medisked
A connected agency means better care.™

Introduction
Managed Care Q&A

As an increasing number of states transition individuals with intellectual and developmental disabilities (I/DD) to managed care, provider agencies are faced with additional complexities to work with Managed Care Organizations (MCOs), including new billing systems, requirements and expectations. We held a Q&A with two experts in the field, Doug Golub, MediSked President, and Kim Opsahl, ANCOR Director of State Partnerships and Special Projects, to answer some frequently asked questions we've been hearing.

Question 1
What do provider agencies need to know to be involved in the stakeholder process as states move to managed care for long term services and support (LTSS)?

Kim: It is really about being engaged – both at the national and state level. It is important to be connected with your state and national trade associations to understand where the direction of services is heading and how providers can be involved. Participation in associations gives providers the opportunity to collaborate on common solutions - like advocacy positions as states are considering managed care or common contract language as a state is actually moving into managed care. Associations also provide an opportunity to hear from peers in other states, in terms of lessons learned and best practices.

> **"If you're not at the table, you may likely be on the menu."**
>
> **Providers should get involved as early as possible to ensure the best interest of the individuals they support.**
> – Kim Opsahl

For many states, the first step to managed long term services and supports (MLTSS) is creating programs for older adults and individuals with physical disabilities. If that is the direction your state is headed, then it is important that providers for I/DD services are at the table, as the design for those programs often lays the groundwork for changes that may eventually include individuals with I/DD. As a result, it is also incredibly important to bring families and self-advocates into these conversations. While it may be tempting to steer clear of these discussions, it really comes down to, "if you're not at the table you may likely be on the menu." Providers should be involved as early as possible to ensure the best interest of the individuals they support.

Doug: Advocacy is key here. The managed care policymakers and stakeholders at the table don't necessarily understand populations with I/DD. Insurance / medical based models just don't fit entirely for individuals with I/DD. There is no medical model that helps to identify why employment supports should be at a certain level for a person. Things like human security, relationships, choices, and goals aren't factored into these systems. What it really comes down to is strong advocacy - from providers, individuals, and family members, so we don't lose services. We need to educate the decisionmakers with a strong stakeholder process to help them truly understand the needs to create a system that best supports individuals with I/DD.

Question 2
What have been some of the biggest challenges for LTSS providers when adapting to managed care?

Kim: Community based organizations need to be ready for the transition, which can be difficult as being prepared is a function of time, transparency, and partnerships. For providers who have moved into managed care, some key issues included: Making sure the organization has a line of credit and possibly adding additional finance staff necessary to manage the claims process. Another challenge is the complexity in dealing with multiple entities with different systems and different levels of interest, experience, and expertise assisting individuals with I/DD and the providers who support them. Additionally, applying MLTSS to services for individuals with I/DD is really pretty new to everyone. There are lots of unknowns and attempts to "fit" us in to existing systems. A huge challenge is programs that are not well conceptualized, planned, and/or implemented

Question 2 cont.

without meaningful legislative oversight, provider involvement at the design phase, and appropriate resources to adequately address needed services and supports.

Doug: If you cannot measure it, you cannot improve it (Lord Kelvin). Identifying how to quantify quality and outcomes is key as states move to managed care. One of the only measures that is used to measure quality for the I/DD community is the National Core Indicators. We need to use the indicators and work to develop additional ways to accurately measure the value of long term services and supports.

Question 3

What can we learn from the medical community's experience with managed care as long term services and supports are shifted?

Kim: ANCOR is fortunate that one of our State Association Executives worked for her state's hospital association when their state moved into managed care. She has been able to offer good feedback and insight into the process – both in terms of advocacy during the design and implementation phase and practical advice to navigate the transition. A main highlight is the importance of the providers not trying to go it alone. It is critical that they bring in people and resources with specialized expertise – legal, information technology, financial - to help them think through the relationships they're engaging in and to build up their business process. Also, it is critical to develop competency in understanding the contracting process so providers can be knowledgeable about the contracts coming before them and negotiate what is best for them. It is also important to focus on articulating your value and the true cost of what you are delivering versus what the state may be reimbursing for the service.

Doug: We've been working with providers for the last several years who are asking us "what can we do to get ready for managed care?." Readiness is one thing, but the move to managed care also requires change in mindset. Providers do the most amazing work and pour their heart and soul into ensuring the individuals they support can live their best lives. Quantifying the trends is not always their first priority, but it is important to make data a focus so the people they're interfacing with on the insurance side and otherwise can see the improvement of quality and outcomes their supports provide. Some of these are health measures since it is the language that managed care specialists will speak, but it is also about using core indicators and other items to quantify employment, individual satisfaction, data by region, by programs, and to get their people to think in a data minded way. You need to collect it, show it, measure it over time and that is what we've been advising. Becoming more structed and capturing data in a different way, providers are currently functioning and speaking to measures that they've been collecting this whole time but can speak to in a more official way.

