Intellectual and Developmental Disabilities (I/DD) Clinical Advisory Group (CAG)

I/DD CAG Member Introductions

I/DD Clinical Advisory Group

Background and Objectives

CAG Background

- Clinical Advisory Groups (CAGs) were created to make recommendations to the State on quality measures, data and support required for providers to be successful, and other implementation details
- NYS convened various CAGs throughout 2016 to discuss the implications of VBP and identify a set of quality measures that could be used to support the NYS VBP program
  - This included a CAG for the I/DD population and a future I/DD VBP Arrangement
- Progress report was issued in December 2016 outlining potential VBP arrangement design, quality measures, and attribution methodology

2016 I/DD CAG Agenda and Dates

2016: Jan 21	Mar 23	May 17	Jul 06
Creating the Right Incentives- Paying for Value	**A Deeper Dive- The I/DD Populations and Total Cost of Care**	**Defining High Value Care for I/DD Population**	**Defining High Value Care for the I/DD Population**
• Working group agenda overview • The role of VBP in achieving high quality, cost effective care • I/DD Services in transition - The Transformation Agenda • High value care in a I/DD context - Total care, total population models with managed care, Accountable Care Organizations, etc.	• Overview total cost of care for I/DD populations • VBP arrangements for the I/DD population • A more nuanced view of use patterns of acute and Longer Term Services and Supports (LTSS)	• Defining the value premise • Special considerations for the I/DD population • Traditional medical and clinical intervention logic Nontraditional intervention logic • Outcome measures to consider – an overview of “food for thought”	• Goal is to select quality measures to incentivize strategic goals • Process and method for selection • Detailed review of quality measures – definition and method for collection and calculation • Facilitated quality measure selection

2016 I/DD CAG Report: Quality Measures

- In December of 2016, the I/DD CAG included 17 quality measures that could be used for VBP quality measures

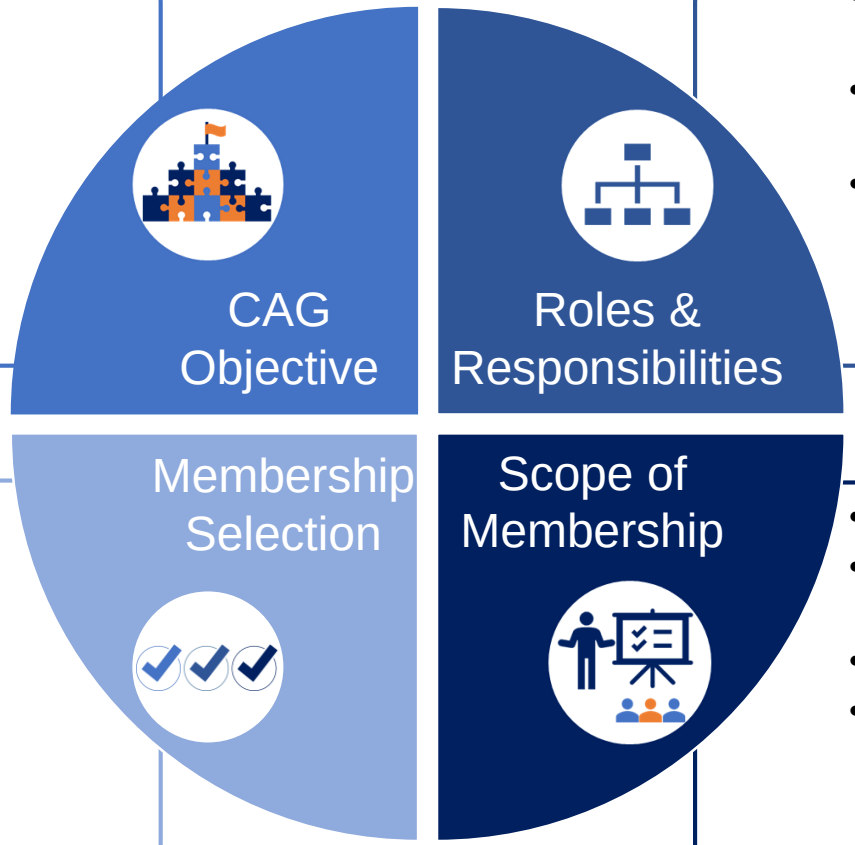
People Choose Where and With Whom they Live	**The Council on Quality and Leadership (CQL) Personal Outcome Measures (POMs®)**
People Choose Where they Work	
People Use their Environments	
People Participate in the Life of the Community	
People have the Best Possible Health	
People Interact with Other Members of the Community	
People Perform Different Social Roles	

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	**CMS**
Proportion of Adults who had blood pressure screened in past 2 years	
Diabetes Composite: Aspirin Use	
Emergent Care for Improper Medication Administration or Medication Side Effects	

Annual Dental Visit (ADV)	**National Committee for Quality Assurance (NCQA)**
Colorectal Cancer Screening	
Diabetes Composite: Hemoglobin A1c Control (HbA1c) (<8.0%)	
Statin Therapy for Patients With Cardiovascular Disease	
Diabetes Composite: Blood Pressure (BP) < 140/90	
Diabetes Composite: Tobacco Non-Use	

I/DD CAG Scope of Work for 2019 and Beyond

- Build upon the work of the 2016 I/DD CAGs
- Review key considerations related to quality measurement from the VBP Roadmap
- Make recommendations and provide feedback for quality measures for I/DD populations



- Attend and actively participate in scheduled CAG workgroup meetings
- Designate an additional individual to act as an alternate
- Present recommendations to the Joint Advisory Council (JAC) prior to the submission of any recommendations to the DOH

- Clinical expertise and industry knowledge of I/DD services and populations
- Geographic diversity
- New stakeholders impacted by transition to managed care
- Total care spectrum experience for the I/DD population

- 2 year commitment
- OPWDD may rotate membership throughout the duration of the CAG
- Meetings held quarterly
- DOH will use feedback from I/DD CAG but has ultimate authority to select measures and reporting requirements for VBP

Joint Advisory Council (JAC)

