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New York State Office for People With Developmental Disabilities (OPWDD) Managed Care Assessment Initial Report

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Section 1 Background and Assessment Methodology

As managed care has gained momentum as a service delivery model for particular segments of the Medicaid population, many states have explored the option of providing people with intellectual and developmental disabilities (IDD) Managed Long Term Services and Supports (MLTSS). MLTSS refers to the delivery of long-term services and supports through capitated Medicaid managed care programs (i.e., fixed monthly payments made to managed care organizations for each Medicaid member enrolled in the managed care organization). New York State and the Office for People With Developmental Disabilities (OPWDD) have been considering such a transition for a number of years including the implementation of smaller pilot programs such as Specialized IDD Plans – Provider Led (SIPs-PL) and the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) plan demonstration. The IDD population includes many of New York's most vulnerable residents and a transition to MLTSS may result in a change to how they receive their services and how the State pays for those services. To that end, per Section 9, paragraph 1(b), of Part Z of Chapter 57 of the Laws of 2018, OPWDD must "assess the quality and outcomes of managed care for individuals with developmental disabilities, including their experiences and satisfaction"[1].

Guidehouse has been retained by OPWDD to evaluate service delivery models and is working in close coordination with OPWDD to draft this report.

Our assessment will include this Initial Report and a Final Report. Guidehouse's Initial Report includes:

- Summary of OPWDD goals and objectives
- Overview of current delivery system in New York including how managed care is used today
- Environmental scan and high-level overview of service delivery models, next steps, and timing of Final Report

Between 2023 and Spring 2024, Guidehouse will continue its work with OPWDD to produce a Final Report by completing the following steps that are detailed in Section 5 of this document:

- Environmental scan, literature review, and data analysis
- Best practices and national trends including how states are currently implementing managed care and other service delivery models
- Stakeholder engagement

The Final Report, to be submitted to OPWDD in Spring 2024, will include:

- **Service Delivery Model Study Methodology and Findings:** Comprehensive summary of the service delivery study methodology and findings focusing on managed care and other options currently implemented nationally.

[1] https://assembly.state.ny.us/leg/?default_fld=&bn=S07507&term=2017&Summary=Y&Actions=Y&Text=Y&Committee%2526nbspVotes=Y&Floor%2526nbspVotes=Y

- **OPWDD Program Goals:** Detailed perspective of OPWDD program goals, objectives, and measures of success to execute and monitor OPWDD's progress towards achieving goals based on the recommended service delivery system.
- **Final Recommendations:** Recommended next steps for selection and implementation of a service delivery model. This will include key program requirements of the recommended service delivery model to successfully serve the IDD population across New York.

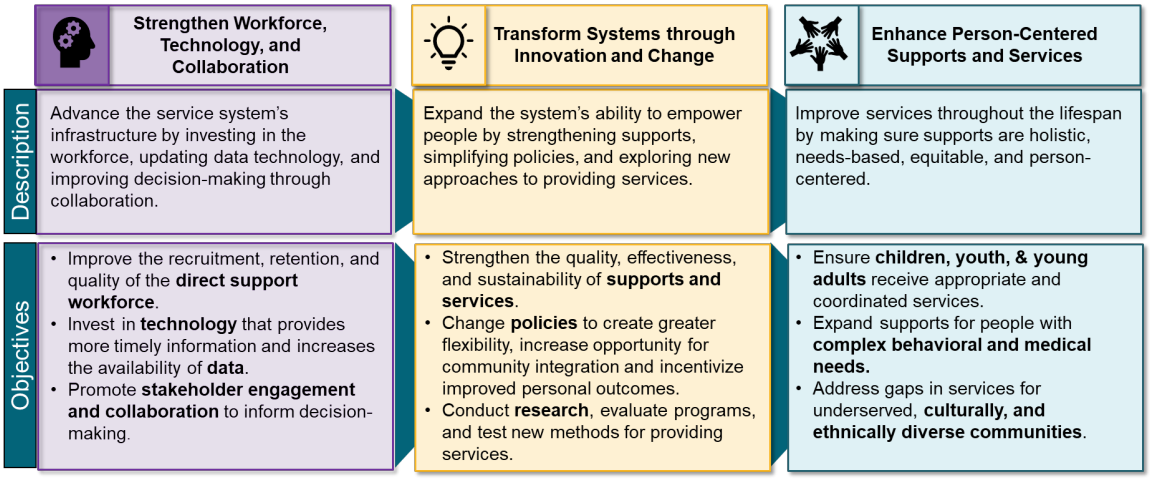
Section 2 OPWDD Service Goals and Objectives

OPWDD is responsible for coordinating supports for approximately 130,000 New Yorkers with intellectual and developmental disabilities, collaborating with nearly 500 voluntary non-profit organizations to provide ongoing support (housing and residential supports, community habilitation, day and employment programs, family support services, and respite). OPWDD services are focused on maximizing opportunities for those with developmental disabilities to live and participate in the broader community.

OPWDD has experienced an increase over the past five years in both the number of people served and the amount in Medicaid expenditures (over 14% over five years), totaling more than $8 billion of total system expenditures in 2021. In addition to the increase in spending and the expanding needs of the community, OPWDD has experienced a decline in available Direct Support Professionals (DSPs)[2] and has experienced a high turnover rate in voluntary DSP positions (averaging 36% annually) while contending with an increase in open position vacancy rates. Collectively, these issues have created challenges for OPWDD and its ability to provide quality and timely services to those in need. In addition to expanding needs and a shrinking available workforce, OPWDD has identified that its current systems and technology – critical to providing valuable insights – are outdated, hampering its ability to maximize impact for its members.[3]

OPWDD looks to address these changing dynamics and demographics with its five-year (2023-2027) Strategic Plan, establishing goals and objectives that will allow OPWDD to operate more effectively within the changing environment. The five-year plan was the result of engaging with, and gathering input from, stakeholders statewide and analyzing state and local data. The result was three strategic goals and associated objectives (Figure 1).[4]

Figure 1. OPWDD 2023-2027 Strategic Plan Goals and Objectives



[2] Direct Support Professionals (DSPs) provide assistance to people with all of their personal needs and help them participate in programs that strengthen their life skills and ensure a safe and comfortable environment.
[3] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf
[4] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf

To ensure OPWDD meets the changing needs of those served and improve their experience, OPWDD is:

- Strategically prioritizing the strengthening of New York's IDD workforce, technology, and cross-system collaborations (Goal 1)
- Evaluating and modifying its policies and services (Goal 2), as OPWDD believes this will serve as the foundation for transforming OPWDD systems
- Setting OPWDD up to achieve person-centered services (Goal 3).

