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

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Section 1 Executive Summary

Guidehouse evaluated the New York State Office for People With Developmental Disabilities' (OPWDD) service delivery system to provide recommendations regarding a potential transition to managed care or another payment model that aligns with OPWDD's strategic goals and objectives to best serve the needs of people with intellectual and developmental disabilities (IDD).

The Final Report does not include an in-depth financial analysis of managed care broadly as a payment model, or on the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) program that OPWDD currently oversees. The engagement was structured to assess managed care as an option to improve the OPWDD system of services by examining the experiences and expertise of other states, national experts and various stakeholders. The recommended considerations for managed care Guidehouse is providing to OPWDD should be further evaluated for financial viability and feasibility through collaboration with the Department of Health (DOH) and the Division of the Budget (DOB).

Our assessment included the completion of an Initial Report and this Final Report.

Guidehouse completed the Initial Report, which is publicly available at:
https://opwdd.ny.gov/system/files/documents/2023/01/nys-opwdd-managed-care-assessment.pdf

The Initial Report included:

- Summary of the OPWDD Strategic Plan goals and objectives.
- Overview of the current delivery system in New York including how managed care is used today.
- Environmental scan and high-level overview of service delivery systems and payment models.
- Next steps and timing of the Final Report.

Fee-For-Service (FFS) vs. Managed Care

FFS: Providers are paid directly by the State Medicaid program under a federally approved rate each time they provide a service.

Example: Every time a person sees a doctor, the doctor receives a payment.

Managed Care: MCOs are responsible for coordinating care for people and receive fixed monthly payments for each Medicaid member enrolled in the MCO.

Example: An MCO receives the same monthly payment for a member with IDD, regardless of whether the member sees a doctor 0 times or 10 times in the month. The MCO is responsible for paying the doctor.

After completing the Initial Report, Guidehouse continued to work with OPWDD to develop a Final Report by completing the following steps that are detailed in Sections 3 and 4 of this document:

- **Stakeholder Engagement (e.g., Townhalls and Focus Groups, Interviews, Surveys, and Stakeholder and Advisory Board Presentations):** Guidehouse conducted the following stakeholder engagement to share information with stakeholders on the managed care assessment, to better understand how the current service delivery system is serving people with IDD, how the current system can improve, and to assess stakeholders' understanding of managed care.
    - *Six* Townhall and Focus Group discussions with **People with IDD, and their Family Members**
    - *Two* Townhall and Focus Group discussions with **Providers and Care Coordination Organizations (CCOs)**
    - *Eight* **Provider Organization and MCO** Interviews
    - Surveys with **People with IDD and their Family Members**
    - Surveys with **Providers**
    - *Ten* **OPWDD Leadership** Interviews
    - *Six* **Stakeholder and Advisory Board** Presentations

- **Data Analysis:** Guidehouse reviewed the National Core Indicators – Intellectual and Developmental Disabilities (NCI-IDD) In-Person Survey (IPS) data to better understand how New York and peer states are performing on NCI quality-related measures.
- **Peer State, Managed Care State, and National Expert Interviews:** Guidehouse conducted 10 interviews with peer states and states with managed care for their IDD population, and 5 interviews with national experts to better understand best practices and national trends including how states are currently implementing managed care and other payment models for people with IDD.
    - *Literature review:* Guidehouse conducted a comprehensive literature review prior to these interviews to gain an understanding of the various programs and nuances in service delivery for the IDD population.

This Final Report builds on the Initial Report and includes:

- **Assessment Methodology:** Overview of methodology for stakeholder engagement, data analyses, and interviews with peer states, managed care states, and national experts.
- **Current State Assessment:**
    - Overview of the current service delivery system in New York.
    - Findings from stakeholder feedback (e.g., Townhalls and focus groups, surveys, and interviews) on how OPWDD can improve the current service delivery system.
    - Findings from the NCI-IDD data review.
    - Interviews with OPWDD leadership focused on how the current service delivery system can be improved.
- **Future State Assessment:**
    - Findings from stakeholder feedback (e.g., Townhalls and focus groups, surveys, and interviews) on what is important to stakeholders regardless of the service delivery system and/or payment model and their understanding of managed care.
    - Best practices and lessons learned from peer states, managed care states, and national experts.
- **Recommendations:** Recommended next steps for New York's service delivery system. These recommendations include programmatic improvements for the current service delivery system and managed care recommendations.

The recommendations included in this report cover two key areas:

- **Programmatic Improvements:** Our assessment identified several key improvement areas for OPWDD that align with OPWDD's Strategic Plan. In many cases, OPWDD has efforts underway to further address these opportunities and improve overall service delivery for New Yorkers with IDD.
- **Managed Care:** Guidehouse does not recommend a transition to full managed care for the whole OPWDD service delivery system. However, should OPWDD decide to implement managed care, Guidehouse recommends first assessing the financial viability and feasibility of implementing a partial managed care model, including establishing mandatory enrollment for managed care focused on physical and behavioral health services for non-dual eligible people with IDD (i.e., Medicaid only, without Third Party Insurance (TPI)), who are not currently enrolled in Mainstream Managed Care (MMC). This model would create specialized Managed Care Organizations (MCOs) focused on physical and behavioral health services. Physical Health services would include but not be limited to primary care, dental care, specialty care such as neurology. The behavioral health services would encompass those included in the Behavioral Health Carve-In for New York State, such as psychiatry,

psychology, mental health, social work support, intensive behavioral health, and other services offered by Article 16, Article 28, Article 31, and Article 32 clinics.

- This recommendation does not impact long-term services and supports. Long-term services and supports would remain in the fee-for-service model through the CCOs, while OPWDD should continue to assess and refine the performance of CCOs and delivery of OPWDD services.

Programmatic Improvements

- **Strategic Plan Goal 1: Strengthen Workforce, Technology, and Collaboration**
  - Workforce Improvement/Wages for DSPs
  - Enhance DSP and Provider Trainings
  - Foster Collaboration with Stakeholders
- **Strategic Plan Goal 2: Transform our System Through Innovation and Change**
  - Increase Efficiency in Accessing Self-Direction
  - Enhance Access to Social Determinants of Health (SDOH) Services
  - Strengthen CCOs ability to Coordinate Services
  - Streamline Administrative Processes
- **Strategic Plan Goal 3: Enhance Person-Centered Services and Supports**
  - Facilitate Individual Choices
  - Complex Needs

Managed Care Recommendations

- Should OPWDD decide to implement managed care, it should first assess the financial viability and feasibility of a partial managed care model focused on **physical and behavioral health services** for non-dual eligible (i.e., Medicaid-only, without TPI) people with IDD, who are not currently enrolled in MMC
- All waiver services should remain in fee-for-service through OPWDD
- OPWDD should continue stakeholder engagement for input on key design elements prior to designing the managed care program. This should also include strategic outreach to assess the experiences and recommendations of the more than 38,000 people IDD who are currently enrolled in Mainstream Managed Care (MMC) plans for their phsyical and behavioral health benefits. This should also include futher consultation with DOH, OMH, and OASAS to gather the experiences and lessons learned from previous transitions of FFS to managed care.
- OPWDD should initiate a procurement process
  - OPWDD should procure for a limited number of qualified managed care plans
  - The plans should demonstrate their experience serving people with IDD and their success in a traditional MCO structure
  - This could also be preceded by the issuance of a non-binding Request for Information (RFI) for MCOs potentially interested in serving people with IDD to gather information and help inform program design.
- The recommended considerations for managed care Guidehouse is providing to OPWDD should be further evaluated for financial viability and feasibility through collaboration with DOH and DOB.
- Future Considerations: As this report explains, managed care has demonstrated the potential to improve quality and coordination of care, including innovative models and program demonstrations that are currently underway in New York. Alternative approaches to comprehensively support the healthcare and long-term services and supports of people with IDD should continue to be evaluated and learned from by OPWDD and stakeholders as potential long-term options.

Section 2 Assessment Methodology

Methodology– Stakeholder Engagement

The Guidehouse team, comprised of IDD, service delivery, managed care, and long-term services and supports subject matter experts (See Appendix H) conducted stakeholder engagement throughout the duration of the assessment to gather insights and feedback to better understand OPWDD's current service delivery system and inform our recommendations. Guidehouse completed the following stakeholder engagement:

- Six Townhall and Focus Group discussions with ***People with IDD, and their Family Members***
- Two Townhall and Focus Group discussions with ***Providers and CCOs***
- Eight ***Provider Organization and MCO Interviews***
- Surveys with ***People with IDD and their Family Members***
- Surveys with ***Providers***
- Ten ***OPWDD Leadership*** Interviews
- Six ***Stakeholder and Advisory Board*** Presentations

Importance of Stakeholder Engagement

Active stakeholder engagement is imperative for a comprehensive evaluation of the current and future state delivery system. Stakeholders have a thorough understanding of the service delivery system. It is important to understand the perspectives and experiences of people with IDD, their families, and providers because OPWDD policy and program decisions have a significant impact on their lives and the lives of their loved ones.

It is important to note that OPWDD is responsible for serving all New Yorkers with IDD, which includes stakeholders with a wide variety of and sometimes differing experiences and opinions about OPWDD's current system.

While peer and managed care states and national experts are not direct stakeholders in the OPWDD service delivery system, we interviewed them to better understand the national landscape of service delivery for people with IDD. We conducted the following interviews:

- Ten ***Peer and Managed Care State*** Interviews
- Five ***National Expert*** Interviews

Townhalls and Focus Groups

To better understand how people are being supported now, Guidehouse facilitated townhall and focus group discussions for people with IDD, their family members, and providers and CCOs currently serving New Yorkers with IDD.

Guidehouse developed separate targeted focus group questions for people with IDD and their family members, (See Appendix C-1) and providers and CCOs (See Appendix C-2). The questions focused on current services and supports and participants' understanding of and thoughts on managed care.

Guidehouse completed a total of eight townhall and focus group discussions with a total of 1,049 participants across the eight sessions:

- Six sessions with people with IDD and their family members.
- Two sessions with providers and CCOs.

Provider Organizations and MCO Interviews

To better understand how provider organizations and MCOs are currently providing services to people with IDD in New York, the Guidehouse team conducted eight interviews with executives from provider organizations and MCOs.

Guidehouse created separate interview guides for provider organizations and MCOs (See Appendix G-1 and Appendix G-2) that included questions on three different topic areas:

1. Background, Roles, and Responsibilities of Providers
2. Experience with People with IDD
3. Data, Reporting, and Monitoring

Surveys

To support the creation of well-informed recommendations, Guidehouse conducted two different surveys, one survey for people with IDD and their families and another survey for providers serving the IDD population in New York State. Guidehouse conducted these surveys to further gather insight about the current service delivery system and stakeholders' thoughts on managed care. Both surveys were publicly available to stakeholders on OPWDD's managed care assessment webpage for over a month and multiple reminders were sent by OPWDD to stakeholders to complete the survey. The survey was released by OPWDD on November 30, 2023, and was closed on January 6, 2024.

Guidehouse created survey questions for people with IDD and their families (See Appendix D-1) on four different topic areas:

- **Topic 1:** Asks people to tell us a little about themselves (e.g., who they are, what region they live in, etc.).
- **Topic 2:** Asks people to tell us more about the services they or their loved ones currently receive.
- **Topic 3:** Asks people about what is most important to them or their loved ones in a service delivery system.
- **Topic 4:** Asks people to share their thoughts on managed care.

Guidehouse created survey questions for providers (See Appendix D-2) on three different topic areas:

- **Topic 1:** Asks providers to tell us about themselves (e.g., what type of provider they are).
- **Topic 2:** Asks providers to tell us more about their organization and the services they provide to people with IDD.
- **Topic 3:** Asks providers to share their thoughts on managed care.

There was a total of 2,222 survey responses received between both surveys: 1,706 survey responses from people with IDD and their families, and 516 survey responses from providers. It is important to note that survey respondents were not required to answer all survey questions and there were several questions that allowed for multiple responses.

OPWDD Internal Interviews

Supported by information from documentation reviews, Guidehouse conducted a series of OPWDD internal interviews to gather insight and feedback on the state of New York's current service delivery system for people with IDD and OPWDD's thoughts on a potential transition to managed care. We conducted 10 senior executive interviews, which covered the following key areas:

- Strengths and gaps of the current service delivery system.
- Utilization of current services offered and potential service gaps.

- Potential impact of managed care for New Yorkers with IDD.
- Opportunities for better integration of services and supports.

Guidehouse created an interview guide (See Appendix B-5) that included questions on five different topic areas:

1. Background, Roles, and Responsibilities of Staff
2. Partners and System Strengths/Opportunities
3. Data, Reporting, and Monitoring
4. Workforce and Access
5. Managed Care and Service Delivery

Stakeholder and Advisory Board Presentations

Guidehouse presented to the following stakeholder groups and advisory boards to share information with them on the managed care assessment and the varying stakeholder engagement opportunities that were a part of the assessment.

- **Self-Advocates Stakeholder Group:** People with IDD who regularly meet with OPWDD.
- **Family Stakeholder Group:** Family members of people with IDD who regularly meet with OPWDD.
- **Developmental Disabilities Advisory Council (DDAC):** Provides recommendations for statewide priorities and goals for services for people with IDD in cooperation with the OPWDD Commissioner.
- **Multi-Stakeholder Group:** Group of advocates including people with IDD, family members, advocates, CCO representatives, and providers who regularly meet with OPWDD.
- **Provider Association:** OPWDD providers and CCO representatives who regularly meet with OPWDD.
- **OPWDD Leadership:** Includes but not limited to OPWDD Commissioner, Deputy Commissioners, and General Counsel.

Peer State and National Expert Interviews

Guidehouse and OPWDD first collaborated to identify peer and managed care states that we could learn from based on the following considerations:

- Similarity of the states' populations to New York State (e.g., program size, demographics)
- Structure (e.g., service delivery systems, payment models, and organizational structure)
- Performance (e.g., quality, and operational performance)
- Alignment with OPWDD Strategic Goals

For the selected peer and managed care states, we completed a literature review on each states' current service delivery system and payment models prior to each interview. Our team, accompanied by OPWDD staff who joined to listen, conducted interviews with state leaders from these states to identify best practices and national trends, including how states are currently implementing managed care and other payment models to best serve people with IDD. Figure 1 identifies the payment models of the selected states and descriptions of each payment model.

Figure 1: Selected Peer and Managed Care States

Payment Model	Description	Selected States
Fee for Service (FFS)	Providers are paid for services after services are provided	**New York[1],** Florida, Massachusetts, Ohio
Managed Care – Physical and/or Behavioral Health	People with IDD receive their physical and/or behavioral health services from MCOs; waiver services are FFS	**New York[1],** Illinois, Pennsylvania[2]
Managed Care – Limited Home and Community-Based Services (HCBS)	Specific waiver services are included in managed care, such as personal care	California, Pennsylvania[2]
Managed Care – Waiver Services with Local Entities	Waiver services provided through counties or similar entities (Note: model not permitted by the Centers for Medicare and Medicaid Services (CMS) any longer)	Michigan, North Carolina
Managed Care – All Services with Licensed MCOs	MCOs coordinate and manage all Medicaid services (including waiver services) and are paid a set amount per month	**New York[1],** Kansas, Tennessee[3]

Guidehouse and OPWDD also interviewed five national experts to identify leading practices for service delivery systems and innovative programming for people with IDD. These experts belong to organizations that have implemented various types of service delivery systems for people with IDD, providing a unique and comprehensive perspective. The organizations include:

- National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- American Network of Community Options and Resources (ANCOR)
- Former State Medicaid LTSS Official
- Florida Developmental Disabilities (DD) Council
- North Carolina Developmental Disabilities (DD) Council

Guidehouse developed interview guides (See Appendix B-1 and B-2) to review key considerations when developing, implementing, and operating effective service delivery systems for people with IDD. We considered the following factors during the development of the interview guides for the peer states, managed care states, and national experts which informs our report recommendations:

[1] New Yorkers with IDD can choose to receive all their services through FFS, through Mainstream Medicaid for physical and behavioral health and FFS for their waiver services, or comprehensive managed care through the FIDA-IDD program depending on eligibility.

[2] This refers to the Adult Community Autism Program (ACAP) enrolling 200 individuals with autism and limited to four counties.

[3] Tennessee MCOs perform case management and service planning for all Medicaid services including LTSS. However, LTSS services are not included in the capitation rate.

- **Person-Centered Approach:** Service delivery systems for people with IDD require prioritization of the unique needs and goals of the people receiving services and supports. The service delivery systems should also promote independence and self-determination.
- **Stakeholder Collaboration and Coordination:** Stakeholders, including self-advocates, should have a platform to discuss care and community resources to drive innovation.
- **Integration and Access to Care:** Support planning for people with IDD should be done in a comprehensive and coordinated way that meets their needs and enables them to participate in their community in the least restrictive setting.
- **Quality of Services and Supports:** Due to the specialized needs of people with IDD, service delivery systems must consider quality assurance and continuous monitoring and feedback mechanisms to ensure that the services are meeting the needs of the individuals and families.
- **Innovation and Choice:** Innovative programming with a wide array of services allows people with IDD the ability to choose an individualized plan that potentially addresses preferences, cultural considerations, and evolving needs.
- **Strengths and Areas of Opportunity:** Strengths and areas of opportunity in a variety of service delivery systems and their relation to OPWDD's strategic initiatives.

