



Transformation Panel

MEETING TITLE: Transformation Panel: System Goals

DATE/TIME: August 6, 2015

- Kerry A. Delaney, Acting Commissioner, Office for People With Developmental Disabilities
- Charles A. Archer, Evelyn Douglin Center for Serving People In Need, Inc. (EDC-SPIN)
- Gerald Archibald, The Bonadio Group
- Nick Cappoletti, Developmental Disabilities Advisory Council Chairperson, Parent
- Donna Colonna, Services for the Underserved
- Susan Constantino, Cerebral Palsy Associations of New York State
- Stephen E. Freeman, Freeman and Abelson Consulting
- Steve Holmes, Self-Advocacy Association of New York State, Inc.
- Steven Kroll, NYSARC
- Clint Perrin, Self-Advocate
- Peter Pierri, Interagency Council of Developmental Disabilities Agencies
- Michael Seereiter, New York State Rehabilitation Association
- Seth Stein, Moritt, Hock & Hamroff (video)
- Arthur Webb
- Rob Scholz, Deputy Director of Contracts, CSEA

Absent:

- Barbara DeLong, Parent
- Ann Hardiman, New York State Association of Community and Residential Agencies

OPWDD Staff:

- Neil Mitchell, Special Assistant to the Commissioner
- Joann Lamphere, Deputy Commissioner, Person-Centered Supports
- Diane Woodward, Statewide Assessment Coordinator
- Kevin Valenchis, Deputy Commissioner, Enterprise Solutions
- Jennifer O'Sullivan, Director of Communications
- Megan O' Connor, OPWDD, Deputy Commissioner, Quality Improvement
- Greg Roberts, Governmental Liaison

Other State Attendees:

- Paul Francis, Governor's Office, Deputy Secretary of Health and Human Services
- Lou Raffaele, Division of the Budget
- Jason Helgerson, DOH, Medicaid Director
- John Ulberg, DOH
- Mark Kissinger, DOH, Director, LTC

KPMG

- John Druke
- Andrea Cohen

DSRIP Team:

- Betsy Lynam

WELCOME AND OVERVIEW OF THE MEETING: ACTING COMMISSIONER DELANEY

- We want to discuss a model today that may address some of the concepts and discussions raised at the last meetings, and how a new model can work for our system
- We want to continue to focus on the idea that the work we are focused on is anchored in the vision we have set for the future:
 - People with developmental disabilities will be accepted as part of our lives and communities, living the lives they choose and experiencing good health, growth, and personal relationships just like anyone else rightly expects out of life
 - Our focus is on the quality of the person's experience, and the outcomes the people we support have told us they want, including community living, employment, and self-direction.
- We selected and are committed to using managed care to realize this vision because we believe that fully integrated, quality services supported by networks of high performing providers with the flexibility to meet people's needs will get us there.
- We have focused on the DISCO model and we have shared with you some information on the infrastructure of the model, as well as the preliminary financial projections related to the model
- We have heard your concerns related to the administrative costs
- We are focused on 3 main components
 - Robust Care Coordination (Day 1)
 - Ability to Provide Integrated Coordination for All Service and Support Needs
 - Ability to Implement Value Based Payments (Day 1)
- Care coordination is a System. We are looking at a system of care coordination, not just the role of a coordinator.
- The model being explored involves an established managed care entity contracting with one or more DISCO / ACO, and Provider Network entities to deliver care coordination and other services.
- The model focuses on responsiveness and personal outcomes and builds a more flexible menu of service options to better support self-direction and community-based alternatives.
- The model utilizes value-based payments to incentivize outcomes and generate savings for reinvestment within the OPWDD system

JASON HELGERSON: A POTENTIAL ALTERNATIVE MEDICAID MANAGED CARE MODEL FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- We want to focus on a care management model that is person centered and gets us closer to a person centered system than we can get in a traditional Fee For Service (FFS) system
 - The Provider Network, as imagined, would be focused on Service Plan Development (within budget for the plan of support), Care Coordination, and establish payment methods including pay for performance for better outcomes
 - In turn, the MCO would contract with a DISCO, or other ACO, to provide care coordination and to ensure that individual needs are being met, as well as having the flexibility to design a person centered care plan
 - The overall goal is to have a more coordinated set of services
- We will continue to move forward with the FIDA pilot plan for the dually eligible population
- It is important to start conversations with CMS to discuss working with the dual population and how we can establish a partnership between Medicaid and Medicare
- Within this model, one of the key differences for the providers will be a shared savings agreement that would cut across the entire population under the DISCO and can be captured to share with downstream providers or to fill in service gaps for individuals who require additional support

- This will help us evolve away from a cookie cutter approach of service delivery and focus on what an individual needs to thrive and have greater flexibility to design person centered solutions
- There needs to be meaningful outcomes that providers are being held accountable for. We need to strive for better measures of quality that can be used to measure success in the system.
- Self-direction can and should be a fundamental part of this model. We want individuals to have all the opportunities for choice, including who provides their services

