



PEOPLE FIRST
1115 DEMONSTRATION WAIVER

Fiscal Sustainability Design Team

July 13, 2011



Courtney Burke
Commissioner



Andrew M. Cuomo
Governor



Nirav R. Shah, M.D.
Commissioner



Agenda

- | | |
|---|--------------------|
| I. Welcome and Introductions | 11:00 – 11:10 p.m. |
| II. Review & Approval of Prior Meeting Summary | 11:10– 11:15 p.m. |
| III. Design Team Parameters / Thoughts & Reactions | 11:15– 11:45 p.m. |
| IV. Review of Expenditure / Rate Info Requested | 11:45 – 12:00 p.m. |
| V. Subgroup Presentation on Review of Other Systems | 1:00 – 2:15 p.m. |
| VI. Group Discussion on Subgroup Presentation | 2:15 – 3:00 p.m. |
| VII. Assessment Tool Subgroup Information Sharing | 3:00 – 3:15 p.m. |
| VIII. Group Discussion / Next Steps | 3:15 – 4:00 p.m. |



Fiscal Sustainability Design Team Members

Tina Chirico - Anderson Center for Autism/FMA	Henry Hamelin – OPWDD, Upstate Staff	Steve Holmes – SANYS	Jay Kiyonaga, OPWDD Co-Facilitator
Al Kaplan – AHRC New York City	John Kemmer – NYSARC	Anne Klingner – Mental Health Association Employee/Parent	David Liscomb – Jefferson Rehabilitation Center/Self Advocate
Dr. Keith McGriff – DePaul Developmental Services / Parent	Regis Obijiski – New Horizons	Ramon Rodriguez – Home Helpers & Direct Link of Amsterdam	Michael Rogers – Co- Facilitator/Self Advocate
Pat Sarli – OPWDD, NYC Staff	Jeff Sinsebox – PRALID	Seth Stein – Alliance of Long Island Agencies, Inc.	Louis Tehan – Upstate Cerebral Palsy



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Review & Approval of 6/20/2011 Meeting Summary



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Design Team Parameters



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Requested Expenditure / Rate Information



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Fiscal Sustainability Design Team Subgroup: Review of Other Systems



Fiscal Sustainability Design Team Subgroup Members

Tina Chirico -
Anderson Center
for Autism/FMA

Steve Holmes –
SANYS

Al Kaplan –
AHRC New York
City

John Kemmer –
NYSARC

Amy Murrisky -
OPWDD

Jeff Sinsebox –
PRALID



Review of Other Systems Subgroup

Charge of the Subgroup:

- Review Key Issues
- Address Pros & Cons
- Share publicly available documents
- Present findings to full Fiscal Sustainability Design Team



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North Carolina

Presented by Tina Chirico



North Carolina– Scope of Waiver

- Target Population: individuals with developmental disabilities, physical disabilities and mental illness
- Innovations Waiver- 1915-b and 1915-c
- Number enrolled: <700 individuals with developmental disabilities
- Services: Care management; medical supplies and equipment; assistance with daily living activities; personal care; specialized transportation; vehicle adaptations; financial management; employment services; day center services; meal services; home health care; counseling and therapy; crisis stabilization; adult day care; respite care; recreational activities; medical day treatment; consumer education; energy and housing assistance; and health screening



North Carolina– Scope of Waiver

- MCO with monthly capitation as the payment mechanism
- Waiting list: Services are on a first come first serve basis, with minimal emergency placements
- Point of entry: Prepaid Inpatient Health Plan (PIHP) through an Local Management Entity (LME). Responsible for enrollment.
- Assessment tool: Support Intensity Scale



North Carolina– Implementation

- Started as a 5 County pilot in 2009 and is in the process of expanding throughout the entire state
- Expansion of provider community through RFA process



North Carolina– Reimbursement/Financing Methodology

- MCO with monthly capitation as the payment mechanism
- Fixed negotiated monthly capitation with an annual cap
- All waiver services at a limit of 112% of the institutional rate annually
- 2% of the monthly capitation payment used for risk reserve



North Carolina– Pros & Cons

- Pros
 - Provider models include the ability to self direct and for relatives
 - ISP authorized based upon support needed as identified in SIS
- Cons
 - No method of dealing with the waiting list, only two options
 - Program in early stages of development
 - Small population served



North Carolina– Applicability to New York State

- North Carolina’s service system is small when compared to New York
- Managed care with capitation
- Focus on individualized services