Methodology – Performance Data (NCI-IDD IPS) Analysis

Guidehouse analyzed service delivery system performance based on the NCI-IDD data which is publicly available online.[4] NASDDDS in collaboration with the Human Services Research Institute (HSRI) launched the Core Indicators Project. This was later expanded to become the NCI-IDD. The aim of this project is to support states' developmental disabilities operating agencies in the development and implementation of performance and outcome indicators and other data collection strategies to measure service delivery system performance. Its scope also includes outcomes of services for children with IDD as well as their families, and data on the workforce supporting adults with IDD. In-Person, Family, and State of the Workforce (formerly Staff Stability) Surveys (IPS) are data sources used to assess outcomes. For additional information on NCI-IDD IPS see Appendix F.

Guidehouse reviewed NCI-IDD IPS data from the 2021-2022 data collection cycle to assess the performance of different service delivery systems. The 2021-2022 data is the most recently available public data. Although the COVID-19 pandemic likely had some impact on survey participation and results, prior data were either not collected or did not encompass the broader populations that OPWDD serves. Additionally, it is crucial to recognize that each state addressed COVID-19 in a unique manner, which is important to consider when comparing data from different states. Given the limitations in survey intake and the varied approaches to service delivery during COVID-19 across different states, our comparison does not directly compare indicators between states. Instead, we focus on examining overarching themes across different service delivery systems.

We reviewed the NCI-IDD IPS data by aligning it to the OPWDD Strategic Plan goals and objectives. The NCI-IDD IPS is an interview-based survey of individuals who are 18 years of age or older and receiving at least one paid service from the State (in addition to case management). Guidehouse selected 24 total indicators that aligned with OPWDD's Strategic Goals (See Appendix E) and addressed themes captured during the stakeholder engagement we conducted. The sub-domains include Access, Choice and Decision Making, Community Inclusion and Belonging, Employment, Health, Wellness, Safety, Service Coordination, and Workforce. There are 53 total NCI-IDD IPS indicators across these sub-domains.

Additionally, Guidehouse received NCI-IDD IPS data from OPWDD for the 2021-2022 period where the data is separated based on CCOs and the FIDA-IDD demonstration, allowing for a comparison of overarching quality and performance related themes between the FIDA-IDD, CCOs, and the national average. It is important to

[4] Survey Reports & Insights - NCI-IDD (nationalcoreindicators.org)

note that the number of people surveyed in FIDA-IDD is significantly lower compared to the number of people surveyed for the CCOs and national average. As of October 2023, out of the 130,000 individuals served by OPWDD, 1,717 people were enrolled in FIDA-IDD.

Section 3 Current State Assessment

This section provides an overview of the current state of New York's service delivery system. We have included findings from stakeholder engagement (e.g., Townhalls and Focus Groups, Interviews, and Surveys) and from our data analyses on the current state of the service delivery system.

Current State of Service Delivery in New York

OPWDD Populations

As of March 2024, OPWDD coordinates supports for approximately 130,000 people with IDD. Although most Medicaid specialized IDD services are paid through FFS, approximately 38,615 people[5] with IDD are enrolled in a Mainstream Medicaid Managed Care (MMC) plan for their medical and behavioral health needs, with a small mix of people with IDD enrolled in other managed care plan types for long-term supports or behavioral health needs. Additionally, approximately 1,717 people with IDD are voluntarily enrolled in the managed care pilot, FIDA-IDD, which offers IDD services under a managed care plan.

For this assessment, people with IDD are included in one of the following categories for health insurance coverage:

- **Duals:** Individuals who receive both Medicaid and Medicare benefits.
    - *Medicaid:* Joint federal and state program that provides comprehensive health coverage to lower-income New Yorkers. Medicaid pays for a wide range of services, depending on your age, financial circumstances, family situation, or living arrangements.
    - *Medicare:* Federal program that provides comprehensive health coverage to New Yorkers 65 years and older, with special eligibility categories available for people under 65.
- **Medicaid Only:** Individuals who receive Medicaid benefits exclusively.
- **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).

Our recommendations would not impact the services people receive that are covered by Medicare only, Private/Commercial insurance, and/or Exemptions.

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 Medicaid-Medicare 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 several initiatives to increase quality and control spending. Care Management for All established a goal of having virtually all Medicaid enrollees served in care management by 2019 under which a MCO would be paid a capitated rate by the State to manage all Medicaid benefits. MRT #90 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

[5] Provided by OPWDD on March 20, 2024

program covers institutional and community-based long-term services and supports; acute and primary care services are provided under the MMC 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 March 2023, approximately 7.8 million New Yorkers were enrolled in some form of Medicaid managed care.

CCOs / Health Homes (HHs)

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. This conversation was accelerated by the Care Management for All initiative, but most people with IDD have been exempted (or "carved out") from Medicaid managed care to date. In April 2018, DOH and OPWDD received approval from CMS to expand the Health Home Care Management program to serve people with IDD through CCO.[6] CCOs are organizations formed by providers delivering developmental disability services that are 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 a person's goals and changing needs including health, preventive care, behavioral services, community supports, and social supports.

The intent of the CCO 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, although a system-wide transition to managed care has 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.

People with IDD Service Array/Utilization: Each CCO assigns a care manager or professional to provide care management and coordinate services for people with IDD. CCOs currently provide six core care management services:

1. **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.
2. **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.
3. **Comprehensive Transitional Care:** From inpatient hospital care to other settings, including appropriate follow-up (e.g., long-term care facilities, back to home).
4. **People with IDD and Family and Caregiver Support:** Coordination of information and services to support each person and their family and/or representative to maintain quality of life, with a focus on community living options.
5. **Referral to Community and Social Support Services**: To ensure that community resources are used, as people pursue meaningful activities consistent with their Life Plans.
6. **Use of Health Information Technology (HIT):** CCOs are required to meet the HIT standards in the delivery of the HH core services. This includes an electronic Life Plan.

[6] https://opwdd.ny.gov/system/files/documents/2020/01/cco-policy-manual-master_acc_1.pdf

Enrollment Transition

In July 2018, people with IDD transitioned to CCOs from the Medicaid Service Coordination (MSC) program. This transition represented a change in system delivery and a first step towards a transition to managed care for the IDD system.

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. People with IDD had a choice whether or not to receive the Health Home Care Management services provided by CCOs. If a person chose not to receive the services, they had to have Basic HCBS Plan Support which was provided by CCOs as MSC was ending.

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

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 services and supports through Health Home Care Management. CCOs can play a critical role in care management and may be needed in any future model to ensure that individuals receiving their long-term OPWDD services and supports can continue to receive comprehensive person-centered care planning using a coordinated network of care managers and providers, maximize their continuity of care and minimize disruption to service delivery while improving their overall experience. CCOs will also continue to play an essential role in community-based and social support service referrals, ensuring alignment with the HCBS settings rule and leveraging community resources so that individuals can pursue meaningful activities consistent with their Life Plans.

1. Mainstream Managed Care (MMC) / Managed Long-Term Care (MLTC) Plans

As referenced above, approximately 38,615 people[5] with IDD are enrolled in MMC plans for physical and mental health benefits. MMCs focus on preventive healthcare and provide enrollees with a medical home. A medical home is a partnership that allows individuals, their providers, and their care team to work together to improve the individual's health. People with IDD who are enrolled in an MMC plan may transfer to an MLTC plan if they meet the MLTC enrollment criteria or become 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 MLTC, Health and Recovery Plans, and HHs. 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 transitioned the IDD care management system to CCOs.[7]

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

In April 2016, Partners Health Plan (PHP) launched the FIDA-IDD demonstration, serving people who voluntarily enrolled, which is approximately 1,717 people in the downstate regions (New York City, Long Island, Rockland, and Westchester Counties). The FIDA-IDD demonstration is a pilot program with a three-way contract between:

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

a. **PHP:** Managed Care Organization for the demonstration

b. **DOH:** As the single State Medicaid agency, leads responsibility for the demonstration[Error! Bookmark not defined.]

c. **CMS:** Monitored demonstration implementation and evaluates its impact on people's experience, quality, utilization, and cost[Error! Bookmark not defined.]

As noted above, as the lead Medicaid agency for New York State, DOH is the official state partner in the three-way FIDA-IDD contract. The State has established an operational organizational framework in which DOH and OPWDD ultimately have separate and distinct, but shared responsibilities for regulatory oversight as it relates to the FIDA-IDD demonstration. This framework is based on a formal letter of agreement between DOH and OPWDD and it is the intent of both agencies to work in a cooperative and collaborative manner.

Under this construct, DOH largely functions in an administrative capacity while OPWDD functions as the operating arm. OPWDD and DOH work closely in conjunction to administer, operate, and maintain the current FIDA-IDD demonstration product. Decisions are typically jointly reviewed between both State agencies.

DOH Roles and Responsibilities:

- Issues Certificate of Authority
- Works with the Office for Temporary Assistance and Disability Assistance (OTDA) and Administrative Hearing Office
- Oversees the Medicaid Provider Network review in the Provider Network Data System (PNDS) for adequacy.
- Monitors quality reporting, performance metrics, and performance improvement
- Oversees interoperability, data systems, and reporting processes such as Health Commerce System (HCS), PNDS, encounter/claims and Roster systems
- Oversees rate setting activities, and of plan financial solvency and risk arrangements
- Manages and oversees the Ombudsman and Enrollment Broker (EB) contracts
- Monitors plan's submission of Grievance and Appeals report
- Oversees member complaints
- Participates on CMS-State Contract Management Team

OPWDD Roles and Responsibilities:

- Ensures that the plan provides continuity of care, care management, comprehensive service planning, review of grievances, and appeals
- Oversees the IDD provider network adequacy
- Monitors plan enrollments/disenrollments, marketing, outreach, and advertising activities for the purpose of ensuring compliance with marketing and outreach regulations
- Monitors IDD systems and program implementation activities for the EB and oversight of the EB enrollment IDD assistance and counseling
- Responds to and investigates member complaints related to developmental disability services
- Provides stakeholder training and education regarding IDD population and service needs
- Participates on the CMS-State Contract Management Team

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. 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 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.

Program of All Inclusive Care for the Elderly (PACE)

PACE is an integrated health plan and provider model that enables individuals to age at home and in the community instead of receiving long-term care in a nursing home. Supported by an integrated medical care and social delivery system, PACE programs are at full risk for all Medicare and Medicaid covered services and receive a bundled capitation payment from both government payors. While most services are delivered by an interdisciplinary team at a PACE certified center, PACE programs develop and manage full provider networks for acute and post-acute services. PACE programs directly involve their enrollees and their providers in a person-centered care planning process for medical, behavioral, and social services, and are deeply focused on community integration with their main goal to enable participants to remain in the community rather than receive care in a nursing home.

While PACE's target population is the frail elderly, it bears many similarities to the IDD population in terms of complexity and long-term care needs. Moreover, New York State received a grant from DOH to integrate the IDD population into their PACE program. The intent of the pilot was to serve people with IDD in an integrated setting through early intervention, awareness, education, staff training, and community-based partnerships to optimize an individual's Quality of Life (QoL), autonomy, and preference to be effectively served in the home and community. The pilot demonstrates a managed care like service delivery option available to people with IDD in New York State. It is important to note that OPWDD does not have direct oversight of the PACE program.

CMS Evaluation of the implementation of the FIDA-IDD Demonstration

CMS contracted with Research Triangle Institute (RTI) to monitor the FIDA-IDD demonstration implementation and to evaluate its impact on enrollee experience, quality, utilization, and cost.[8] RTI released the Preliminary Third Evaluation Report on the FIDA-IDD demonstration in October 2023, and it describes the implementation of FIDA-IDD and includes an analysis of the demonstration's impacts on select outcomes. The report highlighted the following successes, challenges, and lessons learned for the FIDA-IDD demonstration:

- **Successes**
    - **Strong care model implementation by PHP:** The State and CMS thought PHP's implementation of the care model with the It's All About Me (IAM) assessment tool and team of care managers and service coordinators was successful in identifying and responding to enrollees' service needs and goals.[8] PHP's dedication to the IDD population was viewed by PHP, the State, and CMS as key to its ability to meet the needs of enrollees.[8]
    - **High enrollee satisfaction:** While enrollments were lower than expected or desired, enrollees tended to remain in the demonstration. This was viewed by PHP, the State, and CMS as a signal of enrollee satisfaction.[8] Most enrollees and their family members who were interviewed, described high levels of satisfaction with care coordination, speed and efficiency of obtaining medical equipment, and feeling as if their care coordinators genuinely care for them.[8]
        - **Surprising number of aging caregivers enrolling their family members into FIDA-IDD:** The FIDA-IDD demonstration appeared to provide older family caregivers with peace of mind that a dedicated team would help organize, arrange, and monitor all

[8] New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Preliminary Combined Third Evaluation Report (cms.gov)

aspects of their adult children or siblings' needs for health and behavioral services, LTSS including developmental services, and social opportunities that encouraged inclusion in the community.[8] The integrated model of care may have been particularly appealing to older adults without other family members able to take over care coordination tasks.[8]

- **Challenges:**
    - **Low Enrollment:** The eligible population required an extensive network to provide highly specialized care that is necessary to meet the needs of this population. The State also acknowledged that a plan would have difficulty bringing in a large hospital system unless the plan negotiated a favorable reimbursement rate.[8]
        - **Lessons Learned:** Without a deep network of specialty providers as well as generalists, dentists, and others with ability to serve people who may have significant communication and behavioral challenges, drawing more enrollees into the demonstration was not feasible.[8] In reference to including a large hospital system, large plans with tens of thousands of enrollees would likely to be able to negotiate a favorable rate, but smaller plans would not be able to do this.[8]
    - **Opt-in only enrollment:** Voluntary enrollment challenged PHP's ability to make changes to enrollees' service plans. If an enrollee did not agree with a change, they could always go back to FFS.[8]
        - **Lessons Learned:** CMS and State agreed passive enrollment is not a viable option for this population.[8]
    - **Significant Financial Shortfall:** Older, frailer than expected enrollee base, a higher proportion of enrollees living in residential settings than anticipated, and PHP's limited ability to use utilization management techniques to achieve cost savings contributed to the demonstration's financial shortcomings.[8] PHP's ongoing financial shortfall on the Medicaid side was also impacted by capitation rates that did not reflect the experience of the plan.[8] It is also important to note, there are individuals enrolled in providers with greater than average reimbursement that drive higher costs in the FIDA-IDD demonstration.
        - **Lessons Learned:** CMS and state officials acknowledged shortcomings in the Medicaid rate setting process developed for the demonstration and suggested adjustments or additional rate cells for special populations might have mitigated some of the financial strain experienced by the plan.[8] In reference to individuals being enrolled in high-rated providers with greater than average reimbursement, to better manage costs, the demonstration would need to diversify enrollments by including more individuals who are receiving services from providers with lower than average fee-for-service rates.

3. Specialized IDD Plans – Provider Led (SIP-PLs)

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 MMC, including acute and primary care, behavioral health services, long-term services and supports (LTSS), as well as IDD services. It was originally envisioned that some MMC 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 people with IDD 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 health home model.

2. Creation of a policy framework for the implementation of provider-led managed care.[9]

In February 2020, OPWDD issued a revised draft document identifying the qualifications for entities that would become SIP-PL MCOs in New York State. The design objective of SIP-PLs include the following: a recognition of specialized care management needs, the need for IDD-experienced leadership, and medical and dental directors with specialized IDD experience. 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

Although most people with IDD in New York are receiving Medicaid specialized IDD services through FFS, there are approximately 38,615 people[5] with IDD receiving services in MMC and approximately 1,717 in FIDA-IDD.

Nearly 113,000 people with IDD served by OPWDD received their case management services through CCOs.[10] Individuals enrolled in CCOs have a choice of two service options: Health Home Care Management (more comprehensive services) or HCBS Basic Plan Support (for those people that do not desire ongoing case management). The number of people receiving either Health Home (HH) or Basic HCBS Plan Support has remained constant at 97% and 3% respectively, since the implementation of CCOs.

Stakeholder Engagement

Below is the feedback we heard from stakeholders during the townhalls and focus groups, interviews, and surveys on the current service delivery system.

Townhalls and Focus Groups

Participants shared insights on what is working well and what needs improvement in the current service delivery system.

- **Self-Direction is a valuable program:** Participants enrolled in self-direction value the flexibility of the program as they are able to receive services in the manner that they prefer. There is a concern that shifting to managed care will impact this flexibility.
- **Access to services, especially medical and specialized care needs improvement:** People with IDD experience obstacles to accessing care in the current service delivery system due to several factors including but not limited to provider shortages, bureaucracy, intensive administrative processes, and long wait times for receiving approval for services.
    - These obstacles are worse for people with complex needs and when trying to access medical and specialized care.

Figures 2 and 3 provide an overview of the common feedback received from participants during these discussions with people with IDD, their family members, and providers and CCOs on the current state of services and supports.

