Essential Roles of Disability Community-Based Organizations in an Integrated Care Program

The use of Medicaid managed care has proliferated across the states in recent decades. Managed care and other integrated care systems are increasingly responsible for delivering services for older adults and people with disabilities. At the same time, states and other payers are interested in improving health outcomes and transitioning payment systems to focus more on value and seeking ways to connect payment to quality. Disability-focused community-based organizations (CBOs) have long-standing relationships and commitments to improving the lives of people with disabilities. As states and Managed Care Organizations (MCOs) seek to improve outcomes in both health care and long-term services and supports (LTSS), these CBOs have the knowledge, skills, relationships, and expertise that states and MCOs need to be successful. This paper describes the essential roles of CBOs in integrated and managed care programs, including how MCOs can partner with CBOs, the assets and contributions CBOs bring to managed and integrated approaches, and how states can support CBOs in the transition to managed care to ensure better outcomes for people with disabilities.

Background

Medicaid managed care programs are increasingly responsible for managing services for older adults and people with disabilities. While older adults and people with disabilities are frequently the last populations to be enrolled in managed care, and LTSS, are often the last to be carved in, the use of Managed Long-Term Services and Supports (MLTSS) has also grown. According to Truven Health Analytics, in 2004 there were only eight states with an MLTSS program.[1]Today, 22 states operate and MLTSS program (excluding demonstrations to align financing and administration for dually eligible beneficiaries).

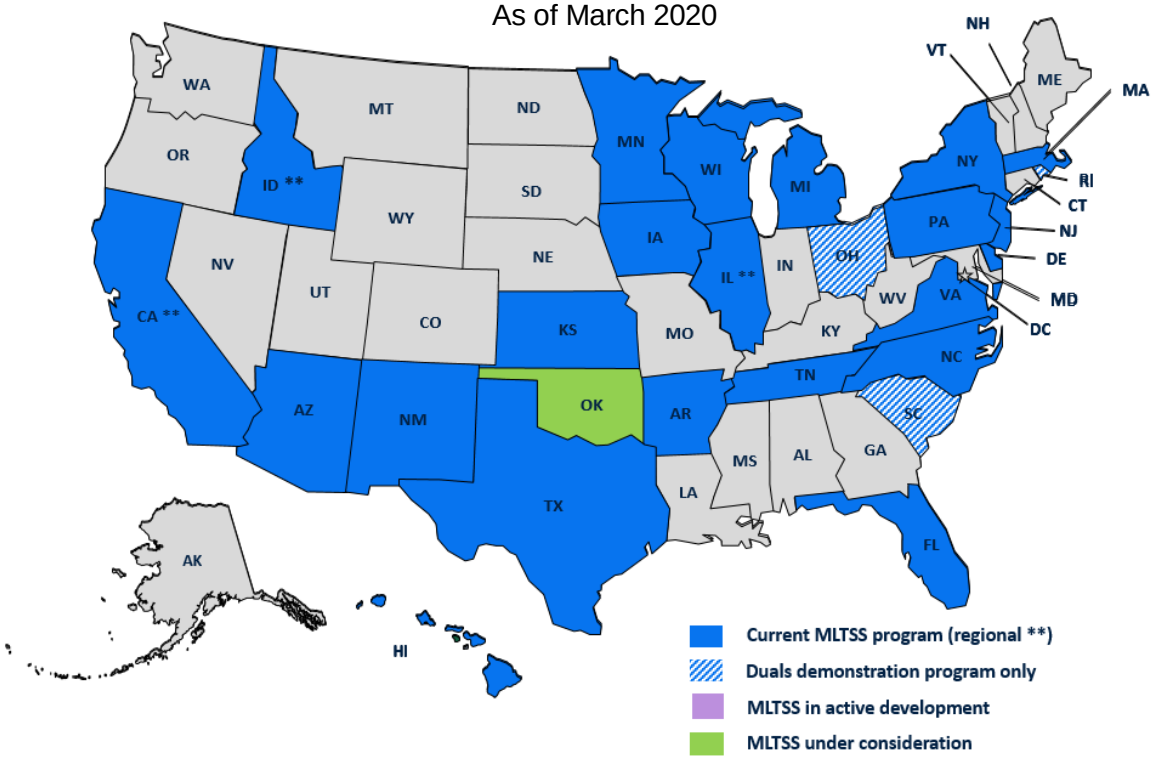
The most common use of MLTSS is for older adults and people with physical disabilities; LTSS for people with intellectual and developmental disabilities (I/DD) remains primarily fee-for-service. As of October 2018, 22 states provide MLTSS programs that cover older adults and/or people with physical disabilities. Six of those states also provide MLTSS for people with I/DD, although three (MI, TN, and AZ) provide this through distinct I/DD programs separate from their MLTSS programs for older adults and people with physical disabilities.[2] North Carolina provides an MLTSS program that only covers people with I/DD and behavioral health disabilities, but does not currently have a program for older adults and people with