As part of transforming its systems through innovation and change, OPWDD will conduct research, evaluate programs, and test new methods for providing services, including reviewing OPWDD's potential transition to managed care or an alternate delivery system. To continually provide the community with high quality, person centered, cost-effective services, OPWDD has invested in studying and exploring the effectiveness and sustainability of its current delivery model as well as alternative delivery models, including managed care, with the goal of implementing the best option for New Yorkers with developmental disabilities.

Section 3 New York State Service Delivery

OPWDD Populations

OPWDD is responsible for coordinating supports for approximately 130,000 people; providing benefits through a variety of service options.

Medicaid Only

Individuals who receive Medicaid exclusively

Duals

Individuals who receive both Medicare and Medicaid benefits

Private/Commercial

Individuals who receive services through private/commercial payers

Exemptions

Individuals who receive coverage through an exemption basis (e.g., Native Americans, individuals with end-stage renal disease)

History of Medicaid Managed Care in New York State

New York State has had a Medicaid managed care program for several decades, with the State's first programs beginning in the 1980s. In 1998, New York State launched its first Managed Care Program for Medicaid-eligible individuals using long-term services and supports (LTSS) in select counties, including adults with disabilities and dual eligibility. In 2006, New York State sought a waiver under Section 1115 of the Social Security Act to expand its Medicaid managed care enrollment and to institute mandatory enrollment into Medicaid managed care, which eventually resulted in the Managed Long-Term Care (MLTC) program. In 2011, New York launched a Medicaid Redesign Team (MRT) effort that included a number of initiatives to control spending and increase quality. One initiative called for mandatory enrollment into managed long-term care for dual-eligible individuals in need of more than 120 days of community-based long-term care. The MLTC program covers institutional and community-based long-term services and supports; acute and primary care services are provided by a different managed care program.

Since mandatory MLTC enrollment, the State's Medicaid managed care program has continued to expand by including new populations and creating specialized managed care programs for individuals with special needs, including those with physical disabilities, frail elders in need of long-term services and supports, and individuals with serious mental illness (SMI) and substance use disorders (SUD). As of November 2022, more than 5.9 million New Yorkers were enrolled in some form of Medicaid managed care. However, most people with IDD have largely been exempted (or "carved out") from Medicaid managed care.

Intellectual/Developmental Disabilities (IDD) Health Homes / Care Coordination Organizations

For several years, OPWDD and the New York State Department of Health (DOH) have considered the possible transition of OPWDD-funded waiver services to managed care. In April 2018, DOH and OPWDD received approval from the Centers for Medicare and Medicaid Services (CMS) to expand the Health Home Care Management program to serve people with IDD through Care Coordination Organizations/Health Homes (CCO/HHs). CCOs are organizations formed by providers of developmental disability services that were designed to provide enhanced care coordination through comprehensive person-centered care management, planning, and coordination through a network of care managers and providers (team-based approach). The care management process includes the development of a Life Plan, which represents an individual's goals and changing needs including health, preventive care, behavioral services, community supports, and social supports.

The intent of the CCO/HH model was to better integrate primary healthcare with Medicaid home and community-based services (HCBS) with more options, greater flexibility, and improved outcomes. Additionally, as part of compliance with the HCBS final rule, the transition provided the opportunity to achieve conflict-free case management, which assures that assessment and coordination of service needs are separate from delivery of those services. Today, despite a system-wide transition to managed care having not yet occurred, there are seven regional CCOs across the State responsible for assessing the needs of their enrollees and for providing conflict-free person-centered care management services.

Membership Service Array/Utilization

Each CCO has a designated care manager or professional who provides care management and coordinates services.

Health Homes currently provide six core care management services:

- **Comprehensive care management:** Initial and ongoing assessment and care management services – to support individual outcomes and integration of habilitation, primary, behavioral, and specialty healthcare and community support services, using a comprehensive person-centered care plan called a Life Plan.
- **Care coordination and health promotion:** Education and engagement in making decisions that promote independence and wellbeing through the implementation of the Life Plan and its continuous monitoring.
- **Comprehensive transitional care:** From inpatient to other settings, including appropriate follow-up.
- **Individual and family and caregiver support:** Coordination of information and services to support each individual and their family and/or representative to maintain quality of life, with a focus on community living options.
- **Referral to community and social support services:** To ensure that community resources are utilized, as individuals pursue meaningful activities consistent with their Life Plans

- **The use of health information technology (HIT):** CCOs are required to meet the HIT standards in the delivery of the Health Home core services. This includes an electronic Life Plan.

Enrollment Transition

In July 2018, people with IDD began transitioning to CCOs from the Medicaid Service Coordination (MSC) program. This transition represented a significant change in system delivery and was considered to be the beginning of the transition into managed care for all New Yorkers enrolled in Medicaid. Despite a formal transition to managed care having not yet occurred, the transition to CCOs offers the opportunity for stronger and more comprehensive coordination of supports and services through Health Home Care Management.

To reduce potential disruption in services, many of the already existing Medicaid Service Coordinators were given the opportunity to transition into new roles as Care Managers in the new CCOs. Initially, enrollment was voluntary and then mandatory for all eligible groups.