Figure 2: Feedback from People with IDD, Their Family Members, and Other Natural Supports on the Current Service Delivery System

Current Services and Supports	
Access to Services	• Some people have had a positive care management experience because they were able to find a care manager who met their needs and supported them for a long period of time

[9] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_mco_qual_doc.htm
[10] https://opwdd.ny.gov/data/care-coordination-organization-profile

	• Despite reporting the success of CCOs' in previous sections of the report, stakeholders expressed overall dissatisfaction with CCOs
	  ○ CCOs did not improve access to care and added additional burdens on individuals and caregivers
	  ○ CCOs are not person-centered
	• Difficulties in accessing care
	  ○ Lack of trained providers, appointment availabilities, wheelchair accessible offices and office equipment
	  ○ Accessibility is worse for those with complex needs and/or those living in rural areas
	  ○ Difficulties traveling long distances to access specialized care
	  ○ Cumbersome onboarding processes
	• Providers who can serve people with IDD do not always accept Medicaid, so people must pay out-of-pocket for services, specifically for specialized care

Medical Care	• Difficulties finding a consistent provider for medical care (both adults and children) • People have been denied hospital care due to their disabilities • People have also been denied due to their insurance coverage (e.g., Medicare/Medicaid)
Specialized Care	• Difficulties accessing specialized care such as dental care, speech therapy, physical therapy, and mental health services
Behavioral Health Services	• Concerns about access and quality of mental health services and a lack of trained providers ○ Need for more therapists with experience serving people with disabilities • Difficulties in finding behavioral health services and specialists, with greater gaps in care Upstate vs Downstate • People have been denied care due to high behavioral needs
Dental Care	• Concerns about access to dental care, long wait times and travel times for people with complex needs • Need for properly trained staff to ensure that dental care can effectively meet the needs of people with complex needs
Therapy	• Concerns about access to physical and speech therapists
Medical Equipment	• Difficulties accessing medical equipment and long wait times to be approved for equipment
Day Habilitation	• Concerns about how long it takes to get into day habilitation programs
Housing	• Increased housing shortages and lack of affordable housing

	• Need for better support for those living in non-certified housing • Need for housing close to caregivers
In-Home Assistance	• Need for in-home assistance with daily activities like dressing, bathing, cooking, and cleaning • Concerns about inadequate support for people living at home, with a call for fair compensation for family caregivers • Challenges in finding residential placements that match the person's needs and the need for more options and providers
Respite Care	• Concerns about access to respite care • Low payment rates for respite care providers are a challenge
Self-Direction	• Most people are happy with their self-direction services and supports • Concerns about long wait times for service approvals, which have led to delays in receiving needed services
Supported Employment Program	• Lack of supported employment programs • People have a hard time finding and getting a job
Transportation	• Concerns about access to transportation in rural areas and the use of public transportation in cities • Challenges in finding rides to work and medical appointments • Calls for compensation for transportation expenses
FIDA-IDD	• White RTI reported overall satisfaction with the FIDA-IDD demonstration in the previous section, stakeholders shared negative experiences with the demonstration ○ Lack of access to services, trained professionals, and poor coordination of services
Workforce	
Finding and Retaining Staff	• Challenges in recruiting and retaining qualified and trained staff • Concerns that OPWDD has no way to evaluate the networks of care to access needed benefits
Training Among Staff	• Lack of properly trained staff to support people with IDD has negatively impacted the care people receive • Need for self-direction staff training and a general orientation • Lack of training for people with complex needs, specifically in specialized care
Staff Payment Rates	• Lower payment rates are a key problem impacting the workforce • Need better pay for Direct Support Professionals (DSPs) and better support for staff working in the field

	• Complex needs are not supported as part of provider rates
Aging Parents of people with IDD	• Concerns about who will provide care to and advocate for their children when parents are unable to ○ As parents/caregivers age, there is difficulty around accessing services that the parents/caregivers have historically provided
Data and Communication Transparency	
Data Transparency	• Lack of communication and timely updates on services
Communication and Transparency	• Lack of access to data for better understanding of the services provided
Community Involvement	• Community involvement and support from OPWDD for meeting people's needs ○ Basic needs are important
Non-English Speaker	• Lack of resources for people who do not speak English
Administrative Burden	
Administrative Process	• There is a lot of paperwork that needs to be completed to access OPWDD services ○ OPWDD application and approval process takes a long time • People have waited years for service approvals • Transition to CCOs added additional layers of bureaucratic burden

Figure 3: Feedback from Providers and CCOs on the Current Service Delivery System

Current Services and Supports	
Access to Services	• Lack of resources to access OPWDD services and guide people through the process of eligibility
Self-Direction	• Delays in approval of self-directed services
Dental Care	• Concerns about access to dental care, long wait times, and travel times for people with complex needs
Access in Remote Areas	• Limited access to services in remote regions
Navigating Services	• Providers have a hard time navigating services
Community Involvement	• Lack of opportunities for community involvement for people with IDD • Include people with IDD in the conversations about data and policy decision-making processes
FIDA-IDD	• There is a shortage of providers because they are not participating in the pilot program

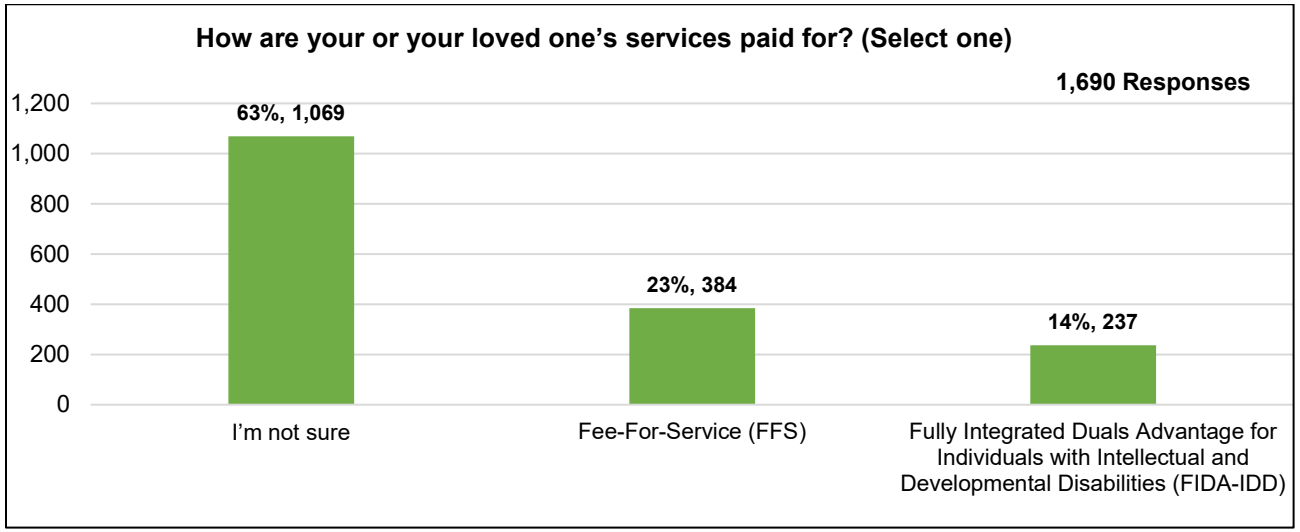
Workforce	
Finding and Retaining Staff	• Concerns about the difficulty of finding and retaining staff
Training Among Staff	• Lack of properly trained staff willing to provide services to people with IDD • Need staff training be transferrable to other agencies
Staff Payment Rates	• Insufficient Direct Support Professionals (DSP) payment rates • Complex needs are not supported as part of provider rates • Concerns regarding the current rate-setting methodology and its failure to keep pace with costs of the delivery system because of retrospective reimbursements
Data and Communication Transparency	
Data and Compliance	• OPWDD needs to be more data driven ○ Important to understand metrics and data to improve capacity and quality of work
Data on Acuity Levels	• Acuity levels do not always capture the actual needs of people with developmental disabilities
Communication and Transparency	• Concerns over changes in regulations without good communication
Administrative Burden	
Bureaucracy	• Concerns about OPWDD's bureaucracy and administrative rules • Delay in people receiving services due to the tedious administrative process

Surveys

Guidehouse received 2,222 survey responses across both surveys for people with IDD and their families, and providers:1,706 survey responses from people with IDD and their families, and 516 survey responses from providers. Both surveys included questions about the current state of OPWDD's service delivery system to better understand how people with IDD are currently receiving services. Most survey respondents were family members of people with IDD and were from either Region 4 (Bronx, Brooklyn, Manhattan, Staten Island, and Queens) or Region 5 (Long Island). It is important to note that survey respondents were not required to answer all survey questions and there were several questions that allowed for multiple responses.

People with IDD and Their Families Survey

Figure 4: Survey results on payment models for services

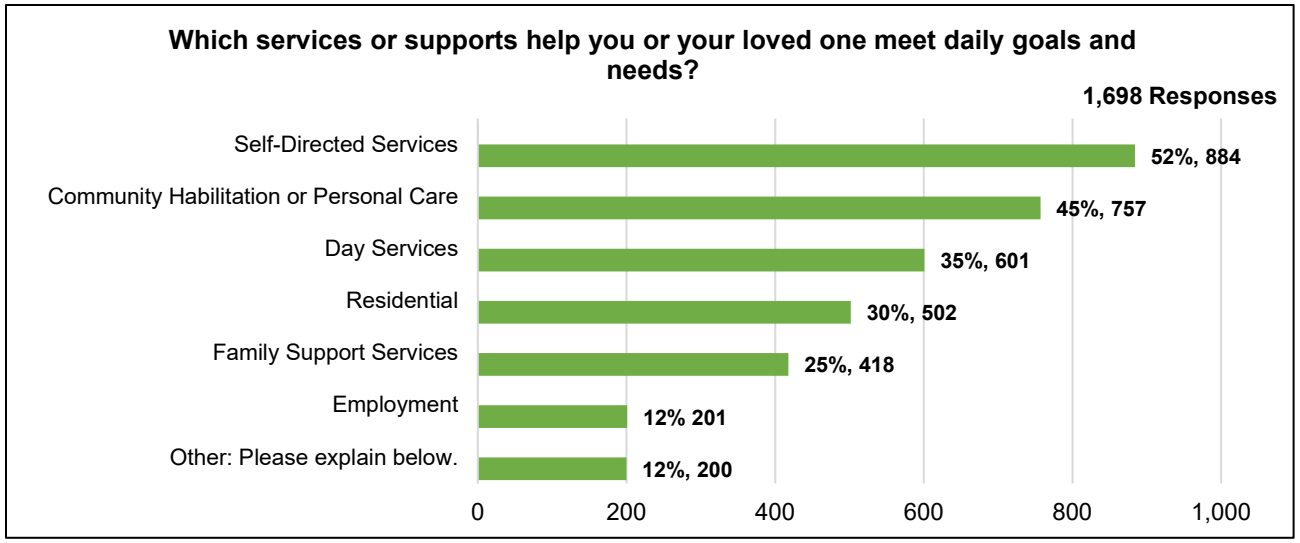


Key Takeaways

Respondents indicated they are unsure how their services are paid for. Similarly, one provider stated in an interview that education is one of the greatest barriers to change in the system.

OPWDD could facilitate townhalls, small focus groups, and/or webinars and have an accessible frequently asked questions (FAQ) document available online to provide stakeholders with information on different payment models that exist in the system.

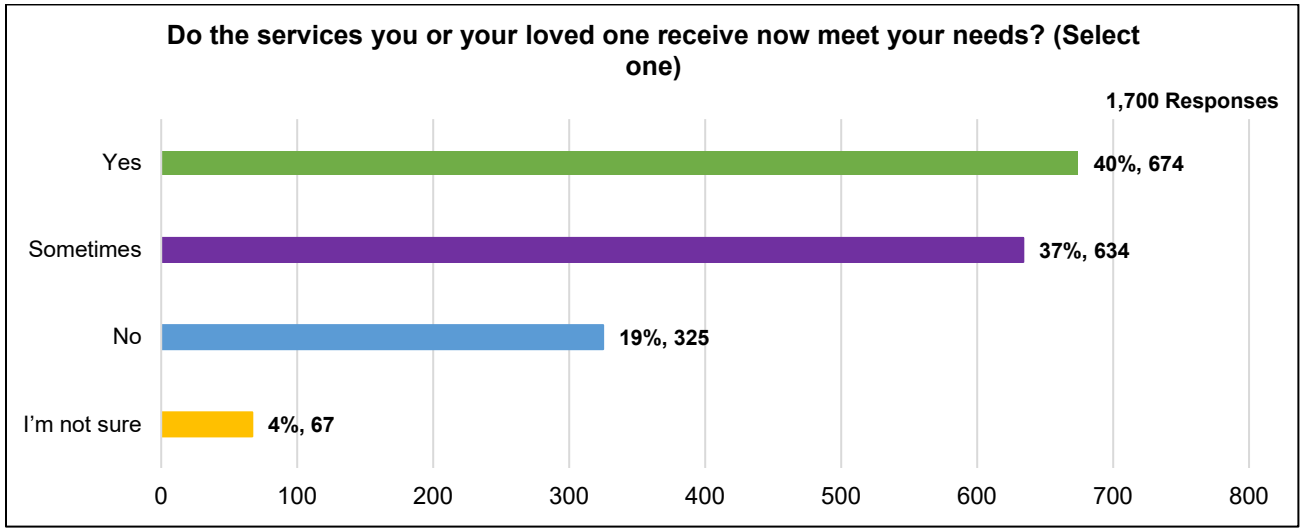
Figure 5: Survey results on services and supports that help people with IDD, or their loved ones meet daily goals and needs



Key Takeaways

Respondents indicated how people with IDD and their families value self-direction, which is *consistent with* what was shared in the townhalls and focus groups. Additionally, the survey also indicates that community habilitation or personal care, day services, residential and family support services assist people with IDD in meeting their goals.

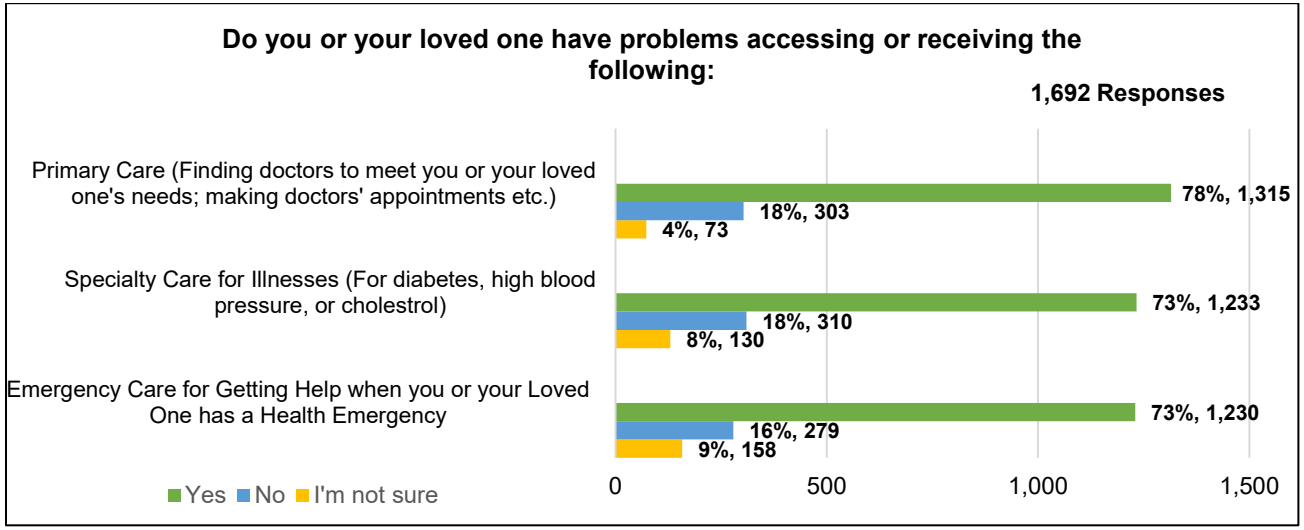
Figure 6: Survey results on whether respondents' needs are met



Key Takeaways

Respondents indicated that their needs were not always met by the services in place. The survey results are *consistent with* what was shared during the townhalls and focus groups.

