



Strengthening Services for the Future

Understanding the People First Waiver
and Managed Care

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Introductory Presentation #3

- In April 2012, OPWDD began development of a series of presentations to introduce stakeholders to the People First Waiver, recognizing that people have varying degrees of understanding about what the waiver will do, and what the process will be.
- This is the third presentation in that series.
- These presentations are available on OPWDD's YouTube channel: www.youtube.com/user/opwddvideo. They are also available by emailing people.first@opwdd.ny.gov or by calling 1-866-946-9733



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The People First Waiver

- Will provide more flexible and person-centered services
- Will develop stronger community-based services
- Will enhance care coordination to meet all of an individual's needs
- Will measure quality of care based on an individual's personal outcomes



Major Areas of Focus

- **Stronger needs assessment** – creating a better foundation for person-centered support
- **Establishing comprehensive care coordination** – moving to managed care to increase coordination and efficiency
- **Expanding the menu** of community-based supports, clinical services, non-certified residential support options and employment supports
- **Developing new ways to measure quality** that look at outcomes for individuals



How Does this Fit in with Statewide Medicaid Reform?

- New York’s Medicaid Redesign Team seeks to:
 - Expand Medicaid managed care enrollment
 - Establish mandatory managed long-term care
- OPWDD said, “Let us design what’s best for the individuals we serve”
- The waiver will take advantage of the best parts of managed care, while avoiding the “medicalization” of our **specialized** system of supports



Ongoing Dialogue on Transformation

OPWDD is continuing to work with CMS to define priority elements of system reform:

- Expanding opportunities and supports for **EMPLOYMENT**
- Expanding **COMMUNITY SERVICE OPTIONS** – supportive housing, community-based services
- Expanding **SELF-DIRECTION** options
- **OLMSTEAD IMPLEMENTATION** – moving people out of institutions



Ongoing Dialogue on Transformation

As we look at these priority policy areas, we are examining:

- How people enter the OPWDD service system
 - Front door
 - Light touch community-based services and supports
 - CAS and person-centered planning
- Effectiveness/outcomes of services – changing how we measure quality
- How people move toward their goals and advance in skills, independence, and inclusion



A New Needs Assessment

“It Starts with Me”

- A thorough assessment will provide the best foundation for planning the most responsive, effective supports for an individual
- Building on the InterRAI developmental disabilities tool OPWDD has developed a coordinated assessment system (CAS) for use in the OPWDD system
- The CAS has 16 domains, each with specific items that identify information to be gathered
- Numerous supplements—children and adolescents, substance use, forensics, mental health—to describe a person holistically
- Interview with individual and other sources:
 - Direct observations
 - Staff/clinicians
 - Family and friends
 - Records (e.g. ISPs, habilitation plans, IPOP, medical records)



Launching the CAS

- New coordinated assessment system will be phased in thoughtfully:
 - Starting with case studies;
 - Moving next into managed care pilot projects;
 - Next into use with all newcomers to the service system; and
 - Eventually, over time, be used with those currently receiving services.
- We will be careful not to disrupt lives, but instead identify opportunities for greater integration and independence based on needs, strengths, and interests



Stronger Community-Based Supports

- Habilitative supports that meet each individual's unique interests and needs
- Identifying when a lower level of support is needed earlier in the process to avoid the need for more intensive services later
- Increasing community-based clinical and behavioral support
- Developing a spectrum of residential support options that range from 24/7 support to complete independence
- Ensuring flexible, more responsive supports for families
- Reducing our reliance on institutional services



Moving to Managed Care

- Developmental disabilities individual services and care coordination organizations (DISCOs) will receive funds, provide person-centered planning, coordinate services, and ensure delivery of services
- DISCOs will provide services through provider networks that can meet all of an individual's needs
- DISCOs will receive a capitated payment—a set amount for each enrollee—and use all of their payments to meet the needs for all enrollees



Understanding the DISCO and the Capitated Payment

Funding Supports Care Coordination and Services to meet Individuals' Needs

- DISCO funding is based on an individual's needs, not allocated based on general service categories
- There is no limit for spending on any individual—the “capitated” rate will not mean limited services
- Capitated payments are determined by actuarial formula to allow DISCOs to successfully meet the needs of all the enrolled individuals



Understanding the DISCO and the Capitated Payment

Per Member Per Month Payments



Individuals do not necessarily receive services that cost the amount of the capitated payment. They receive services identified according to their individual needs, which could cost more or less than the payment they bring to the DISCO.



