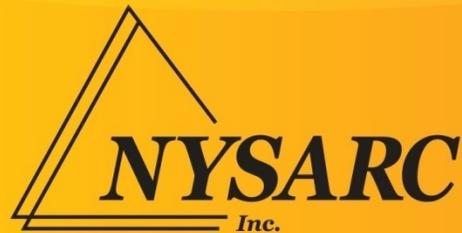


# **NYSARC Statewide Coordinated Care Program for Persons with Developmental Disabilities**

December 4, 2012



**»» *“Many of the problems our disabled residents encounter are not the result of limited resources, but rooted instead in failures in the organization and management of services.”***

**Governor Andrew Cuomo**

State of the State

January 3, 2012

## Executive Summary

- Develop and implement a single statewide integrated and coordinated care system which will be responsible for the provision of a full array of services to people with intellectual and developmental disabilities (IDD) as well as other populations
- The single statewide NYSARC entity , (Managed Care Organization- MCO) would be responsible for overseeing and coordinating all care in collaboration with a health care partner(s) across the state, and would participate with Medicaid and Medicare for these comprehensive services
- To Capture savings and efficiencies NYSARC will develop seven regional Management Services Organizations (MSOs) to collaborate and consolidate regional administrative services and to apply Managed Care principals to acute care services and habilitative long-term care services in a Managed Care framework

# Coordinated Care Reform in NY

- ▶ State's goals are understood
  - Increased coordination and integration
  - Incentivizing preventive and effective care
  - Flexibility to meet needs
  - Improving satisfaction and health outcomes
  - Bending the State's cost curve

# Coordinated Care Reform in NY

- ▶ **Fit with Existing Initiatives**
  - Mandatory Managed Care
  - Mandatory Managed Long Term Care (MLTC)
  - Health Homes
  - Fully Integrated Duals Advantage
    - Nassau County and other downstate Chapters participation in pilot

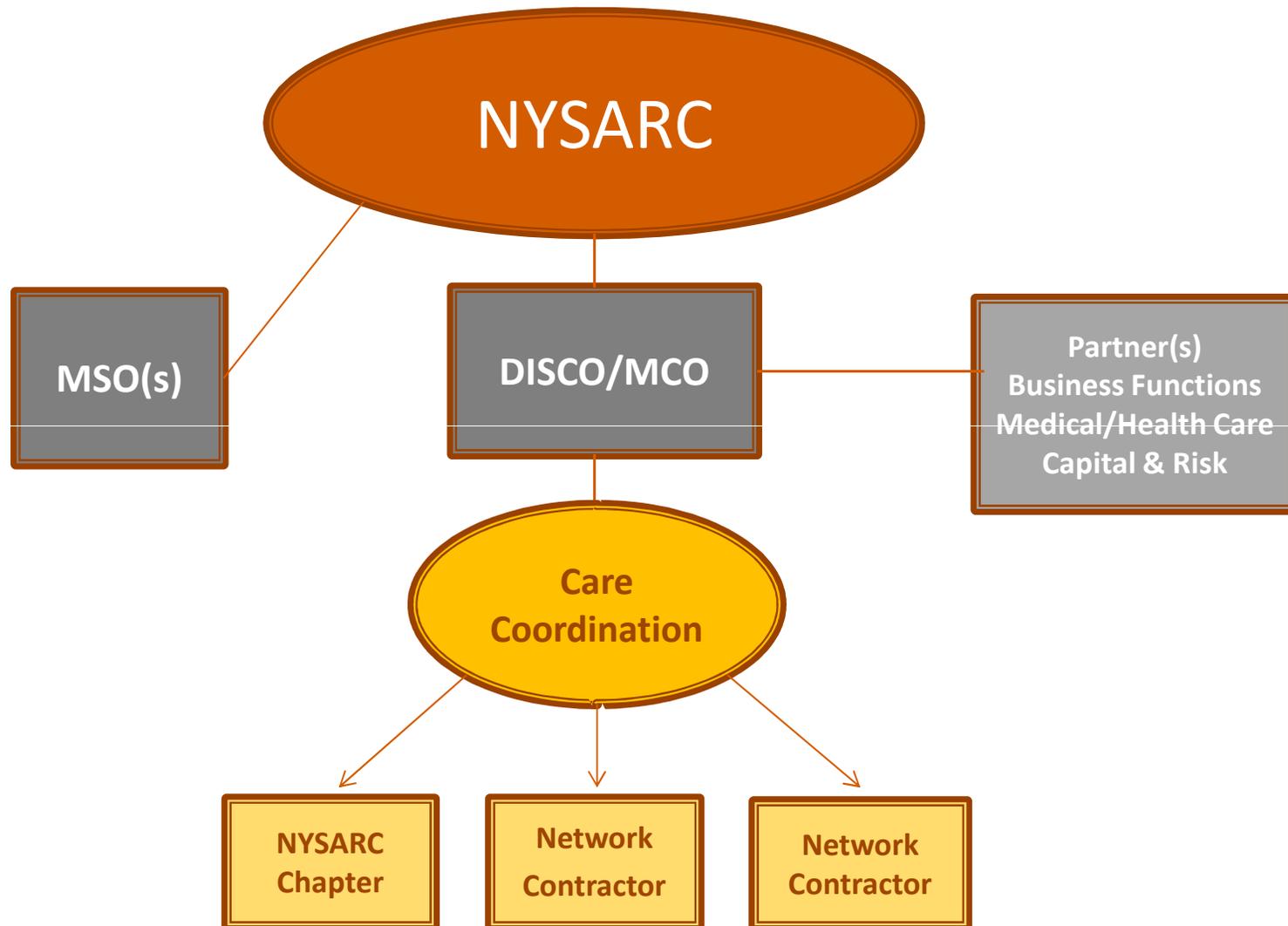
# Why NYSARC?