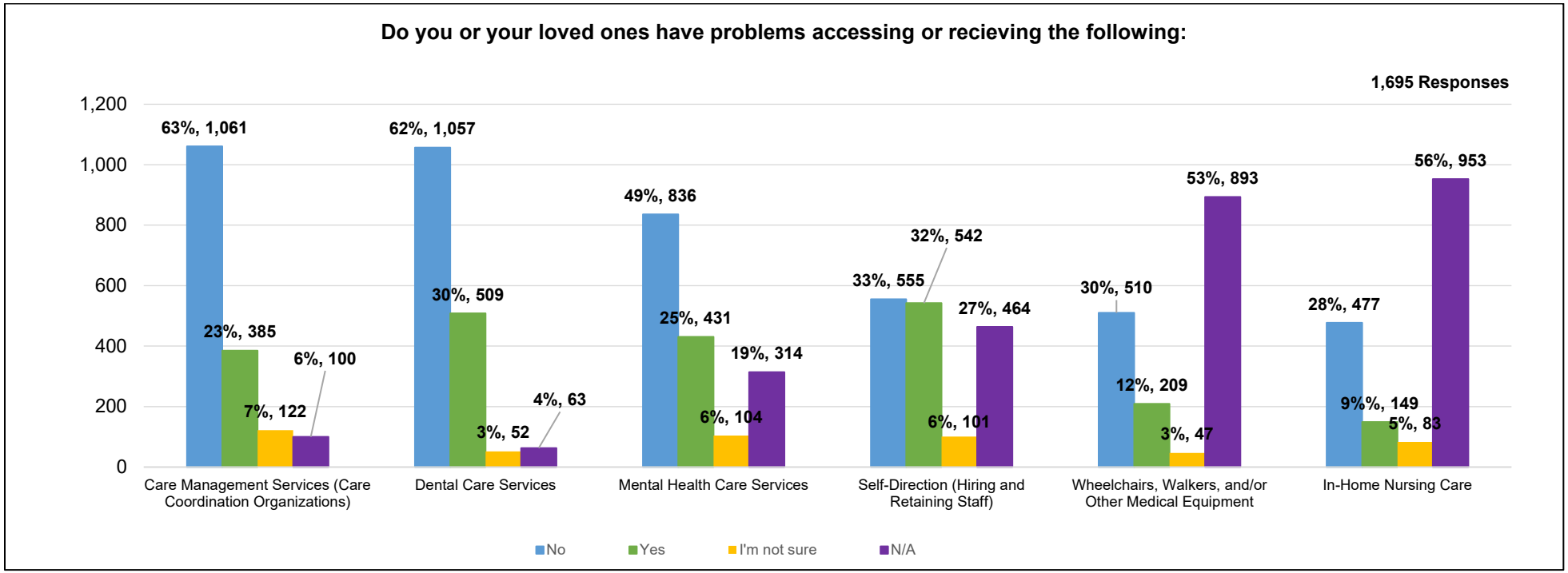
Figure 7: Survey results on access to certain medical services



Key Takeaways

Respondents indicated that they did not have a problem receiving primary care, specialty care, and emergency care. This is *inconsistent with* what was shared in the townhalls and focus groups regarding challenges to accessing primary care, specialty care, and emergency care.

Figure 8: Survey results on access to certain non-medical services

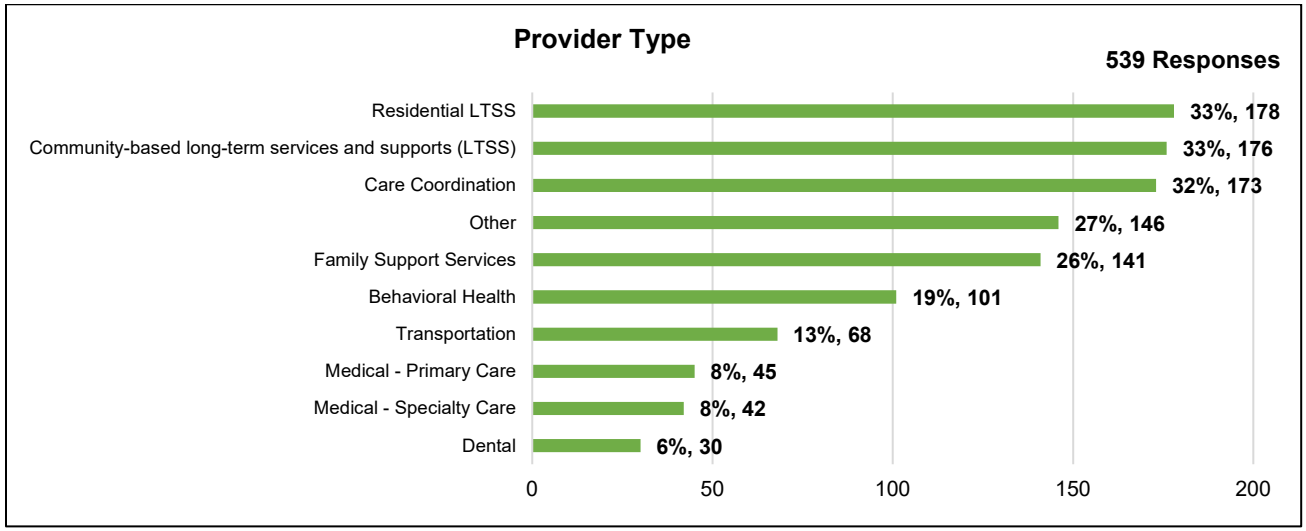


Key Takeaways

Majority of respondents indicated they do not have a problem accessing care management, dental services, and mental health care services in the current system. This is *inconsistent with* what was shared in the townhalls and focus groups. Participants shared it is challenging to have a consistent care manager due to staff turnover and it is difficult to find a provider who has the experience to deliver dental and mental health services to people with IDD.

Provider Survey

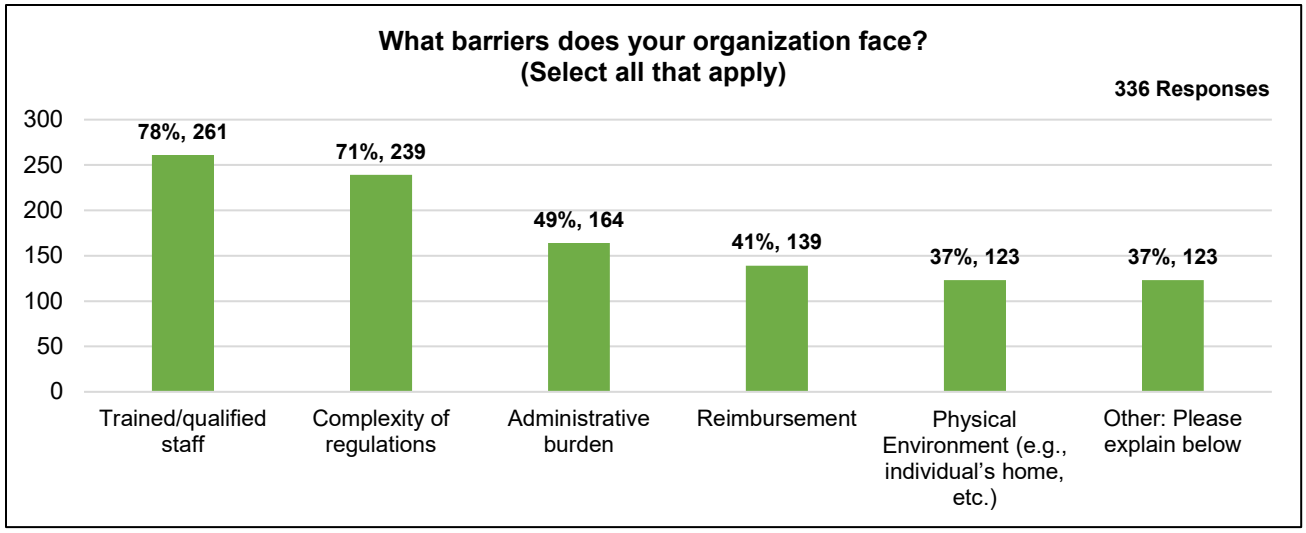
Figure 9: Survey responses on the respondent's provider type



Key Takeaways

There was a low survey response rate from medical providers serving the IDD population (e.g., Primary Care, Specialty Care, and Dental). This is *consistent with* what was shared in the townhalls and focus groups around challenges of receiving adequate medical care due to the lack of medical providers with experience caring for the IDD population.

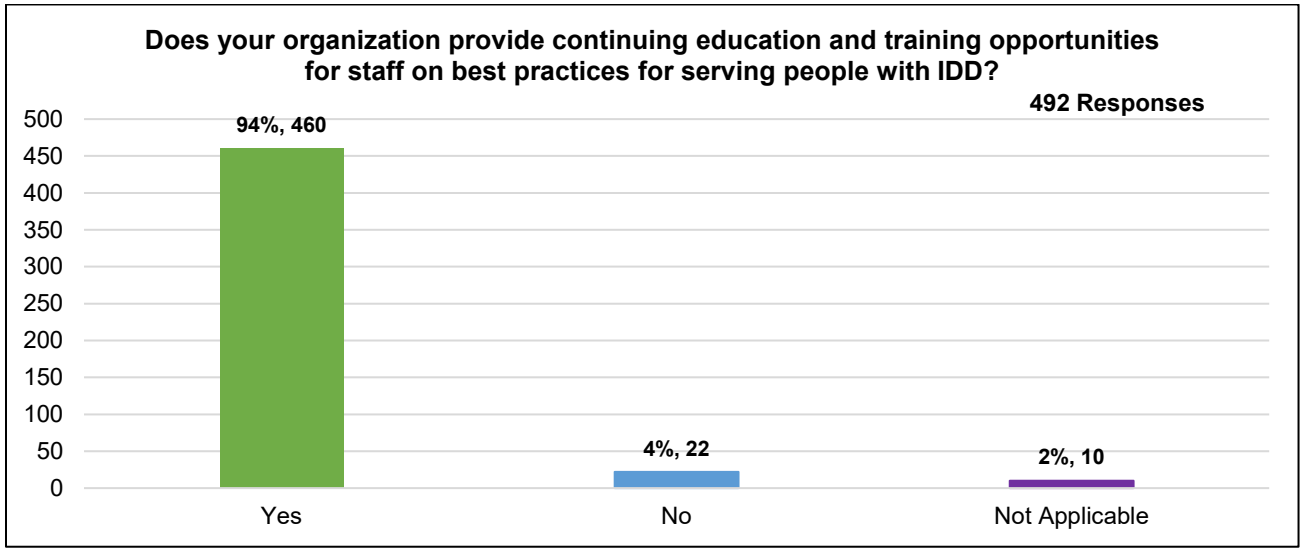
Figure 10: Survey responses on barriers provider organizations are facing



Key Takeaways

Respondents indicated that the most common barriers providers experience in providing care to the IDD population are the lack of trained/qualified staff, complex regulations, and administrative burden. This is *consistent with* what was shared in the townhalls and focus groups. One provider shared in an interview that administrative work takes time away from providing quality services to the people they care for.

Figure 11: Survey responses related to continuing education and training opportunities for staff

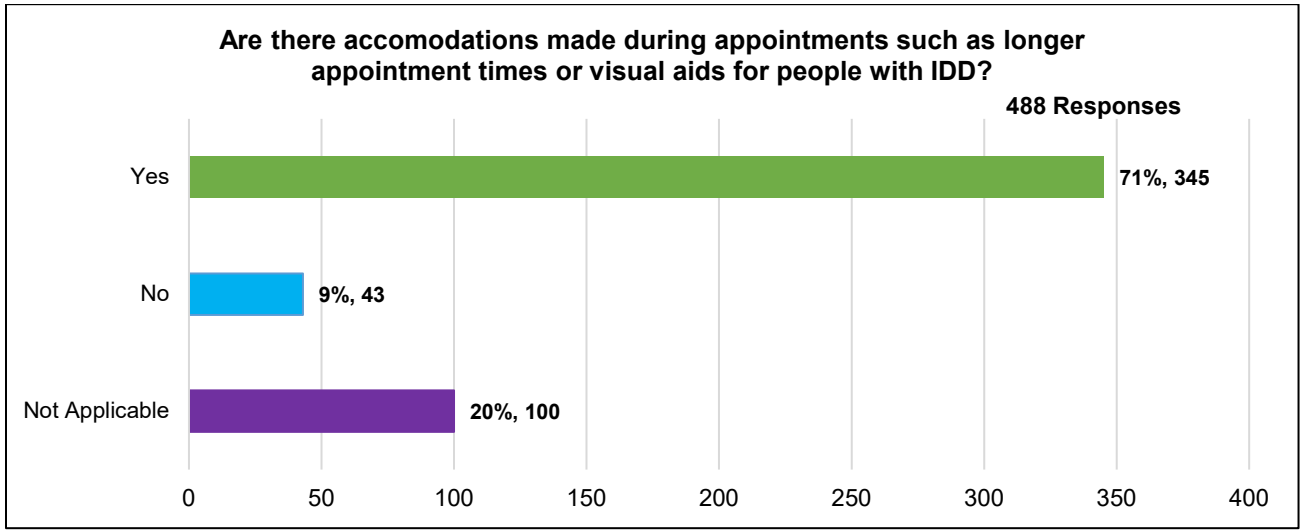


Key Takeaways

Most respondents indicated that provider organizations provide continuing education and training for staff on best practices for serving people with IDD. This is *inconsistent with* what was shared in the townhalls and focus groups.

To ensure staff participation, OPWDD and provider organizations could explore introducing financial incentives for completing such trainings.

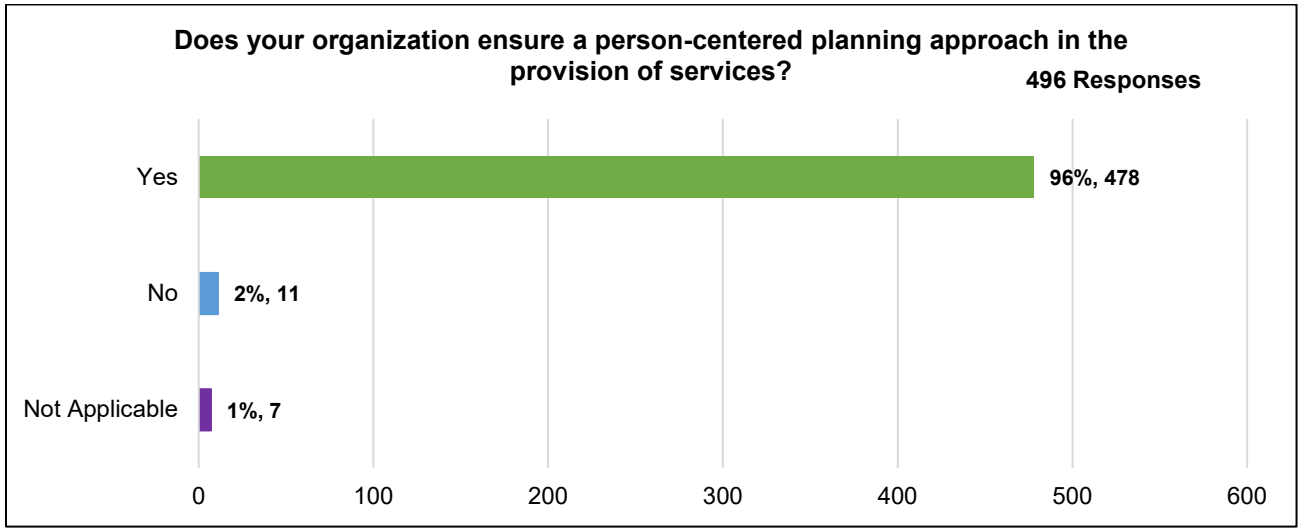
Figure 12: Survey responses on accomodations during appointments for people with IDD



Key Takeaways

Most respondents indicated that providers make accommodations during appointments such as longer wait times, visual aid, etc., This is *inconsistent with* what we heard in the townhalls and focus groups around the difficulties people with IDD have finding providers who are willing to provide such accommodations.

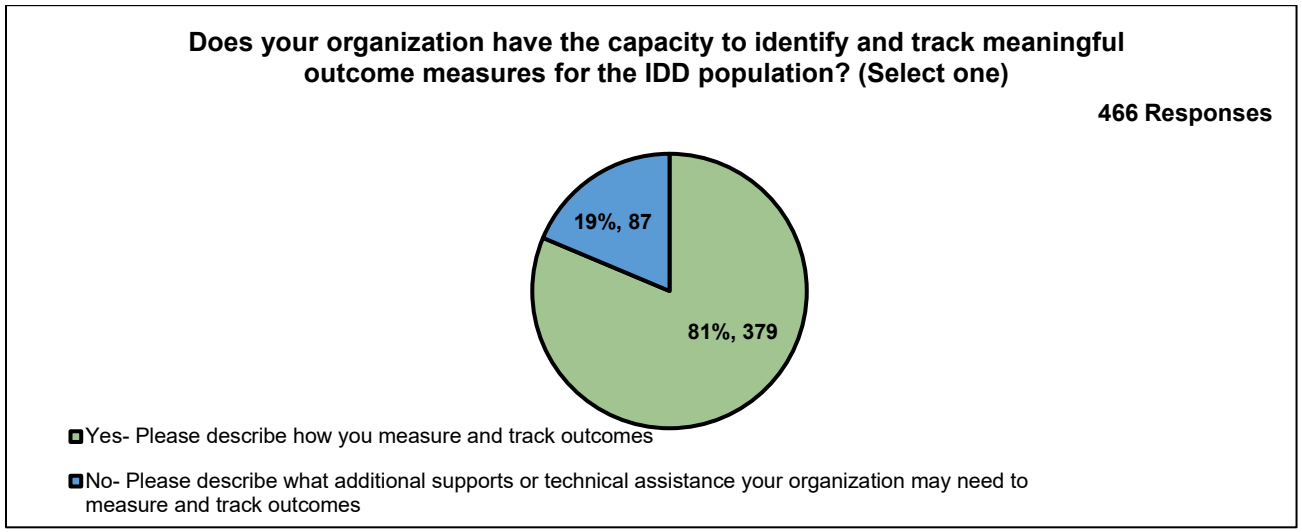
Figure 13: Survey responses on person-centered planning



Key Takeaways

Most respondents indicated that their organization ensures a person-centered approach. This is *inconsistent with* what was shared in the townhalls and focus groups. Both providers, people with IDD, and their families shared the need for a more person-centered approach to the care for people with IDD.

