and can provide consumers with services that are more appropriate and responsive to their unique needs.

Texas is currently evaluating how a managed care approach could be applied to the State's system of IDD services and is considering options for a managed care pilot designed for people with IDD. The purpose of this document is to provide stakeholders with an overview of possible options for this pilot and to solicit their feedback and input regarding those options.

Stakeholders should keep the following in mind, as they review the material on other states and the options for a Texas pilot:

- This consulting project will eventually result in a final report to the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS), which will be shared with the Legislature and state leadership offices.
- This consulting project's final outcome is a plan for a pilot project.
- What happens next with the pilot plan, including whether or not it is implemented, will be up to state policy makers.
- Stakeholders will have additional opportunities to provide input on this project. Other opportunities include communications with HHSC and DADS, existing agency advisory committees, and advocacy work during the next legislative session.

Background

Legislative direction. The direction to develop a plan to implement a managed care pilot for persons with IDD is contained in an appropriations bill rider (Section 48 of Senate Bill 1, Eighty-first Legislature, Regular Session, Article II - Special Provisions Relating to All Health and Human Services Agencies):

"It is the intent of the Legislature that HHSC and DADS shall jointly design a plan to implement a capitated or non-capitated pilot to serve persons with intellectual and developmental disabilities. The agency may contract to conduct a study, which shall include input from individuals receiving services, their families, service providers, mental retardation authorities, advocate organizations, and other interested parties. The plan shall include managed care models employed by other states for this population.

HHSC and DADS shall provide a report to the Governor's Office, Lieutenant Governor's Office, Speaker's Office, Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services Committee, House Human Services Committee, and the Legislative Budget Board by December 1, 2010. The report shall include recommendations for the pilot regarding: geographic scope, options for consolidating waiver services, costs and financing, utilization review, provider network, eligibility, service coordination, quality management, waiver development and federal requirements, and other issues as appropriate."

To address these requirements, HHSC issued a Request for Quote (RFQ) seeking a consultant to perform the activities necessary to develop a plan to implement a capitated or non-capitated pilot to serve persons with IDD. Specific requirements of the RFQ are described below.

- **RFQ activities:** The activities outlined in the RFQ included study of other state systems (the RFQ required that one of those states be Michigan), soliciting input from stakeholders, developing and analyzing options for the pilot, and developing final recommendations on the design of the pilot.
- **Target Population:** The RFQ defines persons with intellectual and developmental disabilities as individuals receiving services in an ICF/MR or from one of the following 1915(c) waivers: Community Living Assistance and Support Services (CLASS), Deaf Blind Multiple Disability (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL).

As a result of a competitive procurement process, HHSC selected Health Management Associates (HMA) to perform this scope of work. HMA is a national consulting firm specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and health data analysis. HMA has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; Boston, Massachusetts; New York City, New York; and Atlanta, Georgia. More information on HMA is available at: <http://www.healthmanagement.com/>.

HMA's final report for the project is due to HHSC and DADS on October 15, 2010. This report will summarize research of other state models, provide an overview of stakeholder input, and offer recommendations and analysis of proposed options for developing a managed care pilot for persons with intellectual and developmental disabilities.

Goals and Objectives. HMA's recommendation of the option to be used in the proposed pilot will be made according to the degree to which the selected option can meet the following goals and objectives:

- Increasing consumer access to services through increasing waiver slots
- Promoting high quality care
- Allowing consumer choice
- Providing services in a cost-efficient manner
- Preventing unnecessary institutionalization
- Allowing for necessary coordination of care across service delivery systems

Feasibility of implementation of the model within Texas' current Medicaid infrastructure will also be a criterion for selecting a model.

Role of stakeholder input. The stakeholder input gathered during this project will inform HMA's recommendations regarding pilot design (e.g. capitated or non-capitated approach, eligibility, provider network, role of consumer choice, etc.). HMA will seek stakeholder input to gauge the prevailing preferences of consumers and family members, understand possible limitations faced by public and private providers, test the interest and capacity of managed care organizations to provide IDD services, and explore other possible options that may not have been considered.

Key Terms and Concepts – Managed Care for IDD Services

These terms and concepts are used throughout this document. Reviewing this information may help with the discussions that follow.

Acute Care. This term refers to services for physical health care – hospital, physician, lab tests, x-rays, etc. One of the questions related to implementing a managed care system for IDD services is whether or not acute care services (in addition to IDD long term care services) would be included.

Centers for Medicaid and Medicare Services (CMS). CMS is the federal Medicaid authority. CMS regulates Medicaid programs and reviews and approves home and community-based services waivers. These waivers are commonly used to deliver long term care services for aged and disabled populations.

Full Risk Health Management Organization (HMO Model). In the full risk HMO model, state Medicaid agencies contract with licensed health maintenance organizations to provide a range of services for a specified population in exchange for a set per member per month payment (capitation). If costs exceed

the capitation payment, the HMO is responsible for the costs. If costs are less than the capitation payment, the plan retains the excess funds. This financial arrangement offers the state increased budget certainty and provides incentives for the health plan to manage the care with an emphasis on preventive and community based care rather than more expensive inpatient or institutional settings. However, states must be careful to have contractual provisions and oversight to ensure the health plan does not unfairly restrict access to needed services.

In addition to required contractual services, the health plan can provide additional services outside of the traditional Medicaid benefit package if it sees benefit to the member. For example, if a health plan determines home modifications will allow a member to leave the hospital sooner or function better and receive appropriate and less expensive care at home, the health plan has the flexibility to pay for that service although it is not a Medicaid covered benefit. Thus, a capitated payment approach provides the health plan flexibility in arranging and coordinating services to meet the needs of the individual member.

In the full risk HMO model, Medicaid providers directly negotiate with the health plan for their rates and other contractual issues. The state does not participate in these negotiations. It is not uncommon for health plans to pay an equivalent rate to the historical fee-for-service rates to some providers, although states do not typically require it. For some services, health plans may pay more or less than fee-for-service rates, depending on the service and the provider.

Home and Community-based Services (HCBS). HCBS refers to the set of services available under federal Medicaid waivers that are designed to help prevent services in a Medicaid-funded institutional setting – generally either an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) or a nursing facility.

Intellectual or Developmental Disabilities (IDD). The preferred term that describes a range of cognitive disabilities and substitutes for “mental retardation” and developmental disabilities.

The federal definition of "developmental disability" is a severe, chronic disability of an individual that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and results in substantial functional limitations in three or more of the following areas of major life activities:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency.

Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP). Prepaid inpatient and ambulatory health plans may be at-risk or may have some other type of state reimbursement and do not provide a comprehensive set of services. A Prepaid Inpatient Health Plan has the responsibility for the provision of any inpatient hospital or institutional services. Behavioral Health Organizations (BHOs)

responsible for psychiatric inpatient hospital services are the primary example of PIHPs. A PIHP could also be a managed care organization responsible only for long-term care services, including HCBS waiver services for individuals with IDD. A Prepaid Ambulatory Health Plan has responsibility for some Medicaid services but does not have any responsibility for inpatient hospital or institutional services and is held to a limited subset of the federal managed care regulations applied to PIHPs and HMOs.