While OPWDD considers the transition to this model to have been successful in some ways, the Office continues to consider further efforts that can be undertaken in collaboration with CCOs, DOH, provider agencies, and stakeholders to strengthen care management.

Mainstream Managed Care / Managed LTC Plans

Today, approximately 36,000 people with IDD are enrolled in mainstream managed care (MMC) plans for physical and mental health benefits. MMCs focus on preventive healthcare and provide enrollees with a medical home. People with IDD who are enrolled in an MMC plan may transfer to an MLTC plan if he or she meets the MLTC enrollment criteria or becomes eligible for Medicare. As described above, the MLTC program covers institutional and community-based long-term services and supports and does not currently include OPWDD services.

OPWDD has explored the possibility of including the IDD population in managed care. This was accelerated in 2011 by the New York State “Care Management for All” initiative emerging out of the MRT’s proposal, which aimed to move all Medicaid benefits and people served by Medicaid into some form of care management. The Care Management for All Initiative spurred the introduction or expansion of several managed care models, including Managed Long-Term Care, Health and Recovery Plans, and Health Homes. However, several groups of people, depending on their circumstances, were previously exempt or excluded from mandatory enrollment, including individuals enrolled in Medicaid waiver programs (e.g., Care at Home), residents of intermediate care facilities and those individuals qualified and identified to receive program services through OPWDD. In July of 2018, DOH and OPWDD undertook a broader step towards Care Management for All when it required that individuals with IDD be enrolled in a CCO.[5]

Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration

The Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration is a pilot program with a three-way contract between CMS, OPWDD, and DOH. Its purpose is to test the success of delivering services that address the whole person and promote enhanced care coordination for full-benefit dual beneficiaries

[5] https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/cco_overview.pdf

aged 21 and older living in a participating region and who are not already receiving developmental disability services through a waiver, a Program of All-Inclusive Care for the Elderly (PACE), or the Independence at Home Demonstration.

In April 2016, Partners Health Plan (PHP) launched the State's only FIDA-IDD, serving a voluntary membership of approximately 1,700 individuals in the downstate region (New York City, Long Island, Rockland, and Westchester Counties). The FIDA-IDD benefit package consists of a comprehensive array of Medicaid and Medicare services including hospitalization, healthcare, dental, behavioral health, pharmacy, and OPWDD-certified developmental disability services.

While limited in terms of the membership sample, relative to the eligible regional and statewide population base, overall experience for individuals enrolled in the FIDA-IDD Demonstration has been positive. For example, enrollees in the program have reported improved care management and better communication and coordination with their specialists, stating that their Primary Care Physicians (PCPs) are usually or always informed about care received from specialists. However, respondents have also commonly complained about transportation benefits, which some have said were better prior to FIDA because they previously had a choice of transportation providers.[6]

Specialized I/DD Plans – Provider Led

MRT's efforts, along with the continued expansion of managed care to other populations, led to the proposed formation in 2019 of provider-led specialty plans (known as SIP-PLs) certified under Article 44 of the Public Health Law. SIP-PLs were proposed to cover all standard state plan services in the mainstream Medicaid managed care benefit, including acute and primary care, behavioral health services, long-term services and supports, as well as IDD services. It was originally envisioned that some Mainstream plans would offer a specialized IDD plan as a separate line of business.

DOH and OPWDD also released a draft version of the New York State Medicaid Managed Care Organization IDD System Transformation Requirements and Standards to serve Individuals with Intellectual and/or Developmental Disabilities in SIP-PLs. From 2018-2020, the transition to specialized managed care was focused on two areas: (1) improvement in care management processes using a home health model; and (2) creation of a policy framework for the implementation of provider-led managed care.[7] In February 2020, OPWDD issued a revised draft document identifying the qualifications for entities that would become SIP-PL managed care organizations in New York State. However, this process was ultimately paused by the COVID-19 pandemic response efforts and a desire to continue to objectively evaluate the proposition of carving the IDD population into Managed Care.

Membership/Enrollment

Currently, OPWDD coordinates supports for approximately 130,000 people with IDD. Although most Medicaid specialized IDD services are paid through fee-for-service (FFS), approximately 39,000 people with IDD are enrolled in a type of managed care including FIDA-IDD, MLTC, Medicaid Managed Care.

[6] https://innovation.cms.gov/data-and-reports/2022/fai-ny-fida-idd-prelim-firstsecondevalrpt
[7] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_mco_qual_doc.htm

Nearly 113,000 people with IDD served by OPWDD received their case management services through CCOs.[8] Individuals enrolled in CCOs have a choice of two service options: Health Home Care Management or HCBS Basic Plan Support. The number of people receiving either Health Home or Basic HCBS Plan Support has remained constant at 97% and 3% respectively, since the implementation of CCOs.

Programmatic Performance

OPWDD actively seeks input on regulatory streamlining of operations and oversight to enhance access to and operations of services through regular surveillance and surveying of programs and services. OPWDD uses several outcome measures to assess programmatic performance, which will be further reviewed by OPWDD and Guidehouse as part of this evaluation.

