



## Transformation Panel

MEETING TITLE: Transformation Panel: Managed Care III  
DATE/TIME: June 2, 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)
- 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
- Rob Scholz, Deputy Director of Contracts, CSEA
- Michael Seereiter, New York State Rehabilitation Association
- Seth Stein, Moritt, Hock & Hamroff (video)
- Arthur Webb

### Absent:

- Gerald Archibald, The Bonadio Group
- Nick Cappoletti, Developmental Disabilities Advisory Council Chairperson, Parent

### 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
- Kate Marley, Director, Waiver Management
- Meghan O'Connor, Deputy Commissioner, Quality Improvement
- Jennifer O'Sullivan, Director of Communications
- Eric Harris, Data Analyst

### Other State Staff:

- Robin Hickey, Developmental Disabilities Planning Council
- Lou Raffaele, Division of the Budget

### KPMG

- John Druke
- Andrea Cohen

## **WELCOME AND OVERVIEW OF THE MEETING: ACTING COMMISSIONER DELANEY**

- Welcome and thank you for joining us today.
  - At the past meetings of the Transformation Panel we have been talking about how to better implement some of things we are trying to do, for example helping to get more people employed, and improving self-direction to help people take control of their services
  - Managed care is the platform to help people achieve the goals they are seeking
  - The transition to managed care is underway and today we are going to look at some of the policy pieces
  - Today we will discuss a financial snapshot
  - We will use this to better understand what the policy discussions are that we want to have with you, the impact this will have on the overall costs, and our ability to serve people with developmental disabilities
  - We will discuss one estimate based on a snapshot in time based on certain assumptions about the care coordination model
  - We anticipate that panel discussions will help us refine our assumptions about the financial model, and help us identify the policy decisions we need to make to help us shape the program
  - We see this as a beginning point to give you something to react to
  - We need to talk about the strategy of how we move forward and the potential for a subcommittee to help with some of the elements, and explore in more detail some of the program design details
  
- **THE FOLLOWING NOTES PROVIDE A SUMMARY OF THE DISCUSSION THAT TOOK PLACE RELATED TO THE BENEFITS OF SYSTEM CHANGE**
  - Overview of the System Changes: Presentation by JoAnn Lamphere
    - The benefits of system change include:
      - Increased satisfaction and choice through person-centered planning
      - Connecting individuals to the services that they need, especially services across systems
      - Supporting meaningful outcomes
      - Increased program efficiency to support compelling system needs. This is a way to make sure we can achieve the right efficiencies to be able to meet the needs of the people we serve
      - Reduce the complexities in the current system and increase flexibility in service structure
      - NYS historically spends significantly more on services than others states. This is a significant portion of national expense: 18% of the Federal Medicaid budget is spent on developmental disability services nationwide
    - Comparing the benefits of managed care to the status quo:
      - More flexible service structure, will better support adaptive technology
      - Potential expansion of and access to providers (network adequacy – have robust providers to meet the needs of people)
      - More individual protections. Managed care entities will have their own grievance and appeals process that will come in first. OPWDD will look at the data of how issues are resolved before they come to a hearings process
      - Referral and authorization processes will be more efficient

- Health information technology will facilitate communication and analysis and problem identification – the care coordinator will provide oversight to ensure the person has their needs met by providers
  - Improved data integrity for quality monitoring and transparency
  - Value based payments, facilitating better outcomes, can be implemented through managed care
  - Enhanced benefits and identification of community resources
- I-DD Total Medicaid Costs of Care \$7.7b (Medicaid only)
    - 61% of this funding goes to certified residential services
    - Some of the people need more intensive services than others
    - Are there ways we can invest more in other services to help free up resources for people who truly need more intensive levels of care? This needs to be carefully examined
    - We can influence costs with care coordination by ensuring people get the right support at the right time
- The challenges of modelling costs and savings
    - There is limited history and experience with managed care for OPWDD services
    - Experts can disagree about key assumptions
    - Costs will vary based on different policy decisions
    - The value of potential efficiencies, including diversions from unnecessarily higher levels of services, can change based on assumptions
    - This is not about seeing less services for people – but seeing more of the right services for people
    - There are a number of key assumptions
    - Many people are interested in employment and looking to live more independently and this factors into the cost modellings – however this does not mean we won't need certified settings for people who need them
    - We have made the assumption that there will be voluntarily enrollment into managed care
    - There will be up front expenditures required for technology to help with care coordination
- Care Coordination Policy Considerations
    - There are a wide range of needs. This requires a targeted care coordination model
    - We need to determine the “right” model, including the level of staffing, the types of services, the qualifications of delivery staff, and the balance of clinical staff and program staff
    - This model assumes healthcare services are brought into managed care
    - We want a holistic approach to services
    - Costs will be driven by different behavioral needs and abilities
    - The panel noted that some states have treated care coordination as a separately funded service, not as administration or clinical costs .We will have to be sensitive about this as it relates to the new rules from CMS

