5.07 Plan Presentation

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Courtney Burke
Commissioner

Andrew M. Cuomo
Governor

Nirav R. Shah, M.D.
Commissioner

Welcome!

AGENDA

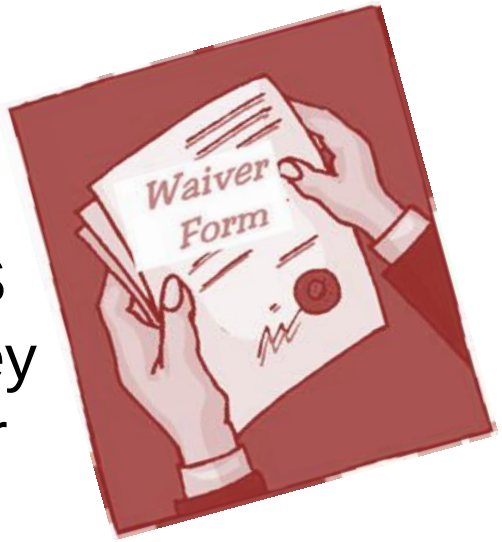
- Overview of the Statewide Comprehensive Plan
- Discuss the next phase of the People First Waiver
- Questions and answers about the Plan and Waiver

What is the Statewide Comprehensive Plan?

- A five-year plan required by New York State regulations.
- It establishes OPWDD's statewide goals and objectives.
- It guides planning, resource allocation and evaluation processes for services .

What is the People First Waiver?

- The OPWDD People First Waiver is an 1115 Demonstration Waiver.
- 1115 Waivers allow states to use Medicaid money in ways that are not usually allowed under federal rules.
- The 1115 People First Waiver will allow NYS to continue receiving federal Medicaid money for services while we look for better ways for people with disabilities to lead lives that are meaningful, productive and important to them.



The People First Waiver is an opportunity to:

- Redesign the system to better support people's health, life skills, and personal outcomes through increased flexibility.
- Focus on principles of person-centeredness, choice, quality, and community.
- Align the services of OPWDD with other agency and community services and with NYS's healthcare reform.
- Ensure fiscal sustainability of the service system.

The People First Waiver is NOT:

- Something that will happen overnight.
- An answer to every problem we may face.
- A Medicaid Block Grant to cap spending on individuals.
- A means to achieve budget reductions.
- A means to restrict or expand eligibility.

Why is the People First Waiver so Important?

- Our world is changing. More and more people are living in their communities, but OPWDD's financial base is still tied to our institutional structure.

- Instead of using funding methodologies that are tied to bricks and mortar, resources should be tied to individuals and based on need.

"Vision"

