



Centers for Medicare & Medicaid Services Questions and Answers

June 2011



Courtney Burke
Commissioner



Andrew M. Cuomo
Governor



Nirav R. Shah, M.D.
Commissioner



This document responds to the Centers for Medicare & Medicaid Service’s thoughtful questions regarding the reforms planned within New York’s developmental disability service system. We are committed to achieving immediate reforms to address our mutual need for transparent funding, and longer-term, carefully planned system changes to achieve programmatic innovations for individuals with developmental disabilities in a care management environment. Our responses are predicated on a waiver that is structured in four phases.

- During the first phase (Year One) of the People First Waiver New York State will work diligently with CMS to initiate a revised institutional rate for its developmental centers (state-operated, campus based ICF-DD programs). This initial phase will also be devoted to the completion of a comprehensive planning process, which engages a full array of stakeholders. This process is now underway and will result in a detailed implementation plan and report to CMS at the conclusion of the first phase.
- During the second phase (Year Two) of the People First Waiver, New York State will implement regional pilot programs that will test methods of organizing care for individuals with developmental disabilities, which are responsive to the recommendations developed during the planning phase of the waiver.
- The third phase (Years Three and Four) of the waiver will begin statewide expansion of those methodologies demonstrated by the pilot programs to be the most successful at furthering person-centered outcomes for individuals with developmental disabilities while better integrating services and enhancing care coordination.
- Finally, it is New York State’s intent to use the entire five-year period of the waiver to develop the programmatic expertise and provider capacity needed to initiate a PACE-like program model that incorporates the full spectrum of medical and developmental disability specialized services into a single, integrated comprehensive service delivery system which integrates Medicare and Medicaid financing.

Introduction

1. The introduction states that New York desires to restructure the current system of care for developmentally disabled (DD) individuals. The concept paper does not fully describe how the system operating under an 1115 waiver would differ from the current system. How does this proposal differ from the F-SHRP demonstration?

Based on the recommendation of the Medicaid Redesign Team, New York State has obtained statutory authority with the enacted 2011-12 budget to begin the transition of long-term care services to a care management environment. Because of the need to develop appropriate program features to address the diverse and unique needs of individuals with developmental disabilities, it is New York’s intent to establish an exemption period before individuals served by the New York State Office for People with Developmental Disabilities (OPWDD) transition to mandatory enrollment in managed long-term care services. The People First Waiver is the vehicle that New York State will use to develop the necessary program features of individualized services in a care



management environment for people with developmental disabilities and transition the existing service system from the fragmented fee-for-service environment in which it now operates to a more organized system of care. While the term of the waiver will provide opportunities for collaborative discovery and design – some key features will guide this work:

- Creation of simplified, sustainable supports for individuals and their families that maximize community living, work, and self-determination; and
- Ultimately, a coordinated, comprehensive system of services that marries acute and preventive healthcare with the more specific supports and services designed for people with developmental disabilities.

2. Please describe the opportunities this demonstration may present to make or sustain systemic improvements to the State's ability to ensure strong quality services to individuals with intellectual and developmental disabilities.

OPWDD and the New York State Department of Health (DOH) began the process for improving quality by first conducting an extensive statewide series of informal listening sessions and more formal public forums to receive input on system redesign options. This input will inform the work of five design teams. One of these five design teams will specifically focus on quality and will make recommendations that are incorporated in all phases of the People First Waiver. (More description of the public input and design team process is provided in response to question 3, [Five Year Plan](#).) In addition, as described later in this document (question 2, [Five Year Plan](#)), the quality framework for the 1115 waiver will incorporate the immediate reforms that OPWDD is now putting in place to strengthen the State care and oversight system as well as a comprehensive continuous quality improvement system.

New York views the 1115 waiver authority as an opportunity to restructure its financial base to support quality improvement efforts and make significant structural changes that are needed to support the growing numbers of people with complex needs in more diverse community settings. Restructuring care coordination and looking at assessment and allocation processes provides an opportunity to redirect State resources toward quality system management and the provision of highly specialized care for individuals with intensive treatment needs. While decisions are not yet final regarding the role of the State in service delivery, there is a clear focus on enhancing quality management in all discussions regarding the development of the People First Waiver.



3. In addition to addressing institutional utilization, please provide information on strategies that the State will use through demonstration to ensure person-centered systems of care for individuals regardless of their service setting (ensuring strong person-centered approaches in any setting, including community-based group homes).

The promotion of person-centered systems of care is a central tenet of the work of all the People First Waiver Design Teams. Strategies the design teams will explore include the development of metrics to assess the degree to which person-centered principles are used in developing plans of care, use of more flexible payment systems within a care management environment that allow more consumer control over choice of care and providers, publication of customer satisfaction measures that indicate the degree to which person-centered principles are used by providers, and reimbursement methodologies that ensure portability and choice.

It is New York's intent that throughout each phase of the waiver individuals with developmental disabilities will have choice between plans, and that within these plans individuals will also have choice of providers and ample opportunities for self-direction including both individual employer and budget authority. New York will take steps to ensure there is an appropriate diversity of providers, in line with individuals' interest in aligning their cultural, community and family histories with a provider of their choice. The implementation plan to be submitted to CMS at the conclusion of year one will include a full description of the strategies that New York State will use to ensure person-centered systems of care.