Non-capitated Managed Care. To implement “managed” Medicaid fee-for-service programs, Medicaid agencies have the option of contracting with an Administrative Services Organization (ASO) - also referred to as a Third Party Administrator (TPA), to provide managed care and health plan administration services. In this structure, the ASO is capable of applying all of the clinical management tools of the managed care industry, including care coordination, case management, health plan benefit administration, and utilization review to administer and manage fee-for-service Medicaid programs—but on a non-capitated basis. The state determines the scope of administrative services to be provided and pays the ASO and administrative fee for those services. In addition to the administrative fee paid to the ASO, states may offer a performance-based incentive payment to the ASO or providers for the achievement of specific clinical and quality outcomes and metrics. For rural areas, the ASO model may be seen as a model to overcome regional barriers to managed care. A more limited provider base and fewer Medicaid beneficiaries can be difficult challenges for the HMO model.

Risk-Bearing Entities in Texas. The Texas Department of Insurance (TDI) establishes regulations for entities that assume financial risk for medical and/or behavioral health services, including IDD services. In Texas, there are multiple entities that TDI allows to accept contracts with financial risk to the entity. For each of these entities, the requirements for licensure differ. These include:

- *Basic Service HMO.* This plan may accept risk and arrange for a comprehensive set of services including acute care, dental, vision, mental health and IDD-related services.
- *Single Service HMO.* This plan may accept risk and arrange for dental and vision services only.
- *Limited Service HMO.* This plan may accept risk and arrange for a limited set of services, such as mental health or IDD-related services.
- *Exclusive Provider Organization.* This plan may accept risk and arrange for services for CHIP and Medicaid programs.
- *Approved Non-Profit Health Corporations.* Although this regulation is specific to non-profit health corporations, all entities are subject to all HMO rules.
- *Delegated Entities.* These entities may accept limited risk under an agreement with an HMO.

Overview of Current Texas System to Serve Individuals with IDD

Medicaid-funded IDD Services. Texans with IDD who are Medicaid eligible may have access to a set of Medicaid-funded habilitation and support services including:

- Targeted Case Management
- ICF/MR services provided at State Supported Living Centers
- Community-based ICF/MR services (most of these settings are six-bed group homes)

Options for a Capitated or Non-capitated Pilot to Serve Persons with IDD

- Four HCBS waivers, including:¹
 - The Community Living Assistance and Support Services (CLASS) Waiver;
 - The Deaf-Blind with Multiple Disabilities Program (DBMD) Waiver;
 - The Home and Community-based Services (HCS) Waiver; and
 - The Texas Home Living (TxHmL) Waiver.

Table 1 displays the number of people served by these programs and their average costs for their IDD services and their acute care/other Medicaid costs.

Table 1: Key Texas IDD Programs – Number Served and Average Costs

Program	Average Monthly Persons Served SFY 2010	Average IDD Services Annual Cost Per Person SFY 2010	Average Acute Care/Other Services Annual Cost Per Person ²
State Supported Living Centers	4,512	\$126,972	NA
Community-based ICFs-MR	6,037	\$55,080	NA
HCS Waiver	17,017	\$41,400	\$4,513
CLASS Waiver	4,671	\$41,124	\$15,209
DBMD Waiver	155	\$47,400	\$3,339
TxHmL Waiver	994	\$11,016	\$4,744

Source: 2010-2011 General Appropriations Act, DADS Key Measures. Note that ICF/MR programs and waivers offer services in a variety of settings. Average costs stated are average of all settings.

Interest Lists. In Texas, the demand for these waiver services is generally greater than the available funding. Interested individuals who cannot access a waiver “slot” are placed on interest lists, on a first come/first served basis. The eligibility determination process begins once a person moves to the top of the interest list, unless they are subject to some of the exceptions described below. The number of persons on the interest list does not necessarily reflect the exact number of persons potentially eligible for the HCBS waivers. Individuals on the interest lists may not actually qualify for services or may receive other services while waiting for HCBS waiver services.

Table 2 displays current interest list data for February 2010 for three IDD services waivers that have interest lists.

Table 2: Interest Lists by Waiver³

HCBS Waiver Program	Persons on List	Average Time on List (Years)
HCS	43,385	3.2
CLASS	30,363	2.7
DBMD	262	0.6

¹ For the purposes of this document and the study overall, the Consolidated Waiver Program was not included within discussions of existing Medicaid funded IDD services because the Waiver is limited to Bexar County.

² Medicaid acute care and other non-IDD waiver costs amounts are from 2008 CMS 372 reports for each waiver.

³ Counts as of February 2010: <http://www.dads.state.tx.us/services/interestlist/>; TxHmL waiver is not included in this chart because the waiver does not have an interest list.

Texas has an expedited process for accessing HCBS waivers for:

- Individuals moving to the community from a private ICF/MR with nine or more beds.
- Children aging out of foster care.
- Children (up to 50 per year) transitioning from an ICF/MR of any size.
- Persons moving to community from a State Supported Living Center.

Texas Compared to Other States. Because of variations in the size of each state and the size of the population of persons with IDD by state, comparative rankings between states can be difficult. However, some observations between Texas and other states can be made:⁴

- Texas spends a relatively large proportion of all IDD spending on institutional services and has a relatively large number of persons residing in ICFs/MR compared to most other states.
- Texas spends proportionally less on HCBS waiver services than most states. Texas spent 29% of its total IDD spending on HCBS waiver services in 2006. Other state comparisons:
 - Arizona spent 70%
 - Florida spent 54%
 - Michigan spent 60%
 - Mississippi spent 11%
 - Vermont spent 83%
 - Wisconsin spent 48%.
- In October 2009, Texas had about 24 million residents and 10,911 individuals in ICFs/MR. Other state comparisons:
 - California had about 36 million residents and 8,800 persons residing in ICFs/MR.
 - Illinois had about 12 million residents and 8,725 residing in ICFs/MR.
 - Michigan had almost 10 million residents and 63 people in ICFs/MR.

IDD Managed Care Approaches in Other States

Overview

To evaluate managed care models that include services for individuals with IDD, HMA reviewed four state programs - Arizona, Michigan, Wisconsin and Vermont. Each state has implemented a form of capitated risk-based managed care that includes institutional and HCBS waiver services for individuals with IDD. Each program design is different. A comparison table is provided at the end of this section that displays key features of the four state programs.

Arizona, Michigan and Wisconsin have been operating their programs for ten or more years (Arizona for over 20 years) and Vermont has operated its program for five years.

⁴ Braddock, David, Hemp, Richard, and Rizzolo, Mary. The State of the States in Developmental Disabilities 2008. University of Colorado, Department of Psychiatry and Coleman Institute for Cognitive Disabilities. Table 7, Page 26.

Arizona has implemented a fully capitated, comprehensive managed care program that encompasses all Medicaid services. The state agency serving individuals with IDD is, in effect, a managed care contractor responsible for delivering or arranging for the delivery of all Medicaid services for members with IDD (acute care services, behavioral health services, long-term care services – including institutional and HCBS services). All Medicaid eligible individuals with IDD who are eligible for long-term care services (at immediate risk of institutionalization) are enrolled into this program, called the Arizona Long-term care System (ALTCs). Acute care services are delivered by HMOs – the HMOs are at-risk for these services but there is a negotiated shared risk arrangement with the DD agency. Behavioral health services are delivered by the traditional behavioral health regional authorities. Long-term care services are delivered by traditional providers under a fee-for-service arrangement. The state IDD agency is at-risk for covered services.

Michigan, using a Prepaid Inpatient Health Plan (PIHP) approach, contracts with the traditional public providers of behavioral health and IDD services, known as the county-sponsored Community Mental Health Service Programs (CMHSPs), for the delivery of all behavioral health and long-term care services. These include HCBS waiver services for individuals with IDD. This program is called the Managed Specialty Services and Supports Program (MSSSP). The CMHSP (or a collaboration of CMHSPs) act as PIHPs to deliver services and are at risk for the covered services. Acute care services are not included in this arrangement.