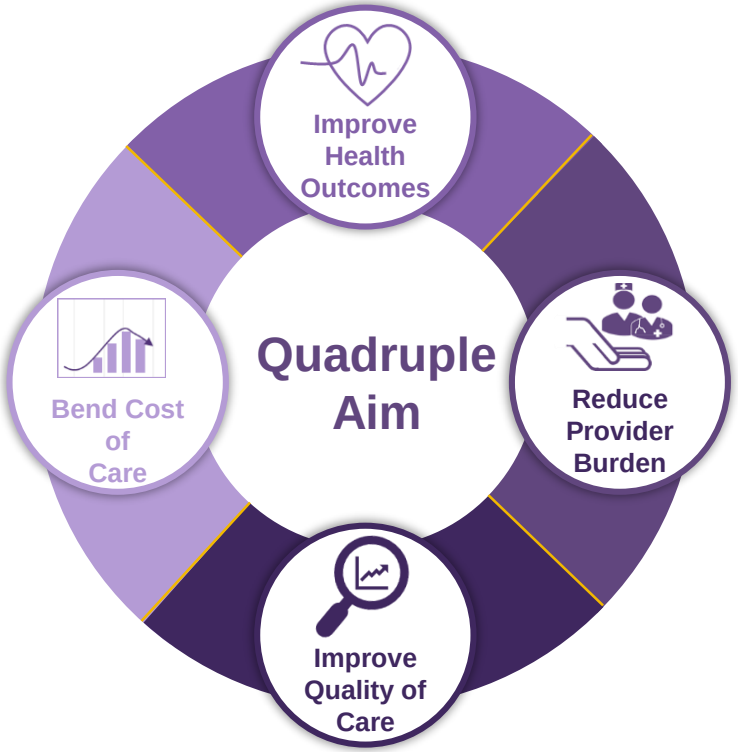
- The purpose of the JAC is to advise the Commissioners of OPWDD and the Department of Health (DOH) regarding the design of managed care models that will provide services to individuals with I/DD.
- The JAC is an extension of the Medicaid Managed Care Advisory Review Panel (MMCARP) which was created by Chapter 649 of the Laws of 1996 to monitor enrollment of Medicaid recipients in managed care plans and ensure access to care in these health care delivery systems.
- The JAC is ongoing and meets quarterly
- The CAG will be presenting its recommendations (on an annual basis) to the Joint Advisory Council (JAC) prior to the submission of any recommendations to the DOH.

I/DD Clinical Advisory Group

Value-based Payments (VBP) Overview

Value-Based Payment Overview

- Value-based payments (VBP) reward health care and service providers with incentive payments for the quality of care delivered (vs. quantity)
- The goals of VBP align with the Quadruple Aim
- VBP is a payment model that incentivizes care coordination and rewards providers and plans when quality targets are met or exceeded
  - Pays for enhanced patient care coordination
  - Pays for managing the cost of care and reducing inefficiencies
  - Paying for the use of evidence-based clinical practices

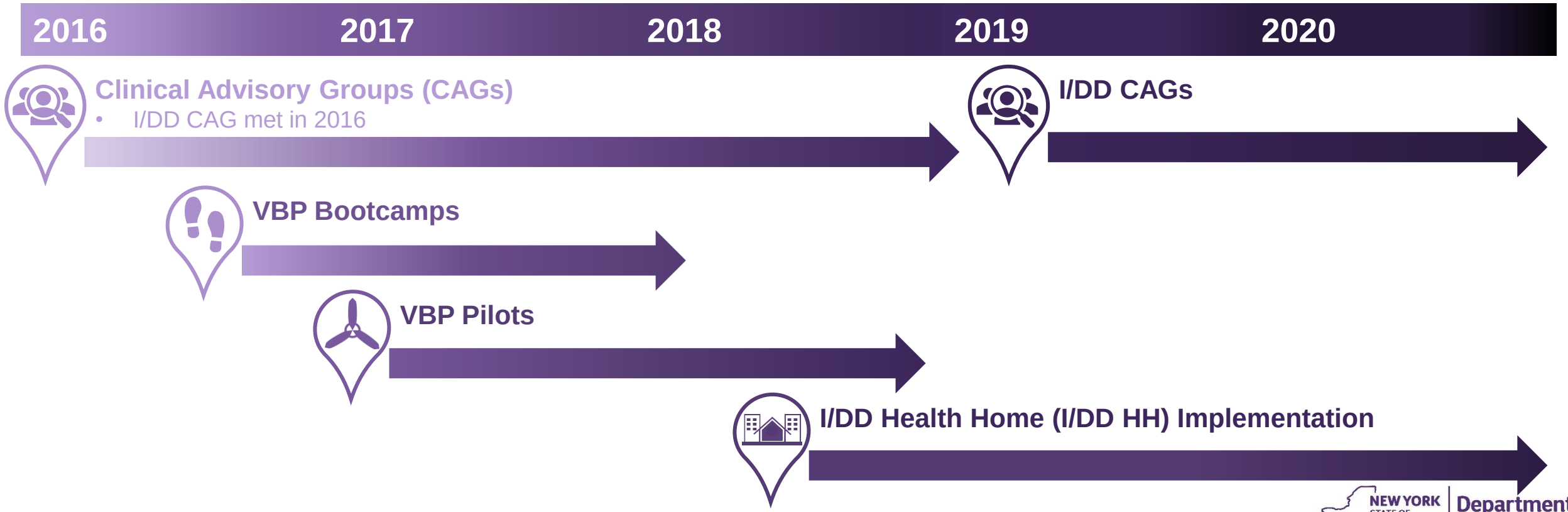


Medicaid Payment Reform: Moving Towards VBP

VBP Roadmap: Five-Year plan for Medicaid Payment Reform

VBP Goal: MCOs required to begin implementing VBP Contracting with providers

VBP Goal: 80% of MCO's provider payments in VBP



NEW YORK STATE OF OPPORTUNITY. Department of Health

New York State's Medicaid Roadmap Review

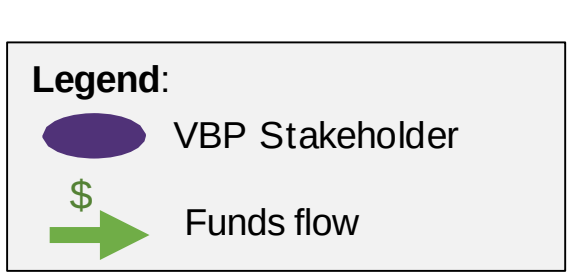
"Is <u>Not</u> an attempt to make providers do more for less."