4. The population breakdowns need to be refined.

- a. Please provide a specific discussion of individuals currently served through the Medicaid program (including those in HCBS and outside) who will be included in this demonstration. Which current waivers would be affected? Please provide additional information on currently non-Medicaid individuals who will be included in the demonstration**

The People First Waiver addresses the service needs of two distinct, if somewhat overlapping populations. These are outlined more explicitly below:

- 1) Medicaid Services to Individuals Eligible for OPWDD Services under State Law.** There are approximately 100,000 individuals eligible under State law for services overseen or certified by OPWDD. Virtually all such individuals also meet ICF level of care eligibility criteria. Presently, these individuals may be receiving HCBS waiver services, ICF/DD services, skilled nursing facility services or community long-term care services under NYS Department of Health (DOH) sponsorship (see answer to "d" below for a more specific breakdown). Such individuals and the services they receive shall be the main focus of the direct Medicaid services funded under this proposed waiver. New York State is currently in the process of further refining the target population for the People First Waiver.



However, individuals currently served in the OPWDD Care at Home Waivers (III, IV, and VI) and the OPWDD Comprehensive Home and Community Based Services Waiver will be subsumed in the People First Waiver. We are also evaluating the potential impacts on people with developmental disabilities currently served through other NYS HCBS waivers, including the Long Term Home Healthcare Waiver, the Bridges to Health Waiver, Care at Home Waivers administered by the DOH, the Traumatic Brain Injury Waiver, and the Office of Mental Health (OMH) Children's Waiver.

- 2) Individuals who will receive Safety Net Services.** The current federal-state rate agreement for setting OPWDD institutional rates permits retention of allowed costs in excess of actual costs as institutional capacity is reduced. Although this rate setting concept was critical to development of the State's current community based service structure, we acknowledge the current agreement requires modernization. New York State proposes the creation of a Safety Net Pool to fund non-Medicaid services presently supported through the revenue in excess of cost in State delivered Medicaid services. The population to be served through the Safety Net Pool will be broader based and will include individuals served by the Office of Mental Health (OMH) and the Office for Alcoholism and Substance Abuse Services (OASAS), as well as OPWDD. We are currently working on a population estimate for Safety Net Services. Please see [Immediate Reforms #5](#), for a description of safety net services.

- b. The percentages of growth are broken down but need to be delineated, e.g. the 22 percent growth of two or more medical conditions, does this include the psychiatric diagnoses which have doubled? Also, Autism diagnoses have grown by 500 percent but what percent of the population served have an Autism diagnosis?**

The count of medical diagnoses is separate from psychiatric diagnoses and includes the following categories based on OPWDD needs reporting:

- Respiratory - e.g. asthma, emphysema, cystic fibrosis
- Cardiovascular – e.g. heart disease, high blood pressure
- Gastro-intestinal – e.g. ulcers, colitis, liver and bowel difficulties
- Genito-urinary – e.g. kidney problems
- Neoplastic disease – e.g. cancer, tumors
- Neurological Diseases – e.g. MS, Organic Brain Syndrome, ALS, Huntington's Disease).

Individuals with an autism diagnosis constitute approximately 17% of total individuals eligible for OPWDD services who are enrolled in Medicaid. While we expect the People First Waiver to improve services to these subpopulations of individuals with developmental disabilities, the scope of the Waiver is comprehensive and targets the much broader population of individuals eligible for OPWDD services who are enrolled in Medicaid.



c. Are the 80,000 individuals receiving community-based habilitation services currently participants in a 1915(c) waiver? If they are in the current DD waiver, will they remain in that waiver or be serviced through the People First Waiver?

The 80,000 individuals referenced receive services through OPWDD’s large waiver and through Medicaid via other home-and-community based options (see response below #4d). These are individuals who are eligible for OPWDD services but are presently served through non-institutional long-term care programs overseen by DOH, as well as individuals with developmental disabilities currently served within OPWDD’s waivers and other HCBS waivers including: the Long-term Home Healthcare Waiver, the Care At Home waivers operated by DOH, the Traumatic Brain Injury Waiver, and the Bridges to Health waiver.

d. Are the 100,000 DD individuals receiving community-based long term care services currently participants in a 1915(c) waiver? How many individuals is this? If they are in the current DD waiver, will they remain in that waiver or be serviced through the People First Waiver? Are the 20,000 individuals currently Medicaid eligible, but receiving no HCBS services or are they non-Medicaid eligible individuals?

There are approximately 100,000 individuals eligible for OPWDD services who are enrolled in Medicaid. This constitutes our working definition of the target population who will receive direct Medicaid services funded under the People First Waiver. (Please understand, however, that there are some smaller subpopulations –especially those currently receiving services under 1915(c) waivers not operated by OPWDD—that New York State may recommend be excluded from the final definition of individuals served under this particular waiver.) The approximate 100,000 figure includes:

- Approximately 1,260 individuals served in institutional ICF-DD’s (i.e., state-run developmental centers and special residential units).
- Approximately 1,900 individuals served in skilled nursing facilities overseen by NYS DOH.
- Approximately 350 individuals in a variety of other institutional settings (specialty hospital, child care facility, psychiatric center, residential treatment facility for children).
- Approximately 6,000 individuals served in community (small model) ICF-DD’s,
- Approximately 66,000 individuals served in OPWDD’s large HCBS waiver and the three smaller OPWDD “Care At Home” 1915(c) waivers.
- Approximately 1,400 individuals served in the DOH long-term home healthcare waiver, and



- Approximately 25,000 individuals who currently access a variety of other Medicaid-funded supports including: personal care, certified home health agency, private duty nursing, adult day healthcare, early intervention, school supportive health services, long term specialty clinic supports, and services funded through a variety of 1915(c) waivers not identified above. A portion of this group includes individuals currently receiving only traditional healthcare services funded through Medicaid (with or without concurrent non-Medicaid “Safety Net Pool” services).