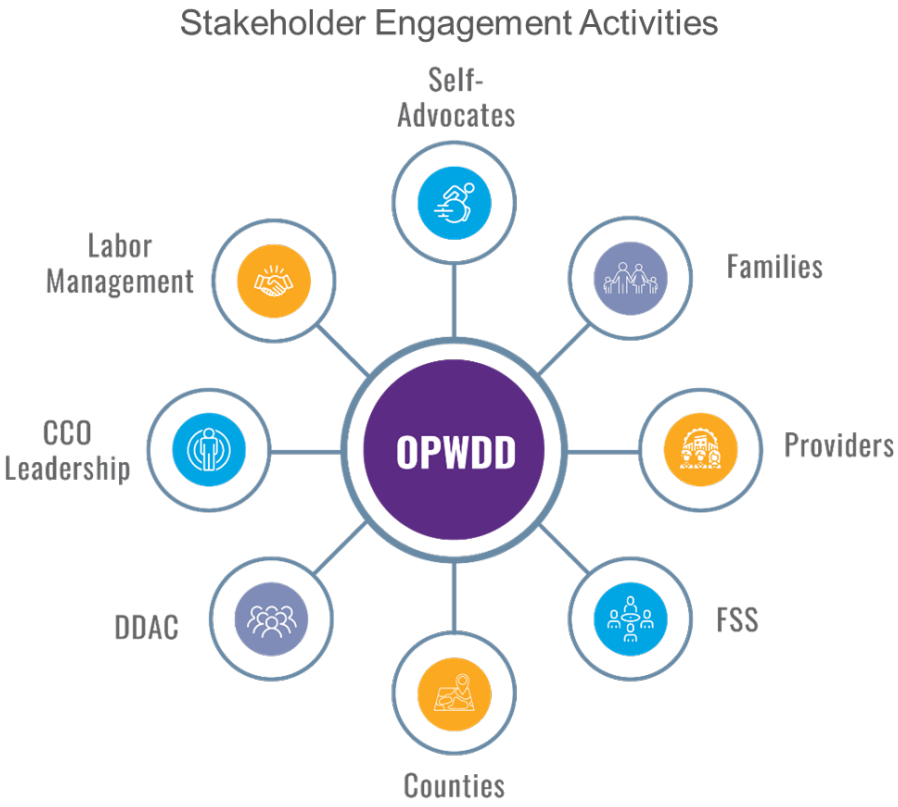
OPWDD Stakeholder Engagement to Date

OPWDD regularly engages with diverse groups of stakeholders to gather perspectives and recommendations on the issues they believe are most important for OPWDD to address. Below is a summary of stakeholder partners with whom OPWDD engages.

OPWDD highly values the input of all stakeholders when making key decisions that impact the population it serves. For example, as part of the 2023-2027 Strategic Plan development, OPWDD held over 30 opportunities for people to provide verbal input. In addition, OPWDD received more than 500 surveys completed by stakeholders, which helped identify the key goals and objectives outlined in Section 2. OPWDD held multiple statewide virtual hearings and numerous remote meetings with targeted constituent groups.[9]

Stakeholders who supported the transition to disability provider-led managed care also were in favor of the integration of developmental disability services, healthcare, behavioral health, and other social care supports as a mechanism for incentivizing high quality and efficient care. Stakeholders who opposed the transition were concerned about the administrative costs associated with managed care. They questioned whether those costs would require reductions in services and supports.

[8] https://opwdd.ny.gov/data/care-coordination-organization-profile
[9] https://opwdd.ny.gov/system/files/documents/2022/11/opwdd-2023-2027-strategic-plan-final-with-links.pdf



Source: OPWDD 2023-2027 Strategic Plan

The stakeholders also acknowledged that the CCO model needs more time and opportunity to demonstrate success and evolve further into a more integrated model, and urged OPWDD to focus on other challenges to the service system, including: the workforce crisis, improving self-direction, improving care for individuals with complex needs, and housing needs. OPWDD used the stakeholder feedback to create its strategic plan.

Additionally, OPWDD will continue to work with its counterparts in other disability networks and state agencies like DOH, Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), Office of Children and Family Services (OCFS), New York State Education Department (NYSED), and the Department of Labor (DOL), to create synergy between systems, share information and data, leverage resources, and provide appropriate services to New Yorkers accessing multiple systems.

Section 4 Service Delivery Models

Relevant State and Federal Statutory/Regulatory Authority, Statutory References

OPWDD provides services and supports to people with IDD through a variety of community and facility-based services. The current utilization of services by people with IDD relies primarily on the Medicaid HCBS waivers and the Medicaid State Plan Fee-for-Service (FFS) delivery model. HCBS is a formal Medicaid State Plan option, giving states the option to receive a waiver of Medicaid rules governing institutional care. Medicaid program waivers offer states additional targeted flexibility to test new approaches to service delivery. Although State Plan options that allow for similar approaches without a waiver have been added to the statute over the years, many states continue to make use of waivers, in part because of the additional flexibilities they provide.

Below we highlight current service delivery authorities with associated descriptions. OPWDD will likely be required to seek CMS' approval to amend existing authorities or develop new authorities if the Office pursues alternative service delivery models. Further, several authorities exist in state statute, some of which will require extension or modification depending on transition planning and decisions related to final product design. States can implement managed care delivery systems under three basic types of federal authorities: State Plan authority [Section 1932(a)], 1915(b) and 1915(c) waiver authority, or Section 1115 waiver authority. Each of these authorities have unique federal regulations states must comply with including having a quality program, providing appeal and grievance rights, reasonable access to providers, and the right to change managed care plans. However, states do have the flexibility to determine statewide application, comparability of services, and freedom of choice.[10]

Table 1. Waiver Programs

Topic	Description	Implication(s) for OPWDD
1915(b)[11]	Provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewide application, and freedom of choice. States typically use two provisions in the law to implement managed care delivery systems.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.

[10] https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html
[11] https://www.macpac.gov/subtopic/1915b-waivers/

Topic	Description	Implication(s) for OPWDD
1915(b)(1) [12]	Primary care case management or specialty service arrangement. This authority allows states to mandate enrollment in a managed care plan or a primary care case management (PCCM) program. Under both models, freedom of choice must be waived to limit the providers through whom enrollees access services.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.
1915(b)(4) [13]	Restriction to specified providers. States may use waivers to limit the number or type of providers who can provide specific Medicaid services – for example, for disease management or transportation. This includes selective contracting by states paying providers on an FFS basis.	Programs must be cost effective, meaning that their use will not cause expenditures to be higher than they would have been without the waiver. To demonstrate cost effectiveness, states trend toward their historic Medicaid costs, and compare these costs to the projected costs of the managed care program.
1915(c) – Home & Community -Based Services	States can develop home and community-based services waivers (HCBS waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.	If OPWDD transitions to a new service model, all services must comply with the HCBS setting rule and the rebalancing of services from institutional care to home care.[14]
1115 Waiver	A demonstration waiver that allows states to test new Medicaid approaches. These waivers are typically designed to demonstrate how changes to program requirements can be used to improve access to care, increase efficiencies, or lower costs without increasing federal Medicaid expenditures.[15]	An 1115 waiver allows OPWDD to implement a new service model that allows the State to expand Medicaid managed care.

