Access and Choice Design Team Meeting Summary

Access and Choice Design Team	**Date of Meeting:** July 29, 2011

Present:
Joe Gerardi; Gerald Huber; Lauren Lange; John Maltby; Maryellen Moeser; Chris Muller; Chris Nemeth; Wendy Orzel; Bradley Pivar; Bob Vasko; Barbara Wale; Al Coley; Roger Sibley; Anne Swartout.

Absent:
Shameka Andrews; John Gleason; Shelly Okure; Peter Smergut

Discussion Topics	**Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.**
Welcome and Background:	• Meeting objectives: to describe and define the essential aspects of individual choice that should be integrated into the People First Waiver and address the charter question, "what aspects of individual choice should be built into a care management model for individuals with developmental disabilities?" • The team reviewed the July 13th Access and Choice design Team discussion and approved the meeting summary with the following minimal changes: Roger Sibley was absent during the July 13th meeting. A team member pointed out that the term "managed care" was not used throughout the meeting but it was acknowledged that team members have been using "care management and "managed care" interchangeably. • The team was informed that the Commissioner's interviews with experts to discuss Accountable Care Organizations (ACOs), Behavioral Health Organizations (BHOs), Program for All Inclusive Care for the Elderly (PACE), and Managed Long Term Care are available on the OPWDD People First Waiver website:

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	http://www.opwdd.ny.gv/2011_waiver • Maryellen, Anne, and Jerry presented some brief updates on the work of the other design teams and technical workgroups as follows: Quality: The Quality Design Team is working on a matrix with six domains which will help agencies to self-assess quality outcomes and operations and perform continuous quality improvement. The thinking is that OPWDD would review against the domains to ensure that agencies are meeting individual's needs and quality outcomes and that health and safety standards are met. An agency ultimately would have a rating between 1 and 5 based on these reviews. The lower the score, the more oversight that an agency would have. Fiscal: The design team has been looking at other states and Managed Care Organization (MCO) components that may be appropriate for the People First Waiver framework. Services and Benefits: Several additional technical workgroups are being formulated: employment, self-direction, and services for institutional transition. Care Coordination: The team is identifying components that are necessary for a care coordination program and starting to put together implementation recommendations. Assessment tools subgroup: All assignments are in. The material will be compiled for the August 16th Access and Choice meeting. Everyone was to look at a specific assessment tool and complete a template to answer questions about that tool. On July 16, 2011, the team had a presentation on the Health Risk Assessment Tool, a web based health tool used for early identification of health risks for further assessment. Hope Levy, a team member who is on the Care Coordination Design Team, will be reviewing this tool in more detail and reporting back.
Background on Care Management:	• To set the stage for discussion on choice in care management, the team reviewed and discussed PowerPoint slides describing "good care management" and how "good care management" can improve the lives of individuals and families through an integrated approach to long-term care and health care that takes into account the whole person rather than focus on distinct and separate domains of an individual's life. It was also discussed

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	that "good care management" can serve to expand choice, flexibility and options available to individuals. This is because payment is based on the delivery of outcomes in a capitated payment model, as opposed to "fee for service" which pays for activity regardless of whether outcomes are achieved. • The Medicaid Redesign Team (MRT) concept of "care management" was also explored: "Care management applies systems, science, incentives, and information to deliver care that best meets [individuals'] comprehensive physical, behavioral and social supports needs effectively. The goal of care management is to improve coordination of care while providing cost effective, non-duplicative services," and to ensure that emphasis is placed on the whole person as opposed to only certain aspects.

Context on Choice, Self-Direction, and System Challenges.
 	