- ▶ Largest not-for-profit organization of its kind in the United States
- ▶ Family governed
- ▶ Largest potential membership
- ▶ One of the largest Medicaid billers in NYS
- ▶ Single Corporation
- ▶ Statewide presence addressing local needs
- ▶ Existing close relationships
- ▶ Strong financial capacity
- ▶ Strong credit rating
- ▶ Case study involvement
- ▶ Existing brand and reputation
- ▶ Ability to “fast track” development and implementation

---

# Project Principles and Aims

- ▶ Habilitation focus
- ▶ Person centered, increased satisfaction
- ▶ Family based, natural supports
- ▶ Employment focus
- ▶ Commitment to innovation
- ▶ Uniform quality standards, outcomes
- ▶ Expand relationships to other sectors
- ▶ Reinvest in system improvement & increased capacity



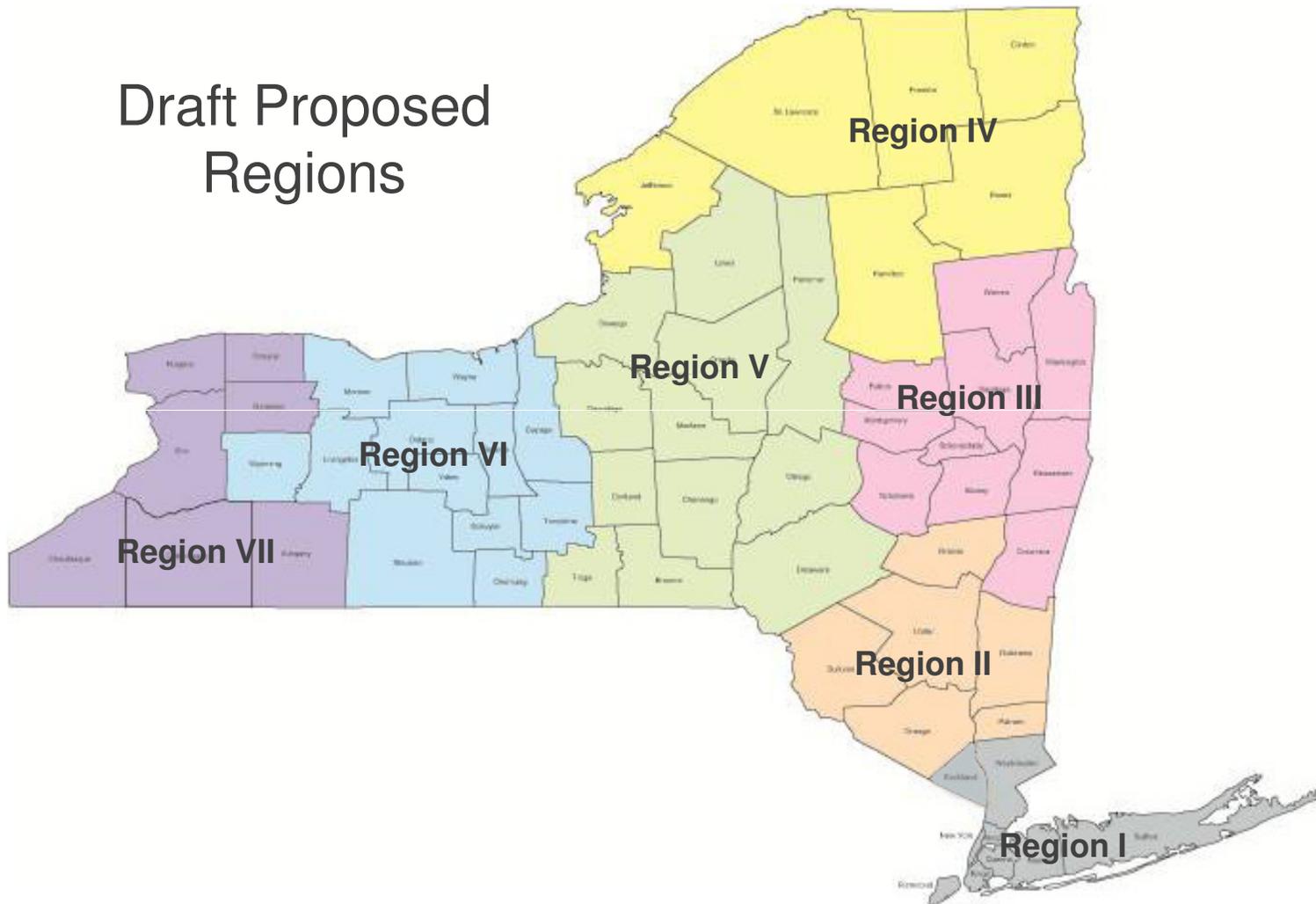
# Project Structure: DISCO/MCO

- ▶ DISCO/MCO will be subsidiary not-for-profit corporation
- ▶ Third party administrator, management service agreement
- ▶ Formal arrangements with care partners, health care and behavioral health
- ▶ Potential for equity arrangements with payors and providers
- ▶ Statewide service area, rolled out by region

# Project Structure: Regional Management Services Organizations

- ▶ Goal: Identify and replicate best and most efficient practices
  - Group Purchasing
  - Shared services
    - Quality assurance/improvement, corporate compliance, HR, IT, finance, etc.
  - Management efficiencies
    - Reduce redundancies
    - Consolidate positions and functions
  - Standardize systems and quality & performance standards
  - Explore regional care coordination function