In fact, under the State´s VBP approach, **reducing lower value care** and **increasing higher value care** in equal proportions should lead to higher margins rather than lower margins.

"*Often, payment reform initiatives initially seem to increase the administrative burden; they necessarily constitute a change from the way current administrative processes and systems operate. They may require upfront investment for redesign and may require providers to temporarily straddle different payment systems simultaneously. Yet well–executed payment reform can significantly offset this complexity by reducing the need for micro– accountability (**such as the need for utilization review throughout the care process**), by not only standardizing rules and incentives across providers, but also by increasing transparency."*

2017 VBP Roadmap - Link

Provider and MCO in Relationship in VBP Arrangements



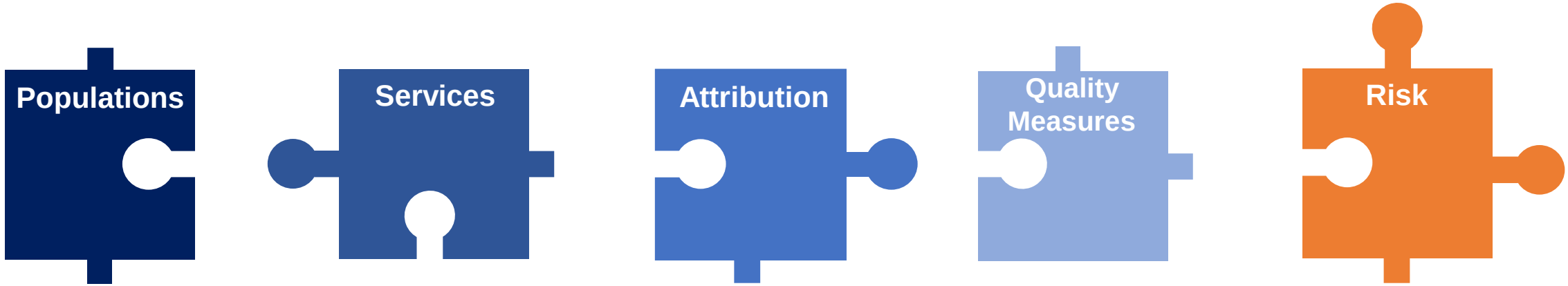
- The **State pays the plan a set Per Member Per Month (PMPM)** payment.
- This is called capitation.

- A contractual relationship between the MCO and a provider where savings may be shared based on quality measures

VBP Arrangement

- Individual providers can work together with an MCO to create a VBP arrangement through provider contracts.

Key Factors of a VBP Arrangement



Who is Covered?	What is Covered?	Which Providers are Responsible?	What is Measured?	What Risk Do Providers Assume?
• The members (patients) covered or not covered under the VBP Arrangement • Members cannot be attributed to more than one type of VBP Arrangement	• Services covered by the MCO that could be included or excluded in a VBP Arrangement	• The members included (attributed) in a VBP Arrangement	• Quality and outcome measures for each kind VBP Arrangement	• Providers move to risk-based contracting (upside or downside risk) for the cost and quality of care for attributed populations

The Role of Quality in VBP

- MCOs and providers select which arrangements might be appropriate for their VBP Arrangement
- MCOs and providers must agree to report on quality measures associated with their selected arrangement(s)
- The specific measure sets and fact sheets for other VBP Arrangements are available in the VBP Resource Library

- The quality measure results are intended to be used to determine the amount of shared savings/losses for which providers are eligible
  - Selected quality measures should also be relevant and appropriate for the services and populations covered under the VBP Arrangement

VBP Arrangements for I/DD Services and Populations

- The VBP Roadmap indicates that VBP arrangements for I/DD populations **are still in development** and **will come after the transition** to managed care
- To assist with this development, the I/DD CAGs will be used to:
  - Assist in defining the “value proposition” for VBP for I/DD services;
  - Promote future stability in a VBP environment by laying proper foundation in managed care;
  - Establish feedback loop from managed care operations and providers to identify the best quality measures and Health Information Technology (HIT) that promote interoperability for VBP; and
  - Advance a Roadmap unique to the I/DD community that addresses expansion of access and coverage for enrollees and addresses the potential risk plans and providers are willing to assume

Quality Measures for I/DD VBP Arrangements

The I/DD CAG will focus on the role of quality in a VBP Arrangement by:

- Analyzing potential data sources for I/DD quality measures;
- Identifying and reviewing existing quality measures that are appropriate for individuals with I/DD;
- Assisting in the prioritization of quality measures that can be incorporated into OPWDD's transition to managed care; and
- Giving insight into the managed care experience to identify quality measures that could be included in I/DD VBP Arrangements.

I/DD Clinical Advisory Group

OPWDD Transformation Updates

OPWDD Goals for System Transformation

People live and receive services in the most integrated setting

People have community participation experiences that are meaningful to them

People have meaningful relationships with friends, family and others that are important to them

People experience personal health, safety and growth opportunities

People exercise choice and decision making in their life and with their daily schedule to the extent possible

Initiatives Supporting Transformation

I/DD Health Homes (I/DD HH)

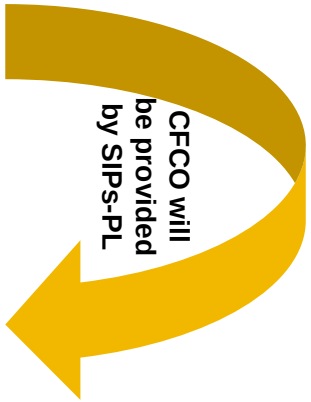
- Providing enhanced care coordination and management to individuals with I/DD