[1] Elizabeth Lewis, Steve Eiken, Angela Amos, and Paul Saucier. The Growth of Managed Long-Term Services and Supports Programs: 2017 Update. *Truven Health Analytics*. (January 29, 2018): pg. 7.
[2] Ibid, page 14-15.

physical disabilities. Wisconsin's MLTSS program includes people with I/DD, people with physical disabilities, and older adults. A small number of dually eligible enrollees have all care integrated under a single program; for others the MLTSS program operates separately from Wisconsin's managed care program for acute and primary health care. As of October 2018, only two states – Kansas and Iowa – have implemented statewide, mandatory, fully integrated MCO-based managed care that includes all populations and services.

Medicaid Managed Long-Term Services and Supports (MLTSS) Status

As of March 2020



Source: ADvancing States

CBOs serving people with Disabilities

Centers for Independent Living

As outlined in the Rehabilitation Act, Centers for Independent Living (CILs) are designed to "promote a philosophy of independent living including a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy, in order to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and the integration and full inclusion of individuals with disabilities into the mainstream of American society."[3]

[3] Administration for Community Living. "Centers for Independent Living." Accessed May 16, 2018. https://www.acl.gov/programs/aging-and-disability-networks/centers-independent-living

CILs provide five core services: information and referral, independent living skills training, peer counseling, individual and systems advocacy, and services that facilitate transition from institutions to the community and youth transition to postsecondary life.[4]Centers may also provide assistance in securing housing, transportation referral and assistance, and other services necessary to improve the ability of individuals with disabilities to function independently and/or continue employment. While serving people of all ages with multiple types of disabilities, people with physical disabilities are often the most represented group among CIL clients. CILs also pride themselves on governance led by people with disabilities, and on employing people with disabilities in both leadership and front-line positions.

Intellectual & Developmental Disabilities Organizations

Intellectual and Developmental Disabilities (I/DD) Organizations include both direct service providers and advocacy organizations. In terms of direct service providers, many offer Medicaid services especially under home and community-based service waivers. In addition, many provide services through Part C Early Intervention, Vocational Rehabilitation programs, and in ICF/IID settings. As Medicaid providers their services are defined at the state level, not federally, but frequently include case-management/supports coordination, residential, in-home, employment, and other day supports.

Direct service providers for people with I/DD vary in size, scope, geographic reach, and in legal structure. Most serve individuals with I/DD across the lifespan, providing support in early childhood through end of life and in all facets of life by supporting people to live, work, and participate in the community. In addition to traditional supports, many develop affordable housing, public transportation options, and other partnerships within the community.

Developmental Disabilities advocacy organizations exist at the state and national level and include a wide variety of advocacy groups, such as chapters of The Arc and self-advocacy organizations; federally-funded entities, such as State Councils on Developmental Disabilities, University Centers for Excellence in Developmental Disabilities, and Protection & Advocacy (also known as Disability Rights) Systems; and other community-based organizations of and for people with disabilities and their families. Both I/DD direct service providers and advocacy organizations have long-standing relationships with the individuals they serve, families, and disability advocacy networks. Frequently, providers and provider associations form key parts of disability advocacy networks and have deep knowledge of the history of services in the state.

Disability, Disparities, and Social Determinants of Health

People with disabilities experience significant disparities in health care access and health outcomes.[5] According to the National Council on Disability, these disparities are rooted in barriers in access to care as well as a history of discrimination, segregation, and devaluing of disabled lives. Barriers are physical and programmatic, such as lack of reasonable accommodation as required under the ADA, as well as

[4] Ibid.

[5] National Council on Disability. The Current State of Health Care for People with Disabilities. (2009). https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf

attitudinal, such as belief among health care practitioners that disability and health are incompatible and people with disabilities cannot live long and healthy lives.