Ideal picture for the future that includes OPWDD's mission

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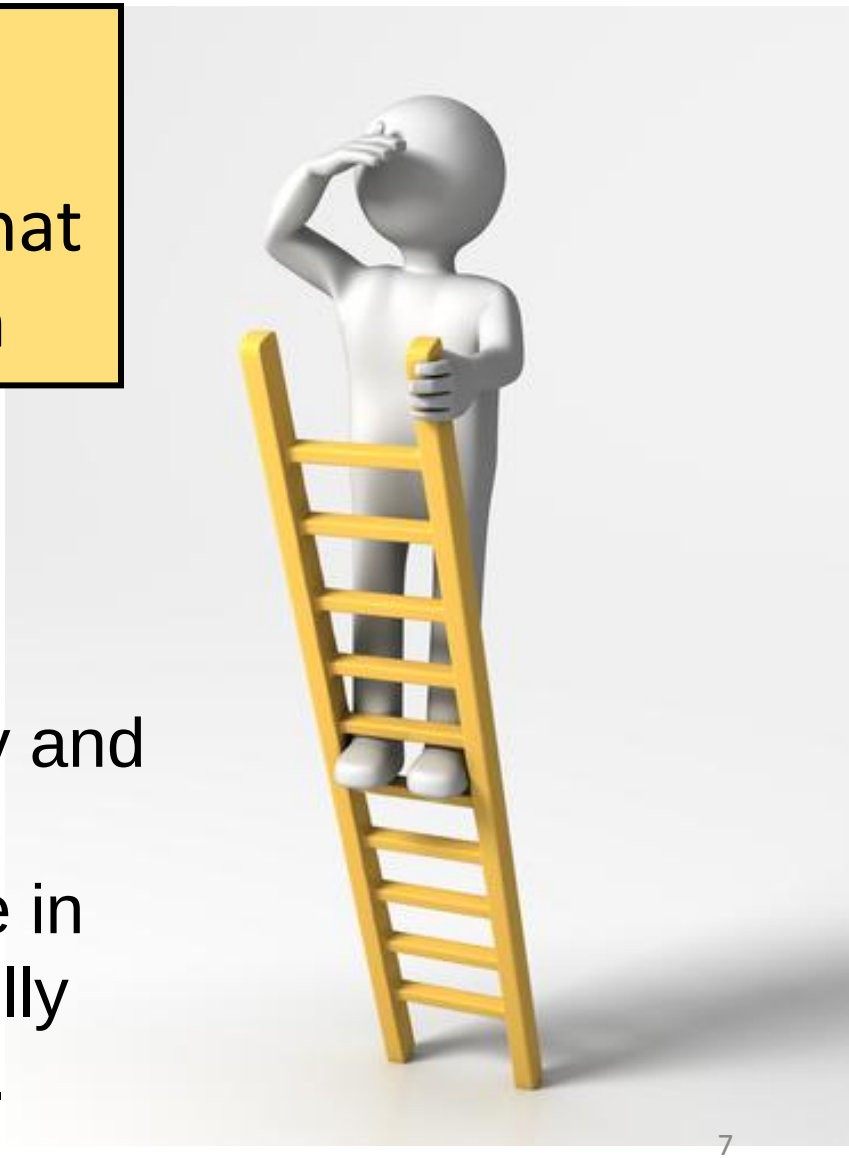
People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth, live in the home of their choice, and fully participate in their communities.



Key Outcomes to be Demonstrated:

1. That improved care coordination for people with developmental disabilities with complex medical and behavioral health needs can be achieved through specialized systems of care management and coordination in community settings.
2. That a transformed long-term care system that places person-centered planning, individual responsibility, and self-determination at the forefront can enhance care and individual satisfaction and lower Medicaid costs.

Key Outcomes to be Demonstrated:

3. That new reimbursement models for institutional and community-based care systems can encourage efficiency, improve accountability, and reduce costs.
4. That an expanded range of community-based services can allow many individuals currently living in institutional settings to transition to the community such that future institutional services can be provided on a temporary transitional basis to prepare individuals for successful community living.

Key Outcomes to be Demonstrated:

5. That redesigned assessment tools and eligibility processes can ensure “no wrong door” access for people who need to access Medicaid services under any State agency.
6. That improved health and safety outcomes can be assured through a transformed comprehensive quality management system that is driven by performance metrics linked to personal outcomes and system performance.

SO WHAT DOES THIS REALLY MEAN?

What will remain the same?

- ✓ Open communication and collaboration
- ✓ OPWDD will continue in its oversight role
- ✓ Health, safety, and rights will continue to be of paramount concern
- ✓ Our service providers will be the foundation of the new service delivery system

What will be different for individuals?

Assessment tools that are strengths-based will lead to person-centered comprehensive care plans that will inform and determine equitable resource allocation

What else is different for Individuals?

- There will be service models that continue to meet individuals' needs, but at a lower cost.
- Greater flexibility in where, when, and how services are delivered.
- Greater access to needed supports across service system.
- Easier mechanisms for self-directed services options.

REFORMED CARE MANAGEMENT

How will the System be different?

- ✓ Services will be financed and paid for in a new way. Capitated care management funding will allow:
  - The broadening of service categories.
  - More innovative community support options.
- ✓ Care coordination will be a team approach.
- ✓ Quality will be measured consistently based on personal outcomes and other performance measures.