> "Readiness is one thing, but the move to managed care also requires a **change in mindset,** to think in a **data minded** way**.**"
> - Doug Golub

Question 4

What are some processes to put in place to minimize interruption to cash flow and revenue cycle management when contracting and billing with multiple managed care payers?

Kim: In talking with some of our providers who have made the transition, they highlighted investing in expanding their business office infrastructure, as well as adding supervisory and accounts receivable staff with a focus on trying to recruit people with insurance billing experience. They also noted the importance of educating frontline staff on authorization and service documentation expectations.

Question 4 cont.

Doug: That's exactly what we have seen. Make the right investments and be prepared for the time it takes to complete provider agreements and test transactions with each payer so you're not surprised when an early round of billing takes longer than it did with established payers.

Question 5

Do you know of any best practices to help ensure that authorizations meet the needs of the individuals?

Kim: Again, in talking with our members who have moved into managed care systems – it comes back to being effective at connecting and using your data on the service and the process side, particularly as it relates to service authorizations. Many of our members identify managing service authorizations as an on-going challenge that requires communication and persistence. One best practice shared by our members is closely managing the service authorization change process and pairing it with an effective risk analysis to be able to engage the MCO in a conversation about risk and benefits related to changes in service authorization, using data to make the case. While it is a cumbersome process, it has been successful in getting authorizations restored so they're in line with what the person needs. Another member highlighted the benefit of multiple levels of oversight and review both at the MCO level and also with the state to ensure service authorizations are aligning with the person's needs.

Doug: One of the best practices is appropriate training for staff. There should be interdisciplinary team meetings and staff should be able to show data like progress on goals, regression on goals, showing that goals were either completed or not over a time period, etc. Providers should show up with data to make a more convincing case when they are dealing with authorizations. Making the case in a clear, compelling, and truthful way that is backed up by hard data is the most effective way to ensure that appropriate authorizations are made.

Question 6

How can we improve the quality and outcomes for individuals receiving managed long term services and supports (MLTSS)? How do you see HIT helping to meet these goals?

Kim: According to what we've heard from our members, this conversation needs to start at the top with the state and how they structure the program as these decisions drive practice at the point of service. There needs to be engaged dialogue between the state, MCOs, providers, self-advocates and families to make sure everyone is on the same page, especially about quality in LTSS for people with I/DD, which can be very different than for individuals with physical disabilities and older adults in terms of the nature, breadth, intensity, and frequency of support and the level of resources needed. The provider community needs to take the lead and having effective HIT to support the effort is critical.

Doug: On the health IT side, populations with I/DD are on more medications than the general population. One of the things that we find is that state data warehouses like health information exchanges (HIEs) and regional health information organizations (RHIOs) are getting better and getting more data. In the beginning, the barriers in front of health IT were interconnectivity. The HITECH Act helped significantly to get medical providers to send their data. North Carolina passed a law that requires all physicians that receive Medicaid funding to integrate with NC HealthConnex, the state HIE. All other Medicaid providers, including DD providers must connect by 2019. As things are getting better, we're finding more opportunities to work on things like medication management, medication lists, and electronic medication administration records (eMAR). The concept of polypharmacy looks at all of the medications someone is on and can put it all together to see if there are interactions and set up the information for a medication reconciliation. There are processes to get PRN medicines on and off of medication lists. Why bother with taking a PRN medication if its only as needed? Someone needs to be looking at this stuff. Health IT can help by making things clearer and easier. Pharmacy is

Question 6 cont.

an easy place to see the value of technology, hospitalizations and procedures also really help especially when tying it in around incidents with falls and seizures. Health IT is here and now and there are use cases that providers can jump into today.

Question 7
Do you know of any best practices for providers to monitor and collect performance and outcome data?

Kim: Producing objective outcomes data has been an area of focus for providers for years. Providers should be collecting and analyzing outcome data before their inclusion in managed care in order to have an ability to articulate the value of their services, as well as to monitor and measure managed care impacts. Without having their own data, providers will be dependent on the state for an understanding of the efficacy of a managed care model.