One of the reasons states move to managed care is to pursue improved quality and health care outcomes; success requires addressing the health disparities experienced by people with disabilities. Additionally, states have also begun to incorporate research on social determinants of health, including for older adults and people with disabilities, into MLTSS programs, increasingly expecting MCOs to improve health outcomes and support the social factors that influence health.

The foundational concepts related to the social determinants of health (SDoH) are not new to the disability community. In the late 20th century, both the independent living movement and deinstitutionalization efforts made terrific strides in improving the lives and health of people with disabilities. Rooted in civil rights, not health research, they also understood that access to housing, education, employment, and transportation would mean happier, freer, and healthier lives for people with disabilities. Disability-focused CBOs are rooted in these ideas. They seek to ensure that people with disabilities have safe and stable housing, access to education and employment, and facilitate access to other essential elements of healthy living, including food assistance programs, income support, and transportation.

Reviews of the research on SDoH have shown positive correlations between employment and health, both for people with disabilities[6] and the general population[7]. A meta-review of the research conducted in 2015 shows that actual and perceived loneliness and social isolation increase mortality risk by 26-32%.[8] Five decades of research also shows that people with I/DD are happier, healthier, more self-determined, and better able to function independently in smaller, community-based settings, and that these settings have a strong correlation with improved health, lower obesity, and improved overall well-being.[9] While disability research has long demonstrated the importance of self-determination, community integration, reciprocity, and belonging to health and well-being, mainstream public health research has more recently begun to focus on the health impact of factors such as loneliness, social isolation, homelessness and unemployment.

As states and MCOs work toward improving quality and controlling costs they will best be helped by understanding, promoting, and continuing state and local disability communities' success in moving LTSS toward non-medicalized, community-based services that can be integrated with physical and behavioral

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[6] Nanette Goodman. The Impact of Employment on the Health Status and Health Care Costs of Working-age People with Disabilities. *The National Center on Leadership for the Employment and Economic Advancement of People with Disabilities (LEAD)*. (November 2015). http://www.leadcenter.org/system/files/resource/downloadable_version/impact_of_employment_health_status_health_care_costs_0.pdf

[7] Catherine E. Ross and John Mirkowsky. *Journal of Health and Social Behavior*. 36, no.3 (1995): 230-243.

[8] Julianne Holt-Lunstad, Timothy B. Smith, Mark Baker, Tyler Harris, and David Stephenson. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science* 10, no.2 (2015): 227-237. doi: 10.1177/ 1745691614568352 http://journals.sagepub.com/doi/pdf/10.1177/1745691614568352

[9] Association of University Centers on Disabilities and American Association on Intellectual and Developmental Disabilities. Community Living and Participation for People with Intellectual Disabilities: What the Research Tells Us. (2015) https://aaidd.org/docs/default-source/policy/community-living-and-participation-for-people-with-intellectual-and-developmental-disabilities-nbsp-what-the-research-tells-us.pdf?sfvrsn=0

health services as part of a comprehensive program. For decades, disability CBOs have been utilizing these services to support people with disabilities to live long and healthy lives, and as such, MCOs and other integrated care entities will be best positioned to successfully reduce health disparities and positively affect the social determinants that influence health for people with disabilities when they form successful partnerships with disability CBOs.

The Essential Role

Community-based organizations that serve people with disabilities have the essential expertise, history, skills, and relationships that MCOs and states need for successful integrated or managed care programs that enroll people with disabilities. These organizations possess unique knowledge of disability issues, LTSS, and a deep understanding of, and connections within, the disability communities in the state, as well as the ability to provide non-medical services that help address social determinants of health.

Disability and Local Expertise: Training, Advice, and Consultation

Many mainstream commercial MCOs are relatively new to LTSS as compared to their other lines of business, especially as it pertains to people with I/DD. As states have expanded existing managed care programs into MLTSS, they are asking incumbent MCOs to quickly get up to speed on LTSS and incorporate these services into their programs. MCOs benefit when they reach out to disability CBOs to access their expertise and knowledge about the local LTSS landscape. This also presents the opportunity to explore ways to partner so that they can successfully implement MLTSS without disrupting service provision or quality while improving outcomes.