Additionally, New York has promulgated relevant statutes governing managed care authority in the State of New York. Some of these statutes will require extension or modification depending on transition planning and decisions related to final product design.

[12] https://www.macpac.gov/subtopic/1915b-waivers/
[13] https://www.macpac.gov/subtopic/1915b-waivers/
[14] https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf
[15] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

Community Integration and Growth of HCBS Services

As OPWDD prioritizes people with IDD receiving person-centered services and supports in community-based settings, it must also make intentional efforts to emphasize the importance of community integration. Community integration supports and enables people with IDD to live, work, and participate in communities of their choice. For people with IDD, this participation also includes full access to civic, religious, educational, economic, and social events occurring in their respective communities. Community integration for persons with IDD and the positive outcomes resulting from such participation, factor heavily in the achievement of positive quality outcomes for state service delivery systems.

Successful rebalancing efforts by states to shift funding and supports from institutional to community-based services, have led to growth in the number of recipients and expenditures for HCBS services. States have made much progress in increasing community options for people with IDD. Today over 75% of people with IDD are receiving services in their home and community. As such, states need to continuously consider how to build HCBS programs to account for anticipated growth and critically evaluate HCBS packages for people with IDD.

High-Impact Policies and Considerations for HCBS Programs for People with IDD

As OPWDD explores transitioning to managed care or other related service delivery models, the Office must take into consideration the impact of state and federal policies and rules and regulations promulgated to support the oversight and operation of the State's IDD service delivery system.

An example of one such consideration is the ruling of the *Olmstead Decision* issued in 1999, which encourages state Medicaid programs to rebalance delivery of LTSS from institutional care to HCBS. In the past 20 years, Medicaid spending has shifted toward HCBS, supported by multiple efforts underway at the federal and state levels to serve more beneficiaries in their communities. With a focus on the Olmstead Decision, OPWDD must determine how potential changes to its service delivery system will impact previous and future rebalancing efforts prior to making such a move. Below we have highlighted several other policies and their implications on changes to the OPWDD service delivery system model.

Table 2. Key National Policies and Their Potential Impact on OPWDD Considerations

Topic	Description	Implication(s) for OPWDD
HCBS Quality Measure Set	The HCBS Quality Measure Set is intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. In doing so, it is expected to support states with improving the quality and outcomes of HCBS.	Historically, CMS and states have struggled to identify a standardized set of quality measures for people with IDD. That is changing as CMS plans to incorporate use of the HCBS measure set into the reporting requirements for the Money Follows the Person (MFP) program and future section 1115 demonstrations. CMS also encourages use of the measure set in 1915(c),1915(i), 1915(j) and 1915{k) authorities. While use of this measure set is voluntary at this time, these changes may require current and future alignment. States are also responsible for establishing quality performance measures for MLTSS programs. In addition to this, states should address key principles when developing MLTSS programs.[16][17]
National Core Indicators (NCI-IDD)	Is a national effort to measure and improve the performance of public developmental disabilities agencies. Performance is measured across four domains: (1) individual outcomes; (2) system performance; (3) health wellness and rights; and (4) family experience.	OPWDD's efforts to measure important elements of person-centered planning, outcomes and satisfaction must be sustained regardless of service delivery model.
HCBS Final Rule Statewide Transition Plan	State plan home and community-based services, and home and community-based settings must have specific qualities (e.g., integrated, privacy, etc.), based on the needs of the individual as indicated in their person-centered service plan. States must also provide conflict-free case management, assuring that assessment and coordination are separate from delivery of services.	The State must ensure that it has proper operations and technology in place to support the HCBS settings requirement. The State will have to ensure that all new services will comply with the final rule. There will also be a need to train all new providers on the rule.

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf
[17] https://www.medicaid.gov/Medicaid/downloads/mltss-summary-elements.pdf

Topic	Description	Implication(s) for OPWDD
Medicaid and Children's Health Insurance Program Managed Care	This final rule advances CMS' efforts to streamline the Medicaid and Children's Health Insurance Program (CHIP) managed care regulatory framework.	OPWDD must ensure appropriate state authorities and final rule compliance measures are in place prior to proceeding with a new MLTSS service delivery model.

Medicaid Managed Care

Managed Care Organizations (MCOs) coordinate and manage care for Medicaid consumers. States pay each MCO a fixed per-member, per-month (PMPM) payment (i.e., capitated payment) for each Medicaid consumer enrolled in that MCO's health plan. These arrangements are risk-based, meaning that if the MCO does a poor job of keeping the consumer healthy and incurs expenses above and beyond what the MCO is paid, the MCO does not receive any more funds from the State. Similarly, if the MCO keeps both consumers healthy and manages service utilization appropriately, it may keep some or all savings from the amount paid by the State. More recently, states have looked to MCOs to provide and coordinate services for more complex populations, such as those requiring LTSS. For the IDD population, these services may include community-based services such as Supported Living, Supported Employment, Housing Stabilization, and Community Integration and Development. Medical and social services are also available to aid individuals with chronic illnesses and significant challenges with performing activities of daily living (ADLs), such as bathing, eating, and toileting, as well as instrumental activities of daily living (IADLs), such as medication management, budgeting, and transportation.