Figure 14: Survey responses on provider organizations' ability to identify and track meaningful outcome measures



Key Takeaways

Most respondents indicated that provider organizations track outcome measures for people with IDD. This is *inconsistent with* what we heard during townhalls and focus groups. Both providers, people with IDD, and their families expressed the need for more robust processes for outcome measures.

OPWDD Internal Interviews

Many of our interviews with OPWDD employees focused on opportunities to enhance the current service delivery system for people with IDD. Overall, employees identified the need to collaborate across agencies, remove duplication in work, consider cultural implications, and gauge overall change readiness. We also discovered a clear alignment with OPWDD leadership and adherence to the OPWDD 2023-2027 Strategic Plan goals and objectives and common themes observed were workforce shortages, health equity, and provider capacity.

Figure 15 includes common strengths and gaps in the current service delivery system we observed during interviews with OPWDD staff that are aligned with OPWDD's Strategic Plan goals and objectives. We have also provided recommendations on how OPWDD could address these gaps in the service delivery system in the column titled "OPWDD Opportunities."

Figure 15: OPWDD Internal Interview Response Themes

Strategic Plan Goal	Response Themes – Strengths	Response Themes – Gaps	OPWDD Opportunities
Strengthening Workforce, Technology and Collaboration	• OPWDD is committed to recruitment and retention for DSPs. • OPWDD leveraged funds from the American Rescue Plan Act (ARPA) to implement initiatives, such as providing supplemental payments to strengthen the workforce. • OPWDD leadership is mission-driven and committed to improving the lives of people with IDD. • IDD providers are committed to providing high-quality care. • OPWDD is committed to improving decision-making through data and technology that will support provider collaboration and enhance the services and supports of people with IDD. • OPWDD is committed to stakeholder engagement (people with IDD, their	• OPWDD has experienced an annual 36% voluntary turnover rate for DSPs. This turnover has impacted providers' ability to deliver services. • Provider capacity is an issue; individuals are being authorized but not receiving services due to lack of providers. • No connections between claims data and critical incident reports. • Data availability and how data integrates with other New York agencies can decrease visibility into performance. • Walls between agencies can be a challenge; especially in identifying, "to whom a person belongs for a given service" (e.g., OPWDD, DOH, Office of Mental Health (OMH), Office of Children and Family Services (OCFS)).	• Provide funding to develop a strong and well-trained direct support workforce with emphasis on recruitment and retention activities, workforce training initiatives that improve the competency and skills of the DSP workforce, and efforts to improve career pathways for both DSPs and Family Care providers. • Ensure the availability of sufficient emergency response/crisis services and intervention teams to decrease wait times in accessing needed community supports. • Further explore in home technology and remote supports including monitored in-home care.

Strategic Plan Goal	Response Themes – Strengths	Response Themes – Gaps	OPWDD Opportunities
	families, providers, and advocate groups). • OPWDD directs efforts to imbed the use of technology in day-to-day services, such as home enabling support, assistive technology process improvements, etc.		
Transform Systems through Innovation and Change	• Single Point of Entry (SPOE) program works well across the State. • The system built around certifying providers and sites which provide a better platform for oversight than other programs. • As a state provider of services, OPWDD can be creative and innovative in addressing the needs of unique populations/step down services.	• Building back community-based services post-COVID Community supports (e.g., dental) are often limited and a challenge for people with IDD. • Provider reimbursement is not based on the needs of individuals; it is based on the cost for providers to deliver the service. • OPWDD is challenged to staff positions needed to make service commitments. • Improvements are needed in services related to the dually diagnosed with SMI and IDD.	• Form strategic provider partnerships, these partnerships will be essential to ensure the right access to care (e.g., partnership with safety net hospitals). • Continue to examine the higher needs funding to determine the right incentives. • Advance the service authorizations and system infrastructure by updating technology to provide more timely information, increase the availability of data, and improve decision-making processes. • Strengthen residential and supportive housing services, recognizing the need for long-term planning as families and caregivers age; encourage coordinated and targeted efforts to connect IDD participants to tenancy supports, community transitional services, and DSPs.

Strategic Plan Goal	Response Themes – Strengths	Response Themes – Gaps	OPWDD Opportunities
			• Institute continuous quality improvement strategies focused on regulatory compliance and the delivery of person-centered care management services. • Incentivize high quality and efficient value-based care through the integration of developmental disability services, primary care, behavioral health, and other social care supports.
Enhance Person-Centered Services and Supports	• For individuals that do receive services, OPWDD is successful at delivering quality services. • OPWDD is committed to the Coordinated Assessment System (CAS) that will assist OPWDD in taking a more person-centered approach in the services individuals are receiving by identifying an individual's level of need.	• Disparity in access to services based on location, ethnicity, race, language, social, and economic factors. • Matching medically frail people and behavioral and culturally different people into group homes creates challenges (e.g., the breadth, scope, and complexity of individuals with unique needs).	• Focus and support of care coordination that accounts for the ever-changing needs of people with IDD over their lifespan. • Improve and modernize the self-direction model using IT solutions that meet the increasing requests of underserved populations while enhancing training for care managers related to self-directed services. • Continue to support and refine the FIDA-IDD demonstration pilot to provide comprehensive, integrated care services for dually eligible beneficiaries with IDD.

Performance Data (NCI-IDD IPS) Analysis

Guidehouse reviewed NCI-IDD IPS data by aligning it to the OPWDD strategic goals. Guidehouse selected 24 total indicators that aligned with OPWDD's Strategic Goals (See Appendix E). The sub-domains include Access, Choice and Decision Making, Community Inclusion and Belonging, Employment, Safety, Health, Wellness, Service Coordination, and Workforce. There are 53 total NCI-IDD indicators across these sub-domains. These indicators also cross the three IPS data sources (administrative record BI, Section I – no proxy respondents, and Section II – proxy respondents allowed).

Guidehouse also reviewed the performance of peer and managed care states including Florida, Illinois, Kansas, Massachusetts, Michigan, North Carolina, Ohio, and Pennsylvania. Although they are peer states, California and Tennessee were not included in this review as there is no NCI-IDD IPS data for these states for the indicators reviewed. Guidehouse determined the performance of each state and service delivery system by comparing its performance with the weighted national average provided with the NCI-IDD IPS data. The weighted national average considers responses from all states with data reported, not just New York and peer states.

When reviewing the select NCI-IDD IPS data Ohio, Illinois, and Pennsylvania had the highest number of indicators which performed better than the weighted national average.

Out of the 24 indicators, Pennsylvania and Illinois had 18 indicators that scored better than the national weighted average, where Ohio had 16 indicators that scored better the national weighted average. It is important to note that there was greater than 25% missing data for one of the indicators where Pennsylvania scored better and for two of the indicators where Ohio scored better. Ohio operates a FFS model, while Illinois and Pennsylvania both operate under a managed care model for physical and behavioral health. Pennsylvania also has managed care for limited HCBS services.

New York scored better than the weighted national average for four of the NCI-IDD IPS indicators reviewed. Those indicators included:

- Person can talk or communicate with staff in their preferred language.
- Person exercises or does physical activity at least once per week for 10 minutes or more at a time
- Person has someone to go to for help when they feel afraid.
- Person went to the emergency room for any reason to get care for themselves in the past 12 months *(lower score is better)*

Our analysis of NCI-IDD IPS data does not clearly indicate whether managed care performs better or worse than other models as there are multiple limitations as mentioned in Section 2. While differences in states and limitations prevent a conclusive comparison, if peer states with similar models generally are consistently scoring above the national average in the same indicators, there is potential to learn from the best practices of these states. But, in our analysis, there is a lack of consistency in state performance across indicators to be able to determine if FFS or managed care models perform better. It appears a program's quality is not directly tied to the payment model. Other factors that could impact performance data outcomes are the intentionality and policies of the states, the level of involvement of state agencies, and the oversight and enforcement of managed care.

Performance Data (NCI-IDD IPS) for FIDA-IDD in New York

Guidehouse received NCI-IDD IPS data from OPWDD for the 2021-2022 period separated by services coordinated through FIDA-IDD and CCOs. This allowed a performance comparison of FIDA-IDD and CCOs and how both are scoring in relation to the national weighted average.

Guidehouse evaluated the percentage point difference between FIDA-IDD and CCO with the national average to analyze performance. To calculate percentage point difference, Guidehouse subtracted the performance score (listed in percentage) of FIDA-IDD and CCOs with the national weighted average. This allows for a

comparison of FIDA-IDD and CCOs and how they performed separately when compared to the national weighted average.

Figure 16 shows the 24 indicators that were reviewed, a positive percentage point difference means for that specific indicator the score was better than the national average. For indicators 12 and 22 a negative percentage point difference means for that specific indicator the score was better than the national average.

Figure 16: NCI-IDD IPS Data Comparison of FIDA-IDD, CCO, National Weighted Average for 2021-2022

Variable Label	% Point Difference (FIDA-IDD and National Weighted Average)	% Point Difference (CCO and National Weighted Average)
1. Staff treats person with respect	-0.33%	0.46%
2. Staff have the right training to meet the person's needs	-5.60%	0.40%
3. Person can talk or communicate with staff in preferred language	1.00%	-0.03%
4. Chose staff or were aware they could request to change staff	-6.70%	0.30%
5. Can change their case manager/service coordinator if wants to	-2.00%	0.30%
6. Person was at last service planning meeting	-1.00%	-0.02%
7. Service Plan includes things that are important to them	-3.09%	-0.03%
8. Has met or spoken with care manager	4.00%	0.43%
9. Care manager knows what is important to a person	-8.18%	-0.02%
10. Everyday Choices Scale	-1.60%	0.38%
11. Has a way to get places needs to go	1.10%	-0.24%
12. Feels afraid in their home, neighborhood, transport, workplace, etc. *(lower score is better)*	-0.41%	0.20%
13. Has someone to go to for help when they feel afraid	-5.71%	0.08%

Variable Label	% Point Difference (FIDA-IDD and National Weighted Average)	% Point Difference (CCO and National Weighted Average)
14. Person gets to do things they like to do in the community as much as wants	3.00%	-0.57%
15. Person does things in the community with the people they want	-5.09%	0.55%
16. Person has a paid job in the community	-8.87%	0.20%
17. Person has community employment as a goal in their service plan	-10.74%	0.75%
18. Has a primary care doctor or practitioner	-16.60%	0.60%
19. Had completed physical exam in the past year	8.00%	-0.30%
20. Had a routine dental exam in the past year	7.60%	-0.40%
21. Had a flu vaccine in the past year	-19.30%	1.30%
22. Went to the emergency room for any reason to get care for themselves in the past 12 months *(lower score is better)*	5.30%	-0.70%
23. Exercises or does physical activity at least once per week for 10 minutes or more at a time	-4.60%	0.30%
24. Life-Decision Scale	No Data Available	

Summary of analysis findings and key themes:

- FIDA-IDD scored better than the weighted national average for 6 of the 24 indicators.
- CCOs scored better than the national average for 15 of the 24 indicators.
- CCOs scored better than the national average for Choice indicators while FIDA-IDD scored worse than the national average for Choice related indicators.
- Out of the six indicators where FIDA-IDD scored better than the national average, the CCOs scored worse on five of them. Both scored higher for different indicators, and it may be beneficial to learn best practices for each of them.
- Indicators where FIDA-IDD and CCOs are performing better than the national average, the point difference is still relatively low.

Section 4 Future State Assessment

As part of our Literature Review, Stakeholder Engagement, and interviews with peer and managed care states and national experts, Guidehouse also gathered insight into:

- Potential elements of a future service delivery system.
- Successful service delivery systems and payment models in other states that OPWDD can consider implementing into New York's current delivery system.

Stakeholder Engagement

Below is the feedback we heard from stakeholders during the townhalls and focus groups, surveys, and interviews on their thoughts and expectations for the future of New York's service delivery system for people with IDD.

Townhalls and Focus Groups

The following outlines the current perspectives of participants regarding the future service delivery system.

- **People with IDD and their family members:** Shared concerns about the implementation of managed care and its ability to improve the service delivery system and the barriers that already exist in the system.
- **Providers and CCOs:** Shared mixed views on managed care. Participants expressed interest in the potential for managed care to address system gaps, while others questioned managed care's ability to reduce barriers in the current system.

Figures 17 and 18 provide an overview of the common feedback received from participants during sessions with people with IDD, their family members, and other natural supports, and providers and CCOs on the future state of OPWDD's service delivery system.

Figure 17: Feedback from People with IDD, their Family Members, and other Natural Supports for the Future Service Delivery System

Service Delivery System	
Managed Care	• Varying views on the implementation of managed care. o Open to considering managed care to address system gaps. o Concerns about how MCOs might not focus on people's needs for services. o Questions about if a managed care system will improve access to services for people with IDD. o Mixed feedback on whether managed care will improve or reduce the current administrative processes. o Others felt that managed care will worsen already tedious administrative processes, especially without any associated regulatory reforms. o Concerns about how capping rates in a managed care system will further perpetuate the staffing challenges. o Concerns about MCOs administrative costs impacting provider payments. o Concerns about how managed care contracting impacts the reimbursements of home health services o Some stated that managed care can speed up processing and approval of

Service Delivery System	
	certain services, especially if regulatory flexibilities and the opportunity to innovate are encouraged. • Agencies and people with IDD need to be prepared for another service delivery system before a transition is made because they already have challenges with the current system. • It is important that all stakeholders be willing to switch to a managed care system before a transition is made. • MCOs will need to be more data and compliance driven.
Measuring Care Progress	• Positive health outcomes are important, and there needs to be ways to measure progress towards these outcomes.
Provider-Led Models	• Need to consider a provider-led model as these models allow for communication among care managers.
Flexible System	• Need for a more flexible system that is outcome-based and eases movement across the system.

Figure 18: Feedback from Providers and CCOs for the Future Service Delivery System

Service Delivery System	

Managed Care	• Do not believe that a managed care service delivery system is going to improve services and supports.
	  ○ Concerns that managed care will create further barriers to service delivery.
	  ○ Concerns about how a managed care system could put providers out of the network for people with IDD.
	  ○ Concerns about changes in self-direction if there is a transition to managed care.
	  ○ Concerns that MCOs lack the skills, experience, and expertise to support people with IDD.
	  ○ Concerns that MCOs will not focus on the needs of people with IDD.
	  ○ Concerns about how capping rates in a managed care system will further perpetuate the staffing challenges.
	  ○ Concerns that managed care will increase bureaucracy and worsen current administrative barriers to accessing care.
	  ○ Concerns that managed care administrative costs will redirect funds away from people with IDD and their services.
	  ○ Concerns that capped rates in a managed care system will not support the complex needs of people with IDD.

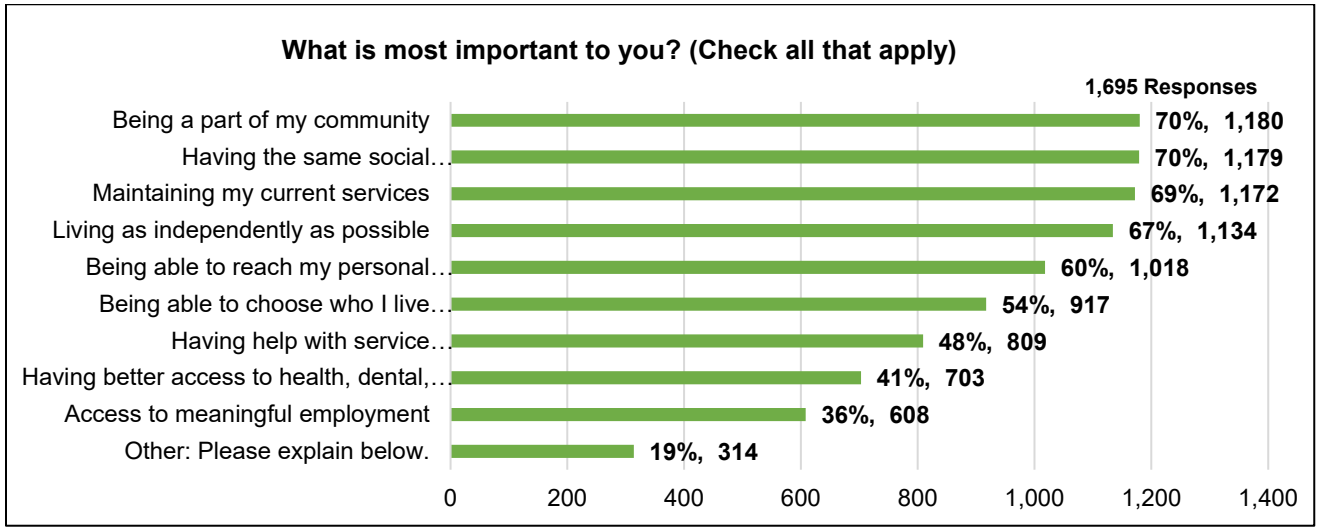
Care Delivery Model	
Value-Based Care and Shared Savings	• Need to implement value-based care and shared savings before implementing managed care • If local providers meet target outcomes, providers will benefit from shared savings

Surveys

Guidehouse received 2,222 survey responses across both surveys for people with IDD and their families, and providers: 1,706 survey responses from people with IDD and their families, and 516 survey responses from providers. Both surveys included questions about the future state of OPWDD's service delivery system, such as what is important to respondents regardless of the service delivery system and their thoughts on managed care. See below for survey results as they relate to the future state of OPWDD's service delivery system. It is important to note that survey respondents were not required to answer all survey questions and there were several questions that allowed for multiple responses.