Strategies and Tools in other states to Enhance Choice and Flexibility.
	• Context on choice, self-direction and system challenges was used to set the foundation for discussion and recommendations. Key areas of discussion (see July 13th PowerPoint for further information):
	  • Design team parameters relating to choice and self-direction
	  • OPWDD commitments related to improving choice from public materials thus far (see Worksheet 1)
	  • Dignity of risk and informed choice
	  • Challenges relating to choice in the current system including administrative practice that sometimes inadvertently limits choice, lack of available options depending upon geography, antiquated reimbursement/payment methods that can sometimes limit flexibility and portability for people, etc.
	  • Self-direction as a variety of approaches to

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	move decision making closer to the individual including budget authority and employer authority. • Maryellen Moeser and Lauren Lange presented PowerPoint slides containing information from other states with managed care that utilize various strategies to enhance choice and flexibility. Specific areas of focus included TennCare CHOICES in Long-Term Care (Tennessee); Arizona Long-Term Care and the Self-Directed Attendant Care Option (Arizona); and Vermont's Flexible Family Funding approach, shared living, rewarding work registry, and continuum of self-directed service options (see July 13th PowerPoint).
Worksheets 1 & 2:	• The team reviewed the worksheets that were sent to them in advance of the July 29th meeting. Worksheet 1 served as a supplement for facilitating recommendations regarding OPWDD's commitments to choice; Worksheet 2 served as a blueprint for stimulating recommendations concerning the essential aspects of individual choice that should be incorporated into the 1115 waiver. • **Key questions**: (1) How should independent advocacy be designed to ensure individuals can make informed choices? (2) What do we need to ensure is included in the People First Waiver and the Care Management/Managed Care Organization Contracts so individuals have appropriate choices and flexibility to best meet their individualized needs?
Preliminary Recommendations related to choice in a care management environment:	The team engaged in discussion regarding Worksheet 1 and 2 and made the following preliminary recommendations outlined below. Due to the importance of this topic and time limitations, workgroup members were asked to complete their worksheets in writing and return to

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Maryellen Moeser so that the final recommendations of the team related to choice could be reflected comprehensively in the worksheets (due August 5th).

Concept of Informed Choice as an Outcome and Quality Indicator:

- The team agreed that the concept of informed choice should continue to be a goal and an outcome for all individuals in the People First Waiver. The team further recommends that care management/care coordination entities be assessed for their ability to help people make informed choices and deliver on those choices as part of the quality indicators/outcome measures that OPWDD uses to measure quality of care management/care coordination. The system must not confuse the means (services/benefits) with the ends which should be a focus on creating support for individual goals through informed choice and person-centered planning. The following is the description of informed choice as endorsed by the team:

  "A person has made an informed choice when he or she has made a decision based on a good understanding of the options available and a good understanding of how that decision may affect his or her life.

  A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the person needs help making a good decision. Informed choices can be about everyday things like what to wear, or big life changing things like where to live, what kind of work to do, or who to be friends with. These decisions can also be about what kinds of services or supports someone wants or needs, and where and how to get them.

  When making an informed choice, a person should understand the risks involved and what can be done to reduce the risks. A person should also realize that his/her ability or desire to make choices may change over time, or may be different for different kinds of decisions. Personal choices should be respected and supported by the people involved in the person's life."

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	Self-direction: • Studies have shown that people who self-direct their supports/services typically drive less spending than similarly situated individuals who do not self-direct their services. The team strongly recommends that self-directed services with **"budget authority"** (person exercises decision making and responsibility for a budget from which they can choose waiver goods and services authorized in their plan) and **"employer authority"** (person exercises choice and control over workers who furnish supports and services by selecting and supervising them) be offered to all individuals in the People First Waiver as an option. Care management entities that are unable to offer a full range of self-directed service options should not be considered as OPWDD contractors. • The team also notes that it is important for people to know the cost of providing services as this knowledge will likely lead to more responsibility and accountability by families and individuals when making decisions about options. As a result, the team recommends the utilization of a **prospective individual budget methodology** that includes some ability to "bank" unused dollars for when they are needed by the individual (see flexible funding below). • Build on successes of Consolidated Supports and Services (CSS) and use the People First Waiver opportunity to simplify and streamline so that all can benefit and take advantage of self-directed services to the extent they choose. • The overall framework for self-direction needs to be extremely flexible. For example, individuals and their circles of support should be able to establish the pay rates for their own self-hires so that they can recruit and retain the best staff possible for their unique needs. Individuals should also be able to hire relatives, neighbors, and family members easily within parameters that are in the best interests of the