Wisconsin has implemented the Family Care Program, which is also a PIHP. Wisconsin contracts with regional managed care organizations (MCOs), to deliver long-term care and behavioral health services including HCBS waiver services, nursing home services, and home health services through the Family Care Program. The program serves frail older adults (65 years of age or older), and people with physical disabilities or with IDD 18 years of age or older. The MCOs may be:

- A county;
- A group of counties acting cooperatively;
- A long-term care district;
- A privately held managed care organization;
- An HMO or similar organization;
- A federally-recognized Wisconsin Indian Tribe; or
- A group of any of the above entities working under a contractual agreement.

The MCOs are fully at risk for the covered services, but a shared-risk agreement is used during the first three years of MCO operation for Family Care.

Wisconsin also operates the Partnership Program. This program includes acute/medical services in addition to the Family Care services. Licensed HMOs that are Medicare Advantage Special Needs Plans deliver the covered services. Partnership is a smaller program than Family Care. In counties where both Family Care and Partnership operate, individuals with IDD may enroll in either program. With one exception (Waukesha County) at least twice as many individuals with IDD choose Family Care compared to Partnership.

Vermont has implemented a comprehensive managed care program operating under its Global Commitment Waiver. While characterized as a managed care program that includes services for individuals with IDD, the managed care arrangement is between the Medicaid agency, functioning as the managed care organization, and the federal government. The program has had no impact on IDD service

delivery – the sole change has been to provide access to Medicaid matching funds for two previously state-funded services.

State Summaries

Arizona

Arizona’s Medicaid program operates under a unique, statewide managed care structure known as the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS arranges for provision of all Medicaid services using risk-based managed care contracts. Medicaid recipients who do not have long-term care needs, primarily low-income families and children, receive their managed care services from health plans that are competitively procured and include governmental (county) entities, private for-profit and not-for profit health management organizations (HMOs). Individuals with IDD who do not have long-term care needs receive their Medicaid services from one of the health plans.

Medicaid recipients with long-term care needs receive all of their Medicaid services, including home and community-based services (HCBS) and institutional services, under a managed care arrangement overseen by the Arizona Long-term Care System (ALTCs), a part of Medicaid. ALTCs is “split” into two population groups: 1) aged persons and persons with physical disabilities; and 2) persons with IDD.

ALTCs contracts with nine program contractors to provide most Medicaid services, including long-term care and behavioral health services, through managed care contracts. Eight of the program contractors are regional health plans that provide acute/medical services to aged persons and persons with physical disabilities. Arizona serves 22,339 ALTCs members with IDD.

The remaining program contractor is the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES is a separate state agency from Medicaid and is the statutorily-authorized division within DES responsible for providing services to persons with IDD. DDD is required by state statute to contract with Arizona Medicaid (and vice-versa). DDD negotiates a managed care contract with AHCCCS. The contract specifies DDD’s responsibilities for Medicaid members with IDD who have long-term care needs. DDD is responsible for delivering or arranging for delivery of all services included in the monthly capitation payment:

- Acute care services (hospital, physician, lab, x-ray, etc.) delivered by sub-capitated health plans;
- Behavioral health services provided through Regional Behavioral Health Agencies under the terms of an Interagency Agreement; and
- Long-term care services including HCBS for persons with IDD, provided fee-for-service by HCBS providers that serve individuals with IDD.

These services are displayed in Table 3.

According to state officials interviewed for this report, over 80 percent of Arizonans with IDD served by ALTCs reside in their own home, family home or a shared home (not owned or leased by a provider). Three percent reside in state institutions. HCBS are an entitlement in Arizona, authorized by the Arizona legislature and available to individuals with IDD at “immediate risk of institutionalization”. According to Arizona Medicaid, substantial cost savings have been achieved by ALTCs even with the entitlement to HCBS.

Table 3: ALTCS (Arizona) - Covered HCBS

HCBS Waiver Services	
Attendant including Self-Directed Attendant Care	Home Modifications
Behavior Management Services	Hospice
Emergency Alert System	Partial Care
Habilitation	Personal Care
Home Health Services	Private Duty Nursing
Homemaker	Respite Care
Adult Developmental Home	Child Developmental Foster Home
Behavioral Health Therapeutic Home	Group Home for Developmentally Disabled
Assisted Living Facilities	Rural Substance Abuse Transitional Agency
Behavioral Health Level II	Traumatic Brain Injury Treatment Facility
Behavioral Health Level III	

Michigan

Michigan implemented a managed long-term care program, the Michigan Managed Specialty Services and Supports Program (MSSSP), in 1998. The program operates under the authority of two Medicaid waivers: a Section 1915(b) waiver and a Section 1915(c) waiver.

The MSSSP is delivered by Prepaid Inpatient Health Plans (PIHPs). The PIHPs are a single Community Mental Health Services Program (CMHSP) or a collaborative of numerous CMHSPs (in more rural areas of the state). The CMHSPs are the traditional county-based organizations serving persons with mental illness, substance abuse or IDD. The PIHPs are selected through a competitive procurement, but the procurement is only opened to non-CMHSP providers if the CMHSP in a service area is unable to enter into a contract with the state. To date this has not occurred.

The PIHPs receive capitated per member per month payments for Medicaid behavioral health, substance abuse and long-term care services including HCBS waiver services. The HCBS waiver services are only available to individuals with IDD. Since 2010, the PIHPs have received two managed care payments each month for the Medicaid covered services:

- One payment is based on all Medicaid eligibles within the PIHP region and covers mental health, developmental disability and substance abuse state plan services including targeted case management and special children's Medicaid services as well as additional services funded from savings (that are similar to the HCBS waiver services but available to all members).
- The second payment is based on the subset of Medicaid eligibles that are also enrolled in the Habilitation Supports Waiver (persons with IDD at the ICF/MR level of care) and covers the cost of these services.

The PIHPs are responsible for serving everyone in their service area who needs the services covered by the MSSSP no matter what "level of care" they are or what their primary diagnosis is as long as they are Medicaid eligible. There is no waiting list for HCBS waiver services for individuals with IDD – anyone who needs and qualifies for Habilitation Supports Waiver services receives these services. In other words, a person with IDD who does not meet ICF/MR level of care and who is Medicaid eligible in any eligibility category can receive services from the PIHP.

Michigan serves over 219,000 persons in the PIHPs annually and over 39,000 are persons with IDD. The PIHPs also contract for state-funded services separate from the Medicaid services. Medicaid-covered HCBS services are displayed in Table 4.

There are no remaining private ICFs/MR in Michigan and only one institutional unit serving individuals with IDD at the state psychiatric hospital. Michigan’s history of changes to the residential system for individuals with IDD began in 1978, when most institutional services were provided at state institutions and a smaller portion at nursing homes for persons with mental retardation. Quality of care problems in the state’s institutions for persons with mental illness and/or persons with IDD prompted efforts to develop community-based options and legislation was enacted changing zoning laws statewide to permit construction of six-bed facilities anywhere in the state. The objective was to replace state institutions with less costly small ICFs/MR. Eventually, between 700 and 800 six-bed ICFs/MR were created, typically operating under contract to the state institutions and in some instances on the grounds of the institution. The ICFs/MR operated as cost-based providers.