As a starting point, some providers have used CMS' information on their prioritized health outcomes and then worked to determine other areas of shared and valued outcomes with stakeholders, funders, and regulatory authorities. Finding those areas of shared and valued outcomes is one of our greatest areas of opportunity, as most outcomes that we've seen so far in managed care programs have been more health related – which is important but doesn't tell the whole story in terms of outcomes for long term services and supports.

> **"Providers should be collecting and analyzing outcomes data in order to have an ability to articulate the value of their services."**
> -Kim Opsahl

In terms of moving toward these health outcomes, some providers have found the Mainstay program, which is focused on helping achieve a healthier weight, helpful. Others have indicated that the Health Risk Screening Tool (HRST) has been useful to measure and monitor health risks.

Doug: One of the interesting things about HEDIS data is that scorecards come largely from claims data and survey data which doesn't tell the whole picture. For a lot of the DD providers, they have different charts, logs, and support mechanisms that aren't necessarily touching HEDIS data. There is a lot of rich data that DD providers have that managed care agencies aren't collecting. As an example, we work with Partners Health Plan, it's the first and only Fully Integrated Duals Advantage Medicaid/Medicare plan for individuals with intellectual and developmental disabilities (FIDA I/DD) in the country. In addition to providing all the Medicaid and Medicare services in the state for their duals, they also provide all the services under the state's developmental disabilities auspice. By doing that, they're also requiring other information from their DD providers in the form of monthly summaries, charting, and other notifications to supplement the claims data and that is pretty powerful. It is more than just finding out that this person lived in a residence for 28 days this month and was in the hospital for two. That's true, but the claims data alone doesn't tell you the whole story.

Question 8
Do you believe the collection and reporting on health outcome data and quality measures will grow in the coming years, as part of the shift towards Value Based Payment methods (VBP)?

Kim: Yes, we see these issues being a focus federally and will likely see movement in this direction. As providers, we know our services and supports provide value, but a challenge will be how do we quantify that so it can be measured and fully recognized. We know it is important and we know how to provide interventions to help individuals achieve their goals, but how can we measure that given the complexities of serving individuals across the lifespan and with varying degrees of needs. It's an interesting conundrum.

The Center for Epidemiological Research for Individuals with Intellectual and Developmental Disabilities (CERIIDD) is one emerging approach to considering this issue. It is an effort growing out of ANCOR's State Association member in Ohio – the Ohio Provider Resource Association. CERIID's focus is to provide information and strategic direction to policymakers, payers, and providers of service utilizing data-driven research to improve health care outcomes for individuals with intellectual and other developmental disabilities (IDD) at reduced costs. To accomplish this, they are focused on building on an extensive network of collaborative partnerships – including ANCOR – to collect and critically evaluate data unique to the I/DD population and offer solutions that will benefit all stakeholders.

Doug: Absolutely, and providers can start to get ready for this move now. Provider collaboratives, oversight, and payers can identify which providers are more successful, which individuals within which age brackets, within which diagnoses, and so on. You can add texture to the data and slice it and dice it in any way you can to help to identify success factors. It's not a simple thing to do, but it is possible to be able to identify trends of value and it is happening today.

Question 9
Individuals with disabilities often have complex care needs. Are there any specific models and characteristics of care coordination that should be considered when moving to managed care?

Kim: In speaking with members in states who have moved to more integrated care systems, they have found it challenging to identify any specific models. This is really an area of great opportunity to move towards more evidence based practice and we as providers - through our national trade association and partnership with other national organizations – need to broker this dialogue in a way that leads to research partnerships that highlight preferred service interventions with recognized theories of change. In the interim, providers should ensure that their existing case management resources are protected to supplement MCO care coordination, as it has sometimes not been fully effective for individuals with IDD in MLTSS.

Doug: This is a developing field that we should all watch closely in the coming years.

Question 10

In relation to the last question, we've seen states develop dozens of different models and programs for MLTSS for different populations including I/DD. Have some models been more well received than others by those with I/DD? What about other stakeholders, such as payers?

Kim: In general, most well-received models have been those that reflected strong collaboration between the state and providers, those that were built around the strengths within existing provider networks, and those that incorporated a thoughtful deployment strategy that allowed for a demonstration of the value to Persons with I/DD before pursuit of wide-scale implementation. Providers should research and become experts in multiple models in order to understand potential impacts on their clients and their organizations, so that they can share that with policymakers and legislators should their state move in this direction.

Doug: There is no clear standard. There are several assessments, each with strengths and weaknesses, and we continue to see adjustments that are similar to what was seen in the more medical-model space over the last few decades. This is a great time to be patient and participate in these models coming together. It's such an honor to work with the individuals, circles of supports, payers, and oversight that are leading the way.