As indicated above in “a”, the population for Safety Net Pool services will be broader and will include individuals served by other New York State Mental Hygiene agencies (i.e., the Office of Mental Health and the Office for Alcoholism and Substance Abuse Services), in addition to individuals served by OPWDD. New York State is currently developing an estimate of distinct individuals to be served by the Safety Net Pool.

- e. Please provide additional specificity regarding age distribution of the population as well.**
Please see table below:

Age Distribution Individuals Receiving Direct Medicaid Services Through People First Waiver (Based on SFY 09-10 Medicaid Data)			
Age Category	Member Months	Member Years	%
Age 00 to 10	124,804	10,400	10%
Age 11 to 20	217,121	18,093	18%
Age 21 to 30	246,738	20,562	20%
Age 31 to 40	171,839	14,320	14%
Age 41 to 50	189,221	15,768	16%
Age 51 to 60	145,334	12,111	12%
Age 61 to 70	72,288	6,024	6%
Age 71 to 80	27,202	2,267	2%
Age 81 +	10,643	887	1%
Totals	1,205,190	100,433	100%



The People First Waiver

- 1. The population numbers for those being served and those to be served are confusing. Clarification is required re: 80,000 vs. 100,000 vs. 80 percent.**

Please see discussion for question four of the "Introduction" section. Additionally, it is important to note that a variety of data sources were used to develop this concept paper. These include Medicaid claims data, State developmental disabilities registry data, and data from a variety of non-Medicaid payment systems. In addition to emanating from various sources, data were drawn for differing time periods and using different techniques. Some recipient counts in the initial paper represent point-in-time estimates, others count unique individuals over a twelve month period, and other estimates made use of actuarial techniques (e.g., member months, member years). Some variation in figures is unavoidable under such circumstances. In the future when working with CMS, New York State will resolve such variations by using a single, consistent dataset when possible and explaining any variation when multiple data sources are required.

- 2. What is the "institutional capacity" for DD individuals with "challenging behaviors?" Is there existing capacity to absorb this population into the current system? What are the challenging behaviors? How will an 1115 waiver serve these individuals better than the existing (or a new) 1915(c) waiver?**

Currently, New York State operates institutional programs at eight campus-based sites. All of the campus settings provide supports to individuals with developmental disabilities who have specialized needs in one or more of the following areas:

- Intensive treatment for those with significant risk management issues
- Mental Health support for people with dual diagnoses or severe emotional dysfunction
- Transitional treatment for individuals with Autism and severe behavioral challenges

There are individuals who are residing at campus-based settings who do not fit the above referenced profiles and who are in the process of transitioning into community supports. The current institutional census is approximately 1,260 with most (1,000 individuals) having specialized treatment needs.

Sufficient capacity does not currently exist in the community to serve most individuals who now are served in institutional settings. The intent of the People First Waiver is to develop a community capacity for the provision of needed clinical oversight, specialized community-based residential services, and a crises response infrastructure to serve these individuals. In addition, current thinking is that OPWDD will maintain an institutional capacity of approximately 300 that will serve as a highly structured transitional program that will support those with the most intense service needs for a time-limited period.



3. **Definitions and specifics are needed for the "specialized systems of care," the "transformed long-term care delivery system," the "new reimbursement models," and the "lower cost services" of the safety net pool. Services, costs, and capacity need to be defined. The State provides an indication that provider based regional care organizations will be utilized. Please provide greater specificity on the intended structures. Will these organizations be at risk for any or all services? In the absence of a capitated model including institutional services, please describe how this model will assist in removing silos and improving community access for individuals in institutional settings.**

Through the design team process and the development of regional pilots in the first two phases of the proposed waiver, New York State will fully define these terms. Providers with expertise in developmental disability services are not generally part of organized care networks. Thus, the challenge of the People First Waiver development is to explore potential models for modernizing and restructuring reimbursement and flow of funds so that it focuses first on individual needs and goals, not on facilities and program expenditures, and develop more organized care networks for the delivery of integrated and coordinated care. Possible models include:

- **A partially capitated plan.** Such a model might allow, based upon need, individuals/families to select from a wide range of community-based long-term care, nursing home or community-based ICF services, and many ancillary services. These plans would be responsible for care managing the balance of the services that members need. Particularly in the first years of the People First Waiver, we anticipate that most plans will be partially capitated.
- **Comprehensive care management organizations** (a single care management organization would manage and coordinate **both** acute and long-term care services under a single monthly capitated payment). The objective of the People First Waiver is that, ultimately, a PACE-like program model will be developed that incorporates the full spectrum of medical and developmental disability specialized services into a single, integrated comprehensive service delivery system which integrates Medicare and Medicaid financing

The model or models that are selected for regional pilots in phase one and two of the waiver will depend on local infrastructure and the degree to which providers with expertise in developmental disability services already participate in existing care networks. The pilots and the transition to a statewide implementation during the later phases of the waiver must be done carefully to ensure there are robust controls and health and safety protections, incentives, and performance metrics in place to ensure all models of care align with People First Waiver goals (adherence to person centered planning principles, provider network standards that ensure individuals can exercise choice among services and service providers, recognition of culturally and linguistically relevant supports, adequate coverage of medical/dental specialties, support of innovative care models such as self-directed services, etc).