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	person. • A viable system to identify individuals that would like to work with people with developmental disabilities should be established—a team member identified this as a "purchasing pool". The Rewarding Work Registry used by Vermont and other states could also be a starting point to facilitate this. There also needs to be a back-up support system established for people who self-direct that can be used when self-hires are unexpectedly not available. This could also be a component of a registry. **Person-Centered Planning and Assessment:** • The group strongly recommends that there be a <u>real</u> commitment to person-centered planning in this waiver. Under the current OPWDD system and through the Medicaid Service Coordination model, it often seems that there is more of a focus on the list of services that can be offered/provided rather than a focus on developing and implementing a person-centered plan that moves towards and results in individualized outcomes. The current system objectives seem to be more transactional, for example, helping the person to get waiver enrolled, and to enroll in specific services from the list available rather than looking at the goals the person wants to achieve in their lives and helping them to utilize community and natural resources as well as traditional services to get there. • In order to ensure a real commitment to person-centered planning and person-centered outcomes as a driving force in this waiver, the team recommends that **adequate resources** be devoted to changing the overall culture and paradigm to one that **values and incentives person-centered** planning and person-centered outcomes. • The group recommends that that there be a formal vehicle for person-centered planning built

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	universally into the waiver and that this thread be carried through all aspects that touch the person from the single point of entry through a "No Wrong Door" to the needs assessment process through agency quality performance measurement. Person-centered planning/outcomes should be a continuous quality element expected of care management and be integrated into contract language. • The team also recommends that any needs assessment adopted through the People First Waiver, start from a person-centered strengths based approach—e.g., conversations and identification of the strengths and preferences of the person and their desired outcomes as well as the needs of the person. • Every individual should have the right to a real and viable person-centered plan based on at least the following: 1. The results of a valid needs assessment process that is independent from service provision and is built upon a person-centered strengths based perspective; 2. Meaningful input of the individual and their chosen circle of support and reflective of the cultural considerations of the person; 3. Availability of independent advocacy/oversight (such as an ombudsman, enrollment/support broker, non-profit advocacy representative, OPWDD staff etc.). In addition to guarding against conflicts of interest from provider self-referral, the presence of an advocate/oversight entity will help ensure that individuals are aware of all available options (i.e., informed choices) and are not wrongfully persuaded. 4. Opportunities for updates and discussions at the request of the person or when needs and individualized circumstances change

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5. Formal and informal strategies and processes to resolve any disagreements that arise in the process
6. Informed Choice (as defined above) every step of the way

- In order to implement this system paradigm shift to person-centered outcomes at the individual and systemic level, extensive training in person-centered planning techniques should be incorporated and person-centered planning certification should be required within the new system—national experts such as Beth Mount or John O'Brien could be utilized to initially develop a formal system/training program that would be required for care coordination staff and others responsible for the person's comprehensive plan. This should also be incorporated into contract language and demonstrated through quality review.

Flexible Funding for Individuals to Enhance and Facilitate Choice:

- As OPWDD has committed to use of more flexible payment systems within a care management environment that allows more individual choice and flexibility, the team recommends the following:

  - Individual access to **flexible funding** so that individuals/families can use what is needed when it is needed without having to fear that funds will not be there when needs change. It was discussed that individuals/families need assurance that if they are keeping loved ones at home while parents age, that there will be options available to their loved ones when they no longer can care for them—this fear often drives people to take what they can get now rather than hold off until they really need the placement/services. In addition, for self-directed services, the team recommends a prospective budgeting methodology that enables

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	advanced notice to the individual of funds available to them and enables them to "bank" unused funds for when they may be needed in the future due to changes in needs/circumstances. - There is a need for an **emergency fund pool** that bypasses lengthy screening/application processes in emergency and crisis situations. - Individual/family **financial incentives** should be developed to encourage movement from costly settings to less restrictive settings and to encourage conservative options and other valued outcomes of the system such as shared living, employment outcomes, etc. - **Flexible funding** such as Vermont's Flexible Family Funding model which offers stipends on a sliding scale to be used at the discretion of the family for any legal goods and activities such as respite, assistive technology, home modifications, individual/household needs, recreational activities, etc. should be developed to enable individuals and families to live together. This model could also be adapted for shared living arrangements and other types of non-certified residential/service options. • The system needs to have great latitude on how money is spent as long as it can be demonstrated that those expenses correlate to outcomes that the system supports. This may mean less reliance on "services" and more benefits from participation in a wide range of community activities. **Independent Advocacy:** • The team acknowledged that there must be a formal mechanism for independent advocacy in the People First Waiver given that care management entities will be delivering or contracting for care coordination