CBOs typically have long tenure and deep community relationships. Disability organizations and advocates are frequently part of a “small world” of strongly networked individuals and organizations, including families, service providers, advocacy groups, faith communities or other non-disability-specific resources. In addition to specific disability and LTSS expertise, this knowledge is invaluable to an MCO seeking to navigate the local landscape and understand the perspectives of the people with disabilities who the plan will serve. Developing meaningful engagement strategies and supportive ongoing relationships that respect the credibility and experience of the disability CBOs may also help the MCO to build trust and address the concerns of disability advocacy communities skeptical of managed care.

According to MCO representatives interviewed for this report, disability CBOs provide community-based expertise that is essential to MCOs’ success. The CBOs know the families, needs, and resources of the community. This goes beyond even disability networks to include schools and businesses that can help MCOs understand the capacities of the communities they are preparing to serve. Importantly, they also help the MCOs understand how disability services have been delivered before the MCOs arrived; MCOs don’t just need to know the service model they are implementing, but how that model will change what individuals, families, and providers experienced previously, and what may be required for a smooth transition to MLTSS.

Interviews with MCOs also emphasized the importance of learning the informal connections and networks of a disability community. MCOs noted the importance of "on the ground networking" before a program is implemented, including learning about possible collaborations, listening to the concerns of people and addressing those fears and challenges to the greatest degree possible, and even providing resources to CBOs for this engagement prior to contracting.

Directors of state disability agencies agreed – disability CBOs have the deep experience from working directly with people with disabilities that MCOs need. They emphasized that if the state is trying to achieve certain program goals, especially increasing independent living or employment, they must work with the providers and organizations who know how to do it right and are interested in prioritizing quality improvements.

MCOs have formed some innovative partnerships that they have forged with CBOs to advance these goals. One MCO interviewed for this report contracts with CILs and Area Agencies on Aging to provide disability and aging awareness and sensitivity training to corporate staff. Another MCO has developed a partnership with CILs to help develop minimum disability accessibility standards for their provider credentialing process, to be incorporated into provider directories.[10] MCOs can support CBOs to build on their knowledge and expertise in a way that supports MCO and state goals, and improves outcomes for members.

CBOs also provided examples of successful partnerships. Centers for Independent Living in Ohio have contracted with MCOs to provide training to case managers on person-centered planning and self-direction. According to representatives of the CIL, these trainings are successful because key disability concepts, like the right to fail and dignity of risk are "embedded" in how the CIL functions and all the work they do. Using the information that they gain from the training, MCO case managers can better support and implement self-determination, engaging in the provision of services that both improve quality of life and are correlated with the social determinants that can improve health outcomes and control costs. Still, CIL leaders identified challenges in contracting with MCOs, stating "our greatest value (i.e. lived disability experience, vision and values of the independent living movement) doesn't exist in any of their codes."

CILs interviewed also emphasized the "dignity of risk" – the idea that independence and autonomy include the opportunity for people to choose for themselves when to take risks, and to allow them to make informed decisions related to safety. This may seem contrary to an MCO focused on health outcomes, but promoting self-determination and choice can increase the individual empowerment, self-respect, and self-efficacy necessary to take positive steps in one's life, including in health.[11]

Organizations serving people with I/DD that were interviewed echoed similar concepts. They noted that integrated and outcome-based models offer promise in moving from traditional, congregate services toward supports that promote individual decision-making, opportunities to work and to contribute, and meaningful community inclusion – models that result in improved health and quality of life outcomes.

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[10] National Council on Independent Living. "Provider Accessibility Initiative." Accessed October 1, 2018. https://www.ncil.org/provider-accessibility-initiative/

[11] The Council on Quality and Leadership. "Dignity of Risk." Accessed May 16, 2018. http://www.cpofnys.org/wp-content/uploads/2016/10/Dignity-of-Risk.pdf

Decades of research has shown that people with I/DD are happier and healthier when receiving services in smaller, more integrated home and community-based settings that promote self-determination.[12] I/DD organizations and CILs are reliable resources that can help MCOs understand the history, perspectives and values important to the disability community, as well as how to design and implement MLTSS and integrated care approaches that will increase quality of life, reduce health disparities, improve health outcomes, and control costs.