Survey for People with IDD and Their Families

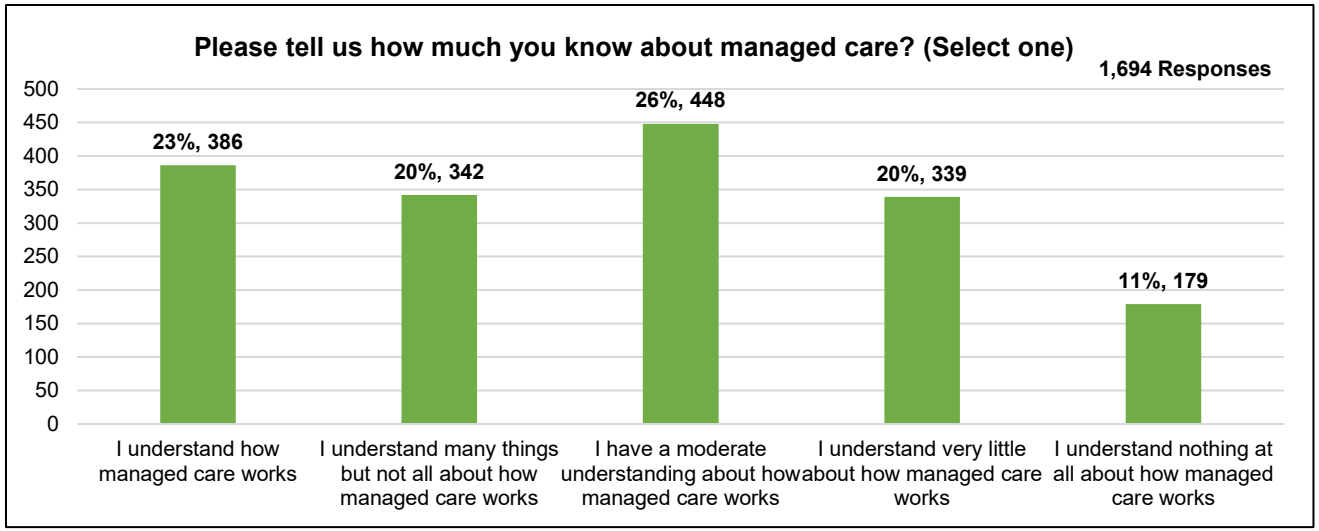
Figure 19: Survey results on what is important to survey respondents



Key Takeaways

Respondents indicated that being a part of their community, having the same social opportunities as anyone else, and maintaining their current services is most important to them. This is *consistent with* what was shared in the townhalls and focus groups. Regardless of the type of service delivery system and/or payment model it will be important for OPWDD to keep people with IDD and their families at the forefront of decision-making processes and what is most important to them.

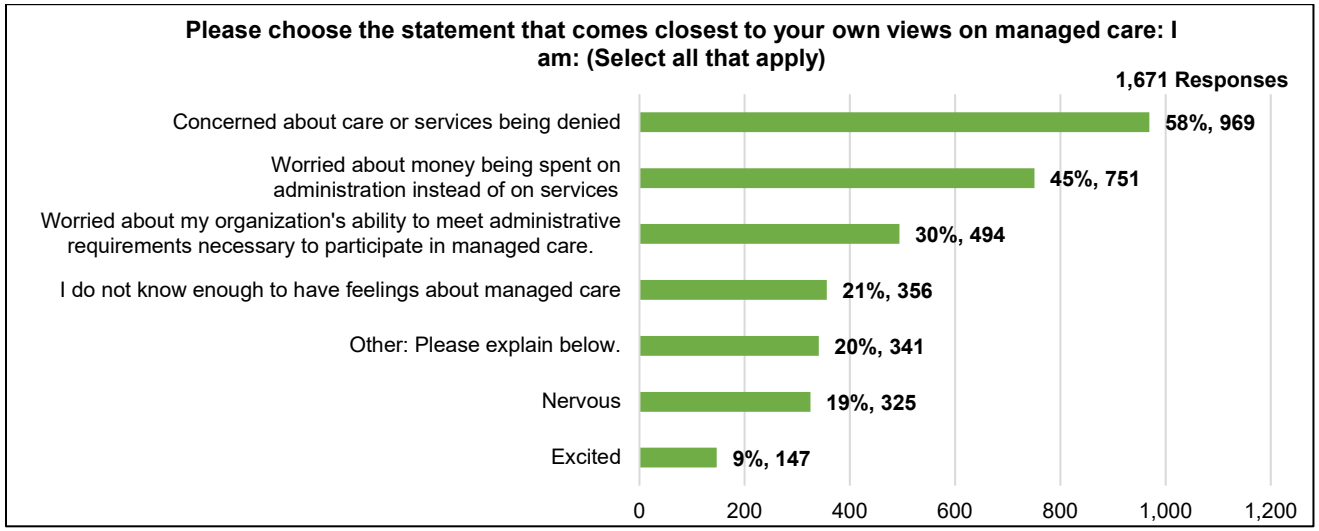
Figure 20: Survey results on what respondents know about managed care



Key Takeaways

Respondents indicated they have a moderate understanding about how managed care works. This is *consistent with* what was shared in the townhalls and focus groups. If OPWDD were to implement managed care, there would need to be an opportunity for education and training for stakeholders to learn about the managed care transition prior to implementation.

Figure 21: Survey results on what respondents are concerned about with managed care

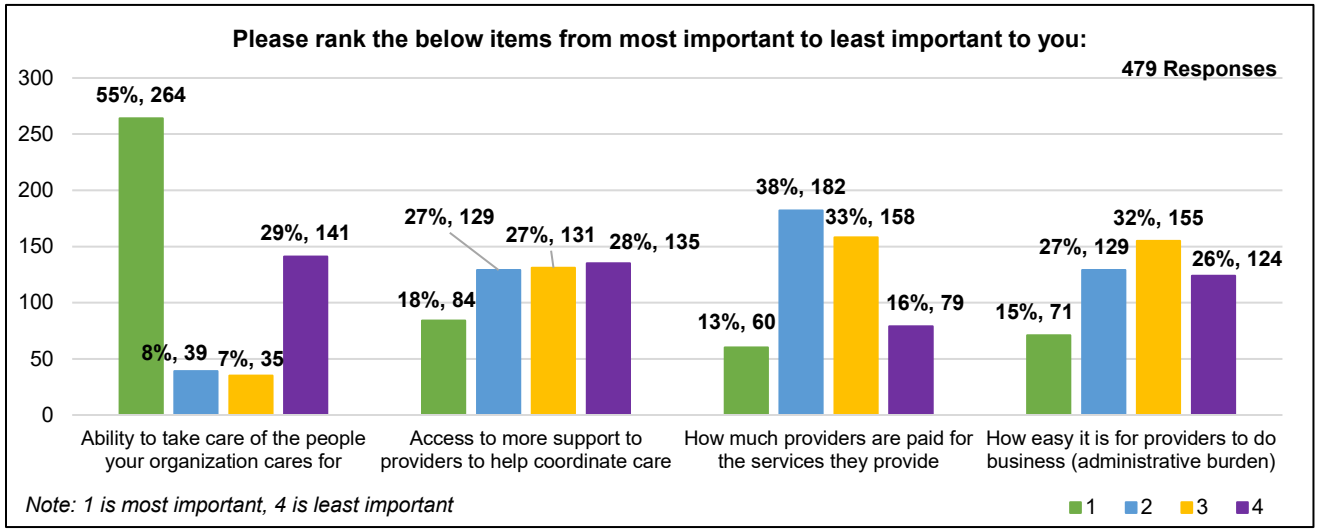


Key Takeaways

Respondents indicated they are concerned that managed care will lead to services being denied. This is *consistent with* what was shared in the townhalls and focus groups. If OPWDD decides to implement managed care, services will need to be closely monitored to ensure that services are appropriately provided. Also, providing stakeholder training and education on managed care will be important.

Survey for Providers

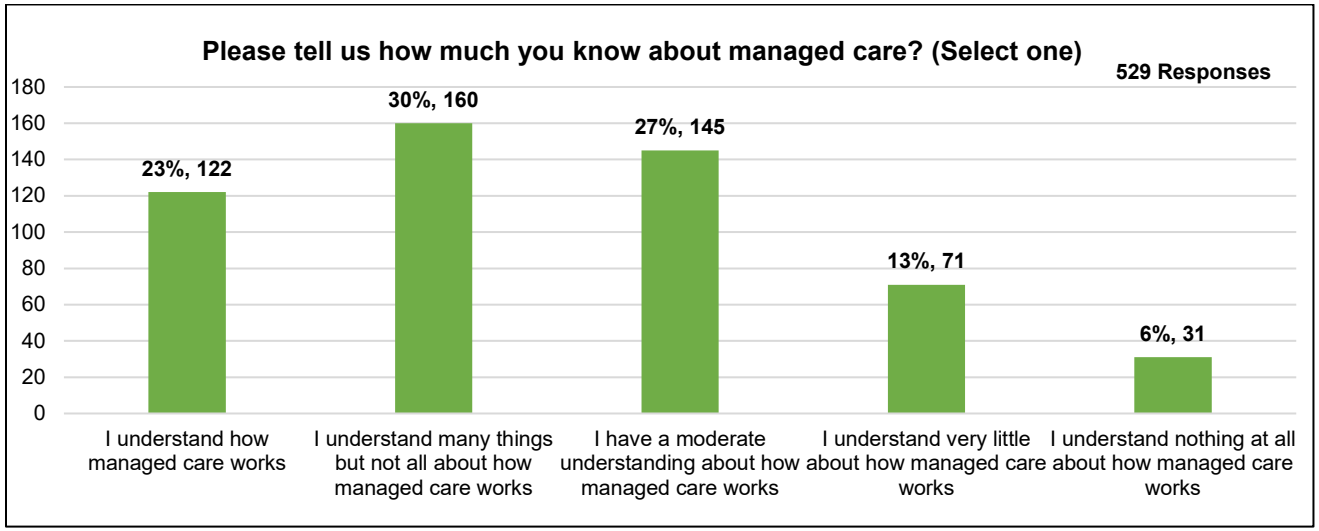
Figure 22: Survey results on what is important to survey respondents



Key Takeaways

Respondents indicated the ability to take care of the people their organization cares for is most important. This is *consistent with* what was shared in the townhalls and focus groups. OPWDD will need to work closely with providers to determine what will help them better support the people their organizations care for. For example, OPWDD could facilitate townhalls and focus groups with a focus on how to better support provider organizations in delivering services to the IDD population.

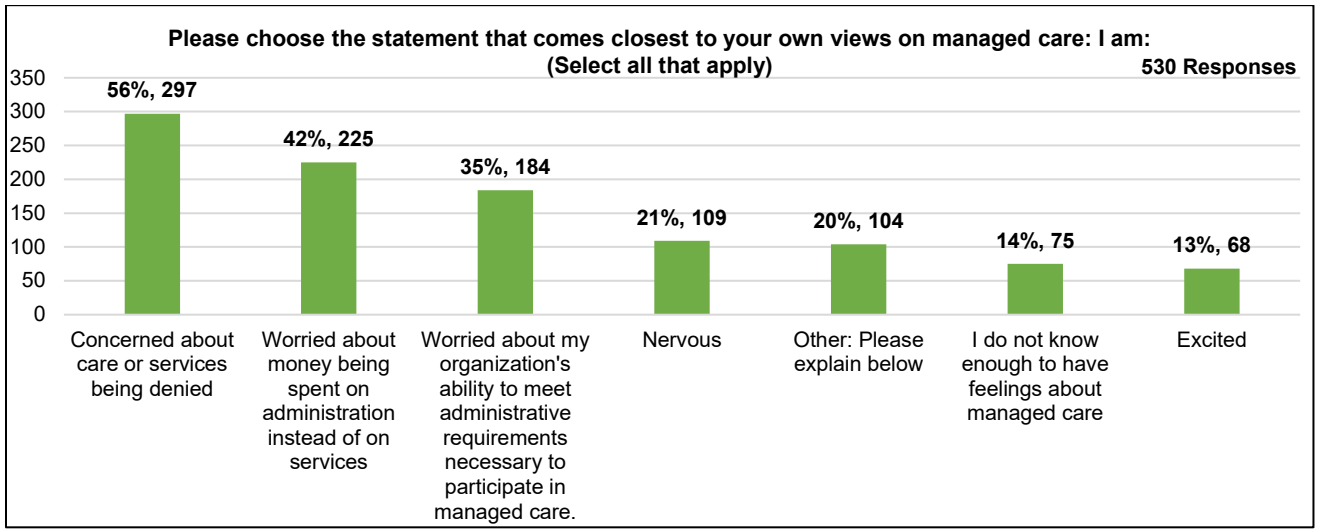
Figure 23: Survey results on what respondents know about managed care



Key Takeaways

Respondents indicated they understand many things but not all about how managed care works or they have a moderate understanding of how managed care works. This is *consistent with* what was shared in the townhalls and focus groups. If OPWDD were to implement managed care, there would need to be an opportunity for education and training for stakeholders to learn about the managed care transition prior to implementation.

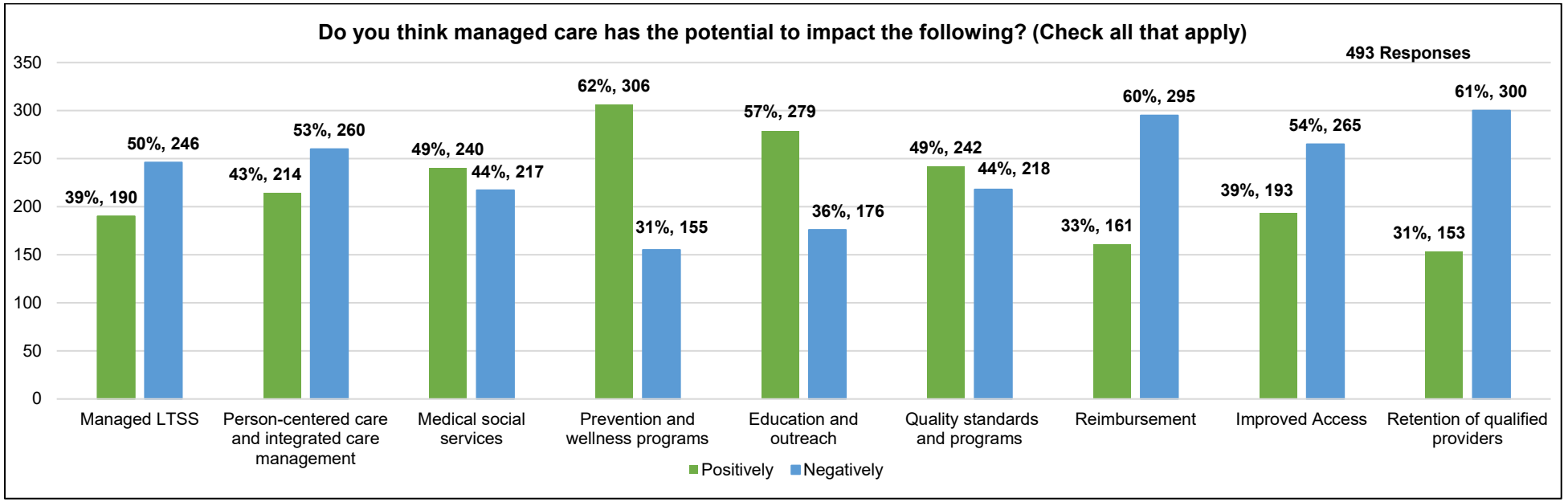
Figure 24: Survey results on what respondents are concerned about with managed care



Key Takeaways

Respondents indicated they are worried about care or being denied for people with IDD. This is *consistent with* what was shared in the townhalls and focus groups, but participants also indicated they were open to managed care if it can help address gaps in the current system. If OPWDD decides to implement managed care, keeping stakeholders at the forefront of decision-making, and including stakeholder training and education on managed care will be important.