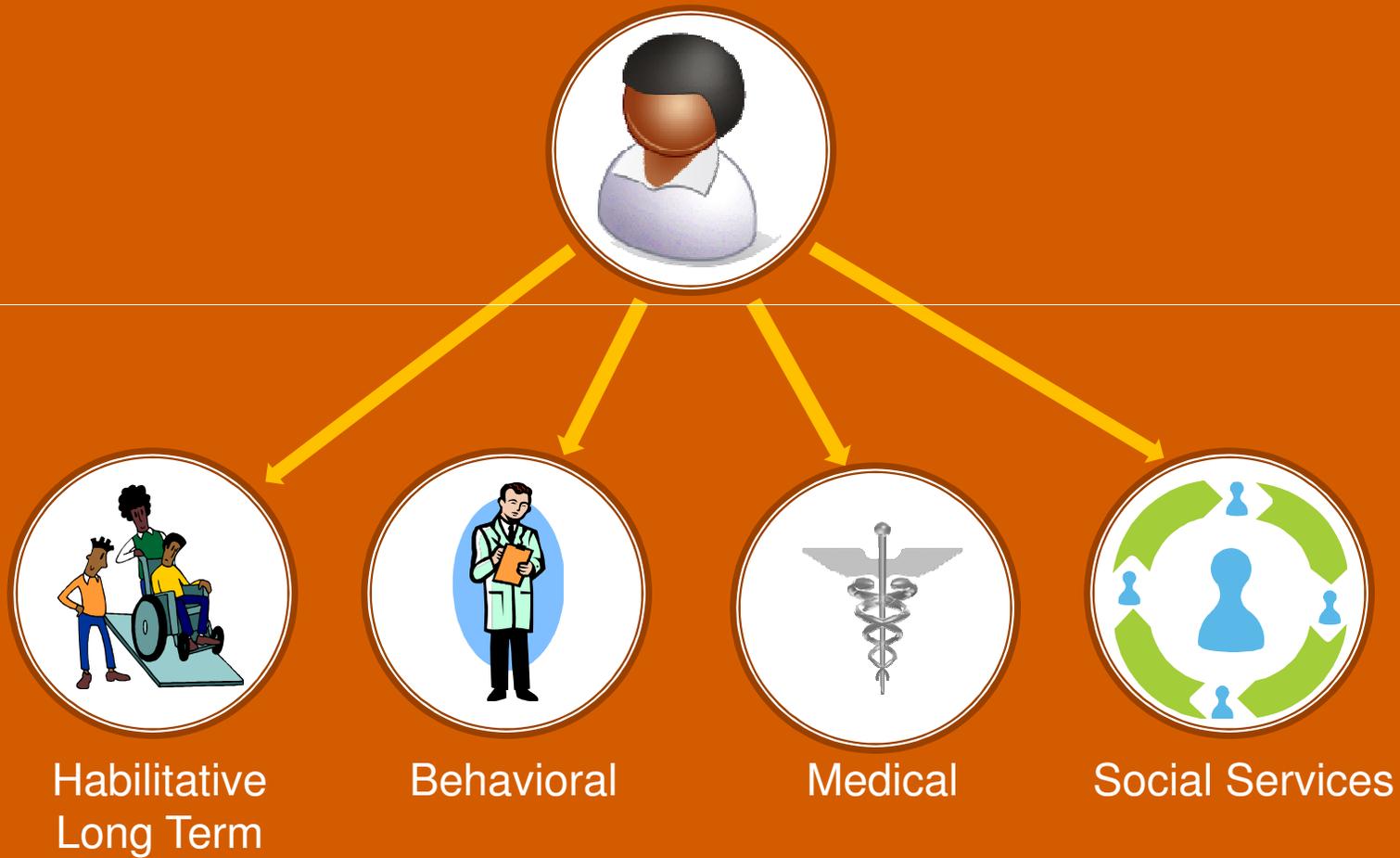
## Draft Proposed Regions



# Integrated Care Coordination

- ▶ Minimize the fragmentation of cross-system services that exists today by giving one entity, the DISCO/MCO, ultimate responsibility for ensuring 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 outcome achievement through person centered methodologies.

## Members: What are members' needs?



---

# Care Coordination Services and Processes

## Services:

- ▶ Review initial assessment and perform reassessments
- ▶ Develop individual care plans, in consultation with person and his/her advocate
- ▶ Management & Coordination of covered & noncovered services
- ▶ Monitor the progress of each person enrolled
- ▶ Evaluate whether the care plan continues to meet needs

## Processes:

- ▶ Generate and receive referrals
- ▶ Share care plan & clinical treatment plan information
- ▶ Obtain consent to share confidential information
- ▶ Provide members with notification of authorized services
- ▶ Enlist the involvement of family/advocates, providers, community organizations

# Person Centered Planning

- ▶ Assessment and the development of each person's Care Plan is preformed by a highly qualified interdisciplinary team
  - Nurse, social worker, psychologist/behaviorist, employment specialist, OT/PT/Speech, advocate
- ▶ Services are designed to include meaningful community inclusion and promote independence and self sufficiency
- ▶ The person's aspirations and choices are core considerations in the person-centered planning process
- ▶ The family is a central resource and partner in all planning and progress