LTSS are delivered in a variety of care settings, which generally fall under two broad categories: institutional (nursing facilities or intermediate care facilities) and community-based (in the home or community settings, such as adult day services). States have been using comprehensive MLTSS programs to manage care for consumers using LTSS, increase access to community-based care, improve member satisfaction and health outcomes, and improve budget predictability. However, no two MLTSS programs are exactly alike. Despite states' increasing adoption of MLTSS, few studies on the value of MLTSS programs have been conducted. States are also mindful of the fact that they will need to carefully monitor the quality of the care provided by the MCOs to these vulnerable consumers.[18]

As of 2021, 22 states, including New York, operate MLTSS programs for various populations. Older adults are the most included population while IDD populations are slowly being integrated nationwide. Among the 22 MLTSS programs that exist:

- 85% include Medicaid primary and acute care
- More than 80% include nursing facility services
- Medicaid HCBS are incorporated in 85%

[18]http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf

- 75% are available statewide
- 25% are in specific regions or counties[19]

Additionally, Ohio and South Carolina operate within the confines of a Financial Alignment Initiative demonstration which coordinates care and aligns benefits for individuals eligible for Medicare and Medicaid although neither of these states include people with IDD in this program. As outlined earlier in Section 3, New York also operates a similar FIDA-IDD program for people with IDD.

Given the unique needs of people with IDD, the decision to transition this population to managed care should be well planned and given appropriate consideration. The provider community for people with IDD is quite different than those serving older adults and people with physical disabilities. Unlike services for older adults, there are very few private pay recipients of IDD services, which makes IDD providers heavily dependent on public resources. Many of the providers started from local advocacy groups, and as a result are often small organizations serving fewer than 50 people. Since services for people with IDD are designed to engage the person fully in their community, there may be different providers for residential versus employment and day services. Moreover, their level of business acumen – ability to set prices, negotiate contracts, and meet stringent accountability outcomes demanded by MCOs – varies greatly across the country. Because the IDD system in most states serves the majority of their participants in home and community settings, not intermediate care facilities for Individuals with Intellectual Disabilities (ICFs-IDD), goals other than rebalancing are typically top of mind for states:

- Increased access to preventive and acute services
- Comprehensive care/service coordination
- Budget predictability and stability.

Managed care may also foster innovation to address social determinants of health (SDOH), also known as social drivers of health, which are "…the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risk."[20] As part of their value-add services,[21] MCOs may pay for or support non-medical services such as transportation, housing, and food insecurity. For example, if an MCO's member has asthma, the MCO could offer a home assessment to identify any environmental asthma triggers.[22] Identifying these asthma triggers in the member's home will not only improve their health outcomes but could also reduce healthcare utilization for asthma-related instances.

[19] http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf
[20] https://health.gov/healthypeople/priority-areas/social-determinants-health
[21] Value-add services are services that MCOs offer to their members for which the state does not pay.
[22] https://academyhealth.org/sites/default/files/implementing_sdoh_medicaid_managed_care_may2018.pdf

In 2012, CMS released guiding principles for MLTSS programs using 1915(b) and Section 1115 authorities. Since then, many of these principles have been embedded in the Medicaid managed care regulations.

Table 3. MLTSS: 10 Guiding Principles [23]

Principle	Description
1. Adequate Planning and Transition Strategies	The most effective MLTSS systems are the result of a thoughtful and deliberative planning process. An adequate planning process includes the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.
2. Stakeholder Engagement	Stakeholder engagement and collaboration are critical pieces to ensure the smooth and efficient transition to managed care for these populations.
3. Enhanced Provision of Home and Community Based Services	Community-based LTSS should be delivered in settings that are aligned with requirements for home and community-based characteristics and in a way that offer the greatest opportunities for active community and workforce participation.
4. Alignment of Payment Structures with MLTSS Programmatic Goals	Payment to managed care plans should support the goals of MLTSS programs including the essential elements established in this document and support three goals of improving the health of populations, improving the beneficiary experience of care, and reducing costs through these improvements.
5. Support for Beneficiaries	All beneficiaries, particularly those most vulnerable, need support and education throughout their experience in the MLTSS program. Common support resources for beneficiaries provided by the state at no cost to the beneficiary are enrollment/disenrollment services, including choice counseling and education on additional opportunities for disenrollment, and an advocate or ombudsman to help beneficiaries understand their rights, responsibilities and how to handle a dispute with the managed care plan or state.
6. Person-centered Processes	Ensuring beneficiaries' medical and non-medical needs are met and they have the quality of life and level of independence they desire within the MLTSS program start with the person-centered planning process. Active participation by the beneficiary, or his/her designee, in the service planning and delivery process, meaningful choices of service alternatives, holistic service plans based on a comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to direct their community-based services, fostering independence, with assurances of appropriate supports are critical components that CMS will expect to see in state applications.

[23] https://www.medicaid.gov/Medicaid/downloads/1115-and-1915b-mltss-guidance.pdf

Principle	Description
7. Comprehensive and Integrated Service Package	Managed care plans have more impact on, and ensure quality delivery of, the services covered in their state contract. When all covered services – including integrated physical health, behavioral health, community based and institutional LTSS – are provided through the managed care plan, the managed care plan staff and/or providers developing, and monitoring service plans are able to provide comprehensive person-centered service planning and oversight of care across all available settings.
8. Qualified Providers	As with traditional managed care plans, MLTSS plans are required to have an adequate network of qualified providers to meet the needs of their enrolled beneficiaries.
9. Participant Protections	People with IDD can be especially at-risk for exploitation and abuse, neglect, inappropriate denial of services, and limited participation in the planning of their services and supports. CMS expects states to mitigate these risks through program design and contracts with appropriate health and welfare assurances, a strong critical incident management system, and an appeals process that allows access to continuation of services while an appeal is pending.
10. Quality	The building blocks of a quality MLTSS program include both existing LTSS quality systems and managed care quality systems. Merging these two systems may provide a state with more sophisticated data capabilities and provide a new opportunity to think holistically about beneficiary outcomes. A comprehensive quality strategy and oversight structure that takes into consideration the acute and primary care, behavioral health, as well as LTSS needs of beneficiaries can provide a framework for states to incorporate more meaningful goals into the program that focus on quality of care and quality of life for beneficiaries. Quality oversight of an MLTSS program may be operationalized differently from the fee-for-service system; therefore, states will need to evaluate their resources to ensure the appropriate type and level of staff is available.