There are many ways that MCOs can work with disability CBOs; for example, MCOs can hire or contract with CBOs to provide:

- Training on independent living, person-centered planning and the disability rights movement for care/case managers, service coordinators, utilization management and prior authorization staff, MCO leadership, and other staff
- Expertise on the capacities, strengths, and needs of the community
- An understanding of the history and current landscape of disability services in a particular market, to help the MCO learn about the system prior to the transition to managed care
- Ongoing advice and consultation, including in meaningful roles on boards and committees advising the MCO
- Knowledge about the disability community and local priorities, including how parts of the state differ from one another, as well as stakeholder expectations
- Assistance identifying gaps and opportunities that the MCO can address, including through value-added benefits and local partnerships
- Identification of the most innovative and successful programs in the community, and ways to support growth of quality services

Provision of Non-Medical Supports and Services

Much of disability CBO expertise lies primarily outside of the medical system. CIL and I/DD organizations alike emphasize their role in providing non-medical services. This includes not only the direct provision of services like home and community-based services, peer support , and case management, but also systems navigation to ensure people have access to transportation, food, and other services.

While primarily funded through the health care system, LTSS for people with disabilities differs from other medical care in several important ways. While some LTSS recipients require frequent medical care provided by licensed professionals, most people with disabilities receive the majority of their services from non-clinical direct support workers who provide assistance with activities of daily living such as personal care, cooking and cleaning, cueing and supervision. The expense of the human labor involved in the provision of these direct supports is the largest share of home and community-based service costs,

[12] Association of University Centers on Disabilities and American Association on Intellectual and Developmental Disabilities. Community Living and Participation for People with Intellectual Disabilities: What the Research Tells Us. (2015) https://aaidd.org/docs/default-source/policy/community-living-and-participation-for-people-with-intellectual-and-developmental-disabilities-nbsp-what-the-research-tells-us.pdf?sfvrsn=0

despite the fact that this workforce is often paid at or near the minimum wage.

Additionally, LTSS is frequently delivered daily, sometimes 24 hours per day, as opposed to the episodic or occasional nature of most health care. Many people with disabilities will require these services and supports for decades, sometimes for their entire lives. Increasingly, a greater proportion of these services are delivered in home and community-based settings, as opposed to medical facilities, as growing numbers of recipients of LTSS prefer to live in the community.

And, importantly, the philosophical underpinnings of LTSS for people with disabilities differentiate these services from other traditional health care. Disability advocates and people with disabilities have long sought to move LTSS away from a medical model of care primarily concerned with clinical care and basic health and safety, with little regard for self-determination, holistic quality of life, civil rights, and community membership to a social and environmental model focused on the accommodations and supports necessary to live full lives in community.

CBOs serving people with disabilities often provide supports that address barriers to health care and reduce health disparities, including assistance related to social determinants of health. For example, CILs provide peer-based support and systems navigation services similar to community health workers. Evidence demonstrating the effectiveness of both peer supports and community health workers in improving health outcomes is strong. Central to these models is the importance of hiring staff who have lived experiences similar to the people they will support. Community health workers have been shown to improve access to care, health literacy, and self-management of chronic conditions like asthma, hypertension, diabetes, and HIV/AIDs.[13] Similarly, peer support services have been found to be effective in reducing inpatient services, as well as improving relationships with providers and engagement with care.[14]

While state managed care contracts typically do not target the development of community health workers specifically for the disability community, one of the MCOs interviewed for this project has engaged a disability organization to provide community health worker services for people with disabilities, with positive outcomes. Additionally, CBOs may also be able to provide health care-oriented services with a disability lens, for example, offering a diabetes management program in a disability-competent and person-centered manner.

Interviews with CIL leaders from across the country show that these services and skills are being used as part of integrated care programs, but still have room to grow to improve outcomes. Interviewees emphasized the importance of pre- and post-acute services as a wrap-around to clinical services. They noted that in a peer support model, individuals may be more likely to ask questions or reveal issues with CIL staff than they are with MCO staff, especially if they are concerned about losing services.