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	as well as service provision to individuals who are members of the care management entity. Individuals should be able to freely choose their advocate(s). • An unanswered question is whether we can utilize grassroots advocacy rather than "institutionalizing" the advocacy function. An option to consider is a network of peers (volunteer and paid). • The team agreed that there should be a neutral appeal agency to advocate for individuals in the event of disagreements with care management entities/care coordination/service providers. This could be a possible role for the state. • The team also acknowledged that "advocacy" for individuals served should be a quality expectation throughout the People First Waiver including for care management, care coordination, contracted service providers, etc. The team recommends that this be added/integrated into a quality domain on the matrix being developed by the Quality Design Team. **Overall Care Management/Care Coordination Structure:** • Individuals should have the choice of at least two care management providers within geographic proximity. To facilitate and enhance choice, diverse provider networks should be encouraged at the onset of implementation of the 1115 waiver. A continuum of care through these networks can provide varying levels of choice for individuals with varying preferences and abilities. • Consider the concept of an independent enrollment broker at the point of entry to the system. There needs to be tools to help people make informed choices about care management/care coordination. • MCOs should be <u>required</u> to subcontract with other providers if they are not able to provide supports that

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	meet an individual's personal/cultural preferences. Do not create a "closed shop"—offer opportunities for individuals to go out of the care management network for choice of providers and self-hires. • Consider establishing a shared risk/risk sharing mechanism where all providers would pay into a pool. This could allow a greater diversity of providers to flourish. Question the assumption that bigger providers are better providers. • Incentive movement out of certified settings (when such placements are more restrictive than necessary). Incentive person-centered planning/person-centered outcomes, advocacy, inclusion, and process/delivery of informed choice. Incentive provider response to community and system needs. Incentive self-direction to encourage movement from certified settings when appropriate (with appropriate supports for individuals). Pay less for "custodial" day habilitation. • Accessible language should be used to communicate with individuals (i.e., preferred language, simplified English, non-verbal demonstrations such as diagrams, drawings and/or sign language). • The circle of support model should be maintained, however there should be an option to waive the requirement of having specific individuals in one's circle. • OPWDD should develop appropriate terminology to replace care management/managed care that reflects the philosophy and the commitments of the 1115 waiver (e.g., DDISCO – Developmental Disability Individualized Support Organization). • OPWDD should develop oversight protocols to make sure care management entities do not exert too much control that ends up limiting individualized

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	choice and options.
Next Steps and Action Items:	**Action Items**: 1. Final recommendations for the July 29th meeting are due August 5th, 2011 to Maryellen Moeser. 2. Assessment Tools technical subgroup report to be compiled for the August 16th meeting by Maryellen Moeser using assignment materials prepared by subgroup members.

Meeting Resources/Sources:

http://content.healthaffairs.org/content/16/4/194.full.pdf

http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1300.pdf

http://www.azahcccs.gov/shared/Downloads/SDACbrochure.pdf

http://www.ddas.vermont.gov/ddas-programs/programs-dds/programs-dds-addl-webpages/programs-dds-management-options

http://www.ijic.org/index.php/ijic/article/view/URN%3ANBN%3ANL%3AUI%3A10-1-100322/160

http://www.ddas.vermont.gov/ddas-publications/publications-dds/publications-dds-documents/dds-publications-other/shared-living-individual-home-supports

http://www.ddas.vermont.gov/ddas-policies/policies-dds/fff-guidelines

CRS Report for Congress, Long-Term Care: Consumer-Directed Services Under Medicaid. http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/rl322191212005.pdf