Additionally, ADvancing States, which represents the nation's 56 state and territorial agencies on aging and disabilities, released its 2017 "Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities: Strategies for Success"[24] report that highlighted various key factors that are critical for a successful implementation of a MLTSS program for people with IDD including:

- Adequate planning time
- Continuous stakeholder engagement
- Thoughtful program design
- Recognition of the unique needs of people with IDD.

[24] http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf

Fee-For-Service

In an FFS delivery model, providers are paid for each service unit they provide rather than receiving a capitated payment for a specific period of time. This payment model is commonly used in hospitals, clinics, HCBS settings, nursing homes, and other healthcare settings. Cost of care is typically determined by the service provided and complexity of the care. As of 2021, there are 43 states that are FFS for the IDD population[25]. With an FFS delivery model, volume of services is sometimes prioritized, and quality and patient outcomes are not necessarily tied to provider reimbursement. This has led some states to consider transitioning to other service delivery models for the IDD population.

The impetus for New York State MRT was to move all populations receiving traditional Medicaid benefits to managed care in order to reduce cost and improve quality with an emphasis on value-based care and Community Based Organization (CBO) participation via the Value Based Payment (VBP) Road Map. As described above, FFS Medicaid for the IDD population includes traditional provider reimbursement and access to Health Home and HCBS services to improve care coordination; however, state payments are not typically tied to quality or health outcomes.

FFS impacts the following goals from the OPWDD strategic plan:

- **Transform OPWDD's system through innovation and change**
    - *Strengthen quality, effectiveness and sustainability of support and services:* Under FFS, providers are compensated based on the delivery of services to individuals with developmental disabilities and their families. Compensation is not typically tied to quality or health outcomes.
    - *Research and innovation:* Providers are paid based on direct service delivery, making it a challenge for states to incentivize innovation through provider payments. The development of pilots accompanied by the need to evaluate outcomes may be prohibited by the lack of reimbursement for already overburdened providers and nonprofits.
- **Enhance OPWDD's person-centered support and services**
    - *Ensure children, youth, and young adults receive appropriate and coordinated services. Expand support for people with complex needs:* Providers have noted that FFS does not reimburse appropriately for care coordination.
    - *Address gaps in cultural and ethnically diverse communities:* Providers and CBOs have noted that FFS does not compensate appropriately for the administrative cost to identify, address, and reduce the gaps in cultural and ethnically diverse communities. There are limitations in Health Homes and HCBS services to tailor solutions to this unique and complex population.

[25] http://www.advancingstates.org/sites/nasuad/files/2021%20%20Demonstrating%20the%20Value%20of%20MLTSS.pdf

Despite the recent trend in MLTSS, the experience of managed care for people with IDD is more limited and LTSS for people with IDD are frequently among the last services to be incorporated into managed care contracts. While the goals of care integration, improving quality, and encouraging innovation are important to IDD systems, only a few states have fully embraced contracted Medicaid managed care for all IDD services due to several reasons, such as:[26]

- Lack of potential cost savings
- Limited MCO experience serving people with IDD in MLTSS
- Limited state experience to set MLTSS-IDD managed care rates
- Need for meaningful quality measures
- Lack of managed care experience among IDD providers
- Unique role of IDD case management and supports coordination

[26] https://www.ancor.org/wp-content/uploads/2022/08/ancor_mltss_report_-_final.pdf

Section 5 Next Steps for Completing the Final Managed Care Assessment

With the submission of this legislative report, Guidehouse, with the support of OPWDD, will move forward with its assessment of potential service delivery models for people with IDD, including managed care, through a collective and iterative approach focusing on how OPWDD can best position itself to achieve its three goals within the 2023-2027 Strategic Plan:

1. Support people in the most person-centered ways
2. Promote practices that strengthen the workforce and infrastructure
3. Advance systems change and innovation across the State.

The assessment will evaluate how the implementation of managed care, or another delivery system, can assist OPWDD in improving services and supports for people with IDD in New York State. The assessment will include the following three key steps:

1. Environmental Scan, Literature Review, and Data Analysis

To achieve these ends, Guidehouse has begun conducting an environmental scan to supplement and strengthen knowledge of current service delivery models outlined in this report and expand understanding of current MLTSS operations, with a specific focus on current supports for people with IDD. This includes a review of documentation, data analysis, and interviews with internal stakeholders.

To complement our qualitative background knowledge, Guidehouse will review quantitative metrics such as program utilization data, care planning, critical incident, and quality measure data to help us understand whether programs are operating and serving HCBS and MLTSS members as intended, and to assess any gaps in service or benefit design that would need to be addressed for implementation. This step allows us to draw objective conclusions and develop hypotheses about the level of preparedness New York's IDD programs have prior to a change in service delivery model. These conclusions and hypotheses will inform and be tested by stakeholder feedback activities and provide a comprehensive understanding of the needs and experiences of people with IDD and their families.

As part of this assessment, we also anticipate analyzing the following initial data points to assess services, efficiency, and cost effectiveness of the current IDD programs including fee-for-service, FIDA-IDD, and Medicaid Mainstream Managed Care Plans:

- Service utilization trends
- Claims data population analysis of Medicaid enrollment, utilization, and care settings
- Annual expenditures and average spend per member to assess potential risk pool challenges
- Critical incident data to cross reference with clinical utilization trends

- Claims data on hospitalizations, emergency department visits, primary care visits, and behavioral health services to inform the current state of clinical integration.