Community First Choice Option (CFCO) included in Mainstream Managed Care (MMC) benefit

- CFCO expands access to home and community-based attendant services and supports
- For CFCO eligible individuals, CFCO services are accessed through the State Plan instead of the 1915(c) Home and Community-Based Services (HCBS) Waiver
- Provider-led Early Adopter MMC plans may provide CFCO services, including Community Habilitation, to members

Transition individuals with I/DD and DD services into managed care

- Allow individuals with I/DD to enroll in managed care to receive DD services, including HCBS, via SIPs-PL



I/DD Health Home Overview

Description

- Medicaid model of care that provides enhanced care management and coordination to individuals with I/DD
  - Integrates primary, acute, behavioral, Home and Community Based Supports (HCBS) in care planning

I/DD HH Goals

- Develop a comprehensive ***Life Plan*** overseen by a care manager
- Eliminate conflict of interest
- Create a foundation of person-centered planning
- Incentivize performance
- Develop/train Medicaid Service Coordinators as Care Managers

I/DD HH Eligibility

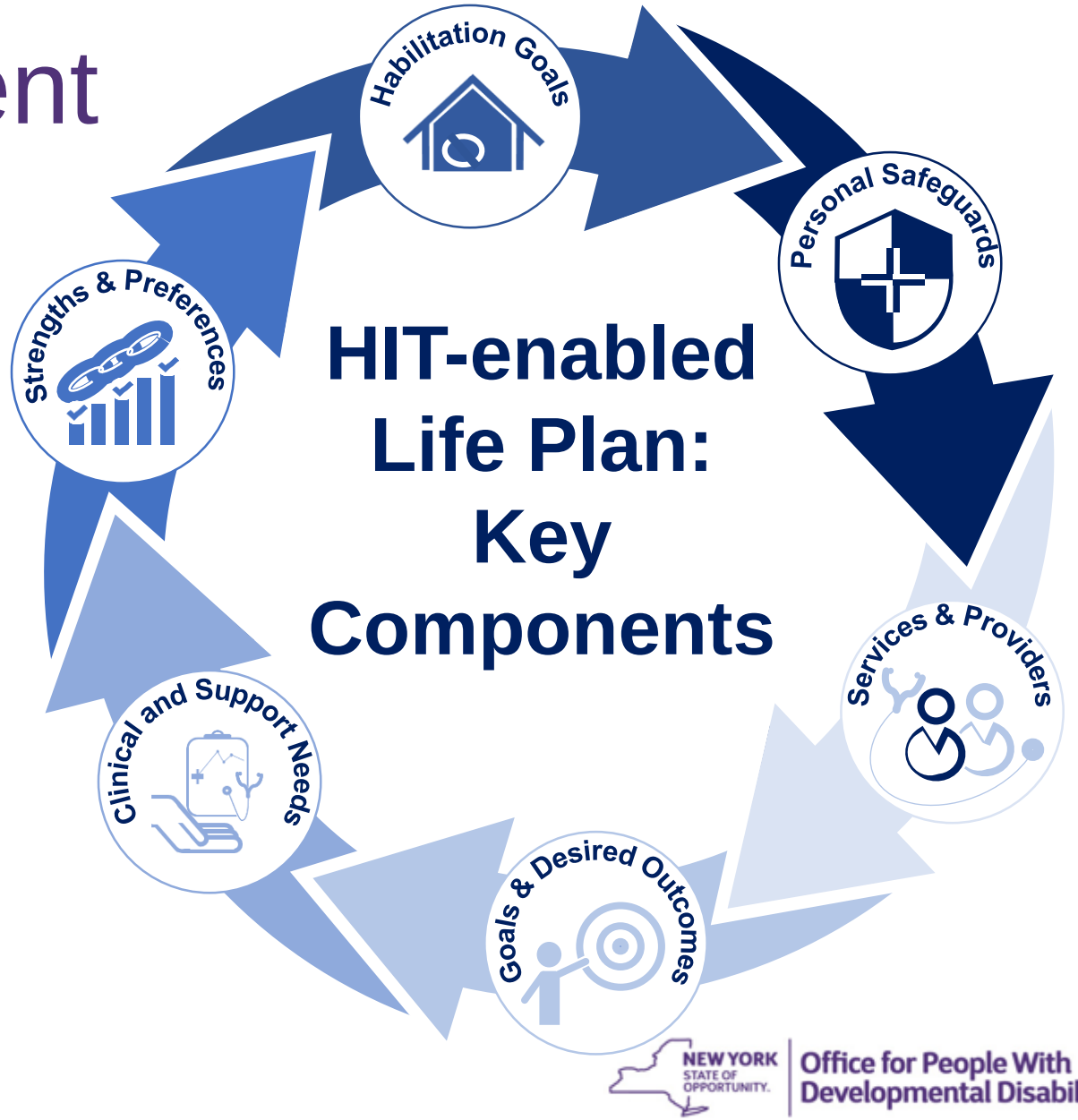
- Adults and children with one of the I/DD HH chronic conditions and meet ICF level of care criteria, including:
  - Intellectual Disability
  - Cerebral Palsy
  - Epilepsy
  - Neurological Impairment
  - Familial dysautonomia
  - Prader-Willi Syndrome
  - Autism

I/DD HH Core Services

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Supports
- Use of HIT to Link Services

Life Plan Development

- A comprehensive assessment process informs key aspects of the Life Plan development
- Collaborative and recurring process driven by the person
- Describes who the person is, what they want to accomplish, and what will help them accomplish their goals/valued outcomes
- Integrates all services and natural supports
- Understandable to the person
- Must be agreed to and signed by the person and their Interdisciplinary Care Team



I/DD HH Quality and Performance Measures

- I/DD HH quality measures are published by NYSDOH and can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_2018_measure_specific_rpting_manual.pdf
- I/DD HHs should monitor the I/DD HH specific measure set until reporting to NYS begins
- These measures focus on the important aspects of enhanced care coordination and management for which the I/DD HHs are responsible for providing to enrollees as they develop the Life Plan