- ▶ Services are dynamic, having the capacity to vary in intensity and in response to the person's current and/or changing needs.

# Program Enhancements

Key benefit of integrated care coordination model: The development of services/programs not available in fee-for service.

# Program Enhancements

- ▶ Personalized residential options
  - Enhanced family care
  - Step-down or up from supervised to supportive
  - In home supports for the whole family (e.g. needs of aging caregivers)
  - Study of characteristics that predict successful transition to more independent settings.

# Program Enhancements

- ▶ Personalized Day Options
  - Expanded supported work options, incentive payments for integrated work outcomes
  - Blended day hab, SEMP, PreVoc
  - Generalized day outcomes
- ▶ Self Direction
  - DISCO/MCO infrastructure to support SD

# Program Enhancements

- ▶ **Clinical services**
  - Clinicians in support role to primary caregivers
  - Target hands on therapy to specific conditions
- ▶ **Applied technology**
  - Utilize smart home concepts
  - More aggressive application of adaptive tech
- ▶ **Transportation**
  - Collaboration with county and public transportation
  - Collaboration across human service sectors
  - Enhanced family and individual responsibility

# Key Concerns and issues

- ▶ Risk Sharing – The Core Issue
  - Untested territory, a vulnerable population, expectation is for shared risk with the State
  - Eventual cost savings, realistic expectations
- ▶ Information Technology
  - IT infrastructure required. Potential grant funds
  - Access to claims, utilization, and individual characteristics
- ▶ Individuals, Families, and Advocates' Concerns