Recommended Financial Platform

Federal Oversight - CMS

State Oversight - DOH & OPWDD

Medicaid Funds & State Funds

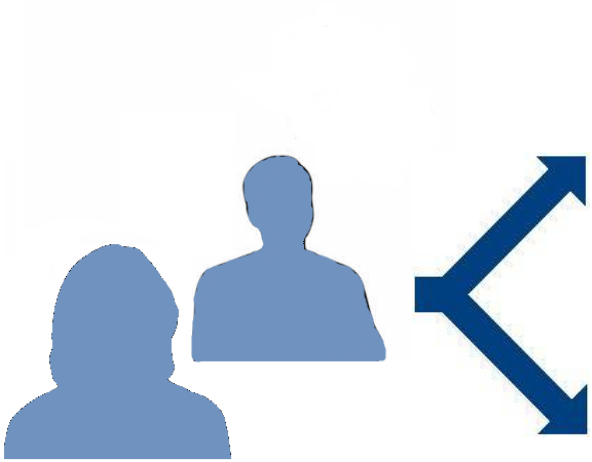
Capitation Revenue Determined by a Needs Assessment Tool(s)

Medicare Funds

Developmental Disabilities Individual Support & Care Coordination Organization (DISCO)

Not-for-Profit, Fiscal Intermediary that Assumes Financial Risk and Provides Support & Care Coordination

- ✓ *Receives all payments and may be direct service provider(s) and/or subcontract all needed services*
- ✓ *May be a comprehensive care entity or a long term care entity with a contractual agreement with a health care entity*



Choice

- DD Services
- Long Term Therapy Services
- Self Directed Services
- Other Long Term Care Services
- Primary Care Services
- Specialty Care Services
- Hospital Services
- Short Term Therapy Services
- Other Healthcare Services

DD/Long Term Care Services | **All Other Healthcare Services**

(may be not-for-profit or for profit)

How will the System be different?

- DISCOs will receive a known and predictable capitation rate for each individual served.
  - Payments will encourage administrative efficiencies and enhance focus on the individual and his/her supports, rather than providers and programs.
- Shifting from a fee-for-service system allows service providers to focus on serving people with all levels of need and equalizing access for all individuals.

DISCOs

- Are a not-for-profit entity with experience working with people with developmental disabilities.
- Are the fiscal intermediaries, care coordinators, and sometimes direct-service providers.
- Reimburses subcontractors through contracts, sub-capitation or other arrangements for all services.

DISCOs

- Will ultimately assume full financial risk for meeting each person's service needs within its capitation revenue.
- Initially, there may be some form of "risk mitigation strategy" while they gain experience operating in a risk environment.