Figure 25: Survey results on what managed care could impact



Key Takeaways

Respondents indicated they think managed care could positively impact “Prevention and Wellness Programs” which may improve medical services for people with IDD. *Consistent with* what was shared by participants in the townhalls and focus groups, it can be difficult for people with IDD to find a consistent primary care physician, go to the emergency department, or receive dental care due to the lack of medical providers. Also, participants indicated in the townhall and focus group discussions that providers are not properly trained to deliver services to the IDD population. One provider explained in an interview that education is one of the biggest barriers to change. Survey respondents reported they think managed care could positively impact “Education and Outreach” which may improve the workforce and enhance services delivered to people with IDD.

Peer and Managed Care State Interviews

From the Peer and Managed Care state interviews, Figures 26-28 spotlight three state programs by service delivery system that are seeing, or expect to see, outcomes OPWDD is looking to achieve with its service delivery system and to accomplish the goals set out in its 2023-2027 Strategic Plan. By examining three distinct service delivery systems that align with OPWDD's Strategic Plan goals, we gained insights into the impact of service delivery systems and the payment models included in these systems.

Figure 26: Fee for Service – Ohio

Strategic Plan Goal	State Programs and Initiatives

Strengthen Workforce, Technology, and Collaboration	• Ohio Incident Tracking and Monitoring System (OITMS): Critical incidents reporting and tracking through a Salesforce monitoring system using Medicaid Claims data.
	  ○ Able to do a comparison to confirm that incidents were reported when they needed to be.
	  ○ Looks at trends to determine corrective actions.
	• Ohio Alliance of Direct Support Professionals (OADSP) and the Ohio Department of Education developed *Direct Support Professional University (DSP-U).*
	  ○ Offered in high school and career/vocational schools and through partnerships with local county boards of developmental disabilities.[11]
	  ○ Provides opportunities for currently enrolled high school students interested in working with people with developmental disabilities to be better prepared for a career in the field.[11]
	  ○ Students participating in the DSP-U program can earn professional credentials while receiving credit toward high school graduation requirements.[11]
	• *DSP Retention Payment Initiative:* Retention payments are distributed quarterly from the Department of Developmental Disabilities (DODD). Local funding and Medicaid government match funds were used to fund this initiative. Final payments were distributed in November 2023.
	• *Competency-Based Training and Longevity Add-On for DSPs:* DSP rate increase for completing the specified trainings.
	  ○ DSP rate increase includes additional 39 cents per 15- minute unit add-on to the Homemaker service.
	  ○ 60 hours of training is required for this add-on, and it is included waiver amendments.

Transform Systems through Innovation and Change	• Value-based payments for employment. ○ Value-based payments for improved outcomes and workforce retention pilot beginning in October 2023 and will be included in waivers January 2025. • *Technology First* initiative ensures that people with IDD have increased opportunities to live, learn, work, and thrive in their homes and communities by

[11] https://dodd.ohio.gov/communication/news/dsp_u

Strategic Plan Goal	State Programs and Initiatives
	using technology when able to. The initiative also promotes remote supports and assistive technology, to reduce the strain of the DSP workforce emergency. ○ The goal of Technology First initiative is to meet individuals' needs and promote independence. ○ Technology First has the potential to decrease staffing needs by removing some of the burden of delivering services off DSPs. ○ *Facility Transformation Pilot:* Pilot project for one of the nine Intermediate Care Facilities (ICFs) operated by New Avenues of Independence.12New Avenues to Independence purchased a home and incorporated assistive and smart technology into the home to increase independence, communication, and community engagement for the people who will live there.[12] ○ Successful implementation of the pilot project will provide a blueprint for moving forward with the acquisition of five new homes by 2024.[12] ○ The initiative has decreased staff needs and increased people with IDD's independence. ○ Received Department of Developmental Disabilities' ICF Supportive Technology Project grant funding. • *Technology Ambassador Program*: People with lived experiences provide mentorship to others on how they use Supportive Technology at home, at school, at work and in the community.
Enhance Person-Centered Services and Supports	• *Employment First Initiative:* Emphasizes person-centered planning and assists individuals in finding their path and maintaining employment. ○ State provides technical assistance to all regions to ensure programmatic success. ○ Awarded a five-year grant to improve competitive employment for people with IDD.
Lessons Learned	• Technology can help address workforce challenges. As seen in Ohio's Technology First initiative technology can help decrease the burden on DSPs. • Peer-to-peer programs like Ohio's Technology Ambassador Program can foster collaboration and improve experiences with technology for people with IDD. • Focusing efforts on employment for people with IDD can help achieve their daily goals and increase involvement in the community which is a common priority of the IDD population.

Figure 27: Managed Care for Limited HCBS Services AND Physical and/or Behavioral Health – Pennsylvania

Strategic Plan Goal	State Programs and Initiatives
Strengthen Workforce,	• Adult Community Autism Program (ACAP) leaders work closely with Keystone Autism Services, who acts as both provider and a managed care organization.

[12] https://dodd.ohio.gov/communication/news/news-new-avenues-to-independence

Strategic Plan Goal	State Programs and Initiatives
Technology, and Collaboration	Stakeholders developed the program with the State which helped prioritize stakeholder needs. • Services include physical health, behavioral health, social, recreational, transportation, employment, therapeutic, educational, crisis, in-home support, and independent living services.
Transform Systems through Innovation and Change	• ACAP is a flexible model that was created due to a higher number of crisis cases. • Emphasis on clinical supports and robust support plan training for behavior specialists.
Enhance Person-Centered Services and Supports	• ACAP was a result of the Autism Task Force's review of services and supports to identify gaps in care for people with autism. • State leaders believe the ACAP could translate to the IDD population due to its person-centered and specialized program design, however Pennsylvania leadership believes that commercial Managed Care Organizations need increased training for specialized populations.
Lessons Learned	• Specialized and flexible programs that deliver services to the IDD population can be successful if the MCOs involved have experience working with the IDD population.

Figure 28: Managed Care for All Services with Licensed MCOs – Tennessee

Strategic Plan Goal	State Programs and Initiatives
Strengthen Workforce, Technology, and Collaboration	• With the implementation of managed care for all services the State maintains a consistent communication with MCOs to ensure quality of services and continuous building of relationship between the State and MCOs. • The State requires each MCO to have a workforce director on staff to support the State's initiatives. • MCOs have provided grants to provider agencies to pay for worker training and certification in support of the workforce crisis.
Transform Systems through Innovation and Change	• Tennessee plans to pivot to value-based payments. • Tennessee Early Intervention System offers therapy and other services at no cost to families of infants and children. • State leaders stated early intervention has made a significant impact on their system.
Enhance Person-Centered Services and Supports	• 24 months of stakeholder engagement allowed for the development of the Employment and Community First (ECF) CHOICES program. Stakeholder feedback suggested that the priority for people with IDD and their families was exploring a meaningful life, independence, and contributing to society. • ECF CHOICES serves 4,000 individuals.

	• The program employs an employment-first approach to service delivery; the benefit package does not include any day habilitation sites.
Lessons Learned	• Stakeholder engagement early and often and a working relationship between the State and MCOs is key to programmatic development and success.

National Expert Interviews

Guidehouse also conducted interviews with five national experts to gain insights on managed care and other service delivery models, program innovations, and design that addresses population goals for people with IDD. Figures 29-33 highlight key insights Guidehouse gathered from national experts and how they align to OPWDD's strategic goals.

Figure 29: Former State Medicaid LTSS Official

Strategic Plan Goal	National Expert Insights
Strengthen Workforce, Technology, and Collaboration	• Tennessee implemented managed care for all services with licensed MCOs. Tennessee conducted stakeholder engagement for approximately two years prior to implementation of their managed care program. • Tennessee experienced programmatic success with older adults and adults with physical disabilities. Based on the success, advocacy groups approached Tennessee leaders to get a similar program for people with IDD.
Transform Systems through Innovation and Change	• Managed care can allow for easier innovation regarding payment methodologies, compared to FFS. ○ Implemented value-based payments for job coaching which rewarded providers for increasing waiver recipients' independence. Once the individual no longer needed job coaching, Tennessee rewarded the provider with a larger payment. This initiative emphasized value outcomes and movement towards independence. • In Tennessee, older adults and adults with physical disabilities were transitioned to managed care, due to heavy institutional reliance on nursing home care services, and to reduce the waiting list. • Transitioning older adults and adults with physical disabilities reduced the cost of care by rapidly expanding access to HCBS, reducing the number of people supported in nursing homes by thousands and much lower cost of care. • Identified cost reduction in the people with IDD who were in managed care versus those who were still in the older HCBS program.
Enhance Person-Centered Services and Supports	• The Employment and Community First (ECF) CHOICES program was designed with advocates and key stakeholders to prioritize meaningful outcomes, independence, and living in the community for people with IDD. ○ Operated by TennCare through its contracted managed care organizations who deliver services to people with IDD.[13] ECF CHOICES helps people with IDD become more independent in the community (e.g., finding a job, learning skills to be able to do things at home and/or in the community to be as

[13] https://www.tn.gov/didd/employment-and-community-first-choices.html

Strategic Plan Goal	National Expert Insights
	independent as possible).

Figure 30: National Association of State Directors of Developmental Disabilities Services (NASDDDS)

Strategic Plan Goal	National Expert Insights
Strengthen Workforce, Technology, and Collaboration	• People with IDD and other key stakeholders who would be impacted must be involved from the beginning to increase programmatic success of managed care. • A transition to managed care and maintaining the "mom and pop" service providers for home and community-based services waivers is challenging due to the administrative aspect of Managed Care Organizations. • A managed care program needs to develop person-centered, quality-based contracts that are strictly enforced.

Transform Systems through Innovation and Change	• Tennessee is a standout State in how it infuses flexibility in its managed care model.
	  ○ They have a clear vision of the role of the State and oversight of MCOs, they incentivize quality outcomes and strictly enforce contractual provisions.
	• Contracts with MCOs need to be value-based and states need to be explicit in expectations of provider networks that reflect the values of their State. Value-based payments can be a "tool" to help states achieve their system goals and improve health outcomes. The following states have supplemental payments:
	  ○ Ohio and Tennessee have incentives for employment and technology.

Enhance Person-Centered Services and Supports	• Service delivery must be used as a tool to accomplish goals, not as the end goal. • Continuous learning about the needs of people with IDD and their families is needed to assist in quality improvement of any service delivery system.

Figure 31: American Network of Community Options and Resources (ANCOR)

Strategic Plan Goal	National Expert Insights

Strengthen Workforce, Technology, and Collaboration	• Advocated for provider led managed care.
	• Emphasized the need to use value-based payments to drive high quality care and reimburse providers
	  ○ Are people with IDD working in jobs they want?
	  ○ Are they living/residing where they want to?
	  ○ States can use value-based payments to achieve people's individual goals.
	• Emphasized the importance of including people with IDD and their families extensively involved in stakeholder engagement for any program.

Transform Systems	• ANCOR recommends the ACAP in Pennsylvania: 200 people with autism are

Strategic Plan Goal	National Expert Insights
through Innovation and Change	enrolled in this program and it is limited to four counties. *Note: Pennsylvania implemented managed care for physical and/or behavioral health and for limited home and community-based services.* ○ ACAP is paid as a Prepaid Inpatient Health Plan (PIHP) and operated under a 1915(a) waiver. It is fully functioning MCO assuming risk across all participants with a capitated funding model which includes all Long-Term Services and Supports and routine health care.[14] ○ Keystone Autism Services, a subsidiary of Keystone Human Services, is the entity that operates ACAP and is responsible for the coordination of comprehensive services including physical and behavioral health, and long-term services and supports to adults over 21 with a diagnosis of autism.[14] ○ Keystone also functions as the MCO and develops individual service plans through its internal case management function. The integration of case management and comprehensive services including physical health care creates a highly effective clinical treatment and support environment.[14] ○ ANCOR reported high levels of satisfaction, lower than average turnover, and the program consistently meets quality benchmarks.
Enhance Person-Centered Services and Supports	• Identified challenges with moving towards managed care for long term services and supports. ○ MCOs potentially lack the experience and understanding of the IDD population. • When designing a program, the focus should be on quality outcomes and service coordination and case management needs to happen as close to the point of service as possible to be effective for people with IDD.

Figure 32: Florida Developmental Disabilities (DD) Council

Strategic Plan Goal	National Expert Insights
Strengthen Workforce, Technology, and Collaboration	• State participates in ongoing collaboration with non-provider Community Based Organizations (CBOs) to mitigate service delivery gaps. • Florida's Developmental Disabilities Council identified the consumer directed care program, where individuals hire their own service providers, as a successful program. • Prior stakeholder engagement regarding managed care identified resistance from families and people with IDD. Concerns included were disruption of services and low-quality care.
Transform Systems through Innovation and Change	• Florida is implementing a pilot for the Comprehensive Intellectual and Development Disabilities Managed Care Pilot Program, operating under the

[14] Improving-Lives-Ensuring-Sustainability.pdf (ancor.org)

Strategic Plan Goal	National Expert Insights
	authority if Section 1915(a) and Section 1915(c) of the Social Security Act.[15] managed care to offer more options for service recipients to choose from (Proposed effective date is January 31, 2023)[15] two regions (the Miami area and the Tampa-St. Petersburg area) have been identified for the pilot. ○ **1915(a) Waiver:** States can implement a voluntary managed care program simply by executing a contract with companies that the State has procured using a competitive procurement process. CMS must approve the State to make payment.[16] ○ **1915(c) Waiver:** States can develop 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.[16] • This waiver creates[16]: ○ A voluntary, comprehensive program consisting of managed medical assistance, LTC Waiver services, and Florida Developmental Disabilities Individual Budgeting (iBudget) Waiver services. ○ Service for up to 600 individuals who reside in two pilot regions: Region D (Hardee, Highlands, Hillsborough, Manatee, and Polk counties) and Region I (Miami-Dade and Monroe counties). ○ Eligibility for individuals 18 years of age or older who are eligible for Medicaid and assigned to one of the categories 1 through 6 as established in s. 393.0659(5) F.S.
Enhance Person-Centered Services and Supports	• Florida has 22,000 people categorized as pre-enrollment to the iBudget Waiver. ○ People considered as pre-enrollment are on the In Lieu of waitlist and is prioritized for future enrollment. People on the waitlist receive services from other state programs, faith-based and community-based organizations. ○ There are seven pre-enrollment categories that is based on characteristics and level of needs. ○ All people categorized as pre-enrollment receive employment services.

Figure 33: North Carolina Developmental Disabilities Council

Strategic Plan Goal	National Expert Insights
Strengthen Workforce, Technology, and Collaboration	• North Carolina faces workforce challenges similar to New York, not having enough providers to meet the demand for IDD services in the State. • State collaborates with the IDD Caucus who are legislative champions for the State's IDD population (e.g., integral in getting more waiver slots, more

[15] https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/comprehensive-intellectual-and-developmental-disabilities-managed-care-waiver
[16] https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html#:~:text=1915(a)%20Waiver%20Basics,in%20order%20to%20make%20payment.

Strategic Plan Goal	National Expert Insights
	services, etc. approved)
Transform Systems through Innovation and Change	• North Carolina operates a Managed Care Waiver services with local entities. ○ In October 2018, the CMS approved North Carolina's 1115 waiver that included its transition from a FFS model to a managed care model. ▪ **1115 Waiver:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.[17] ○ North Carolina has a Standard Managed Care Program and is currently rolling out Tailored Plans. ▪ Available to individuals with substance use disorders and behavioral health needs, and the IDD population. ▪ Managed care services are provided to people with IDD through the Innovations waiver and services outside of managed care are provided through the Community Alternatives Program for Children (CAP-C) and Community Alternatives Program for Disabled Adults (CAP-DA) waivers. These two waivers mainly provide services to individuals with severe physical disabilities who would otherwise be in a nursing facility. ▪ Managed care is statewide with six "locally grown" managed care organizations and 15,000 waiver slots. ▪ Transition to managed care took 2-3 years and preparation took 5 years to engage the community and legislators.
Enhance Person-Centered Services and Supports	• Transition to managed care was decided on to provide more options for people with IDD needing services. • Meaningful employment and day supports delivered through MCOs. Managed Care Organizations provide 1915(b)(3) and in lieu of services for people who are Medicaid eligible and on the waitlist for home and community-based services. ○ **1915(b) Waiver[18]:** States can also implement a managed care delivery system using waiver authority under 1915(b). There are four (4) 1915(b) waivers: ▪ (b)(1) Freedom of Choice - restricts Medicaid enrollees from receiving services within the managed care network ▪ (b)(2) Enrollment Broker - utilizes a "central broker" ▪ (b)(3) Non-Medicaid Services Waiver - uses cost savings to provide

[17] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[18] https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html

Strategic Plan Goal	National Expert Insights
	additional services to beneficiaries ▪ (b)(4) Selective Contracting Waiver - restricts the provider from whom the Medicaid eligible may obtain services • Local management entities offer people with IDD peer or family services, support animals, and inclusive playgrounds.