4. Does the State have specific plans for facility closure(s) at this time? Please provide a brief transition plan. Please provide current institutional census information and anticipated impact of demonstration on that census.

Currently, there are plans underway to create community services for all 275 people who currently live in Developmental Centers and do not have specialized treatment needs. There are also preliminary plans to close or significantly reduce the institutional census at all remaining campuses, reducing the available capacity to 300 over the course of the initial five year waiver period. This will be accomplished by enhancing the community capacity to address more intensive needs, and in particular, to make available short term intensive crisis services for people with behavioral challenges. There will also be additional community residential capacity developed which focuses on the needs of people with risk behaviors, as well as individuals with developmental disabilities who also have a psychiatric diagnosis.

The current institutional population is approximately 1,260 people, and is configured as described here:

- General Developmental Center Population – 275 people in 4 campuses (Bernard Fineson, Brooklyn, Broome and Taconic)
- People with Autism – 70 people in 2 campuses (Cap Dist and Bernard Fineson)
- People with Multiple Disabilities - 210 people on 5 campuses (Bernard Fineson, Brooklyn Broome, Staten Island and Taconic)
- People with Special Behavior Needs – 110 people in 4 campuses (Bernard Fineson, Brooklyn, Broome, and Finger Lakes)
- People with Intensive Treatment Needs – 570 people in 6 campuses (Brooklyn, Broome, Finger Lakes, Sunmount, Taconic and Valley Ridge)
- People in transitional living arrangements – 22 people (Sunmount)



- 5. Has the State conducted specific community service gap analysis to determine where infrastructure must be improved to ensure strong community services for individuals with significant support needs, including challenging behaviors? What strategies will be utilized to shore up those systems?**

The infrastructure improvements are in the areas of access to clinical relapse prevention services to assist individuals with significant risk management histories; crisis intervention services; structured supports during the day and evening to address downtime; use of technologies that assist in the supervision of people with high risk behaviors and access to mental health supports and substance abuse prevention services. The waiver design teams will be reviewing these service gaps and developing strategies across systems with the goal to allow people to more seamlessly access the supports that are central to their successful transition out of an institution, as well as to prevent the need to access the intensive services in an institution. Strategies that enable people to go across systems to get the supports they need will greatly enhance the creation of individual plans that address the various supports an individual may need to ensure success.

- 6. Will the State use the demonstration program to tier access to institutional services and offer HCBS as a preventive service in advance of institutional utilization?**

Tiered access to institutional services and community-based service provision in advance of institutional services are central topics for discussion by the design teams.

Five Year Plan

- 1. Will the specialized managed care models to be developed be Special Needs Plans (SNPs)? What is the relationship with this model and NYS's "Integrating Care for Dual Eligible Individuals Initiative?" Please provide additional specificity on the nature of the systems of care anticipated, network structures and readiness requirements (where different from current FFS provider network), all services covered, geographic or population differences in approach to system development, and transition and implementation strategies.**

The People First Waiver will better organize Medicaid services for individuals with developmental disabilities, thus preparing the developmental disability service system to take full advantage of opportunities available through the Integrated Care Initiative. These opportunities include the development of a better understanding of the full pattern of healthcare utilization for people with developmental disabilities with access to Medicare data, and ultimately to better coordinate care for the large numbers of dual-eligible individuals who are served by OPWDD. The service system supporting individuals with developmental disabilities has remained entirely outside Medicaid care management networks, and thus is not readily integrated within dual Special Needs Plans at this time.



During the initial phase of the waiver, New York will provide more detailed information regarding systems of care anticipated under the remaining phases of the People First Waiver. It is our intent that the first two years of the waiver period will provide time for planning and development of opportunities for regional piloting of models that integrate specialized developmental disability services and other long-term care supports. Where provider capacity exists, we anticipate that there will be early pilots that test models for integrating specialized developmental disability services with healthcare services and enhance care coordination across both sectors. Two of the more sophisticated, multi-system providers that deliver developmental disability services are now developing pilot proposals that we hope to test during the initial years of the People First Waiver.

2. Please provide detailed information, for each system of care to be utilized, specific strategies to ensure quality and the health and welfare of individuals served through the program.

The People First Waiver Quality Design team is charged with recommending reforms that will enhance the development of an integrated, comprehensive quality framework driven by performance metrics that are linked to both individual outcomes and system performance. Further, the Quality Team will formulate recommendations that will shape pilot and program development under the People First Waiver so that quality expectations are embedded in the design of People First program models throughout all phases of implementation. The team will also examine operational aspects of quality oversight/quality management (e.g., surveys, consumer satisfaction, National Core Indicator (NCI), National Accreditation, Consumerism Outcome Management Plan Assessment Self Survey (COMPASS), provider self-assessment, cross-systems reviews, etc.) by the state and throughout OPWDD to enhance performance and achieve outcomes. It is New York's intent that the People First comprehensive quality framework can provide information to measure progress towards the demonstration goals articulated in the initial People First Waiver concept paper and ultimately in the report that is submitted at the conclusion of phase one of the waiver. New York State has engaged key academics and researchers to be part of the design effort so that these key features, as well as evaluation and accountability tools are fully integrated into design and implementation. We will also be looking to CMS and NASDDDS and other knowledgeable entities to learn from efforts in other states.