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Wisconsin

Presented by Al Kaplan



Wisconsin– Scope of the Waiver

- Family Care Waiver, 1915-b and 1915-c
- Target populations: adults with developmental disabilities, individuals with physical disabilities and the frail elderly
- Number enrolled: 37,000; 41% are individuals with developmental disabilities
- Services: Care management; medical supplies and equipment; assistance with daily living activities; specialized transportation; financial management; employment services; day center services; meal services; home health care; counseling and therapy; adult day care; respite care; skilled nursing services; recreational activities; medical day treatment; consumer education; energy and housing assistance; and health screening.
- Assessment tool: Wisconsin Adult Long Term Care (LTC) Functional Screen₁₈



Wisconsin– Scope of the Waiver

- MCO with monthly capitation as the payment mechanism
- The MCOs provide a menu of services to Family Care Enrollees through contracted providers. One MCO is run by a county, six are public LTC districts and three are nonprofits.
- Waiting list: Originally, people were served within 90 days of registering. In 2011 with budget cuts and spending caps in place, there is currently no provision to deal with the 6,000 people waiting for services
- Point of entry: Enroll through Aging and Disability Resource Centers (ADRC) and are directed to services by Managed Care Organizations (MCOs). ADRCs function as the “single point of entry”
- The ADRCs are operated by individual counties, groups of counties or tribes. MCOs are private nonprofit organizations, counties or public long-term care districts established as local units of government



Wisconsin– Implementation

- Started as a five County pilot in 1998 and expanded in 2007 as other counties opted in (60 of 72 counties currently participate)
- Monies were given to the counties as “planning funds”



Wisconsin– Reimbursement/Financing Methodology

- All long term care services are rolled up in the capitated rate
- There is a monthly negotiated amount for each individual and it is added up for each provider and divided by the number of individuals that the provider serves
- The Functional Screen and negotiation of the rate is used for risk adjustment of the capitation payment
- Two categories of funding: comprehensive care and intermediate care. 96.8% of participants are in comprehensive care. The average monthly rates are \$1,800 to \$2,800 for the physically disabled and elderly and \$2,900 to \$4,600 for individuals with developmental disabilities
- MCOs must live within their allocations, although they do borrow from reserve funds



Wisconsin– Pros & Cons

- Pros
 - The system appears simple in terms of access and implementation
 - Regulation and approval are streamlined
 - Access to services had improved (until the 2011 freeze)
- Cons
 - The quality review is unclear
 - Too easy to abandon the system's goals (access, waiting list reduction, fair pricing);
 - Not attractive to innovators
 - MCO insolvency



Wisconsin– Applicability to New York State

- The capitation payment system and the waiting list access prior to 2011 appeared to function relatively well as people with needs had more access than they ever had and the payments reflected need
- The intake system through the Resource Centers appears to be a concept that has merit and is worthy of review



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Arizona

Presented by Amy Murrisky



Arizona– Scope of the Waiver

- 1115 statewide demonstration Waiver
- Target populations: elderly, people with physical and developmental disabilities
- Number enrolled: 22,000 individuals with developmental disabilities
 - *88% of the services are supported in their own or family home
- Services: attendant care, behavioral health, day treatment & training, employment, habilitation, home health aide, home nursing, hospice, housekeeping, employment, ICF, residential services, case management, individualized supports, respite, room and board, therapies, transportation, home modifications; **Acute Care**- inpatient, outpatient, medical supplies, DME, pharmacy, adaptive aids, dental, rehabilitation, podiatry, home health services, etc.
- Eligibility tool: State functional assessment



Arizona– Scope of the Waiver

- MCO with monthly capitation as the payment mechanism
- The Division of Developmental Disabilities (DDD) is the MCO for service to people with developmental disabilities and acute services
- Waiting list: None
- Point of Entry: Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, determines eligibility based on income and conducts pre-admission screenings for health needs that includes a functional assessment
- Individuals with developmental disabilities who are found eligible for long-term care enroll into the Arizona Long Term Care System



Arizona– Implementation

- Data is critical piece in planning and budgeting in a capitation system
- Support coordinators are part of the assessment process and service planning
- Focus on individualized supports



Arizona– Reimbursement/Financing Methodology

- Capitation as the payment mechanism
- Fixed rates are established for services and paid through DDD as the MCO
- All services are rolled up in the rate, including case management, ICF, acute care services and a 5 % administrative cost
- Capitation payment is negotiated each year with the legislature
- High cost outliers are handled by building in a 1 to 2% risk contingency fund to account for high cost services and catastrophic type needs



Arizona– Pros & Cons

- Pros
 - Provides services to all individuals who are eligible
 - No waiting lists
- Cons
 - Service provision to all individuals who are eligible creates a financial risk
 - Limited residential services