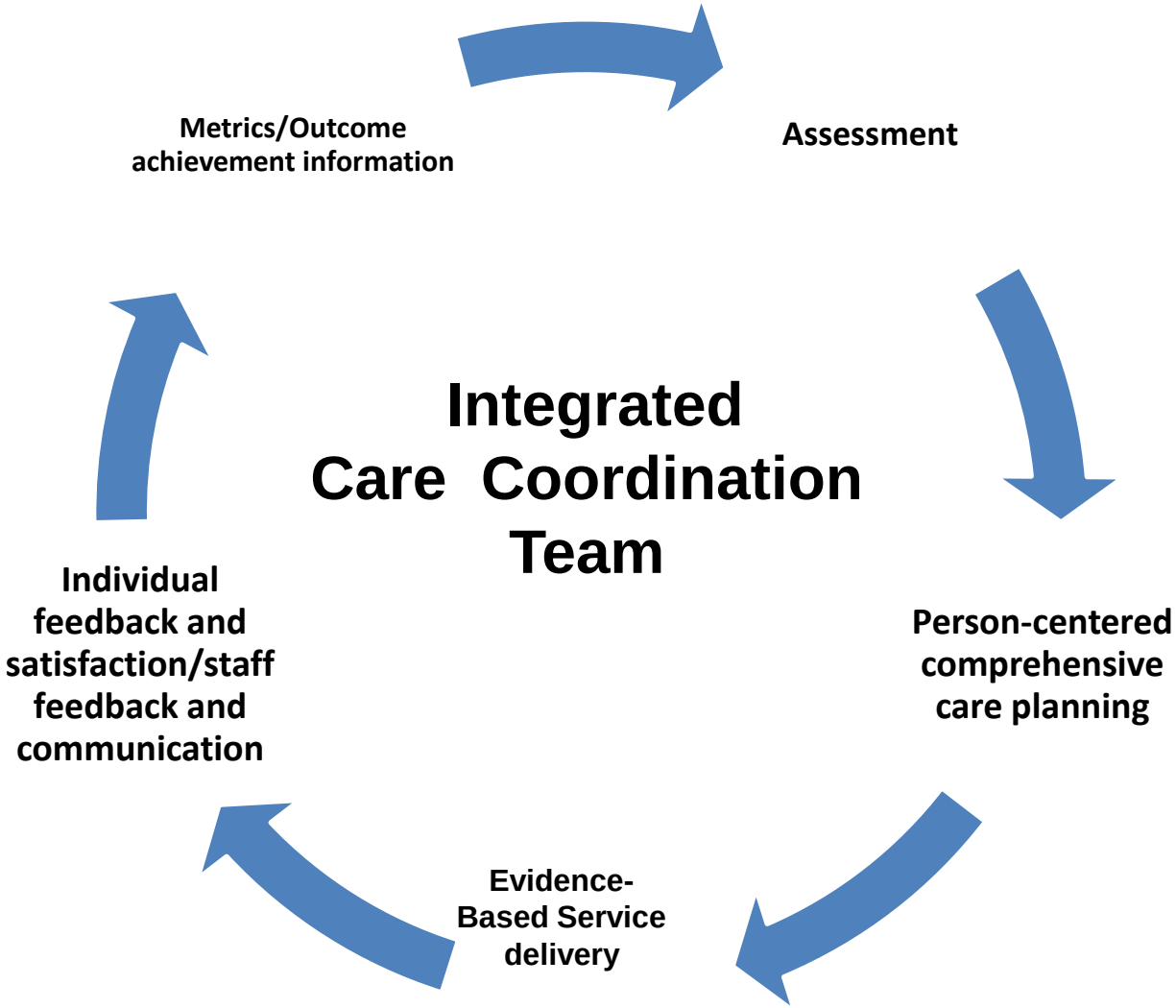
COMPREHENSIVE CARE COORDINATION

Comprehensive Care Coordination within the Care Management Infrastructure

Comprehensive care coordination is a person-centered interdisciplinary approach to addressing the full range of a person's needs, integrating habilitation, medical and behavioral health care and support services.

Care Coordination Model

- True person-centered tools and methodologies to drive outcome achievement
- Team approach to care coordination
- Education, training, & demonstration of competency for team members
- Incorporate benchmarks in the care plan to assess the progress that an individual makes
- Access to care coordination whenever it is needed by the individual
- Procedures to find and develop neighborhood resources


Integrated Care Coordination Team
Assessment
Person-centered comprehensive care planning
Evidence-Based Service delivery
Individual feedback and satisfaction/staff feedback and communication
Metrics/Outcome achievement information