I/DD HH Measures	Numerator Description	Denominator Description
Implementation of CQL POMS	Number of I/DD HH members with Life Plans with a minimum of two POM measures	Total number of I/DD H/H members with Life Plans
Implementation of personal safeguards	Number of HH members with Life Plans that reflect personal safeguards	Total number of I/DD H/H members with Life Plans
Transitioning to a more integrated setting	Number of I/DD HH members who have moved to a more integrated setting from a 24-hour certified setting	Total number of I/DD H/H members in a 24-hour certified setting
Employment	Number of I/DD HH members who are competitively employed	Total number of I/DD H/H members who indicate a desire to pursue employment in their Life Plan
Self-direction	Number of I/DD HH members enrolled in self-direction	Total number of I/DD HH members who indicate a desire to self-direct in their Life Plan
Bladder and Bowel Continence	Number of I/DD HH members with a Life Plan in place that includes reporting of support or device needs, bowel/incontinence tracking protocol and/or management protocol	Total number of I/DD HH members with an identified bladder/bowel health risk
Falls	Number of I/DD HH members with a Life Plan that includes supervision, contact guarding, adaptive equipment, environmental modifications or other directed support	Total number of I/DD HH members with an identified risk of falls
Choking	Number of I/DD HH members with a Life Plans with choking safeguards	Total number of I/DD HH members with an identified risk of choking

Community First Choice Option (CFCO)

Description

- CFCO is an optional State Plan authority created under the Affordable Care Act to allow States to offer home and community-based services to eligible Medicaid enrollees
- Expands access to attendant services and supports to help with everyday activities

CFCO Service Delivery

- Provides consumer controlled, personal assistance services and supports for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and health-related tasks
- Services must be provided across all Medicaid-eligible populations (DOH, OMH, and OPWDD)
- Must be provided in the community

CFCO Eligibility

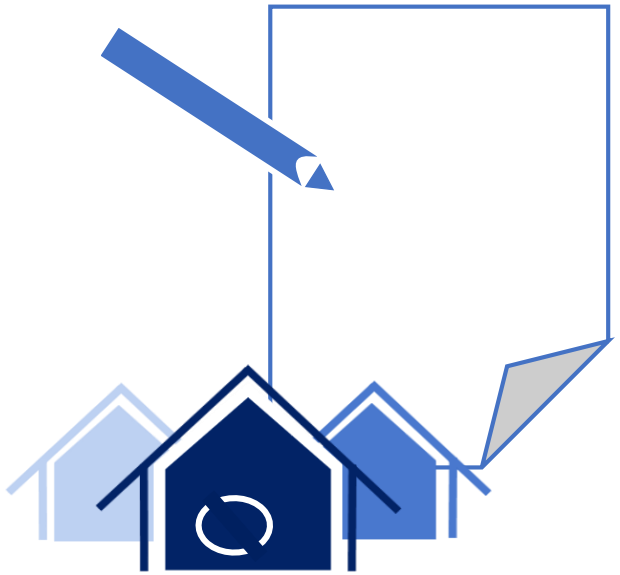
- State Plan Services under CFCO are available to individuals who fulfill all of the following criteria:
  - Eligible for Medicaid
  - Have an institutional level of care as determined by the functional assessment used for that population
  - Living in their own home or a family member's home (not a congregate setting)

CFCO in Managed Care

- Many CFCO Services are already included in the managed care benefit package offered to eligible enrollees:
  - Consumer Directed Personal Assistance
  - Home Health Aide
  - Homemaker/Housekeeper (Personal Care Level 1)
  - Personal Care Level 2
  - Personal Emergency Response System

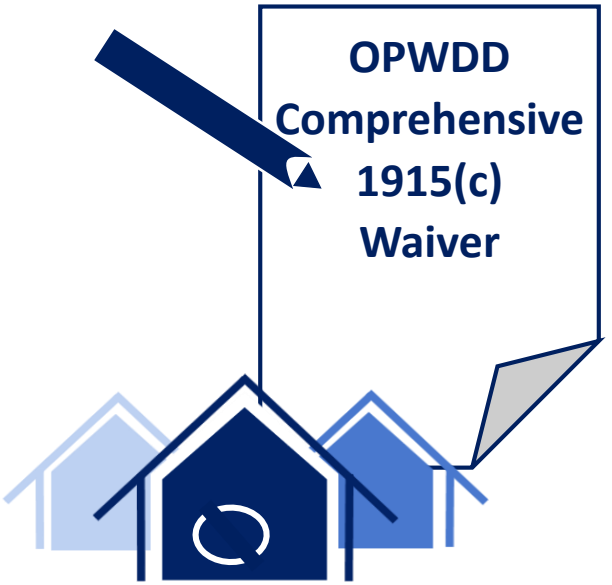
CFCO Services

- Many CFCO services overlap with HCBS covered under 1915(c) Waivers and will also transition to mainstream managed care



CFCO Authorized Services

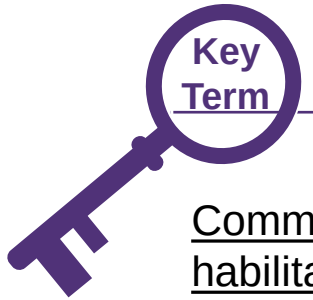
- Assistive Technology (AT)*
- Vehicle Adaptations (V-mods)*
- Community Transitional Services (CTS)*
- Environmental Modifications (E-mods)*
- Community Habilitation * (Skills Acquisition Maintenance and Enhancement (SAME))
- Personal Care
- Home Health Care Aide
- Consumer-Directed Personal Assistance Services
- Personal Emergency Response (PERS)
- Home Delivered Meals
- Congregate Meals
- Moving Assistance
- Durable Medical Equipment (DME)