PANEL DISCUSSION: A POTENTIAL ALTERNATIVE MEDICAID MANAGED CARE MODEL FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- We want a program like this which, in very real ways, can give people control over their service planning
- We need to bring the DD community on board and there are ways we can do this better and continue to engage them
- We need to keep talking about sustainability and support around administrative efficiencies. There are opportunities to explore this further
- The model lets different providers, at different times, take on different elements of risk sharing. This model can support providers being at different points on the spectrum, which provides flexibility
- The move to bundled payments helps get away from some of these restrictions to providing more individualized care. The regulations need to be reviewed and changes should be considered. There are ACO regulations and there are some advantages to using these regulations. This may be more beneficial, rather than an IPA, to have a more formalized structure
- Right now we have a system of “have and have not’s” and different experiences in State and non-State or voluntary services. We have a system that has been a budget based allocation of services, as opposed to service allocation based on demand
- The variation in the model provides further rationale for how to get to a more equitable service delivery and this is a priority and should be included in the managed care contract
- That which is measured in the system will be what people focus on, and we need to determine that up front. Outcome measures for individuals with developmental disabilities should not be the same as the healthcare measures
- We want to have a comprehensive plan that looks at the holistic needs of the individual – health and developmental disability - and design a very person centered system for that. This will require providers to be more flexible and provide services in a new way and focus on a person centered care plan
- We need to continue to examine how care planning will work in this new model. There are a few moving parts:
 - MCO level is not familiar with this population
 - DSRIP is moving faster than OPWDD Transformation
 - CMS has requirements we need to follow
- An amendment to the current statewide 1115 waiver could integrate the OPWDD components into the rest of the program and make it part of the larger transformation, forgoing the need to seek a new Medicaid waiver
- We need to work on addressing the duals, and how the Medicare model will participate in the Medicaid models. There are concerns related to Medicare ACO models that are associated with savings being taken off the top
- We don’t know what an 1115 waiver means to our population and we need to articulate this better and share this with families. We need to talk concretely about what the advantages are
- With regard to the outcome measures, we need to articulate these, as a way to document and measure the benefit of those services

- There is some concern with the value based payment (VBP) methodology. The benefit of the VBP model is to quickly capture savings and efficiencies from better care coordination
- We could look at larger insurers who can help to capitalize more quickly – this would give us more flexibility on risk reserve and help with some of the financing
- The procurement approach needs to be further explored. We should look to partner with entities who have the experience and don't have a reserve problem and understand the model
- We should make sure the focus on capitation be on developmental services and not on medical services. We don't want to over stress the providers
- We don't want to institutionalize rate rationalization
- We want people to be accountable for outcomes
- We are still talking about voluntary enrollment for Day 1
- Key to this is the service gaps – we want to make sure the first priority is meeting the needs of people with service gaps. This is key to demonstrating progress and success
- We want to focus on outcomes and where OPWDD and DSRIP meet, and maintain a focus on person centered care
- Rate rationalization is rigid and driving us away from flexibility. The accountability on units of services takes time and resources and impacts the ability to move towards transformation/focus on quality and outcomes
- We should look at the unintended consequences of rate rationalization and we should be monitoring this. We don't want provider's viability to be threatened, and their ability to move forward into the new future to be reduced. We don't want providers to become insolvent. However, we need to get through rate rationalization and serve the 130,000 people served by OPWDD. If we can look at changes in regulations to make it easier, that helps - but we can't stop it and we need to get through it. We can continue to talk about how to work through this together.

OPWDD PRESENTATION: A POTENTIAL ALTERNATIVE MEDICAID MANAGED CARE MODEL FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

PLEASE NOTE: THIS HYPOTHETICAL MODEL IS FOR DISCUSSION PURPOSES AND ONE OF SEVERAL MODELS BEING CONSIDERED BY THE PANEL

1. ADMINISTRATIVE LEVEL – MANAGED CARE PLAN – FULL CAPITATION
 - May perform individual needs assessments
 - Develops total support budget for individualized plan
 - Pays providers per DISCO direction
 - Helps to enroll individuals with developmental disabilities on a voluntary basis
 - Establishes independent advocacy in conjunction with provider networks

2. NETWORK LEVEL – OPWDD PROVIDER NETWORKS (DISCO/ACOs) – SUB CAPITATION
 - Obtains services & supports according to individualized plan under agreement with Managed Care Plan
 - Coordinates services with member provider agencies
 - Establishes value-based payment agreements (tied to outcomes) with providers according to provider ability
 - Authorizes provider payment for Managed Care Plan

3. PROVIDER LEVEL – MEMBER AGENCIES
 - Provides services according to individualized plan
 - Achieves individualized outcomes/ creates value

- Receives payment per terms of value-based payment agreement with Network

PANEL DISCUSSION: A POTENTIAL ALTERNATIVE MEDICAID MANAGED CARE MODEL FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- With regard to shared savings we need to make performance metrics, and the DISCO, and all parties pre agree as to how savings are shared and how collectively we are holding each other accountable. We want to incent people to work together and achieve good outcomes
- Flexibility will help move people to independent living. It helps to change the dialogue and have a more flexible framework. We don't want to be focused on what a bed costs

NEXT STEPS:

- OPWDD to convene a small group to flesh out the issues related to the model explored in this meeting
- OPWDD to continue to meet with actuaries and work on costing
- Save the dates are being sent out for the listening sessions. These will be focused on testimony in a number of critical areas