The quality framework that will be enhanced for the 1115 waiver will incorporate the immediate reforms that OPWDD is now putting in place to strengthen the State care and oversight system. Those reforms are focused on **Ensuring Quality**, with particular focus on building strong relationships with individuals with developmental disabilities and effective incident management systems, **Employee Excellence**, and **Empowering Individuals and Families**. The ongoing reform initiatives are embedded in the culture of OPWDD and are articulated, with status reports and related pertinent documents, on the OPWDD Web Site, (www.opwdd.ny.gov).



3. Please describe in greater detail the stakeholder input process undertaken to date (are there ongoing opportunities for input? Were there specific recommendations from the group?).

OPWDD and DOH have initiated a state-wide stakeholder input process that includes stakeholder membership in the People First Waiver steering committee, design teams, public in-person opportunities for comment, printed materials and online opportunities to share recommendations. A web site is available as an information hub for waiver development activities (www.opwdd.ny.gov/2011_waiver). Since the April 18, 2011 inception of the Web site, it has been visited more than 3,000 times.

The steering committee (membership list attached) includes six members who are themselves individuals with developmental disabilities or are family members of people with developmental disabilities. There are five design teams that address key waiver development areas (access and choice; quality; care coordination; services and benefits; and financial sustainability). The teams are now being formed and are each co-led by a member of OPWDD leadership and a member of the OPWDD stakeholder community (individuals, family members and providers). Design team membership is limited to approximately 15 representatives who are representative of the broader stakeholder community.

More broad public input opportunities were provided via listening sessions and public forums. OPWDD Commissioner Burke attended seven listening sessions across New York State, where she met with individuals and families, discussed the objectives of the waiver, and sought individuals' recommendations about what works well and the aspects of our current service system that are most in need of change. Over 275 individuals and family members participated in the listening sessions and a report is now available on the People First Web Page. OPWDD and DOH launched a series of public forums supporting the development of the 1115 waiver on May 25, 2011. A total of approximately 500 people participated in public forum sessions held in New York City, Schenectady and Rochester and via video conference in an additional seven sites. In addition, an online survey was available and was accessed by another 150 people on the People First web site so that individuals could submit recommendations if they were unable to participate in one of the in-person or video conference forums. The recommendations submitted at the public forums and online will be included in a report that will be published online in July.

OPWDD and DOH will continue to provide online opportunities for public input during the course of the waiver development, and also intend to conduct other in-person opportunities toward the conclusion of the waiver development process. In addition, OPWDD has briefed the federal and state recognized tribes of New York at their recent quarterly meeting in New York City and will provide additional public notices as required.



4. Please provide specific information on the linkages to mental health supports and services and integration of acute and primary health to ensure and facilitate a person centered approach to care delivery.

The People First Steering Committee includes representatives from the New York State Office of Mental Health, the Department of Health and the Office of Alcoholism and Substance Abuse Services. In addition, the Executive Director of the New York Association of Psychiatric Rehabilitation Services and several leaders in the healthcare field also participate on the steering committee. (See appendix for list of steering committee members and their professional affiliations.) This high-level and experienced leadership will assist New York, particularly during the first two phases of the waiver, to structure services under the People First Waiver so that care coordination integrates the health, mental health and specialized developmental disability service needs of enrollees.

5. What is the difference in the coordination that will be provided by the managed care organizations that is not being provided through the current DD system? What are the deficits in the system now that requires this change?

Currently individuals with developmental disabilities receive care coordination through several vehicles:

- Individuals with developmental disabilities living in ICFs and nursing homes have care coordinated as part of residential service delivery.
- Individuals in the OPWDD home and community based services waiver through targeted case management services (delivered by either OPWDD or not-for-profit providers) or as a waiver service, known as Plan of Care Support Services (PCSS).
- Children enrolled in the OPWDD Care at Home (CAH) Waivers receive care coordination through CAH case management services.

These different program models have promoted person-centered planning principles in the development of care plans for the individuals served, but may be focused on care in the residential setting or on OPWDD community-based supports without comprehensively addressing both healthcare and long-term care needs.

One deficit is that the current planning process does not always well serve adults with developmental disabilities who have complex medical needs or individuals of any age who need psychiatric care in addition to developmental disability services. Because the person's care may be fragmented between health, mental health and developmental disability services and there is a lack of information sharing between providers, it is often difficult for a service coordinator to navigate the complex administrative structures and to obtain timely information from providers in other systems. By linking our efforts into one comprehensive waiver, we will be removing a key systemic barrier to previous efforts to better coordinate these supports and services. This link will provide an important focus for demonstration efforts in the early years of the waiver.