With the advent of the PIHPs, the PIHPs were given the option to continue to operate the facilities as ICFs/MR or to “convert” the facilities to HCBS waiver homes (adult foster care homes). Providers overwhelmingly chose the HCBS waiver option as a way to achieve cost-savings resulting from elimination of the ICF/MR costs related to licensure and certification. At the time of this “conversion” fears were raised by state surveyors around the ability of the homes to provide a high quality of care absent the ICF/MR regulatory oversight. As a result, the state developed an extensive quality oversight system for the facilities, including developing fire-safety requirements similar to the ICF/MR requirements but suited to the community-based group setting. The state also transitioned individuals with IDD remaining in the state institutions to community settings. Transitions began with the lowest need individuals and are expected to be completed in the next year with movement of the last 10-11 highest need individuals. Typically, these individuals have severe behavior issues.

State interviewees noted that the system capacity has to be built gradually and trust must be developed over time to accomplish the shift away from highly-regulated facilities to the community-based options of today. Interviewees also noted the results have been positive – there have been bumps on the road but in general individuals have done well and thrived in community-based settings.

Table 4: Michigan MSSP - Covered HCBS Waiver Services

HCBS Waiver Services	
Chore Service	Out of home Non-Vocational Habilitation
Community Living Supports	Personal Emergency Response System
Enhanced Dental	Pre-Vocational Habilitation
Enhanced Medical Equipment & Supplies	Private Duty Nursing
Enhanced Pharmacy	Respite Care
Environmental Modifications	Supports Coordination
Family Training	Supported Employment

Wisconsin

Wisconsin operates two managed care programs that include long-term care services: Family Partnership (“Partnership”) and Family Care. Partnership includes all Medicaid services and predominantly serves frail elders. Family Care is the larger program and serves a larger proportion of individuals with IDD. Family Care was implemented in 2000 and operates under the authority of a 1915(b) waiver and two 1915(c) waivers (one for elders and individuals with physical disabilities and the other for individuals with IDD). Family Care began as a pilot and is now operating in 53 counties with enrollment of over 26,000 individuals.

Family Care covers long-term care (including nursing home, ICF/MR and HCBS waiver services), behavioral health services, and state plan HCBS such as home health and therapies, but not acute care services. The list of covered HCBS waiver services is displayed in Table 5.

Family Care MCOs must be certified by Wisconsin Department of Health Services as meeting all requirements of statute and rule that include requirements related to adequacy of the network, expertise in long-term care and the ability to manage a network within the capitation payment. In addition, the MCOs must demonstrate the capacity for financial solvency and stability. The MCOs are not required to be licensed HMOs.

Family Care implementation is typically preceded by up to three years or longer of planning in the region(s) where implementation is scheduled. In addition, Wisconsin state staff have a very close relationship with MCOs. The state reports that daily contact with the MCOs to respond to questions and provide technical assistance is typical. Once Family Care is fully implemented in a county or region, HCBS become an entitlement.

Family Care is one aspect of Wisconsin's long-term care system transformation. The state has also implemented a comprehensive nursing facility and ICF/MR restructuring program and a State Center reduction initiative. ICF/MR restructuring includes mandated court review of each individual's community-based plan – if the court finds that the community is the most integrated setting suited to the individual with IDD's needs, the court orders community services. Counties must serve the individual in the community in accordance with the court finding or assume 100% of the cost of institutional care. Since starting this restructuring in 2006, more than 50 percent of ICFs/MR have closed.

HCBS are an entitlement in Wisconsin once Family care is fully implemented in a county or region. The entitlement was authorized by the Wisconsin legislature. Wisconsin serves over 26,000 persons in Family Care: about 9,100 are persons with IDD. The state believes their overall long-term care program changes are rebalancing the long-term care system. Initial evaluations have found Family Care to be cost-effective overall and to achieve savings in some areas and for some groups. Additional evaluation has been recommended.

Table 5: Wisconsin - Family Care Covered HCBS

HCBS Waiver services	
Adaptive aids	Housing counseling
Adult day care services	Personal emergency response system (PERS)
Care/case management services	Relocation services
Communication aids	Residential Nursing services in adult family homes, community-based residential facilities & residential care apartment complexes
Consumer-directed supports	Home modifications
Consumer education and training	Respite care services
Counseling and therapeutic resources	Skilled nursing services
Financial management services	Specialized medical equipment and supplies
Habilitation including day programs, supported employment, prevocational services & prevocational futures planning	Specialized transportation services
Home delivered meals	Supportive home care (SHC) services
Supportive home care (SHC) services	

Vermont

Vermont is operating its entire Medicaid program, except long-term care for elders and adults with physical disabilities, under a Section 1115 Waiver: The Global Commitment Waiver. The state Medicaid agency has entered into a managed care arrangement with the federal government – essentially the state Medicaid program is the managed care organization.

The waiver’s sole impact on the agency serving individuals with IDD is to leverage Medicaid matching funds for two previously unmatched service types: employment supports and family supports. Services remain fee-for-service and there are no Medicaid HMOs in Vermont.

The additional federal financial participation that results from matching family support funding is returned to the waiver and not specifically to the DD agency (Division of Disability and Aging Services, Department of Disabilities, Aging & Independent Living, Developmental Disability Services).

Vermont has no ICFs/MR and no residents with IDD in state institutions. Vermont has implemented a “priority” system (State System of Care Plan) for provision of services and supports for individuals with IDD. In FY 2008, the Vermont Division of Disability and Aging Services provided supports to 3,545 people with developmental disabilities in Vermont

There were 241 people on Vermont’s Applicant List at the end of June 2008, representing people who are eligible for services based on their disability but whose needs do not meet the State System of Care Plan’s funding priorities.

Table 6 on the following page provides a comparison of key features of the study states’ IDD services.

Table 6: Comparison of Key Features – Study States

Feature	Arizona Long-term Care System (ALTCS) – DDD Contract	Michigan Managed Specialty Services and Supports	Wisconsin Family Care	Vermont Global Commitment
Enrollment	Access to all Medicaid services is through DD agency that holds a managed care contract with Medicaid	Everyone who needs behavioral health & long-term care services &/or HCBS waiver services for persons with IDD	In Family Care counties, Medicaid eligible persons with LTC needs may enroll in Family Care	All Medicaid recipients, except aged persons and person with physical disabilities are enrolled in Global Commitment
Population covered	Persons with IDD	Children & adults who require specialty services and supports due to MI, SA or IDD.	Adults with physical disabilities, developmental disabilities and frail elders.	All persons except persons in Choices for Care waiver (persons at nursing home level of care)
Level of Care (LOC) requirements	At immediate risk - nursing home or ICF/MR	Only applicable to HCBS waiver services offered by PIHPs	Nursing home or at-risk (includes ICF/MR)	NA
Includes Medicare/Medicaid (dual) eligibles	Y	Y	Y	NA
Includes HCBS waiver services	HCBS waiver-like services HCBS are an entitlement	Y HCBS are an entitlement	Y HCBS are an entitlement once Family Care is fully implemented in a county	Waiver-like services (converted from 1915(c) waiver)
ICF/MR services	Less than 12 facilities and declining	1 state ICF/MR facility left with 10-12 people	Private ICFs/MR declining	VT has no ICFs/MR
Includes self-directed services⁵	Y	Y	Y	Y
Reimbursement	DD Agency PMPM, fully at-risk, reinsurance Sub-capitated health plans – shared risk	PMPM, with shared risk (risk corridors)	PMPM Risk shared first 3 years then full risk Specified reserves required	No change to DD agency except access to matching funds for supported employment and family supports
County, Traditional Organizations or HMOs?	DD Agency for IDD Services; Sub-capitated Health Plans for medical services	PIHPs are county CMHSPs	Community-Based MCOs	(No HMOs or managed care organizations)
Authority	1115 waiver	1915(b)/(c) waivers	1915(b)and two 1915 (c) waivers	1115 waiver
Statewide	Y	Y	N (53 counties)	Y

⁵ In Michigan and Wisconsin a budget amount is made available by the managed care entity to the participant to purchase services and supports. In Arizona and Vermont consumers hire their own employees to provide HCBS waiver services.