Person-Centered Services Delivered



How Care Coordination will Work

- DISCOs will be required to serve people with all levels of service need
- Everyone will have a choice of providers within their DISCO's network
- Every person will have the option to self-direct an individualized service budget
- DISCOs will coordinate care from multiple systems—initially only long-term supports like OPWDD services, behavioral health, and personal care, but eventually fully comprehensive care, including acute medical
- Independent advocacy and due process rights will be available



Core Responsibilities of the Lead Care Coordinator

- Leader of an interdisciplinary team
- Responsible for the oversight and coordination of the entire care coordination team
- Ensures the care plan is properly implemented and the person's needs are met
- Monitors the overall cost of a service plan to ensure services are appropriate to identified needs

Improving Quality/Improving Accountability

- Measure meaningful indicators of quality such as:
 - Individuals' progress using benchmarks and milestones
 - Effective DISCO governance
 - Individual/family satisfaction
 - Support for DSPs
 - Quality improvement
- Create a quality rating scale that is available to the public
- Use new technology to improve coordination of care, services, and personal outcomes





Looking at Personal Outcomes

Goals

- Looking at outcomes for individuals to indicate how the **provider, the DISCO, and the system** are performing
- A continuous quality improvement approach throughout the system

Developing and Tracking OPWDD System Metrics

- Short- and long-term tracking
- Multiple purposes: process and performance management; accountability; input to system goals and objectives; target areas for improvement; continuous quality improvement



Personal Outcome Measures (POMs)

- The Council on Quality and Leadership (CQL) has developed valid, reliable personal outcome measures and a method for using POMs to assess how well services support meaningful outcomes
- Different than National Core Indicators (NCI), which are system outcome measures
- Information on CQL and POMs is available at www.thecouncil.org and www.opwdd.ny.gov.



Personal Outcome Measures (POMs) Measure if People:

Are connected to natural support networks	Have intimate relationships
Have best possible health	Are safe
Exercise rights	Are treated fairly
Are free from abuse and neglect	Experience continuity and security
Decide when to share personal information	Choose where and with whom they live
Choose where they work	Use their environments
Live in integrated settings	Interact with other members of community
Perform different social roles	Choose services
Choose personal goals	Realize personal goals
Participate in the life of community	Have friends
Are respected	



CQL Personal Outcome Measures (POMs)

- OPWDD will require DISCOs to use POMs in their quality improvement processes
- OPWDD will establish practice guidelines for care coordinators that incorporate POMs
- Additional clinical and functional outcome measures will be needed to measure the effectiveness of care coordination



CQL Personal Outcome Measures (POMs)

DISCOs will:

- Be trained/certified to conduct POM interviews
- Report POM results to OPWDD annually
- Use POM process for continuous quality improvement

OPWDD will:

- Validate that DISCOs are using POM measures and approach
- Review DISCOs' operations to ensure they are using POM results in the care coordination process and in continuous quality improvement
- Use POM data to examine statewide system quality



OPWDD Oversight of DISCOs

New York State oversight will mirror the functions of the DISCO:

- Financial management
- Medical management
- Care coordination
- Compliance activities/quality reporting
- Administration
- Member services/grievances



DOH Fully Integrated Demonstration

- Fully integrated dual advantage programs (FIDAs)
 - A managed care plan for people receiving both Medicaid and Medicare
 - Provides comprehensive array of Medicare, Medicaid, and supplemental services including personal care, acute health care, mental health, substance abuse services, and all OPWDD People First Waiver services
- Both the FIDA program and the People First Waiver have the same objectives, but the FIDA is the first demonstration of comprehensive care
- Following the three-year demonstration, FIDAs will likely transition to DISCOs

Learning By Doing

Demonstration and Piloting

**FIDA's Early
Demonstration
Comprehensive
Care**

**DISCO Pilots
Focus on LTSS**

**Ultimate Objective
Comprehensive Care**



DOH Duals Demonstration – How it will Work

- **July 2013** (Phase 1) – Voluntary enrollment into managed long-term care plans—individuals will not experience any changes in OPWDD services
- **January 2014** (Phase 2) – Voluntarily enrolled members will automatically transition to FIDAs through which they will receive all of their supports and services
- There will only be up to three FIDAs in New York State



Ongoing OPWDD Reform Activities

- **Regulatory Reform Workgroup** – to recommend needed regulatory and policy review and revisions
- **Information Technology Workgroup** – to recommend standards and common practices needed, etc.
- **Care Coordination Transition** – to create a plan to guide the transition from Medicaid service coordination to care coordination
- **DQI** – developing DISCO oversight infrastructure



Next Steps

- Revise request for application (RFA) for pilot DISCOs, post new version – April 2013
- Develop DRAFT DISCO contract – April 2013
- Develop communications/outreach plan for the transition to managed care
- Continue negotiations with CMS to finalize agreements



How Can I Get More Information?

OPWDD webpage: www.opwdd.ny.gov

Email comments and questions:

People.First@opwdd.ny.gov

View video series on OPWDD's
YouTube channel: opwddvideo

Contact OPWDD's information line:
1-866-946-9733 or TTY: 1-866-933-4889