Arizona– Applicability to New York State

- Arizona’s service system is small when compared to New York
- Managed care with capitation
- Focus on individualized services
- Arizona’s system is heavily reliant upon natural supports



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Vermont

Presented by Jeff Sinsebox



Vermont– Scope of the Waiver

- Global Commitment to Health demonstration waiver is an 1115 Waiver
- Target populations: individuals with developmental disabilities, physically disabled, TBI, and a large number of state mandated categorically and needy populations
- Number enrolled: 3,900 individuals with developmental disabilities
- Services: Service Planning & Coordination, Community Supports, Employment Services, Home Supports, Respite, Clinical Interventions, Crisis Services, Bridge Program, Flexible Family Funding, Offender Services, PASRR Services, Children's Personal Care Services, Public Guardianship
- Eligibility tool: functional assessment



Vermont– Scope of the Waiver

- Mandated managed care enrollment
- Waiting list: Yes, for those who do not meet funding priorities or at maximum capacity
- Point of entry: Access is gained through a Designated Agency (DA), private nonprofit, within a participant’s locality
- DA’s completes intake assessments and assist individuals with the enrollment process. Approvals are secured through the state committee system
- OVHA, the state Medicaid office, is also the MCO that enters into Intergovernmental Agreements (IGA’s) with other state departments to purchase services for beneficiaries. OVHA is responsible for external quality review audits and management of the cap.



Vermont– Implementation

- The waiver was developed and implemented rapidly
- Nine months from concept paper to legislative approval
- Many services under the 1915 (c) waiver have been continued
- For individuals with developmental disabilities, eligibility requirements have not changed significantly
- The largest impact of the waiver came on the state and agencies that had amended reporting and tracking duties



Vermont– Reimbursement/Financing Methodology

- Individualized budgets capped by an Authorized Funding Limit. DAs and/or Fiscal ISOs work with the individual to maximize their allocation
- Each distinct service within the waiver has limits of dollars and/or hours that the state allows. Individual unmet needs and identified priorities dictate the number of dollars and hours up to the cap allowed with the Individual Support Agreement Guidelines that each participant receives in their budget allocation.
- The maximum cap for an individualized budget is \$200,000 annually
- Individuals in self managed, family managed, or shared managed services are responsible for overages if the authorized funding limit is exceeded
- Under fiscal pressures, the Division on Disability and Aging may choose to reduce the DA's base allocations targeting administrative efficiency, non direct service items, and global rate reductions to individualized budgets



Vermont– Pros & Cons

- Pros
 - Enhanced flexibility in the use of Medicaid by the state
 - Fiscal intermediaries allow for self-direction, self-determination and creative service approaches. Individuals, families, agencies, and other stakeholders have influence over who gets funded.
 - DD system has created an extensive Shared Living system constituting 77% of all residential options at an average annual cost below \$30k
- Cons
 - The federal cap in Vermont may have been set artificially high
 - Participant satisfaction has not improved significantly
 - Eligibility processing involves multiple entities and can be cumbersome and time consuming



Vermont– Applicability to New York State

- Vermont’s system of services is relatively small compared to New York
- To utilize elements of the Vermont system, New York would have to find ways to streamline processes
- Vermont’s offender program may be worth exploring to address any desire for deinstitutionalized forensic programs in New York
- Vermont’s shared living program also warrants exploration. The potential to create IRA vacancies or avoid IRA placements by moving people into these cost effective options is significant.
- The Bridge Program is a coordinated care program for children with DD ages 22 and under
- Vermont’s system is heavily reliant upon natural supports



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PACE

Program for All-Inclusive Care for the Elderly

Presented by Deb Franchini



Key Elements

- Capitated managed care program for the frail elderly
- Provided by a not-for-profit or public entity
- Comprehensive medical and social service delivery system
- Uses an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services based on the participants' needs
 - Interdisciplinary team includes (at a minimum) a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center supervisor, home care liaison, health workers/aids, or their representatives, and drivers or their representatives.



Eligibility

- Voluntary enrollment for individuals
- Enrollee must be:
 - Age 55 years or older
 - Meet a Nursing Facility level of care
 - Live in a PACE organization service area



Requirements of PACE Organization

- Not-for-profit or public entity that is primarily engaged in PACE services
- Have a governing board which includes community representation
- Be able to provide the complete service package regardless of frequency or duration of services
- Have a physical site to provide adult day services
- Have a defined service area
- Have safeguards against conflict of interest
- Have demonstrated fiscal soundness
- Have a formal Participant Bill of Rights



PACE Organization Characteristics

- Can be licensed as an Managed Care Organization
- Provides care and services in the home, community, and the PACE center
 - PACE center meets State and Federal safety requirements and include adult day programs, medical clinics, activities, and occupation and physical therapy facilities.
- Has contracts with specialists and other providers in the community