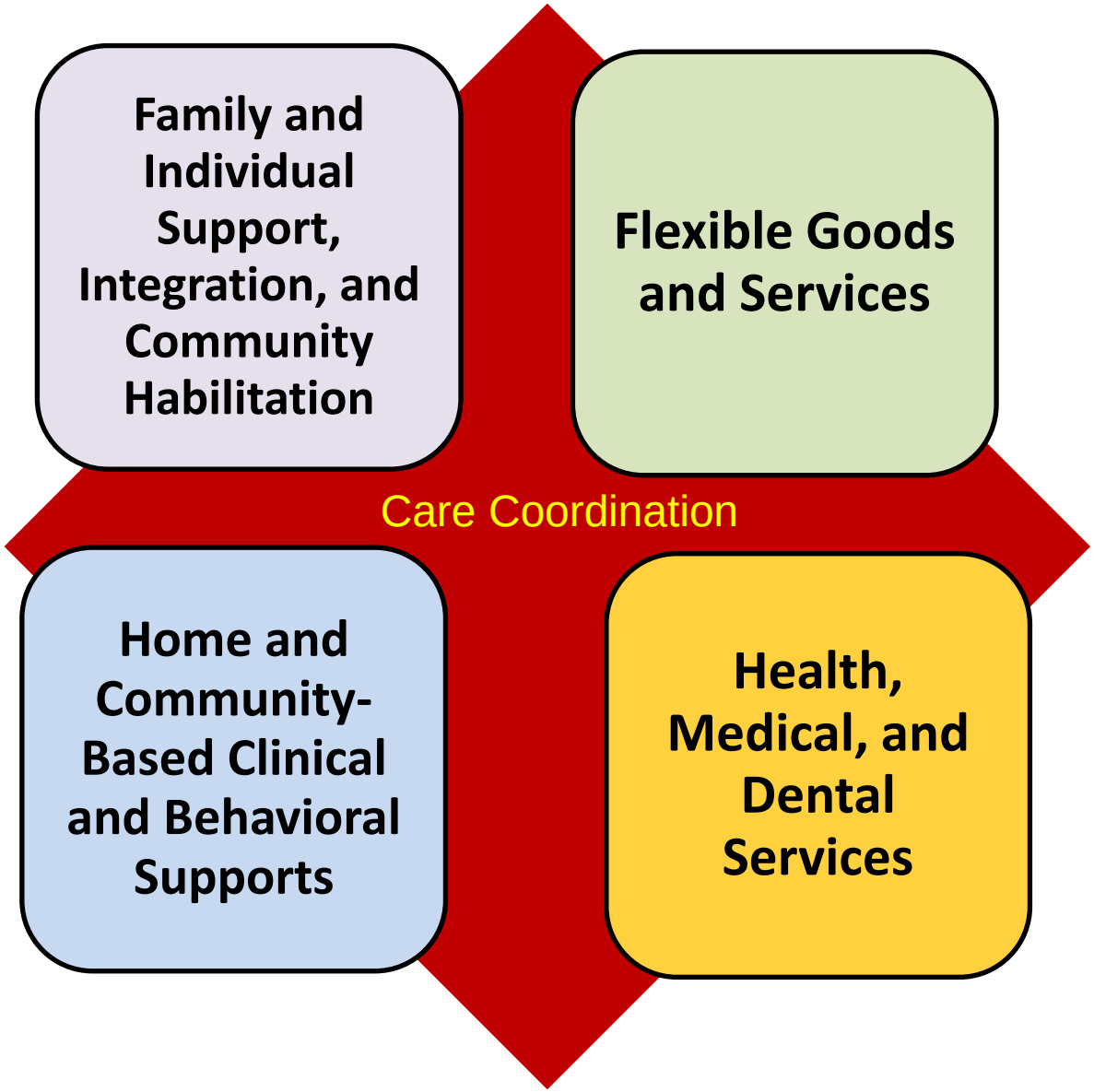
Benefits of Care Coordination

- Minimize the fragmentation of cross-system services that exists today by giving DISCOs the ultimate responsibility to ensure that each person's full range of needs are met.
- Effectively coordinate the right level of supports and services for each person.
- Help drive individual outcomes achievement through true person-centered methodologies and strengths-based needs assessment tools.

RESTRUCTURING OUR SERVICES

People First Waiver Services

- Broader more flexible range of community-based service options.
- Life plan with self-direction opportunities through real and ongoing person-centered planning for all enrollees.
- Encourage employment, citizenship, life-long learning.