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[13] E. Lee Rosenthal, J. Nell Brownstein, Carl H. Rush, Gail R. Hirsch, Anne M. Willaert, Jacqueline R. Scott, Lisa R. Holderby and Durrell J. Fox. Community Health Workers: Part Of The Solution. Health Affairs 29, no.7 (2010):1338-1342. doi: 10.1377/hlthaff.2010.0081. http://content.healthaffairs.org/content/29/7/1338

[14] Matthew Chinman, Preethy George, Richard Dougherty, Allen S. Daniels, Sushmita Shoma Ghose, Anita Swift, Miriam E. Delphin-Rittmon. Peer Support Services for Individuals with Serious Mental Illness: Assessing the Evidence. Psychiatric Services. Vol. 65. No. 4. (April 2014):429-441. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300244

CBOs have been in operation for decades and have trusted relationships with their communities. Their staff also have a personal commitment to helping individual's access services which enhances their role as a trusted peer and/or partner in assisting individuals to navigate the system. Often participants who are receiving case management from their MCO will return to the CIL and/or the I/DD organization with questions, especially related to navigating the system or understanding their benefits. CILs also report that they often continue to follow up with people, especially people they know who are unlikely to check their mail or understand letters they get from the Medicaid agency. Frequently CBOs continue to provide this support even though they are not under contract to do so because they have relationships with the individuals involved. These are examples of the human and relationship-based community connections that disability CBOs bring to an integrated care system.

MCOs may hire or contract with CBOs to provide:

- Direct services within their expertise, such as case management, personal assistance services or supported employment. The most common contracted services of the MCOs interviewed included:
  - Personal care
  - Respite
  - Community transition
  - Consumer direction
  - Employment supports
  - Transportation
  - Financial management services
  - Behavior management
  - Day habilitation
  - Home modifications
- Peer support/community health work
- Systems navigation, including of both the health care system and access to housing, transportation, healthy food, and other needs
- Community transition – the supports to leave an institution or nursing home and move back to the community
- Nursing home diversion – to help people avoid nursing homes by connecting them to appropriate HCBS and other services
- Wellness services, such as chronic condition prevention and management
- Non-medical transportation
- Case management or service coordination delivered with disability expertise and with a focus on person-centeredness and independent living
- Advocacy and assistance programs
- Caregiver support services

Supporting Successful Partnerships

Despite the great value that these CBOs bring to managed and integrated care systems, states and MCOs often need to find ways to better support them in the move to managed or integrated care. For states, this means creating an environment for a successful MLTSS program through extensive stakeholder

engagement, clear policy goals for the new program(s), supporting providers in transitioning to new administrative and billing systems, and contract terms that prioritize quality and independent living. For MCOs this means working closely with providers as they transition to MCO business operations and understanding their capacities and potential hurdles. This may include assistance with health information technology and interoperability, addressing cash flow concerns, and offering community-based providers support beyond that traditionally offered to health care providers.

States

States can set an environment for successful MLTSS programs by engaging with disability stakeholders early and being clear about their policy and programmatic goals. Working closely with disability CBOs early on will ensure that states understand what is working well in the system, as well as what could be improved.

States should also understand the significant support most disability CBOs will need in transitioning to MCO business operations. Most disability CBOs are small nonprofits, many are accustomed to grant-based work or fee-for-service billing to one state agency and they often supplement this work with fundraising. They frequently do not have the cash on hand to withstand the payment lags that are common in other areas of health care, and lack a payer mix used by other health care providers to cover losses in Medicaid payments. States should ensure that providers have resources, information and opportunities to access assistance – either from MCOs or from the state itself – to navigate the transition. Expectations of MCO support for provider transitions should be included in contracts.

States can also engage CBOs in the development of systems for beneficiary support. Federal Medicaid managed care regulations require stakeholder engagement in the design, implementation, and oversight of a state's MLTSS program (42 CFR § 438.70), as well as the creation of a Beneficiary Support System (42 CFR § 438.71). The system must include choice counseling, training providers, and helping individuals understand managed care. Specific to LTSS, the system must also provide an access point for complaints and concerns, enrollment, and access to covered services; education on grievance, appeal, and fair hearing rights; as well as assistance navigating that system. Many Disability CBOs have already been conducting this work and are a natural fit for LTSS-specific activities. Beyond minimum federal requirements, states can also engage or encourage applications from Disability CBOs to participate in MLTSS ombudsman and other state programs.

States can assist CBOs in the transition to managed care by:

- Conducting meaningful stakeholder engagement throughout the process, from planning through ongoing implementation
- Facilitating relationships between MCOs and CBOs following contract award
- Setting network adequacy requirements to protect access to disability CBOs and maintain continuity of care for enrollees
- Requiring MCOs to monitor and report on denied or rejected claims
- Providing extensive technical assistance to providers before, during, and after implementation
- Incorporating requirements or supports for disability CBOs related to the state's policy goals
- Engaging CBOs to participate in or form the Beneficiary Support System and related functions

Managed Care Organizations

MCOs can also provide critical supports to ensure the success of their state programs. This involves not only contracting with CBOs for the services and expertise outlined above, but ensuring providers can weather the transition and continue to provide high quality services. MCOs interviewed identified challenges related to large, multi-state entities working with small, community-based organizations: information technology interoperability, lack of staffing to navigate change, and lower financial capacity than the providers that MCOs are accustomed to contracting with.