*The CFCO Service overlaps with OPWDD Comprehensive Waiver

Community Habilitation in Managed Care

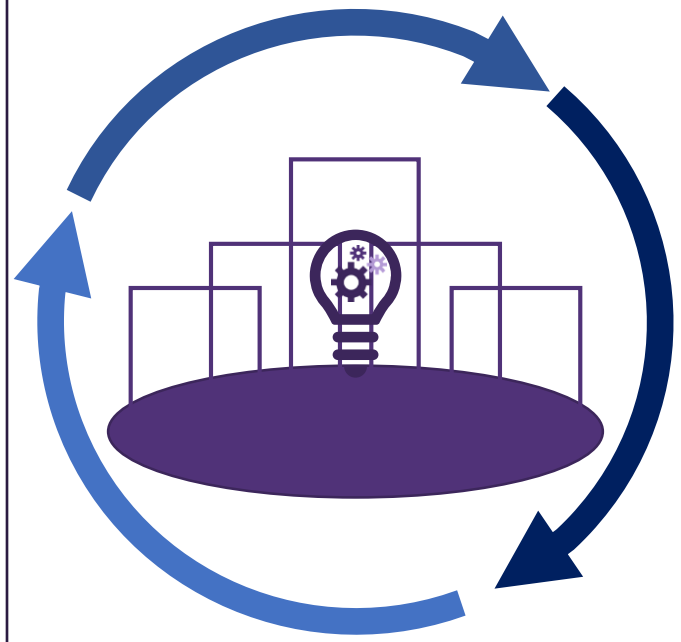
- All CFCO services will be included in the mainstream managed care benefit package, including community habilitation
- For community habilitation providers serving individuals enrolled in an MCO:
  - Provider must either contract or have 'single case agreement' with the MCO
  - Claims will be submitted to, and paid by, the MCO
  - Future service amendment requests are submitted to the MCO



Key Term	Definition
Community habilitation	Face-to-face services occurring largely in community (non-certified) settings to facilitate and promote independence and community integration
Single Case Agreement	An agreement between a non-contracted provider and the MCO in which the provider is reimbursed for services regarding an individual's case

Early Adopters Mainstream Managed Care (MMC)

Early Adopters	Description	Covered Services

	• Provider-led MCOs that have extensive experience coordinating care and delivering DD services to individuals with I/DD in New York State
	• Provides an early framework to help provider-led MCOs gain experience serving individuals with I/DD managing Mainstream Managed Care benefits
	• It is anticipated that Early Adopters will become SIP-PLs
		• Mainstream Managed Care(MMC) Benefits:
		  • Medical services
		  • CFCO services
		  • Other covered Medicaid State Plan services

SIP-PL Qualification Document

Qualification Document

"Medicaid Managed Care Organization I/DD System Transformation to Serve Individuals and/or Developmental Disabilities in Specialized I/DD Plans-Provider Led (SIPs-PL)" *(Draft)*

Key Objectives of the Document

- Posted to the DOH Website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm
- Identifies the legal authorities to allow the DOH and OPWDD to implement and oversee implementation of managed care for DD services
- Details the required standards and conditions to becoming a specialized managed care plan serving individuals with I/DD
- Outlines an early framework to integrate individuals with I/DD and DD services into managed care

SIP-PL Requirements

- OPWDD began holding public forums to inform, educate and receive feedback from individuals, families and other stakeholders on the SIP-PL requirements

3.0 Performance Standards	**3.1 Organizational Capacity**	**3.2 Personnel**	**3.3 Member Services**
3.4 Service Delivery Network Requirements/Access to Care	**3.5 Continuity of Care**	**3.6 Network Monitoring**	**3.7 Network Training**
3.8 Utilization Management	**3.9 Clinical Management**	**3.10 Cross System Collaboration**	**3.11 Quality Management**
3.12 Reporting and Performance Measurement	**3.13 Claims Processing**	**3.14 Information Systems and Website Capabilities**	**3.15 Financial Management**
3.16 Reserve Requirements for SIPs-PL			

SIP-PL Overview

Description

- A specialized MCO led by provider organizations in the OPWDD system that have a history of serving New Yorkers with I/DD
- Must be controlled by 1 or more qualifying non-profits

Delivery Model

- State makes capitated payments to SIP-PL covered benefits and services
- Individual and provider protections to ensure continuity of care included
- SIP-PL contracts with services providers, including HCBS providers
- As I/DD providers and SIPs-PL gain experience, can move to VBP for certain services

Eligibility

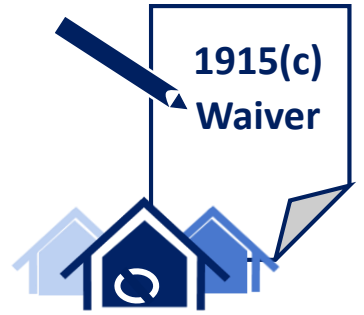
- Eligible individuals include those:
  - Enrolled in OPWDDs Comprehensive HCBS Waiver
  - Individuals Living in ICF/IIDDs
  - Individuals with both Medicaid and Medicare, and eventually third-party health insurance
  - Individuals with I/DD already enrolled in managed care
- Excludes: Residents of Development Centers/Small Residential Units/ and residents of residential health care facilities at the time of enrollment

Key Requirements

- Certified to operate as Article 44 Medicaid Managed Care Plan
- Key personnel must have experience serving individuals with I/DD
- Report performance on required quality measures to the State
- Ensure continuity of care by maintaining individual's current Life Plan during SIP-PL transition and enrollment

SIP-PL Covered Services

Phased-in Over Time



Medical/Health	CFCO State Plan Services	Care Management	Other State Plan Supports	OPWDD Services
• Inpatient Hospital • Preventive and Outpatient Services • Lab and Radiology Pharmacy • Therapy Services • Emergency Services • Dental • Vision • Clinic services	• Assistive Technology • Vehicle Adaptations • Community Transitional Services • E-mods • Community Habilitation • Personal Care • Home Health Care Aide • Consumer-Directed Personal Assistance Personal Emergency Response (PERS) • Home Delivered Meals • Congregate Meals • Moving Assistance • DME	• SIP-PL I/DD Health Home Care Management	• Long/Short Term Supports and Services • Outpatient and Inpatient Behavioral Health and Substance Use Disorder (SUD) Services • DME/Products/Supplies • Long Term Residential Placement	**1915(c) Waiver Services, such as:** • Self Direction • Community Habilitation • Pathway to Employment, • Prevocational Services • Residential and Day Habilitation • Supported Employment (etc.) **Other Benefits, including:** • ICF/IID • Article 16 Clinics