Following these initial data reviews, collecting rich qualitative data via surveys and interviews will be imperative to determining a well-informed recommendation on the most appropriate service delivery model. Bringing quantitative and qualitative data elements together will offer a full circle view of New York's current state and the potential impact of transitioning the IDD delivery system to managed care.

2. Best Practices and National Trends

Guidehouse will continue to evaluate best practice care management models for the IDD population and transitions to managed care models among a diverse array of states to gain comparative insight on their existing model and structure.

Best Practice and Peer State Literature Review

Guidehouse will continue its document review of publicly available studies and assessments. The research will consider information on care management models, managed care transitions, quality measures and outcomes, and community-based service delivery. We will conduct detailed document reviews of best practice states based on performance (e.g., key performance indicators) and peer states with similar population, structure, and cultural dynamics as New York State. This best practice and peer state research will include an analysis of each selected state across key focus areas, such as:

3. Stakeholder Engagement

Meaningful engagement with diverse stakeholders is a key component of this effort. Input provided by stakeholders in the past has helped OPWDD identify opportunities not otherwise observed by state staff and lead to more effective outcomes. Given the length of time a potential change in service delivery model has been under consideration by OPWDD, a significant volume of stakeholder feedback has already been received about the topic. Guidehouse will begin by reviewing prior stakeholder engagement findings including all notes, summaries, and

comments regarding previous and ongoing stakeholder engagement activities to identify key themes related to managed care or other service delivery models for people with IDD such as:

- Comment or recommendation is within OPWDD's jurisdiction and purview to create change
- Comment is mentioned frequently or identified as high priority by independent commentors
- Comment is relevant to the stakeholder engagement aims and objectives

Through reviewing previous notes and stakeholder engagement results, Guidehouse will identify historical and emerging themes, key stakeholders, and a thorough background of engagement initiatives already undertaken by the State. The results of the review will be used to inform the development of Guidehouse's stakeholder engagement methodology of questions for future stakeholder engagement.

Based on the results of this review, and with the assistance of OPWDD, Guidehouse will develop targeted questions related to the managed care study, focusing stakeholder engagement on four groups:

1. Statutory Advisory Boards
2. New Yorkers with IDD and Natural Support Engagement and their Providers
3. Managed Care Constituency
4. Other Internal, State and Local Government Partnerships.

Statutory Advisory Boards

Given the vulnerable nature of the population OPWDD serves, there are advisory boards that have been established to oversee and support these people with IDD. Guidehouse and OPWDD will engage with these groups to gather important guidance and insights into a potential change in service delivery model.

- The Developmental Disabilities Advisory Council (DDAC) is a key stakeholder that was established within the NYS Mental Hygiene Law and is tasked with providing recommendations on statewide priorities, planning and process evaluations. The DDAC is comprised of self-advocates, providers, and family members.
- The Joint Advisory Council (JAC) for managed care was created to provide input and make recommendations about care improvements and improve transitions of services for their people with developmental disabilities and their families.

New Yorkers with IDD and Natural Support Engagement and their Providers

A study focused on connecting with New Yorkers who rely on OPWDD's services directly will help Guidehouse to understand the implications of any policy or program changes under consideration. Collecting feedback from people with IDD and their families will be key to

understanding the importance of considering how policy changes at the State level will impact services.

This assessment also spans across multiple providers and provider types. It will be critical to involve providers during the project life cycle. In addition to engaging individuals who receive services from OPWDD, OPWDD has already begun to identify a comprehensive and diverse list of waiver providers, associations, and other provider stakeholders with whom Guidehouse will engage. The goal of these engagements is to assess and identify the quality and outcomes of the managed care environment and to identify potential opportunities where managed care may support or hinder OPWDD in achieving its strategic goals.

Managed Care Constituency

Given the current role of managed care across New York for other populations, Guidehouse may also engage representatives of MCOs to better understand their perspective around how certain service delivery models may best benefit New Yorkers with IDD. This group may include CCO and FIDA-IDD leaders and employee representatives.

Other Federal, State and Local Government Partnerships

Guidehouse may also have conversations with CMS to understand CMS expectations if a transition to managed care were to take place, and to cultivate a positive and engaging relationship with CMS to ensure the most beneficial technical assistance is available. In addition to CMS, it will also be beneficial to discuss the potential transition with state agencies and local government partners.

OPWDD will also conduct ongoing education and stakeholder engagement activities with the general public. Educating the public is particularly beneficial for policy and program initiatives involving the IDD population and understanding what service delivery model may be best for the population. The IDD population is a vocal and engaged group that is very active in policy decisions regarding their care. Continuous education efforts would provide OPWDD the opportunity to explain policy decisions and gain buy-in from key stakeholder groups.

Final Report

The Final Report will be based on comprehensive information and research collected throughout the study and significant stakeholder engagement, as outlined above. From a compilation of quantitative and qualitative information, the Final Report will present data-driven recommendations for discussion among stakeholders and decision-making of what service delivery model can most effectively support the individualized needs of people with IDD and help to achieve OPWDD's goals.

As Guidehouse prepares the Final Report and recommendations, we will work with OPWDD to explore recommendations on service delivery models, including managed care, and program requirements that yield progress toward the goals outlined in the 2023-2027 Strategic Plan. Guidehouse intends to include the following elements in the Final Report:

- **Service Delivery Model Study Methodology and Findings:** Comprehensive summary of the service delivery study methodology and findings after completing all research and

stakeholder engagement activities, focusing on managed care and other options currently implemented nationally.

- **OPWDD Program Goals:** Detailed perspective of OPWDD program goals, objectives and measurements of success to execute and monitor OPWDD's progress towards achieving goals based on the recommended service delivery system.
- **Final Recommendations:** Recommended next steps for selection and implementation of a service delivery model. This will include key program requirements of the recommended service delivery model to successfully serve the IDD population across New York.

Guidehouse appreciates OPWDD's partnership and collaboration in the development of this Initial Report and looks forward to working with OPWDD and the IDD stakeholder community to complete our assessment and Final Report.