- 6. Is there an existing infrastructure and/or expertise that can be used to create these "specialized managed care/care coordination organizations?" is there a difference between the "specialized managed care organizations" mentioned in the first paragraph and the "care coordination" organizations mentioned in the second paragraph? Will the care coordination organizations provide the medical and long-term care services mentioned in the first paragraph? How will these organizations differ from the existing state and voluntary providers in the current DD system? Will the State service providers serve in the role of coordination organizations?**

As discussed earlier (People First Waiver, #3), there are several models that are currently under consideration and will be explored by the design teams and during pilot testing in the first phases of the waiver. The intent is that with the flexibility available through an 1115 waiver, New York will have the opportunity to operate regional pilots that will test methods of organizing care for individuals with developmental disabilities. The current providers that are likely candidates for pilots are large agencies that provide community-based developmental disability services and operate specialized clinics that provide primary and specialty long-term therapies. In at least one case, the provider is already part of an extensive healthcare system that includes hospitals, long-term care facilities, home health agencies and more than 9,000 physicians.

The role of the State is under discussion, but at this time it is unlikely that OPWDD would take on this role.

- 7. How is the comprehensive plan of care and care coordination and case management services provided by experienced regional DD providers different from the existing system?**

The key difference is that care planning under the People First Waiver will be comprehensive and will address the person's healthcare needs and long-term care needs in an integrated manner. In addition, we will seek to create more accountable ways of ensuring and monitoring the degree to which coordination fully embodies principals and hallmarks of person-centered planning. The development of regional pilots during the first two phases of the waiver will provide opportunities to test care systems that promote integrated care, particularly for individuals with complex healthcare needs or health management needs. The development of quality performance outcome measures specific to care coordination will also be a key feature of the new system.



8. What will be the determination of the reimbursement basis, whether it is individual budgeting, global budgeting, or capitation? How does global budgeting differ from a fee for service system? What will determine the payment methods?

Reimbursement methodologies will be tied to the delivery systems that are ultimately employed. The Fiscal Sustainability Design Team is addressing this subject area and will make rate methodology recommendations based on the need to develop equitable, sustainable rates that are sensitive to the support needs of individuals.

9. Please provide a detailed 5 year plan, identifying major tasks to be accomplished in each year. Is the three years for development part of the five years of the five year plan? What happens in years four and five?

As discussed earlier, New York is seeking a five year waiver period that will incorporate four distinct phases. These four phases are outlined below.

<p>Phase One: Waiver Year One</p>	<ul style="list-style-type: none"> • Modernize institutional setting based rate • First phase of transition from institution to community living • Completion of a comprehensive planning process • Submission to CMS of detailed implementation plan
<p>Phase Two: Waiver Year Two</p>	<ul style="list-style-type: none"> • Continued Movement from institution to community living • Pilot regional long-term care management models that promote consumer-directed funding systems and where the capacity exists, comprehensive care management pilots that integrate services across health and long-term care services • Development of community-based services to support range of needs associated with individuals with severe behavior issues • Develop and test quality outcome measures for service delivery in statewide care management environment for specialized developmental disability services



<p>Phase Three: Waiver Years Three, and Four</p>	<ul style="list-style-type: none"> • Transition to Medicaid Care Management for Healthcare Services • Continued Movement from Institution to Community • Evaluate pilot demonstrations and begin statewide transition of long-term care services to care management environment
<p>Phase Four: Waiver Year Five</p>	<ul style="list-style-type: none"> • Continue statewide transition of long-term care services to care management environment • Expand Alternatives that Integrate Health & LTC <ul style="list-style-type: none"> ○ Contractual arrangement between MLTC & MC Health Care providers for coordination of services with separate payments to each, ○ Development of PACE-like program model for more fully integrated care (single capitated Medicaid & Medicare payment to a single provider). • Final Movement from Institution to Community

10. How many of these individuals reside in a nursing facility or ICF/MR? How many are in community placement? What are the Medicaid expenditures (institutional/non-institutional)? How are they being funded?

Approximately 1,900 individuals reside in skilled nursing facilities. There are 1,260 individuals residing in institutional model ICF-DD's (i.e., state-run developmental centers and special population units). Additionally, we estimate that there are an additional 350 individuals with developmental disabilities in other institutional placements reimbursed by Medicaid (e.g., OPWDD licensed specialty hospital, facilities operated by foster care agencies, residential treatment facilities for seriously emotionally disturbed children, and state-run psychiatric hospitals).

The remaining individuals are in some form of community residential settings. Please note that New York State does not typically consider small-model ("community") ICF-DD's to be institutional settings. These facilities operate in a manner that is fundamentally different from a developmental center or a nursing home. In addition to the approximate 6,000 individuals residing in such community ICF-DD's, another approximate 90,000 individuals receive community based supports and services through a home and community based services waiver, and/or non-institutional long-term care program authorized in the State Plan (e.g., personal care, certified home health agency), and/or long-term clinical supports (specialty clinics, early intervention, school supportive health services), and/or various non-Medicaid programs.



SFY 2009-10 Medicaid expenditures for institutional services (as defined above) were approximately \$2.5 billion. Expenditures for community ICF-DDs were approximately \$1.0 billion. Expenditures for all other community based long-term care supports totaled approximately: \$6.1 billion. Finally, over \$500 million was expended by Medicaid on traditional healthcare services. For these purposes we are defining "traditional healthcare services" as inpatient, outpatient (including hospital outpatient, free-standing clinic, private office visits), pharmacy, managed care premiums, and various ancillary healthcare services (durable medical equipment, laboratory, referred ambulatory, transportation, etc).