Care Management in Managed Care

- The SIP-PL is responsible for the provision of Care Management for I/DD enrollees
- Care Management provided by the SIP-PL must comport with the person-centered planning requirements in the managed care Model Contract. For enrollees with I/DD, the Care Management must also comport with the I/DD HH services model and with the person-centered planning regulation found in 14 NYCRR § 636, subpart 636-1
- The requirements for the Care Management provided to enrollees with I/DD will be described in the forthcoming policy document

Public Comment Overview

- A Public Comment period was held in 2018 and 78 comments were received
- About 50% of the comments were from parents
- Others were from six of the seven I/DD Health Homes, provider association members, OPWDD providers, and several advocacy groups
- Major Themes:
  - Request for an extension of the timeline
  - Enhanced public outreach and stakeholder engagement
  - Concerns related to access to specialty providers and the potential loss of services, including the impact on self-direction
  - Clarification on the relationship between I/DD Health Homes and SIPs-PL
  - More information on the grievance and appeals process
- Response to Public Comment forthcoming

I/DD Clinical Advisory Group

Next Steps for OPWDD

Managed Care for I/DD Services

- The development of managed care, grounded in the tradition of specialized I/DD services, will better support the needs of the population as it ages
  - Ensures better access to cross-system care through enhanced care coordination and care management
  - Promotes strategies that will drive continued improvement in I/DD services
- Early Adopter plans will gain experience coordinating care for individuals with I/DD by providing medical coverage and CFCO services to enrollees
- Over time, the State will implement SIPs-PL to better integrate traditional medical services with HCBS and other OPWDD services to meet growing and changing needs of individuals with I/DD
  - The phasing-in of OPWDD services into managed care will be gradual and detailed in the SIP-PL Requirements Document
  - For I/DD providers, this will require beginning readiness activities to build capacity to move to managed care and eventually move to VBP models

Managed Care Roadmap: Short Term

I/DD Health Homes

Operationalize Quality Measures

- Develop specifications for I/DD Health Homes measures

Data Exchange

- Data exchange to share Life Plans and patient data with SIPs and other stakeholders

Care Manager Employment

- I/DD Health Homes must directly employ Care Managers providing service coordination

Comprehensive Life Plan

- Develop an approved, HIT-enabled Life Plan to authorize services

Early Adopters MMC

Managed Care Readiness

- Ongoing training, education, and technical support for managed care

Voluntary Enrollment

- Begin voluntary enrollment of individuals with I/DD into Early Adopters
- Early Adopters cover CFCO HCBS benefits, including Community Habilitation

CFCO SIP Benefit Package

- CFCO will also be included in SIP-PL benefits

SIP-PL

SIP-PL Policy Updates

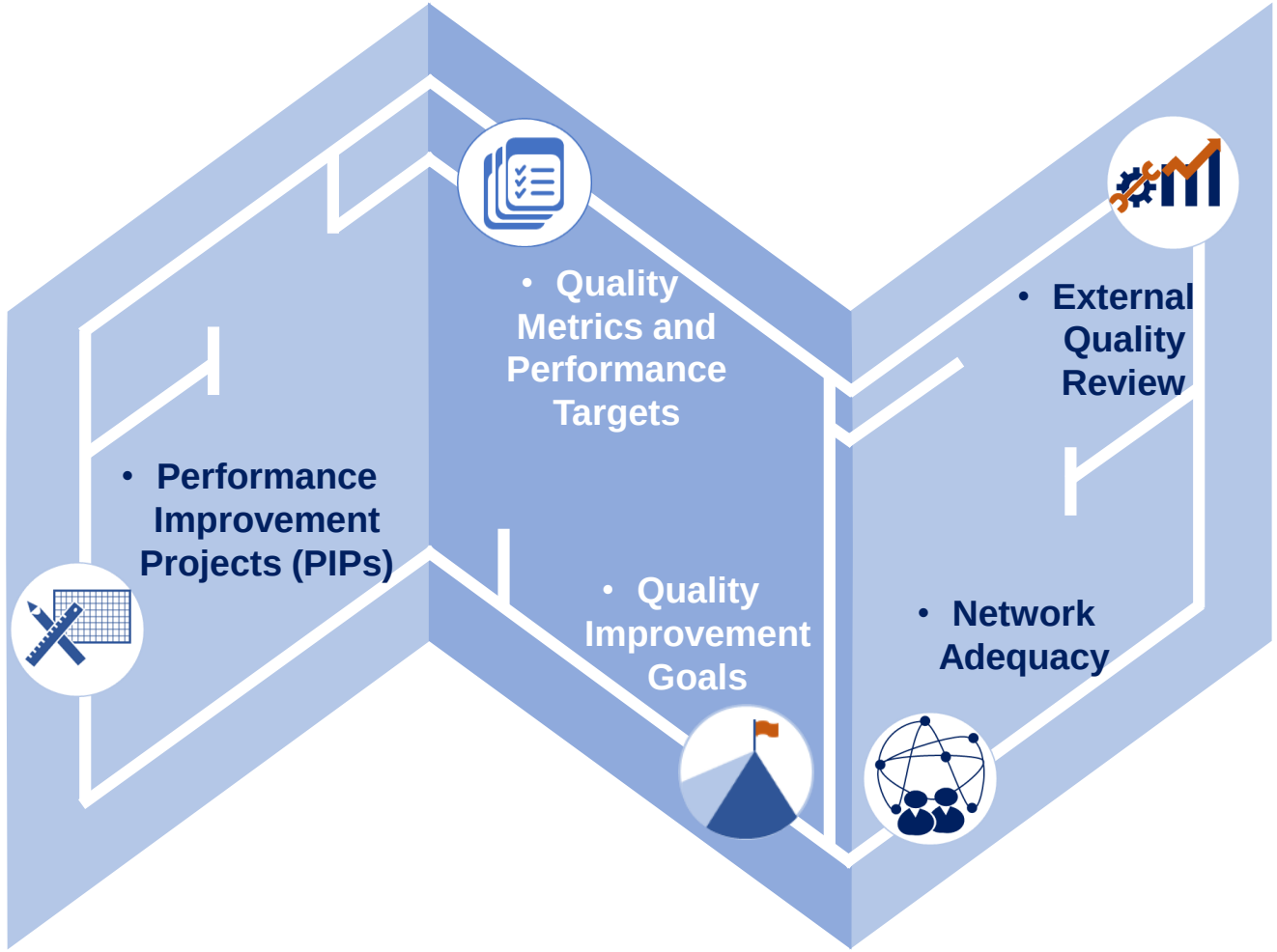
- Finalize SIP-PL Requirements Document
- Draft Managed Care Policy Paper

