Deep Dive: Transition to Managed Care

Background, and how planned changes could affect SD services

You will notice that we are repeating some concepts here in the service of clarity, to make sure we're all in the same conversation.

As most of you are aware, over the next 6 years people with Intellectual and Developmental Disorders (I/DD) will follow the rest of NYS Medicaid's 6 million users into managed care, and OPWDD will have less of a voice in the day to day control over services. Our understanding at this time is that OPWDD will continue to be responsible for the Front Door and eligibility determination, as well as oversight and quality assurance, but the program will be run by Managed Care Organizations through the NYS Department of Health.

Now is the time for family members of participants in self-directed services with employee and budget authority to publicly air their concerns so inconsistencies can be addressed and problems can be solved before Care Managers and Managed Care companies and have major roles to play.

Below, we'll give some background, then detail our understanding of the changes that are coming and how they will affect people who self-direct and their families.

What is Medicaid?

Medicaid was created in 1965 to help with medical costs for some people with limited income and resources. It is a joint federal and state program: in New York the state and federal government each pay half of the costs. Each state sets its own eligibility criteria, and whoever meets the criteria is enrolled. Almost all Medicaid services in NY are currently delivered through managed care; OPWDD services are the last to be included.

How are OPWDD services related to Medicaid?
Long term services for people with Intellectual and Developmental disabilities are paid for mostly with Medicaid funds through a specific funding stream called a waiver. The waiver allows states to have more discretion over eligibility and services offered. Currently, services for people who use, for example, self-directed services (com hab, support brokerage, job coaching, FI, respite and IDGS) are delivered through a 1915(c) waiver. However, under managed care, all OPWDD services will be delivered through the state's 1115 Waiver. (Note: this does not mean that your family member's services will change; it only refers to how the services are funded).

What is Managed Care?

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and

additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.
(From Medicaid.gov)

As mentioned above, the vast majority of New York state's Medicaid services are being delivered through managed care, to over 6 million people. In contrast, OPWDD serves over 130,000. Numerically, we are a drop of water in the ocean of NYS Medicaid; however, we do account for a disproportionate amount of the cost.

Although some families are continuing to advocate for a "carve out" of OPWDD services from managed care, we believe that ship has already sailed, and our current goal is to protect and strengthen self-directed services.

OPWDD is planning to transform to a managed care system in two steps. Initially Care Coordination Organizations (CCOs) will take over what has been the MSC role (with the addition of coordinating health services) in 2018 on a voluntary basis in some areas. By 2024 will have moved to a fully capitated system, organized as Health Homes. Initially enrollment will be voluntary, and then mandatory for all eligible groups. Some categories will be excluded from the medical side, for example people who are covered under their parent's insurance and people who have both Medicaid and Medicare. (Note: OPWDD states they plan to allow current MSCs to transition to Care Manager roles, if they wish).

Why are all these changes happening now?

Federal and State Initiatives

CMS introduced, and New York has embraced, the Triple Aim for health care:

1. Improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

2. Improving health by addressing root causes of poor health, e.g., poor nutrition, physical inactivity, and substance use disorders

3. Reducing per capita costs

A further incentive for states: Follow the money!

To help states achieve these goals, the Affordable Care Act sweetened the pot with financial incentives, several of which New York is using:

- Conflict Free Case Management
- Care Coordination Organizations

- Health Homes
- Community First Choice Option.

Although each of these initiatives has the potential to improve services for people with I/DD, they will result in significant changes. The changes at OPWDD are a just small part of the transformation of the entire Medicaid health care delivery system in New York State. They will bring many advantages but people need to be mindful of how self-directed services may be affected.

What is Conflict-Free Case Management (CFCM) and why is it required?

> **Recent federal regulations require that an employee of an agency that provides waiver services for an individual (for example, com hab or day hab), must not provide case management or develop the person-centered service plan.** The intention of this Federal rule is to ensure that case management services are person-centered and promote the service recipients' interests, not those of the provider agencies. CMS required OPWDD submit a transition plan to comply with the conflict-free standards for service coordination by October 1, 2016
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> **Adapted From OPWDD: "Amendment 01" Overview WebEx Q and A, August 2, 2016**

What is a Care Coordination Organization (CCO)?

New York State is meeting its obligation for CFCM by creating Care Coordination Organizations. The organizations will be developed by existing I/DD provider agencies and provide care management and coordination specifically for people with I/DD. They will coordinate all Medicaid funded and other community services for enrollees.

Concerns with NYS's plan for CFCM
We strongly support the concept of CFCM. However, most current MSCs work for voluntary agencies that provide direct services, and will continue to work for them as Care Managers although their paychecks will have the name of a different entity on top.

With CMs working for the MCO, and given the pressure from MCOs to control costs, will they be able to act as strong, impartial advocates for their clients who self-direct?

What is a Health Home?

A health home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the "whole-person" across the lifespan.
From Medicaid.gov, Health Homes (Section 2701) Frequently Asked Questions.

What is a Coordinated Care Organization/Health Home?

To be able to transition gradually into managed care, OPWDD will first transfer care management to CCOs. CCOs will be paid by capitation, that is, they will be paid a specific amount of money for each person they serve, depending on the individual's support needs. Only the care management will be capitated initially, not any other services.

Over a few years, many CCOs will become full-fledged Health Homes, responsible for coordinating AND providing (within themselves and through contracts with other entities), all of the services described above.

By using conflict free case management through establishment of CCOs, New York will receive increased funding for care coordination. Instead of 50% New York will get 56% federal matching funds (also called fmap).

What does that mean for me?

A major difference is that there is no mechanism to change your CM in the way that you could change your MSC, a potential problem. (On the other hand, the CM will have the resources of the Interdisciplinary Team to provide expertise).

This change is one example of why it will be critical for participants and their families to have access to a neutral advocate, referred to as an ombudsperson in other Medicaid long term care settings.

What is the Community First Choice Option?

The "Community First Choice Option" (CFCO) allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. This State plan option was established under the Affordable Care Act of 2010.

This option became available on October 1, 2011 and provides a 6-percentage point increase in Federal matching payments to States for service expenditures related to this option. From Medicaid.gov

Before CFCO the state, people with different diagnoses and long term support needs had access to different services. Now everyone covered under Medicaid is eligible for the same long term care services

CFCO is all about getting people out of nursing homes and other institutions, and keeping them from entering, or as the state puts it “rebalancing” Medicaid funding from institutions to the community. In the rush to reach this goal (a great goal!) we’re concerned that DOH may run over self-direction on the way.

Specifically, in trying to “streamline” self-directed services, it’s crucial that its customization, flexibility, and creativity not be lost in the name of efficiency and bringing the services to scale.