



Transformation Panel

MEETING TITLE: Transformation Panel: System Goals

DATE/TIME: July 16, 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
- Sheila Carey
- Donna Colonna, Services for the Underserved
- Susan Constantino, Cerebral Palsy Associations of New York State
- Barbara DeLong, Parent
- Stephen E. Freeman, Freeman and Abelson Consulting
- Ann Hardiman, New York State Association of Community and Residential Agencies
- 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
- John Belmont for Rob Scholz, Deputy Director of Contracts, CSEA

Absent:

- Robin Hickey

OPWDD Staff:

- Neil Mitchell, Special Assistant to the Commissioner
- Diane Woodward, Statewide Assessment Coordinator
- Helene DeSanto, Deputy Commissioner, Service Delivery
- Joanne Lamphere, Deputy Commissioner, Person-Centered Supports
- Jennifer O'Sullivan, Director of Communications

Other State Staff:

- John Ulberg DOH
- Jack Stein DOH

KPMG

- John Druke
- Andrea Cohen

DSRIP Team

- Betsy Lyman
- Ryan Ash

WELCOME AND OVERVIEW OF THE MEETING: ACTING COMMISSIONER DELANEY

- Welcome and thank you for joining us today.
- We are working on sending out dates for the next sessions. We want to include pieces from the subcommittees. These meetings will probably run into September
- We are working on schedule for the public forums. Dates will be finalized in next few weeks.
- OPWDD is working with actuaries to complete a refinement of the financial models and respond to the feedback from the Panel. Further data and information is being included and we want to make sure it is accurate in all regards before it is released
- Our goals for today are to:
 - Review critical elements and models of managing care
 - Discuss the models and their advantages and limitations
 - Develop consensus about which model(s) to continue to pursue
- Three models we will talk about and discuss:
 - Health home model
 - ASO model (brought forward for consideration)
 - DISCO / ACO model
- The model to be adopted must have certain transformational elements
 - Care Coordination (Day 1)
 - Ability to coordinate all health and OPWDD Medicaid benefits
 - The ability to implement Value Based Payments (VBP) (Day 1)
- The State has committed 90% of Medicaid spending will be in Value Based Payments (VBP) in the next 5 years. We are having regular discussions with DOH and what that will mean for our services. We are starting to discuss those services. Any interim step we set up has to have the ability from day 1 to be able to implement VBP.

JOHN ULBERG: PRESENTATION ON THE DIFFERENT LEVELS OF VBP

- A fundamental aspect of how we are approaching managed care is a shift away from Fee For Service (FFS)
- At the end of five years we want to have a reimbursement system that pays for value and helping people reach their personal outcomes
- We want to capture savings and reward providers for providing good quality care and providing care in the right environment
- We have a number of examples related to primary care and how VBP works for primary care. For example, the delivery of a baby. This will include prenatal care and postnatal care. The event has a beginning point and an end point. A fixed amount of money gets allocated to the hospital and the incentive is to reduce total cost of care. The doctor and hospital can keep the savings of the bundle if they meet the quality metrics. And, the patient benefits from better care
- It is recognized we need to work on examples which apply specifically to the DD population, and non-episodic services that are required for a lifetime
- The goal of Value Based Payments (VBP) is to capture savings and reinvest back into the system
- Acting Commissioner Delany noted that there will be challenges in developing the right outcome measures for the DD population
- VBP is in its infancy – we are highlighting developments that are underway and this will not be something we can do to in one year – we have to determine the timeline that is right for OPWDD
- There are different levels of VBP and the different levels determine the payment structures and the levels of risk.
 - Level 0 is Pay for Performance and performance improves payment goes up.

- Level 1: Provider operates in a FFS environment and we set a benchmark for quality. An arrangement is made between the provider and plan as to how the savings are to be shared.
- Level 2: FFS environment, upside / downside risk, and shared savings. The provider takes on upside risk and gets more opportunity to generate savings.
- Level 3 is sub capitation in whatever environment is established – the providers are at full risk, whatever is saved is kept by the provider and there are ways to reduce risk and make sure we don't destabilize the system
- A roadmap for VBP with additional details and definitions is approved and published on the DSRIP website
- We have setup a series of workgroups to discuss the technical design and regulatory aspects, and an OPWDD workgroup will be set up.

VBP AND PANEL DISCUSSION

- To make this work we need to think practically about the regulations and administrative work requested and where changes can be made.
- New York State is at the cutting edge of Medicaid reform and VBP and using bundle payments. On the long term care side we see a real opportunity.
- If savings are realized but the provider is not meeting the quality benchmarks the provider will not get the bonus
- It is our job to look at where there is variation in spending and opportunities to improve care quality. Our job is to inform the market place on where savings can be generated and quality can be increased
- Members of the panel reminded everyone of the importance of staying cognizant of the language we use, it is still very healthcare focused and we think in terms of services and supports for individuals
- The Panel discussed that identifying outcomes and behavior health goals for the DD population is much more challenging. There are a number of areas and factors unique to this community that need to be discussed and considered. This is very different from the healthcare system
- It was noted that VBP should be focused not just on financial savings, but providing the flexibility of choice and improving the quality of care
- We need to stay focused on the goals we set out with, improving the quality of an individual's life.
- Families are concerned that the DISCO or other entity won't want to work with high risk individuals.
- We need to put safeguards in place to make sure this is not happening and monitor this regularly. Families need support, and to have a voice to make sure this is not happening
- Rates need to be risk adjusted, you can raise rates to help incentivize an underserved population
- We need people in the DD community to help determine the quality measures and outcomes for OPWDD services
- There is a concern families and individuals won't understand VBP and think we are just taking money out of the system. We need to communicate this well. We need to focus on the fact that there will be reinvestments and the goal is to improve quality of service and serve more individuals.
- First we need to define value and how we measure it, and then we can talk about financial incentives
- VBP can be used as a potential tool to increase the support and training of professionals and help improve the workforce