Quality Strategy

- Update Managed Care Quality Strategy to include individuals with I/DD into managed care

Managed Care Quality Strategy

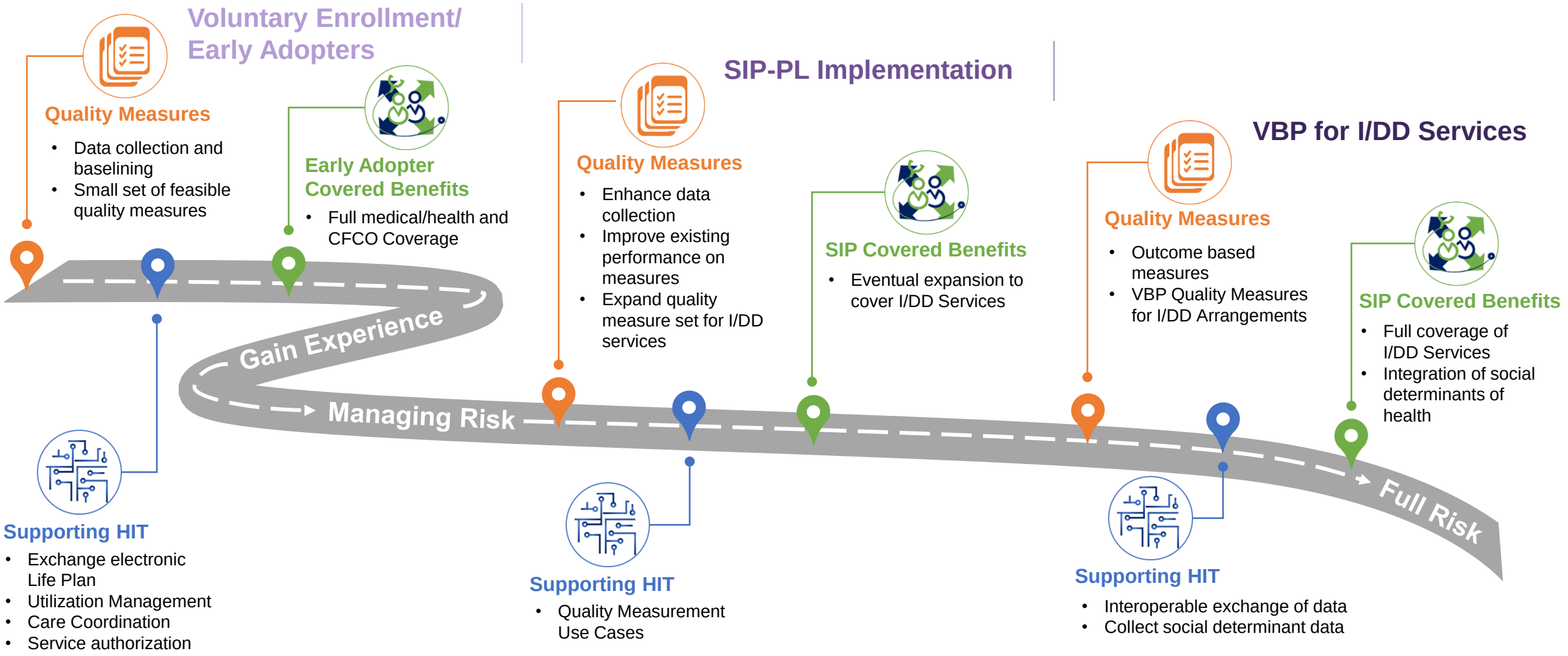
- A blueprint for states and their MCOs to help assess the quality of care of enrollees and set measurable goals for improvement
- The Quality Strategy is required to be updated as services and populations move to managed care
- Requires a Public Comment Period



VBP for I/DD Services

- Managed care is the foundation of the NYS Medicaid VBP Roadmap
- VBP will build off the SIP managed care design to build a VBP Roadmap unique for I/DD services
  - This benefit design will help determine what data, measures, and HIT supports stakeholders will need to develop and mature to move towards VBP
  - This Roadmap can account for improving the volume of managed care enrollment, the expansion of covered I/DD services, and the amount of risk undertaken by plans and providers
- VBP will require a stable managed care environment to ensure stakeholders can adequately define their “value proposition” and build the infrastructure to support valued outcomes

Roadmap to VBP for I/DD Services



I/DD Clinical Advisory Group

Next Steps for the I/DD CAG Members

I/DD CAG Timeline

Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec

I/DD CAG #1: May 2019

- I/DD CAG Member Charge and Objectives
- VBP 101 to provide overview of VBP concepts/approach
- OPWDD Transformation Updates to apprise stakeholders of major initiatives OPWDD is currently supporting
- Next Steps for OPWDD to identify short and long term strategies
- Next Steps for I/DD CAG

I/DD CAG #2 Summer/Fall 2019

- Agenda TBD

I/DD CAG #3: Winter 2019

- Agenda TBD

Additional Opportunities to Participate

- The VBP Measure Support Task Force (MSTF) will be meeting on Friday, May 17th, 2019 from 2:30-4:00 pm
  - The VBP MSTF was created to assist with the assessment of quality measure data capture, calculation mechanisms, and reporting feasibility for the NYS VBP program
  - Please contact Tina.Browne@health.ny.gov to participate in this meeting

I/DD Clinical Advisory Group

Wrap-up