Large, for-profit MCOs may be used to working with large hospital systems and provider groups who have very different capacities and resources available to meet MCO contracting requirements. For example, one MCO described a challenge that the liability insurance required for all contracted providers exceeds what most disability CBOs carry; most disability CBOs have not had the need for such insurance, nor the ability to afford it.

MCOs can deploy staff to states early in the process, including before an RFP is announced, to begin building relationships and understanding the service system on the ground. MCOs interviewed noted that they were most likely to be the ones reaching out to disability CBOs as many of them may not have the capacity, staff or expertise to proactively reach out to MCOs. For those who do have the capacity or desire to initiate connections with MCOs, they should feel empowered to do so and should approach the MCO with their value-proposition. This positions the CBO as a capable and wiling partner with specific skills, programs or resources to offer the MCO.

MCOs should also ensure providers are ready to transition to their billing systems and recognize that many will be unaccustomed to health care claims and billing. MCOs can also take steps to address the payment lags or claims denials that are common in mainstream health care. The typical CBO may not be able to financially withstand any delay in payment. Even if it is not required by states, MCOs should monitor their denied or rejected claims for trends that may reveal challenges being faced by providers.

Small CBOs have often been the first to develop innovative and unique services to meet specific needs. MCOs interviewed identified challenges contracting with these very small providers but also expressed interest and commitment in making those relationships work, especially if the CBOs offered innovative services. These included potentially using non-contract funds to support a program to get to scale or exploring value-based payment options based on the successes the CBO is achieving.

MCOs can support CBOs in the transition to managed care by:

- Offering enhanced provider relations support, especially in billing and claims
- Working collaboratively to develop contracts, and providing flexibility on credentialing if appropriate to the provider, while maintaining quality
- Proactively reaching out to CBOs to initiate relationships before enrollment begins
- Analyze claims trends, including uncorrected claims, to identify provider challenges

Conclusion

Community Based Organizations – Centers for Independent Living, Intellectual and Developmental Disabilities providers, and other organizations – have an essential role in the success of a managed or integrated care system. They provide the non-medical services that are supported by the literature to help improve health, and they hold the history and expertise MCOs need when entering a state. People with disabilities continue to face disparities in health care outcomes and access. As states promote outcomes- and value-based health care, states and MCOs will need to build partnership with disability CBOs that ensure the success of their programs and improve health and services for people with disabilities.

Interviewees

Business Acumen MCO Advisory Committee:

Pat Nobbie, Disability Policy Engagement Director, Anthem

Mary Pat Sherry, Director, Market Development, AmeriHealth Caritas

Sarah Triano, Manager, New Product Innovation & Development, Centene Corporation (Kristin Murphy, Director of Market Development for Centene participated in the interview)

Catherine Anderson, Senior Vice President, Policy & Strategy, UnitedHealthcare

State Agency Representatives:

Maureen Casey (Arizona), Assistant Director/CEO, Arizona Department of Economic Security, Division of Developmental Disabilities

Curtis Cunningham (Wisconsin), Assistant Administrator for Long-Term Care Benefits and Programs Division of Medicaid Services

Lisa Mills (Tennessee), Deputy Chief, TennCare Division of Long-Term Supports

Patti Killingsworth (Tennessee), Assistant Commissioner and Long-Term Care Chief TennCare Bureau, Department of Finance and Administration

Developmental Disabilities Providers:

Robert Barker (Pennsylvania), President/CEO, Keystone Autism Services

George Klauser (Minnesota), Executive Director, Altair ACO

Ed Matthews (New York), CEO, ADAPT Community Network

Centers for Independent Living:

LouAnn Kibbee (Kansas), Independent Living Program Manager, Southeast Kansas Independent Living Resource Center

Melanie Hogan (Ohio), Executive Director, LEAP

Bill Henning (Massachusetts), Executive Director, Boston Center for Independent Living

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