Services

- Package of services includes, but is not limited to, all Medicare and Medicaid covered services as well as others determined necessary by the interdisciplinary team of the participant
- Service delivery settings include an adult day health center, home and inpatient facilities



Reimbursement Under PACE System

- PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee
 - Medicare: Blended 3-part formula
 - Medicare Advantage Rate
 - Based on individual eligibility for Medicare Part A, Part B, or both
 - Risk adjustment
 - Based on participants status
 - Uses appropriate CMS-HCC (Centers for Medicare & Medicaid Services - Hierarchical Condition Categories) model
 - » Community, long-term institutionalized, End-Stage Renal Disease, or new enrollee
 - Frailty adjuster
 - Community-based and short term institutionalized participants - receive adjustment
 - Long-term institutionalized participants – no adjustment



Reimbursement Under PACE System

- PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee
 - Medicaid:
 - Monthly capitated payment negotiated between the PACE organization and the State Medicaid Agency.
 - Accounts for comparative frailty of participants
 - Less than the amount that would otherwise been paid under the State plan if participants were not enrolled in PACE
 - Is a fixed amount regardless of participant's changes in health status
 - Can be renegotiated annually
- Pace providers assume full financial risk for participants' care without limits on amount, duration , or scope of services



Participant Choice

- Participants, with the help of PACE doctor and other care providers, make decisions about their own care
- No higher authorities will overrule what the individual, doctor and other care providers agree is best for the individual
- Appeals can be filed by participants if they disagree with the interdisciplinary team about their care plan



Comparison of Other Systems

	Arizona 1115	North Carolina 1915-b/c	Vermont 1115	Wisconsin 1915-b/c
Populations served	All Medicaid recipients. ALTCS-ICF, People w/physical & developmental disabilities, Elderly	People w/physical & developmental disabilities, mental illness	People w/physical & developmental disabilities , TBI, other	Adults w/physical & developmental disabilities , frail elderly
Number of individuals served with DD diagnoses	22,000	<700	3,900	15,000
Type of System	Managed Care	Managed Care	Managed Care	Managed Care



Comparison of Other Systems

	Arizona 1115	North Carolina 1915-b/c	Vermont 1115	Wisconsin 1915-b/c
Mandatory enrollment?	Yes	No	Yes	No
State operated services?	Yes	Yes	No	Yes – Institutional and competes through the MCO
Entities involved	AHCCCS (Medicaid Agency), Arizona Long Term Care System (ALTCS), Health Plans, DDD (state agency and MCO)	Prepaid Inpatient Health Plan (PIHP), Local Management Entity (LME)	OHVA (Medicaid Agency and MCO), Designated Agency, Committees	Aging and Disability Resource Center (ADRC), MCO



Comparison of Other Systems

	Arizona 1115	North Carolina 1915-b/c	Vermont 1115	Wisconsin 1915-b/c
Eligibility tool tied to reimbursement /tool used	No/State functional assessment	Yes/SIS	No/State functional assessment	Partially/State functional assessment
Financial methodology	Capitation	Capitation	Individualized Budget	Capitation
Payment amount	\$3559/mo	Up to 135,000/yr	Individualized budget Up to \$200,000/yr.	\$2,900 to \$4,600/mo.
Accommodate risk?	1-2% contingency fund	Mandatory risk pool-2% of capitation payments	No	Reserve funds



Comparison of Other Systems

	Arizona 1115	North Carolina 1915-b/c	Vermont 1115	Wisconsin 1915-b/c
Accommodates risk?	1-2% contingency fund	Mandatory risk pool-2% of capitation payments	No	Reserve funds
System in place to achieve savings?	No In 2011, provider cuts, institutional rate freezes, member cost sharing	No	No Established with the goal of flexibility	No In 2011, enrollment and expansion caps, service providers cuts



Comparison of Other Systems

	Arizona 1115	North Carolina 1915-b/c	Vermont 1115	Wisconsin 1915-b/c
Key implementation issues	Increased federal requirements with an 1115 waiver	Started as a 5 county pilot and expanded to the entire state	Amended reporting and tracking duties	Started as a 5 county pilot and expanded to 60 of 72 counties



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Access and Choice Assessment Tool Technical Workgroup Update



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Group Discussion



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Group Discussion/Next Steps



Future Meetings

44 Holland Avenue, Albany, NY 12229
Conference Room 4B

Meetings are scheduled from 11am to 4pm on:

- Wednesday, July 27th
- Wednesday, August 10th
- Wednesday, August 31st