Family and Individual Support, Integration, and Community Habilitation
Flexible Goods and Services
Care Coordination
Home and Community-Based Clinical and Behavioral Supports
Health, Medical, and Dental Services

FOSTERING INNOVATION

Flexibility to Innovate
New Options for Supporting People

- Increased flexibility and stronger connections fosters innovation.
- Shared living opportunities.
- Innovative residential options.
- College Experience Model.

The primary outcome of our service system is a richer life for people with developmental disabilities.

ENHANCING AND ALIGNING QUALITY INFRASTRUCTURE

Enhancing and Aligning the Quality Infrastructure

- Accountability for Health and Safety
- Measuring Quality

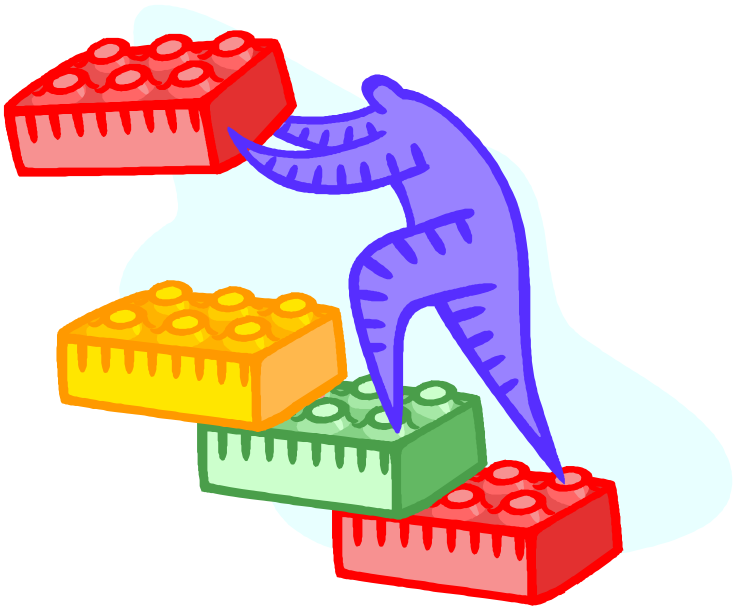
- **Quality will focus more on the identified personal outcomes for individuals receiving services.**
- **Agencies will establish systems to address self-assessment and quality improvement**
- **An agency's quality rating will be made available to the public through a variety of means.**

The Quality Scale

- Defined benchmarks which differentiate one level of quality from the next.
- There are five levels: At level 5, an agency has an aggressive action plan for self-correction and self-improvement. At level 1, an agency requires OPWDD monitoring and is just meeting regulatory requirements and is at risk of early alert status.

The Quality Scale's six domain areas

1. Individualized Services, Planning, and Service Delivery
2. Protections, Health and Safety, Rights and Environmental Supports
3. Supporting Family, Natural supports and Community connections, Community Inclusion
4. Workforce Performance
5. Quality Improvement Plan
6. Governance and Leadership



Timeline and Important Next Steps in the People First Waiver

Phase 1

- Reform of the fiscal platform
- Begin transitioning individuals living in institutional settings to community settings
- Award pilot projects across the state

Phase 2

- Monitor/Evaluate pilot projects
- Continue transitioning individuals from institutions to community settings
- Begin executing implementation plan to operationalize reforms

Phase 3

- Continue executing implementation plan
- Evaluate pilots and begin statewide transition to the DISCO model for long-term care services
- Begin transition to managed care model for health care services

Important Next Steps

- Ongoing dialogue with CMS
- Completion of Waiver Application
- Development of RFI/RFA for Pilot Projects

Careful Planning and Roll-Out

- Transition of services for individuals and families.
- Careful planning of assessment process and movement toward a more equitable system.
- Focus on the transition of financing.

Questions

And

Answers

Public Resources

People First Waiver Web page:
www.opwdd.ny.gov/2011_waiver

People First e-mail address for comments and questions: People.First@opwdd.ny.gov

People First comment line:
1-866-946-9733 or TTY: 1-866-933-4889

Thank You