Other States

While other states continue to propose managed care arrangements that include long-term care services for people with IDD (Florida and North Carolina for example), these states have either not implemented managed care to date (Florida) or are facing opposition to implementation (North Carolina).

One state that implemented a managed care approach previously has had to revise their financial management method and this experience suggests the limits of the non-risk-based approach to managing services. Colorado had a “quasi-managed care system” until 2007. The Community Care Boards (CCBs) received payments based on an average service rate for their individual region and persons served. The CCBs negotiated agreements with individual providers. Payments were for the “traditional” services for persons with IDD, including HCBS waiver services. CMS disapproved the structure saying the payment arrangements would no longer be permitted. Payments also had to be “unbundled” and questions arose about the need to separate case management from service delivery (since the CCBs could deliver services or contract for services or both).

Common Themes - Study States

Institutional and ICF/MR Beds Have Been Substantially Reduced or Almost Eliminated

The four states reviewed have transitioned, or are close to transitioning, out of the private or private and state ICF/MR “residential” model to HCBS waiver residential settings and to individuals’ homes and other supported living arrangements. They have also either substantially reduced their state institutional population or are in the process of doing so.

In Michigan, the Prepaid Inpatient Health Plans (PIHPs), comprised of one or a group of Community Mental Health Programs (county-based organizations), chose to transition from ICF/MR settings to waiver settings because it was cost-effective to do.

In Wisconsin, a multi-pronged approach was employed implementing an entitlement to HCBS with implementation of Family Care and placing counties at-risk for ICF/MR expenditures. This included requiring court-ordered review of community plans for persons with IDD and a court determination of which setting was the most integrated setting that could meet the individuals needs – HCBS or ICF/MR.

In Arizona, 85% of persons served by the IDD agency either live in their own their home, family home or a shared home not owned by a provider.

HCBS Are an Entitlement in Arizona, Michigan and Wisconsin

Arizona and Michigan offer HCBS to all individuals who meet an institutional level of care. Wisconsin also offers HCBS as an entitlement once Family Care is fully implemented in a region or county, which typically takes up to three years.

Traditional IDD Providers Are the Managed Care Organization in Two States

The two states implementing risk-based managed care for institutional and HCBS services for persons with IDD (Michigan and Wisconsin) either contract exclusively with managed care organizations that were the traditional providers (Michigan) or include these providers (Wisconsin) as eligible MCOs.

In Michigan, the Prepaid Inpatient Health Plans (PIHPs) are comprised of one or a group of Community Mental Health Service Programs (county-based organization).

An MCO in Wisconsin must be an entity that is legally able to enter into a risk-based contract. Family Care MCOs may be: a county; a group of counties acting cooperatively; a long-term care district; a privately held managed care organization; an HMO or similar organization regulated by the Office of the

Commissioner of Insurance; a federally-recognized Wisconsin Indian Tribe; or a group of any of the above entities working under a contractual agreement.

Michigan and Wisconsin Have Regionalized some Aspects of Their Programs

Michigan has 49 Community Mental Health Service Programs (CMHSPs) but 18 Prepaid Inpatient Health Plans (PIHPs). The CMHSPs had (since the mid 1980s) been operating under a “global budget” comprised of multiple state and federal funding streams. The regionalization of the 49 CMHSPs in order to form the PIHPs provided a more efficient and financially viable system for delivery of the contracted services and management of funds and permitted expansion of HCBS to individuals who did not meet institutional level of care (funded from the savings achieved through managed care). The CMHSPs continue to function as the single entry points for access to behavioral health and DD services.

In Wisconsin, some counties have formed Long Term Care Districts (originally called Family Care Districts), which are regional units of government created specifically to plan and administer services to eligible frail elderly people and people with physical and developmental disabilities. The Long Term Care Districts may elect to become a Resource Center - providing information and referral, eligibility determination and case management services, or the Family Care managed care organization (called Care Management Organizations in Wisconsin), but may not be both.

None of the Reviewed States Have Implemented a Fully Capitated, Risk-Based Model that Delivers All Services (including acute care) through a Managed Care Organization

None of the reviewed states have implemented a risk-based capitated managed care plan where a managed care organization (that is not the state), receives a monthly per member payment to provide all Medicaid services including acute care (medical), behavioral health, and long-term care services.

Options for a Texas Capitated or Non-capitated Pilot Program

This section describes three options that Texas could pursue to develop a managed care pilot for people with IDD. These three options include capitated and non-capitated models, and are informed by (but not identical to) models used in the study states. These three models describe *a range* of possible options and are intended to prompt feedback from stakeholders. **Additionally, there may be ways to develop a managed care pilot that are not reflected in any of the proposed options; stakeholders are strongly encouraged to put forward alternative options if they believe there are other models worth considering.**

Assumptions for All Texas Model Options

While states differ widely in how they approach IDD services, the experience of the study states helps to consider what the possible IDD managed care options could be for Texas.

The following key assumptions apply to all three managed care options described below.

- Implementing any of the managed care pilot options would be a very complex undertaking and a major service system redesign, even within a pilot area.
- An overarching goal of all of the pilot options would be to create additional waiver slots by delivering more cost effective services.
- All of the options would require careful planning prior to implementation and an extensive implementation process.
- Long term improvements and efficiencies can be reasonably assumed, based on experience in the study states, but immediate, short term savings in the cost per person served are unlikely and all of the options would entail some startup costs.
- The pilot options do not contemplate any managed care arrangements that would apply to State Supported Living Centers (SSLCs) or assume any reductions in the numbers of SSLC residents. The pilot options apply to community-based IDD programs.
- The managed care options would include the following programs: community-based ICFs/MR, HCS waiver, CLASS waiver, and TxHmL waiver. For the purposes of the pilot, the DBMD waiver is not included due to the program's very specialized purpose and very small size – 155 individuals. If the state decided to implement the pilot in other areas, after the pilot period, this program could be phased in at a later date.
- The states that appear to have made the transition to capitated IDD managed care, Michigan and Wisconsin, have focused on cost-effective HCBS residential and supported living options, such as foster care, family home, and shared homes. To contain costs under any of the options, Texas would need to similarly pursue less expensive supported living options.
- Transitioning services to the point where all IDD services are under one, new unified waiver(s) may require some setting size flexibility, such as allowing six-bed HCS settings. In order to make the transition that the study states have made, the managed care entity in the pilot area would need to have some flexibility under their contract to determine setting size. Most importantly, the managed care entity will need to promote and increase the number of lower cost supportive living options, such as adult foster care, family home, and shared housing.