— Overview of Managed Care Estimated Impact: Presentation by JoAnn Lamphere

- For our discussion purposes we made a number of assumptions to illustrate a “Year 5” mandatory enrollment program; that is, we are taking a snapshot of what a Year 5 would look like if we transitioned from voluntary to mandatory enrollment during the 5-year timeframe
- The numbers can and will change based on our discussions and the policies that are ultimately implemented
- This illustration will help us have a high level discussion on costs and reinvestments
- To understand these costs we had to develop a baseline of the number of people being served. This needs to be further refined
- It is important to define, in simple language, what the eligible services are under managed care
- The number of DISCO(s) and FIDA(s) that will be running may change. This can impact the costs of the program
- A per member per month calculation was used.
- The cost components for managed care include:
  - Administration (staff, IT, finance and administration, network management, claims adjudication, etc.)
  - Resource Management
  - Care Management
  - Risk Contingency: representation of what the insurance department requires to keep in reserve
- We need to make sure we are funding efficiently to help us with the investment required and we want to talk to the Panel about where spending should be focused
- The DISCO will provide the managed care administration.
- More people taking advantage of integrated services will reduce the cost of service delivery
- There is a focus on diverting to other models of care as opposed to assuming people will automatically move into full-time day habitation
- Costs can also be saved through providing preventative care, and helping people stay out the emergency department

— Overview of Managed Care Estimated Impact: Panel Discussion

- The Panel noted that service demand can’t only be based on past trends. For example, there is an increase in young children with autism. We need to plan for the future.
- It will be important to analyze data from the Front Door so that we know who is coming into our system.
- The panel also noted it is important to account for people who are currently waiting for services, and the impact this will have when they move into managed care. This can be an increase in the capacity that we serve today
- Enrollment analysis is an important exercise and needs to be completed
- There are different costs related to starting the program and sustaining it. Year over year these costs may change. It is important to understand the difference between investment costs, and the costs to sustain the program
- The savings from the managed care model will be reinvested into service delivery

- Evaluating Managed Care Assumptions for OPWDD Services Discussion: Panel Discussion:
  - The Panel understands that assumptions have to be made to develop cost estimates. It would be helpful to have definitions and further clarity on some of the cost categories and assumptions, for example reserve funding
  - Further analysis is required on how managed care will result in savings and how those savings will be reinvested
  - There should be a subcommittee to discuss care coordination and the different cost drivers and how managed care impacts and relates to workforce, health homes, etc.
  - We don't want to take money out of the system, we want the flexibility to be more creative and responsive to spend money in the right way. We want to people who can transition into a community based setting being given that opportunity
  - We want to see a mix of service options
  - We need to work with families on the ground to help prepare for the transition to managed care
  - There are many questions related to advocacy and self-direction within managed care. More information for families is required to better explain how this will work. We want the individual to be at the center of planning
  - Affordable housing options are an important component of success
  - It is important to communicate benefits and changes in clear language so that everyone can understand
  - Families need to know who they can call with questions and concerns
    - Should we revisit the role of the Regional Liaison?
  - It is important to have measures that can determine an increase in satisfaction
  - If someone comes to the DISCO and requires a certified service, the DISCO is required to provide it. We need to further explore what this looks like and how services will be delivered
  - There will be a need for strong oversight at the DISCO level to help achieve high levels of satisfaction

#### **NEXT STEPS**

- Establish a subcommittee on care coordination
- Establish a subcommittee on workforce
- OPWDD to provide additional details on definitions and assumptions related to the cost categories
- Explore the regulations and changes required to achieve the necessary flexibility
- Continue to develop a regional communications strategy to be rolled out – we want to hear what people have to say and document it