11. Will stronger PASRR efforts be a part of the demonstration?

Yes, it is our intent that the 1115 waiver will strengthen the PASRR process, improve information sharing and facilitate the provision of specialized services when the person is best served in a Nursing Facility, but needs these additional services.

12. Will the State use a nursing facility level of care or ICF/MR level of care, or both to determine eligibility and a level of care? What assessment will be utilized? Will the State use the Level of need assessment employed through the current 1915(c) waiver or a new assessment?

Our initial thinking is that both instruments will be in use. There is a strong interest in re-evaluating the ICF/MR level of care instrument to tier access to institutional services and more intensive residential services. We are also evaluating the possibility of developing another resource needs assessment tool.

13. How will the State transition people from existing 1915(c) waivers into this waiver? What will be the timeframe?

Working with CMS, New York State will develop a detailed plan that will describe a transition period under the 1115 authority so that there is continuity of care for individuals currently enrolled in 1915 (c) waivers operated by OPWDD. We suggest that CMS and New York State come to a mutually acceptable agreement that allows current services to continue during year one of the waiver. In addition, during the first year of the waiver a transition plan will be developed which will be a critical component of the report submitted to CMS at the conclusion of year one.



14. Does the State intend to use existing 1915(c) providers, including State operated and voluntary providers? Will there be an opportunity to solicit other qualified providers?

The intent is that providers in the 1915 (c) waiver will transition into the 1115 waiver. As new models of care are developed over the course of the five year demonstration we anticipate that there will be shifts in the provider pool. These changes will occur as healthcare is integrated with long-term care services, and also as some providers that now act independently as Medicaid providers may transition to down-stream contracting arrangements with care management entities (see also [Introduction](#), #2). Although changes are anticipated, it is New York's intent that there will continue to be a diverse provider pool that is capable of delivering culturally relevant services that reflect the needs of communities across New York State.

Immediate Reforms

1. How many is "most" of the State's institutional population that will be supported by community based services?

With the recent closure of the West Seneca Developmental Center, the current institutional census is now at 1,260 and the institutional capacity will be further reduced to 300 over the course of the initial five year waiver period. Over the years, OPWDD and its provider community have demonstrated their ability to create community supports for individuals who had lived in institutions, and the plan is to continue the trend and create community based supports for the majority of the 1,260 individuals who currently reside in New York's institutions.

2. What are the targets/timeframes to transition individuals out of institutions? Is this how savings will occur? How will the State's Money Follows the Person demonstration program be used to further these efforts?

Please see the response to question #4 in [The People First Waiver](#) section of this paper. At this time, the Money Follows the Person demonstration does not extend to individuals in OPWDD's 1915 (c) waivers.

3. Define the "temporary basis" that institutional care will be available for? Who are the individuals that this care will be available for?

The length of stay will be based on the individual needs of the person, the assessment of clinicians regarding his or her readiness for community placement and the development of the needed community supports to provide for safe and effective long-term community living. The expectation is that individuals will access the intensive treatment services that the institution provides for no more than 36 months, and that these intensive services will be provided in a transitional model. People will access the institution with a plan that describes the community based supports needed and the types of services that will be needed in the community to facilitate a successful transition. The individuals that this care will be made available for are those who currently access intensive behavioral supports in institutional settings, as well as those with similar needs who will be seeking services in the future. There are some existing community settings with demonstrated success in serving people who have transitioned from institutions, and these settings use strategies that can be studied for development of future supports in the new waiver environment.



4. What are the rates of reduction of the number of institutional individuals over the last five years?

The institutional census has decreased by more than 300 over the previous five years, from 1,600 to a current census of 1,260 residents.

5. What are “safety net services?” Are these services currently being claimed as Medicaid services? How much is currently spent on safety net services? Safety net services seem to be 1915(c) services or other federally funded services. What is the need for these services?

Safety net services are a variety of programs primarily funded by the State's Department of Mental Hygiene. These include crisis, respite and other family support services; non-residential services, including day training, workshop and other employment programs; and residential services, like Individualized Supports and Services, which offers housing supports – primarily rent and utility subsidies – to enable individuals with developmental disabilities to live independently in their own homes in the community.

Safety net services are not currently being claimed as Medicaid, though the services may “mirror” Medicaid eligible programs, and they frequently serve individuals who are otherwise Medicaid eligible. In fact, these services are designed to avoid a system in which Medicaid eligible individuals access more costly medical services. By assuring that these safety net programs are available, the State is trying to prevent the utilization of more costly Medicaid services. In the aggregate, roughly \$3 billion annually is spent on these safety net programs.

A detailed and comprehensive listing of proposed safety net services, including descriptions, historical State expenditures, the number of individuals receiving services, and the criticality of continuing to fund these services will be forthcoming shortly.

6. Safety net services are described in part as services provided to individuals that are not enrolled in the Medicaid program. The waiver target population is defined as Medicaid enrolled individuals, please explain. How many non-enrolled Medicaid individuals are obtaining services? What are these costs? How will access to these services be determined (including availability statewide, etc)? The services mentioned are Medicaid coverable under HCBS and other authorities, so clarity on target population for this group of services will be very helpful.