- Total waiver service cost caps, similar to the cap structure currently in place in the TxHmL waiver, may be a tool worth considering limiting per person IDD expenditures in return for serving larger numbers of consumers. This does not preclude case by case exceptions for individuals, but would help to make funding available for more individuals.
- Under any of the pilot options, increasing the array of available services and consumer-directed services would be a key objective.
- None of the three pilot options would create an *entitlement* to HCBS Services. Each option is designed to create incentives to manage IDD services more cost effectively and to direct any savings to serving additional people. However, the amount of savings potentially available is very unlikely to be sufficient to completely eliminate interest lists. For Texas to eliminate interest lists and make HCBS an entitlement (which some of the states profiled in this document have done) would require new, additional funding, for community-based IDD services.

Pilot Option One:

Non-Capitated Enhanced Management for Persons with IDD

Overview. Pilot Option One reflects elements of the IDD service delivery structures in Michigan and Wisconsin. Integral to the success of these states' models is decentralization of service and budget management from a state role to a local role. This decentralized approach has been an important factor in reducing reliance on the more costly ICF/MR service model, achieving cost efficiencies, and promoting improvements in consumer choice and control.

To achieve the cost savings needed to fund additional home and community-based waiver slots, these two states have decentralized the management of the IDD service system and have, for the most part, phased out the use of the community and institutional ICF/MR model and instead emphasized lower cost HCBS supportive living options as part of their service array. The few remaining ICFs/MR have become a very small portion of overall long-term care spending. Residential services and supportive living supports for the IDD population are provided through a wide range of HCBS options, which offer more flexibility and less federal regulation than the institutionally-modeled ICFs/MR, which must comply with extensive federal regulations. The study states have made progress in the reduction or elimination of interest lists due, in part, to downsizing or elimination of institutional settings.

This option is not a capitated, risk-based managed care model, but rather uses an enhanced management approach where a MRA or a collaboration of MRAs would have more direct management of contracted ICF/MR and HCBS waiver services and how IDD budget dollars are used in their region. This is not to say that the state agency's role (DADS) would be diminished, but the agency's role in the pilot area would change in a significant way, to a funding entity and contractor relationship for IDD services with the pilot area MRA/MRAs.

The existing MRA structure, which already incorporates some complementary roles, would be used as the management entity for this option. The pilot MRA entity could be selected either through negotiation with DADS and interested urban area MRAs or through a competitive procurement process limited to existing urban area MRAs.

For the purposes of the pilot, the technical contracting functions for ICF/MR and HCBS waiver services would not change from the current structure; those functions that are currently the responsibility of DADS will remain with DADS. However, the authority over the service mix (ICF/MR, HCBS waiver services) and the interest list within the pilot area would shift to the local level and be managed by the MRA and be driven by consumer choice. For example, the MRA/MRAs would make a regional

determination and plan on what the array of ICF/MR programs and HCS providers would be in the pilot area.

In contracting with the MRA or MRAs for the pilot program, DADS would set performance expectations and reporting requirements for the pilot area. This is similar to existing DADS/MRA relationships, but would decentralize some functions that currently operate at the state agency level.

This option could lay the ground work for a partially or fully capitated system at a later date or, if successful, it could remain a non-capitated system. The decentralized approach proposed in this pilot option is not a novel approach - similar service structures exist in the study states as well as others states. For Texas however, this pilot approach would likely result in a more regional IDD service structure. To be successful, this pilot option assumes that an interested MRA or a collaboration of MRAs would choose to participate in the pilot. MRAs are local entities governed by local boards, so the decision to become a pilot site would be a cooperative venture between DADS and interested MRAs.

Key features of the option would include:

- The pilot area would be an urban area MRA or a collaboration of an urban area MRA and adjacent MRAs. As with the other pilot options, a large service population base is needed to test some to the pilot assumptions and would help to ensure the best chance of success.
- The pilot area MRA/MRAs contracted with DADS under the pilot would directly manage program interest lists and available waiver slots allocated to their pilot area, as well as ICF/MR to HCBS conversions and would promote lower cost HCBS supportive living options. Interest lists are currently managed at the state level now, on a first come/first served basis (with some exceptions) with MRAs adding and removing individuals who seek services in their area. Under this option, the MRA would be responsible for the interest list for their area by county and would directly manage the list as well as the available waiver slots.
- In return for additional resources under the pilot contract with DADS, including funding for additional MRA staff to manage the enhanced responsibilities under the pilot, the pilot area MRA/MRAs would commit to performance goals under the contract including creating additional waiver slots by achieving overall savings. These targets would be adjusted for each year of the pilot roll out, but the expectation would be a reasonable reduction in the area's interest list within the available IDD budget for the pilot area.
- The MRA/MRAs contracted under the pilot would assume authority over the pilot area's community-based ICF-MR programs and the CLASS, HCS and TxHmL waiver slots within their areas.
- Survey and certification as well as ICF/MR licensing would remain at DADS as currently configured and would not be contracted to the pilot area MRA/MRAs.
- Pilot MRA/MRAs would be required to use local IDD stakeholder advisory groups or committees to help inform their planning efforts for this model.

State Statutory or Federal Waiver Changes Required. This option may require statutory changes to the MRA authorizing legislation to authorize the pilot. Amendments to the existing Medicaid IDD waivers would likely be required or, depending on negotiations with the federal Centers for Medicare and Medicaid Services (CMS), a new combination Medicaid 1915(b) and 1915(c) waiver could be required.

Programs and Services Affected. This option would affect the community-based ICF-MR program, the HCS waiver, the CLASS waiver, and the TxHmL waiver. As noted earlier, this option would not affect the DBMD waiver. This option would not involve the management by the MRA of acute care (hospital,

physician, lab, x-ray, etc.) or behavioral health care services—all non-IDD Medicaid services would continue to be managed under the current system.

Reimbursement. Since this is not a risk-bearing, capitated model, no entity would enter into a risk-based managed care contract under this model. The MRA/MRAs would take on more local control over the array of existing IDD services. The pilot area MRA/MRAs would receive additional reimbursement that would support its enhanced role in managing coordinated and cost-effective care for the IDD population. Reimbursement would include:

1. *Monthly Administrative Payment:* The MRA would receive a monthly payment to support specified administrative functions.
2. *Performance-based Payment:* A periodic-based payment would be available for the achievement of specific program and quality outcomes and process metrics. The pilot administrator would be eligible to receive a portion of the payment with a majority designated as a pass through to direct care providers.

Issues and Considerations. As with all of the options, Option One raises a number of considerations. Stakeholders are encouraged to think through these considerations as they provide comment.

- MRAs currently have a significant role in determining service eligibility, providing choice counseling, case management, and quality monitoring for IDD programs. Pilot Option One would significantly expand this role in managing the IDD service mix in the pilot area. This expanded role would require additional administrative funding for the participating pilot MRA/MRAs.
- This model provides the participating MRA/MRAs with some initial experience that will be useful should Texas implement a fully capitated, risk-based model in the future.
- MRAs would likely be at risk for some financial penalties if they failed to meet the contract targets for reductions in interest lists.

Pilot Option Two:

Fully Capitated, Non Integrated, Managed Long-Term Care for Persons with IDD

Overview. Of the three options, Pilot Option Two most closely resembles the Family Care Program in Wisconsin and the Michigan Managed Specialty Services and Supports Program. Under this approach, a managed care organization (MCO) would be competitively procured by DADS and would be responsible and at-risk for all IDD services for eligible individuals in the pilot area. The MCO or MCOs for this pilot would receive an actuarially-determined capitation rate for all services under the pilot.

This pilot option would consolidate most long-term IDD services under a new waiver authority. Capitation would be for IDD services only and would not include acute Medicaid or behavioral health services.