- We need to look at the regulatory reform that is required to help support this and meet our goals. That is a critical element
- We need to explore further how VBP impacts people who have unmet needs
- We need more research of what is going on in the DD world related to trends, needs, quality, desirable outcomes, etc. This is an important analysis. There is also value in constructing a feedback loop.
- We need a balance. We are not all satisfied with FFS, we know we can do more with the dollars, we can provide better care. There are many challenges and we need to have an on-going review and assessment of the impacts
- Going forward we should also look at impacts for the dually eligible population, and where we can derive savings from the Medicare side
- The Panel asked a few questions about how providers will enter into the VBP system.

DISCO ACO MODEL PRESENTATION

- A hybrid model, in which existing managed care plans coordinate with newly established downstream OPWDD provider network organizations was discussed
- Under this idea, the IDD population would be enrolled in managed care plans for coordination of their acute and long term medical care needs. Concurrently, the managed care plans would enter into arrangements with newly established OPWDD provider network organizations (i.e. DISCO) for coordination and delivery of DD services
- The managed care plan would be responsible for performing needs assessments and developing a budget for an initial care plan, as well as reimbursing individual providers and bearing the financial risk associated with covering their enrollees
- The OPWDD provider network organizations would be responsible for working within that budget to establish payment methods for DD services, provide Care Coordination, and induce pay for performance for better outcomes
- Later, we would expect progressively involved risk agreements between the managed care plan and the OPWDD provider network organizations (i.e. DISCOs) to meet performance goals
- Initial ramp up will be voluntary and linked to plan and provider network readiness; requiring demonstration of adequate network and enrollment
- MLTC would be capitated at a fully capitated rate. The benefits of the proposed model include:
 - Allows the Medicaid program to provide care coordination and management to people across the spectrum of OPWDD services and, ultimately, medical services
 - Leverages existing infrastructure of established managed care plans which, due to their size and experience, should be able to manage overall care and deliver benefits to individuals (through DISCOs) more efficiently than newly established entities
 - At the same time, care coordination system is anchored within experienced OPWDD provider networks
 - Could utilize 1115 Waiver authority, which allows for greater administrative flexibility to expedite implementation
 - Offers greater flexibility for service delivery and payment than current FFS system
 - Moves off of a FFS reimbursement system and provides an avenue to migrate to Value Based Payments
 - Positions the State for future possible inclusion of Medicare service benefits with potentials for additional efficiencies
- Considerations of the model
 - And BIP can help set up and get these up and running

DISCO ACO PHASE-IN PRESENTATION

- DISCO/ACO would be responsible for working within a budget to set payment for DD services, provide care coordination, and induce pay-for-performance for better outcomes
- The DISCO/ACO would assume the responsibility of coordinating care, and be incentivized to control cost due to potential opportunities for savings available under risk sharing arrangements with the upstream MLTC plans
- People voluntarily enroll in MLTC for coordination of their care needs
- Potentially provide financial incentive (e.g. enhanced rates) for providers to join a network

PANEL DISCUSSION:

- We need to focus on why this model is less expensive. For example:
 - There is an economy of scale – utilization, network development
 - The incremental administration costs can be less
 - Risk reserves and surplus requirements can be smaller by running it through an already established large plan
- The system is very large – we want to keep our eye on the system and avoid financial trouble. We need safeguards in place to monitor performance
- All plans that want to participate will have to go through a readiness assessment
- Administratively we want to have less plans to serve the number of people in the DD community, to focus the funding on service delivery
- This model is not the same as Health Homes model. This moves away from FFS and utilized VBP
- There is potential for the IPA plans to work under this model. They are seeing goals related to value
- With regards to an 1115 waiver, we need to understand the different levels of flexibility under the different models.
- Families are concerned the intention to save money takes funding away from service delivery even though no cuts to services are proposed. As mentioned before, this needs to be well communicated and addressed
- One of the things people like about the DISCO, is that it is a model with experienced people we know and like working with us. We have a lot of experience in our field and we want that to be part of our process
- A good thing about this model is that you may be able to get some trials or pilots in place with MLTC and IPA and engage more DD providers quickly
- OPWDD noted that they are working with actuaries to explore implementation costs.
- We control the level of risk reserves and how comfortable we can get on reducing them
- Incremental costs for new populations are higher and this should be explored further
- There is a learning curve for the adoption of new skill sets and this needs to be factored in

NEXT STEPS

- OPWDD will be asking for the Panel's help to develop this model further and discuss whether it should be pursued
- Additional meetings will be scheduled