A partial listing of safety net services that are proposed for inclusion under the State’s 1115 Waiver includes:

- Housing and residential supports to 13,000 individuals with developmental disabilities to remain in their own home or with their own families;



- Support to non-profit providers to deliver more than 73,000 non-Medicaid family support services, primarily respite and crisis intervention services, which supports more than 43,000 individuals with developmental disabilities and their families and are critical in helping keep families together;
- A variety of programs and services including sheltered workshops and the Special Olympics;
- Support for the Institute for Basic Research in Developmental Disabilities in Staten Island to conduct autism research and to develop behavioral intervention support plans that assist caregivers of individuals with challenging behaviors, and;
- A variety of other programs and services serving at-risk individuals, including those with co-occurring disorders. These include programs funded within the Department of Mental Hygiene (OPWDD, OMH and OASAS), as well as certain services for the developmentally disabled and other at-risk individuals in the Office for Children and Family Services, the Department of Education and the Office of Temporary and Disability Assistance.

A more detailed, comprehensive listing of proposed safety net services, including descriptions, historical expenditures, and the number of individuals receiving services, is being developed. We plan to continue to work in collaboration with the Federal government to ensure appropriate statewide access.

7. The State needs to provide a list of the safety net services subject to “negotiation.”

A detailed and comprehensive listing of all proposed safety net services, including descriptions, historical expenditures, the number of individuals receiving services, and the criticality of continuing to fund these services will be forthcoming shortly. Also, see the responses to #5 and #6 above.

8. What is the price differential between safety net services in the proposal and all the Medicaid services currently paid for by Medicaid?

In general, the safety net services are designed to avoid more costly Medicaid medical and long term care services.

9. What is the intent of allowing individuals to use commercial insurance? Does this mean that if cost effective, the 1115 Waiver will pay commercial insurance premiums and the individual is covered by commercial insurance rather than Medicaid?

At this time we do not envision that commercial insurance will play a large role in funding services under the People First Waiver.



10. How will the quality be incentivized?

The work of the People First Waiver Quality and Fiscal Sustainability design teams will provide more concrete responses based on the development work in year one of the waiver. Options being considered will depend on the care management structures that are ultimately put in place, but may include the following:

- Pay-for-performance strategies that incentivize quality performance by paying differential rates based on provider attainment of key program outcomes
- Publication of quality measures so that individuals and families can select providers based on consistent performance measures
- Other non-financial incentives such as variable surveillance schedules and risk based assessments that target quality oversight resources toward the review of lower-performing providers.

It is New York State's intent that these types of quality incentives will be built into the contract requirements for all People First services. Thus, quality enhancement measures will be part of the service design itself and not largely relegated to surveillance activities, which are separate and apart from initial service design.

11. Are the out-of-state placements mentioned because the 1115 waiver will bring these out-of-state placements back in-state? What special needs that cannot be met by public schools are being discussed here? Are the other needs currently being met by health providers?

It is New York's intent to provide school-age children and young adults currently served out of state with appropriate in-state service opportunities so that they can live in communities that are closer to their families. Most out-of-state placements are made because the student needs around-the-clock care and specialized behavioral supports.

12. When will the Quality Improvement metrics be developed? What Quality Management resources are being targeted and how will this be more efficient and effective?

The development of quality improvement metrics begins now and will continue throughout the five year period of the waiver. A Quality design team, with representatives from all stakeholder groups, will recommend reforms that will enhance the development of an integrated, comprehensive quality framework driven by performance metrics that are linked to both individual outcomes and system performance. The Quality design team will also examine potential reforms related to the operational aspects of quality oversight/quality management (e.g., surveys, consumer satisfaction, National Core Indicators (NCI), Consumerism Outcomes Management Plan Agency Self Survey (COMPASS), provider self-assessment, cross-systems reviews, etc.) by the state



and throughout OPWDD to enhance performance and achieve outcomes. In addition, the Quality design team will be charged with recommending how the People First Waiver comprehensive quality framework can provide information to measure progress towards the People First Waiver goals articulated in the concept paper.

This work of the design team is augmented by the highly respected academics and researchers who will join with our broad stakeholder group to guide the formulation of key metrics.

Conclusion

- 1. What will budget neutrality for this waiver be assessed against, e.g. the standard institutional reimbursement for ICF-MR and NH services or the inflated developmental center ICF/MR reimbursement rate?**

It is our understanding that budget neutrality assessment in 1115 waivers is subject to negotiation with CMS and will be based on the federal costs with and without the program and fiscal reforms approved in the People First Waiver.

Appendix A

- 1. Appendix A is described on page 2 as representing the "array of long-term care services currently available...." Many of the services included are not considered long term care. Why are they on the list?**

The term "long-term care" was included on page two in error. We apologize for any confusion.

- 2. How is the total 94,836 recipients related to the 100,000 total number previously discussed?**

The 100,000 figure represents New York State's current (SFY 2009-10) best estimate of individuals eligible for OPWDD services who are enrolled in Medicaid. The data provided in Appendix A is from a somewhat earlier time period (FFY 2007-08). Over the past five years, the population envisioned as participating in the People First Waiver has seen annual rate of increase of between 2% to 3%. Growth rates above the annual increase in New York State's general population have resulted from increased life expectancy for individuals with developmental disabilities, increased incidence of individuals diagnosed with autism in the population as a whole, and an expansion in Medicaid services available to children (i.e., individuals begin receiving Medicaid services earlier than in the past.)