The managed care organization (MCO) for this pilot option could be an MRA with managed care experience, an MRA in partnership with an experienced MCO, a qualified non-profit entity, a qualified for-profit entity, or other organization able to bear financial risk under Texas law.

Key features of the option would include:

- The pilot area would be a large urban area. Because the MCO would be fully at-risk in this model, a large population base is essential to ensuring the financial viability of the MCO.
- The MCO would be competitively procured based on an RFP issued by DADS. The RFP would set standards for qualified bidders: all bidders would have to demonstrate the capability to perform

MCO operations and would also have to demonstrate significant experience in managing services for the IDD population.

- Generally, federal Medicaid rules do not permit a single MCO for this type of program. At least one other qualified entity might be required, assuming necessary experience can be demonstrated. It is possible a modified procurement could be negotiated with CMS during the initial phase of this program (such as was possible in Michigan) that would allow for a single MCO.
- The selected MCO for Option Two would need to be an entity legally able to bear risk under Texas law. Alternately, state legislation could be created to allow for an alternative type of managed care entity. However, requirements related to financial soundness would still need to be met as a result of federal Medicaid managed care requirements.
- Assuming full financial risk, through a capitation payment, could be either negative or positive for the MCO. If the MCO achieves savings relative to the amount they are paid per member per month (PMPM) they may retain all or a portion of this amount. Conversely, if the MCO expends more than they are paid, they must assume the risk for this loss. However, various options designed to protect consumers and ensure the MCOs financial viability can be implemented. These include shared risk with the state, required reinsurance (the MCO must purchase insurance to cover any losses), and reinvestment requirements (a portion of “profit” is reinvested into services or program expansion).
- The MCO would be required to provide the full range of current services available under HCS, CLASS and TxHmL and could choose to phase out and convert community-based ICF/MR programs to residential and services options available under the waiver options.
- Current IDD providers in good standing with DADS in terms of licensing, survey and certification for Medicaid would be considered significant traditional providers for the pilot program and the MCO would be required to engage in good faith efforts to contract with these providers.

State Statutory or Federal Waiver Changes Required. New Medicaid waiver authorities would be required for this option – most likely a 1915(b) and a new 1915(c) waiver (the waiver combination used by Michigan and Wisconsin and for Texas STAR+PLUS). Negotiations with the federal government on this waiver would probably need to include a request to limit the choice of MCOs to one entity in a specific region (authorized through the 1915(b) waiver).

Programs and Services Affected. This option would affect the community-based ICF/MR program, the HCS waiver, the CLASS waiver, and the TxHmL waiver. As noted earlier, this option would not affect the DBMD waiver. This option would not involve the management of acute care (hospital, physician, lab, x-ray, etc.) or behavioral health services. All acute care and behavioral health Medicaid services would continue to be managed in the current Medicaid structure.

Reimbursement. The MCO would be paid on a capitated basis (a per member per month payment) and would be either fully or partially at-risk. The reimbursement would include a risk-adjusted capitation payment that is commensurate with the risk of the consumers served by the plan. Due to the anticipated small enrollment in the MCO, it is likely that the financing arrangements would need to include risk-corridors or stop-loss mechanisms, particularly in the first few years of the pilot program.

Issues and Considerations. Option 2 raises a number of considerations. Stakeholders are encouraged to think through these considerations as they provide comment.

- The MCO selected for this option will need to have both capitated managed care experience and significant experience with managing services for the IDD population. This combination could be difficult to procure, given the pilot nature of this project and the limited number of potential members.
- MRAs that would be interested in being the MCO for this option may find it challenging to implement the necessary administrative structure to operate a fully capitated, risk-based program. The financial management, member services, quality management, and reporting requirements (e.g. - encounter data) required for Medicaid managed care programs may be particularly challenging.
- It is likely that an initial no-risk or shared risk period with the state would be required to permit the MCOs to gain experience.
- In addition, Wisconsin's experience demonstrates that the necessary planning could be a multi-year process before the first consumer would be enrolled into this pilot option.

Pilot Option Three:

Fully Capitated, Integrated Managed Long-Term Care for Persons with IDD

Overview. Pilot Option Three would integrate IDD services with acute and behavioral health services. Developing an integrated, managed long term care model for person with IDD could be done either by building on to the existing STAR+PLUS managed care structure or by developing a model separate from STAR+PLUS, with a separate, new procurement. From an administrative standpoint, building on to the existing STAR+PLUS model would likely be the easiest to implement, since the basic managed care structure for the pilot exists today and would not have to be built from the ground up.

As background, STAR+PLUS currently serves aged and physically disabled individuals who receive Supplemental Security Income (SSI) or who qualify for the Community-based Alternatives (CBA) waiver services. Enrollment in STAR+PLUS is voluntary for children who receive SSI. STAR+PLUS incorporates outpatient acute care services as well as long term care services (Primary Home Care, Day Activity and Health Services, and CBA waiver services). Commercial Health Management Organizations (HMOs) contract with the Health and Human Services Commission (HHSC) and receive an actuarially-determined capitated monthly payment. The capitation payment amount varies depending on which STAR+PLUS service area the member lives in and whether or not they are also entitled to Medicare. If the member is eligible for CBA waiver services, the capitation rate reflects the additional cost to provide that array of services.

There are two suggested scenarios under the Pilot Option Three approach:

1. Based on a successful negotiation between current STAR+PLUS health plans and HHSC/DADS, the IDD population in the pilot area would become a new population within STAR+PLUS. The IDD population would have a separate, actuarially-determined capitation rate. Prior to a contract amendment to add the IDD membership, the health plan or plans would need to demonstrate that they have the experience and expertise, either in-house or through a partner organization, to manage services for individuals with IDD. This approach would be the easiest to implement, but it would limit the potential MCOs to the existing STAR+PLUS plans in the pilot area, assuming they were interested in serving the new IDD membership.
2. Alternatively, HHSC, with DADS' assistance, could issue a new Request for Proposal (RFP) for a new integrated managed care program that would include acute care, behavioral health and IDD services for the pilot area. This approach would be more difficult and take more time to

implement, as it would require a new procurement within the pilot service area. Unlike scenario one, this scenario would allow an MRA to bid to be the MCO either independently or in partnership with a commercial MCO.

Key features of this option would include:

- All acute care, behavioral health, and IDD services would be the responsibility of the MCO.
- The integrated program would be required to provide the full range of current services available under HCS, CLASS and TxHmL and could choose to phase out and convert community-based ICF/MR programs to residential and services options available under the waiver options.
- In return for increased flexibility on service design, the contracted MCO or MCOs in the pilot area would be expected to reduce interest lists in their area by specified targets.
- The MCO/MCOs would be required to demonstrate readiness to manage IDD services and to engage in a formal planning process with the pilot area's consumers, MRA, and current provider base.
- Current IDD providers in good standing with DADS in terms of licensing, survey and certification for Medicaid would be considered significant traditional providers for the pilot program and the MCO would be required to engage in good faith efforts to contract with these providers.

State Statutory or Federal Waiver Changes Required. This pilot option would require an amendment to the 1915(b) and 1915(c) waivers that currently authorize the STAR+PLUS program or a new set of 1915(b) and 1915(c) waivers for an integrated managed care program outside of STAR+PLUS. The addition of the IDD service population to the STAR+PLUS program would require federal approval.

Programs and Services Affected. This option would affect the community-based ICF/MR program, the HCS waiver, the CLASS waiver, and the TxHmL waiver. As noted earlier, this option would not affect the DBMD waiver. This option would involve the management of acute care (hospital, physician, lab, x-ray, etc.), behavioral health services, and IDD services.⁶

Reimbursement. The MCO would be paid by the State on a capitated basis (a per member per month payment) for a defined set of covered benefits and services including acute and IDD services. The MCO would be fully at-risk for the provision of all covered services. An actuarially sound, risk-adjusted capitation payment would be developed to reflect the potential costs for the full range of services for persons with IDD.

Issues and Considerations. Option Three raises a number of considerations. Stakeholders are encouraged to think through these considerations as they provide comment.

- All acute care services for the IDD population would be managed by the STAR+PLUS MCO or a new MCO under this model, so some individuals could have to switch from their current physician or other health providers to providers in the MCO network.
- It is possible that the size of the pilot area's potential IDD membership could be too small to attract a willing STAR+PLUS health plan. It is also possible that CMS could require a choice of two MCOs under the new waiver, further reducing the size (per health plan) of the new IDD membership.

⁶ STAR+PLUS plans are not capitated for Medicaid hospital services in Texas, but have responsibility for managing the utilization of hospital care.

Options for a Capitated or Non-capitated Pilot to Serve Persons with IDD

- Experience in other states with combining the management of acute and IDD services under a single managed care entity is almost nonexistent. So this pilot approach would break new ground and would not have the benefit of building on experiences in the study states or other states in general.
- The ability of the MCOs to bring strong IDD experience into their care management operations, either through in-house staff or partnerships would be critical to the success of this approach.
- The MCO selected for this option will need to have both capitated managed care experience and significant experience with managing services for the IDD population. This combination could be difficult to procure, given the pilot nature of this project and the limited number of potential members.
- If the State were to open up the competition to more organizations beyond the current STAR+PLUS health plans, MRAs or other entities interested in being the MCO for this option may find it challenging to implement the necessary administrative structure to operate a fully capitated, risk-based program. The financial management, member services, quality management, and reporting requirements (e.g. - encounter data) required for Medicaid managed care programs may be particularly challenging.

Table 7 on the following page summarizes some key elements of the three proposed options.

Table 7: Overview and Comparison of Proposed Options:

IDD Managed Care Pilot Options:	Pilot Option One: <i>Non-Capitated Enhanced Management</i>	Pilot Option Two: <i>Fully Capitated, Non-Integrated, Managed Long-Term Care</i>	Pilot Option Three: <i>Fully Capitated, Integrated, Managed Long-Term Managed Care</i>
Enrollment	Includes adults and children	Mandatory for adults; Enrollment status of children to be determined	Mandatory for adults; Enrollment status of children to be determined
Uses Risk-based Capitation?	No	Yes	Yes
Includes services other than IDD services?	No	No	Yes Includes acute (medical care) & behavioral health services
What Entities are Eligible to Be the Managed Care Organization (MCO)?	Not a traditional MCO model. MRA role enhanced to include greater responsibility for IDD service array and managing interest list.	Any entity that meets specific requirements. (e.g. MRA or MCO or partnership).	<u>Two options:</u> 1. Limited to existing STAR+PLUS MCOs; IDD population is added to current member base. 2. Create new procurement open to qualified entity.
Provider Contracting and Payment Rates	Contracting function and payment rates continue to be determined at state level, but service array mix and interest list management are moved to the MRA/MRAs in the pilot area.	The MCO determines provider payment rates and requirements through contract negotiation with individual providers for long-term care services. The MCO directly pays providers for the services rendered under the contract.	The MCO determines provider payment rates and requirements through contract negotiation with individual providers for acute and long-term care services. The MCO directly pays providers for the services rendered under the contract.

Considerations and Questions for Stakeholders

Below are suggested questions for stakeholders to consider. HMA encourages stakeholders to submit written comments, to ensure that all stakeholder input is accurately captured.

General Questions:

1. How can managed care approaches be appropriately applied to long-term care services for persons with IDD?
2. Do you think that managed care approaches have some potential for cost-effective services and decreasing the size of IDD interest lists?

3. What are the strengths of the current system that should be preserved under a managed care pilot?
4. What are the weaknesses of the current system that a managed care pilot should be designed to correct?
5. Do you agree with the goals and objectives that will be used as criteria for model selection (found on page 5)?
6. If not, what other or additional criteria should be used?
7. Do you have specific suggestions for pilot options that are different from the three options outlined in this document?

Option Specific Questions (for Each Option):

- Is this option one that the State should consider pursuing?
- What are the strengths of the proposed option?
- What are the weaknesses of the proposed option?
- Are there specific conditions that you would place upon your support of this option? Examples:
 - a. Only if the option led to a decrease in the interest list.
 - b. Only if the waiver(s) became entitlements.
 - c. Only if certain populations were included/excluded.
 - d. Other _____

Public Hearings, Contact Information, and Process to Provide Input

Rationale for Meeting Locations and Times:

The choice of cities was informed by likelihood of maximizing stakeholder input. HMA sought input from stakeholders to determine what areas would be likely to ensure maximize stakeholder involvement and also fulfill the requirements of having meetings in varied Texas locations. Times of the meetings include a mix of business hours and non business hours.

Public Meeting Schedule:

- **Fort Worth**: Wednesday, June 23, 3:00-5:00, Fort Worth Botanical Gardens, 3220 Botanic Garden Boulevard, Fort Worth, TX 76107, 817-871-7686
- **El Paso**: Friday, June 25, 11:00-1:00, El Paso Marriott, 1600 Airway Blvd., El Paso, Texas 79925, 915-779-3300
- **Longview**: Monday, June 28, 5:00-7:00, Holiday Inn Express Longview North, 300 Tuttle Circle, Longview, Texas 75605, 903-663-6464
- **Austin**: Tuesday, June 29, 3:00-5:00, Austin City Hall, 301 W. Second St., Austin, TX 78701, 512-974-2668

If interpreter or other services are required for any of the above public meetings, please provide notice to Kim McPherson at 512-473-2626 x 14 or at kmcpherson@healthmanagement.com at least 72 hours in advance of the meeting.

Process for Stakeholders to Provide Public Input:

Stakeholders may provide input at each of the four public meetings. Stakeholders are encouraged to address the stakeholder questions on page 27 in their comments.

Stakeholders are also encouraged to also submit their comments in writing, as described below or by providing HMA staff with written comments at the public meetings.

Individuals wishing to provide written comment on the proposed options can do so emailing comments to Clare Seagraves at clare.seagraves@hhsc.state.tx.us. Comments may also be mailed or faxed to:

Clare Seagraves, Policy Analyst, Office of Health Services, HHSC, at 4900 N. Lamar Blvd., Mail Code BH 4100, Austin, Texas 78751; by fax: 512-424-6591.

Comments must be received by July 1, 2010.

Next Steps

After the public meetings, HMA will collect and summarize the public comment received and provide that information to HHSC and DADS. Taking the public comment into consideration, HMA will develop a final report on a plan for a capitated or non-capitated pilot to serve persons with IDD and submit that report to HHSC and DADS. This final report will also reflect additional analysis on the potential for cost savings associated with including medical/acute care services within a managed care model for persons with IDD. HMA's final report including recommended options is due to HHSC and DADS by October 15, 2010.

HHSC and DADS are required to submit a final report to the to the Governor's Office, Lieutenant Governor's Office, Speaker's Office, Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services Committee, House Human Services Committee, and the Legislative Budget Board by December 1, 2010.