Section 5 Recommendations

Guidehouse has developed recommendations that can help OPWDD reach the goals it has outlined in its 2023-2027 Strategic Plan:

1. **Programmatic Improvements:** Stakeholders (People with IDD, Families, Natural Supports, Providers, and CCOs) expressed areas of improvement that were aligned with OPWDD's Strategic Plan. OPWDD has already included these areas of improvement and corresponding action plans to address them in their Strategic Plan. OPWDD needs to continue to build on the goals of the Strategic Plan and address stakeholder concerns regardless of any changes to the service delivery system.
2. **Managed Care**: Should OPWDD decide to move forward with a transition to managed care, it should first explore the financial viability and feasibility of creating MCOs focused on physical and behavioral health services for non-dual eligible people with IDD (i.e., Medicaid only, without TPI), who are not currently enrolled in MMC. Mandatory enrollment would be necessary to sufficiently support capitated rates. Long-term services and supports would remain in the fee-for-service model through the CCOs, as OPWDD continues to assess and refine the performance of CCOs and delivery of OPWDD services.

Programmatic Improvements

Access to services was the chief concern that stakeholders shared. Stakeholders shared challenges that impact access to services which include provider shortages, extensive application process for services, and long wait times for approval of services. OPWDD has several goals outlined in the Strategic Plan to address access to services for people with IDD including increasing access to meaningful employment and day activities, making regulatory and policy changes to improve health equity and access, and improving capacity to serve people with complex needs.[19] Figure 34 highlights the areas of improvement OPWDD should continue to focus on to improve the current service delivery system.

Figure 34: Programmatic Improvements by OPWDD Strategic Plan Goal

Areas of Improvement	Reason for Improvement	OPWDD Strategic Plan
Strategic Plan Goal 1: *Strengthen Workforce, Technology, and Collaboration*		
Workforce Improvement/Wages for DSPs	• Stakeholders we engaged with expressed the need for a more substantial increase in wages for DSPs to incentivize these providers to join and remain in the IDD field.	• Invested over $30 million to increase wages for providers including DSPs.[19] • Allocated $1.5 billion towards supporting recruitment, improving retention, and increasing wages for DSPs.[19] • Includes supplemental, one-time payment to support current DSPs and Family Care providers who worked during the pandemic and remain employed in the OPWDD service system, with an additional bonus if the worker is fully vaccinated

Areas of Improvement	Reason for Improvement	OPWDD Strategic Plan
		against COVID-19.[19]
Enhance DSP and Provider Trainings	• Stakeholders expressed the need for qualified and adequately trained providers for people with IDD.	• Establish partnerships with high schools, higher education institutes (e.g., State Universities of New York (SUNY)), other state agencies, and regional workforce entities. These partnerships would provide new DSP training and credentialing opportunities.[19]
Foster Collaboration with Stakeholders	• Stakeholders who were engaged for this assessment expressed the importance of having the stakeholders, especially people with IDD and their families at the center of the decision-making process for any future service delivery system changes. • Increased stakeholder engagement efforts will improve communication and transparency with stakeholders which stakeholders also expressed as a concern to Guidehouse.	• Facilitate several stakeholder workgroups, committees, and councils including regularly scheduled meetings with self-advocates, parents, provider agencies, associations, CCOs, and DDAC. • Conducted extensive stakeholder engagement for this managed care assessment (e.g., Stakeholder and Advisory Board Presentations, Townhalls and Focus Groups, Interviews and Surveys).
Strategic Plan Goal 2: *Transform our System Through Innovation and Change*		
Increase Efficiency in Accessing Self-Direction	• Stakeholders explained the value of self-directed services and the positive impact it has on the lives of people with IDD.	• Addressed several ways they plan to increase capacity and access to services in the Strategic Plan.[19] • Collaborating with groups for Support Brokers and Fiscal Intermediaries (FIs) in underserved communities.[19] • Addressing potential HCBS waivers reforms that will enhance the self-direction model and participating in the national learning collaborative focused on self-direction.[19] • Conducting a self-direction assessment to improve services and address any gaps in the current system.[19]

[19] OPWDD 2023-2027 Strategic Plan (ny.gov)

Areas of Improvement	Reason for Improvement	OPWDD Strategic Plan
Enhance Access to SDOH Services	• Stakeholder engagement highlighted concerns about the lack of access to housing, transportation, and employment programs	• Building a separate Executive Office of Diversity, Equity, and Inclusion (DEI) to address disparities among marginalized communities. DEI office will partner with CBOs, multicultural providers, and people with lived experiences to establish culturally responsive interventions.[19] • Working to improve access to employment programs, transportation, housing supports, and regulatory flexibility.[19]
Strengthen CCOs ability to Coordinate Services	• Stakeholders highlighted dissatisfaction and insufficiencies with CCOs impacting current services.	• Conducting a CCO evaluation to improve services and address any gaps in the current system.[19] • Continuing to foster collaboration with DOH, CCOs, provider agencies, and stakeholders to gather recommendations for strengthening care management.
Streamline Administrative Processes	• Stakeholders highlighted concerns about bureaucracy and challenging administrative processes that negatively impact the quality and timeliness of services.	• Working on improving administrative processes to enhance accessibility to services, such as self-direction and Family Support Services (FSS). • Training FIs and Support Brokers to assist people who are self-directing and their families with administrative tasks.
Strategic Plan Goal 3: *Enhance Person-Centered Services and Supports*		
Facilitate Individual Choices	• Stakeholders indicated the value of programs assisting people with IDD that maximize independence.	• Addressing the following services to enhance quality and ensure independence: self-direction, employment and day program services, housing support and residential services, overall health services, technology and modifications, assessment of needs, front door activities, and supported decision-making.[19]
Complex Needs	• Stakeholders highlighted increased barriers for people with complex needs and a lack of focused	• Working to increase access for those with complex needs by collaborating

Areas of Improvement	Reason for Improvement	OPWDD Strategic Plan
	interventions.	across agencies.[19] • Working to expand crisis and behavioral support programs, such as Crisis Services for people with Disabilities (CSIDD).[19] • Improving the accessibility of services for people with complex needs to reduce the need for unnecessary hospitalization and emergency services and provide focused and adequate support.[19]

Managed Care Recommendations

Over many years, OPWDD has taken various steps toward managed care for all services. Based on a variety of factors, such as stakeholder feedback and the challenges and complexities of the current service delivery system, Guidehouse does not recommend a transition to full managed care for the whole OPWDD service delivery system. Should OPWDD decide to implement managed care, Guidehouse recommends first assessing the financial viability and feasibility of implementing a partial managed care model, including programmatic and implementation considerations described below.

For future consideration, as this report explains, managed care has demonstrated the potential to improve quality and coordination of care, including innovative models and program demonstrations that are currently underway in New York. Alternative approaches to comprehensively support the healthcare and long-term services and supports of people with IDD should continue to be evaluated and learned from by OPWDD and stakeholders as potential long-term options.

Given the opportunities to improve the overall system outlined above that require policy and funding changes that will not be addressed by MCOs, OPWDD can focus on improving its current system and processes rather than moving forward with a comprehensive change to the current service delivery system by implementing managed care for all services. That said, through the course of this assessment, there were some areas where a focused managed care model could potentially improve services, access, and outcomes for New Yorkers with IDD.

Managed Care Recommendation

Should OPWDD decide to move forward with a transition to managed care, it should first explore the financial viability and feasibility of creating MCOs focused on physical and behavioral health services for non-dual eligible people with IDD (i.e., Medicaid only, without TPI), who are not currently enrolled in MMC. In this model, the MCOs would be specialized entities with specific, demonstrated experience serving people with IDD and understanding their unique needs. Physical health services would include but not limited to primary care, dental care, and specialty care such as neurology. Behavioral health services would include those included in the Behavioral Health Carve-In for New York State, such as psychiatry, psychology, mental health, social work support, intensive behavioral health, and other services offered at Article 16, Article 28, Article 31, and Article 32 clinics.

Long-term services and supports should remain in the FFS model through the CCOs.

Program Design Elements and Implementation Considerations

Should OPWDD implement managed care, there are key design elements that will impact the likely long-term success of this type of program.

Figure 35: Recommended Managed Care Design Elements

Program Design Element	Rationale / Benefit
1. Implement mandatory statewide managed care focused on physical and behavioral health services for non-dual eligible people with IDD (i.e., Medicaid only, without TPI), who are not enrolled in MMC. Long-term services and supports would remain in the FFS model through the CCOs.	• Promotes consistency, **increased coordination of behavioral health and acute care services by qualified clinicians and professionals,** and equity of services for all New Yorkers with IDD. • Enforcing mandatory enrollment is essential, as opting for voluntary enrollment would result in the system operating in disparate ways for acute and behavioral health services for this population. • Allows OPWDD to focus state resources on monitoring and proactive management of MCO performance to ensure MCOs provide appropriate, high-quality services to people with IDD.
2. Limit the number of MCOs to plans that specialize in serving people with IDD	• Selecting MCOs that demonstrate their experience and success with delivering services to people with IDD is crucial to the success of the program. This could also be preceded by the issuance of a non-binding RFI for MCOs potentially interested in serving people with IDD to gather information and help inform program design. • Reducing the number of plans can benefit both providers and OPWDD, as it reduces the administrative burden on providers and enables a more concentrated monitoring for OPWDD. • Managing many plans can pose administrative difficulties and be confusing.
3. Consider the geographical differences that exist in New York State	• OPWDD should consider the implications of the differences between Upstate and Downstate regions, such as network adequacy. ○ OPWDD could require cross-collaboration between MCOs to address these gaps between geographic locations of the State.
4. Conduct ongoing stakeholder engagement during the design phase of the program	• OPWDD should continue on-going engagement with self-advocates, family members, caregivers, providers, other state agencies and other advocates to provide input on the design process. This should also include strategic outreach to assess the experiences and recommendations of the more than 38,000 people with IDD who are currently enrolled in Mainstream Managed Care (MMC) plans for their physical and behavioral health needs. • This will identify additional elements and requirements that the MCOs would be required to meet as part of their contractual obligations with OPWDD. • This is one important part of a broader and critical need to extensively plan and refine the implementation of managed care.

Implementation

The implementation of this type of program is also a key factor to the success and using a phased approach during the transition to managed care, even for a targeted population such as this, is crucial.

Figure 36: Managed Care Implementation Considerations

Implementation Considerations	Rationale / Benefit

1. Use a phased-in approach to implementation of managed care	• OPWDD should initiate the transition to managed care in specific regions first as part of a phased implementation.
	  ○ OPWDD should look to strengthen care coordination for people currently in MMC and overtime initiate a secondary transition to provide people with IDD in MMC with the option to change to these specialized managed care plans.
	  ○ This secondary transition would avoid disruption in care for people current enrolled in a MMC plan.
	• Starting in select areas allows for the accumulation of valuable insights and the refinement of strategies based on experiences at each step of the implementation.
	• Incorporating these insights into subsequent phases allows OPWDD, MCOs, and providers to continually improve and optimize the managed care transition process.

2. Conduct ongoing stakeholder engagement and maintain clear communication channels with stakeholders during the transition process	• Conducting stakeholder engagement and outreach activities throughout the transition process fosters transparency and builds relationships.
	  ○ Assess stakeholder opinions and collect feedback, incorporating it into subsequent phases.
	  ○ Address stakeholder concerns proactively and conduct comprehensive sessions to provide detailed insights into managed care and its broader impact.
	  ○ Establish a member advisory board, including self-advocates, who will contribute to advising OPWDD and the MCOs on matters ranging from contracting to implementation and evaluation.
	  ○ Include CCO Care Managers with experience addressing continuity of care between all providers, whether providers of IDD services or community providers of other related health and social services on the advisory board.

3. Conduct training and education with stakeholders	• Prior to going live, OPWDD should provide education on the anticipated changes and actively seek stakeholder input for key design elements. • Use various communication channels such as in-person townhalls, local small group sessions, and online public comment platforms.

Implementation Considerations	Rationale / Benefit
	• Maintain a regularly updated and publicly accessible FAQ document to address concerns and questions and communicate key decisions through newsletters. • Ongoing training and education are essential during the transition to ensure people are consistently informed and aware of the changes.

Financial Viability and Implementation Feasibility

The recommended considerations and elements of design for managed care Guidehouse is providing to OPWDD should be further evaluated for financial viability and feasibility through collaboration with the Department of Health (DOH) and DOB. In doing so, the development of cost and reimbursement structures, and scalability, can be refined in a manner to ensure implementation is effective and achievable.

Procurement

Should OPWDD choose to implement this type of focused managed care model for physical and/or behavioral health services for non-dual eligible people with IDD, OPWDD should initiate a procurement process to identify MCOs that are well-positioned and have demonstrated success in both a traditional MCO structure and serving people with IDD.

This process should include:

1. Thorough evaluation of MCOs based on their experience in providing services to people with IDD. OPWDD can assess MCO experience by the issuance of a non-binding Request for Information (RFI) for MCOs potentially interested in serving people with IDD in order to gather information and help inform program design.
2. Innovative program design.
3. Workforce capacity-building experience.
4. Commitment to identified outcomes and these outcomes should encompass measures assessing both quality outcomes and SDOH ensuring a comprehensive approach to care.
5. OPWDD can require MCOs to contract with willing, specialized providers with a background in IDD services as part of the contractual agreements. This addition ensures that expertise and experience specific to people with IDD are integrated into the contracted services, enhancing quality of care.

This procurement process is essential to the identification of MCOs that would be responsible for providing services to these New Yorkers with IDD. New York does not currently use a formal procurement process to identify MCOs to provide physical and behavioral health services. Beyond meeting basic qualification requirements, a formal procurement may provide for additional IDD specific accountability measures to be considered as part of the review process and allow OPWDD to assess and further compare the responses of qualified MCOs interested in providing these services. Moreover, this formal process may also increase the State's opportunity to learn innovative and creative strategies from each MCO on how they will best serve people with IDD and promote the selection of the highest scoring MCOs to serve this population based on a predetermined scoring rubric.

Program Oversight and Accountability

OPWDD, DOH, and OMH each have a stake in elements of this managed care model and share responsibility for MCO performance. Rigorous oversight and enforcement of MCO contracts are important to the program's success. Inadequate collaboration between OPWDD and other agencies (e.g., DOH, OMH, and OASAS) is a significant risk to the success of such a program.

To address this issue, OPWDD should:

1. **Proactively assume a leadership role in oversight communication and the delegation of responsibilities.**
    a. By taking this role, OPWDD can reduce accountability gaps and clarify the allocation of services among agencies.
    b. This proactive approach aims to foster better coordination, communication, and overall service continuity for people with IDD.
2. **OPWDD should provide a comprehensive breakdown and thorough documentation outlining the specific roles and responsibilities of individuals and departments within the managed care system.**
    a. This detailed information aims to eliminate any potential confusion by clearly defining who is responsible for what, ensuring effective communication and streamlined operations throughout the managed care service delivery system.
    b. These roles and responsibilities should be clearly delineated in the contract language.

Implementation of Access Related Initiatives

People with IDD encounter various health inequalities when it comes to obtaining healthcare, and several social determinants of health contribute significantly to these challenges. Guidehouse's engagement with stakeholders revealed that obstacles such as lack of flexibility, inadequate transportation, housing shortages, limited supported employment initiatives, and insufficient resources for non-English speakers are prevalent. It is imperative to address these issues to enhance health outcomes among people with IDD.

Collaboration with Community

1. **Community Based Organizations (CBOs)**
    a. Require MCOs to partner with CBOs to elevate support for people with IDD and ensure broad and diverse outreach and feedback. CBOs include Independent Living Centers, Self-Advocacy Associations, the State Ombudsman program, Disability Rights Organizations, Family Support Services, Disability Advocates, and local Arc New York Chapters. MCOs can leverage CBOs' comprehensive understanding of patients' needs, fostering a more person-centered approach that positively influence the health of people with IDD and enhances the quality outcomes of MCOs. It is imperative for MCOs to explicitly outline this partnership in their proposal, providing a detailed explanation of their commitment to collaborating with CBOs for comprehensive and person-centric care.

2. **Federally Qualified Health Centers (FQHCs)[20]**

   a. MCOs should establish partnerships with FQHCs due to their ability to facilitate access to services, foster community engagement, and provide patient-centered care. Collaborating with FQHCs, MCOs should adopt a community-oriented and patient focused approach, thereby enhancing health outcomes within the managed care service delivery system.

   b. MCOs can provide grants to FQHCs with proven expertise in assisting people with IDD. This strategic support aims to leverage the experience of FQHCs to improve the quality of services specifically tailored to the needs of people with IDD. Advantage Care Health Centers, with two locations on Long Island, New York, is one such example of an FQHC with roots in neurodiversity care. With a strong focus on collaboration and innovation, Advantage Care offers a full range of services for comprehensive care delivery and has engaged in models and programs that promote integrated, coordinated care. For example, Advantage Care has received PCMH designation by being in value-based care contracts, realigning incentives and creating practice transformation for people with IDD, ultimately leading to better, more patient-friendly outcomes.

FQHCs

FQHCs are safety net providers that provide services typically given in an outpatient clinic.

FQHCs include:

1. Community health centers
2. Migrant health centers
3. Health care for the homeless health centers
4. Public housing primary care centers
5. Health center program “look-alikes”
6. Outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization

Medicare pays FQHCs based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services given by an FQHC practitioner.

3. **The PACE Model**

There are opportunities to accelerate PACE growth in New York State with a focus on the IDD population, especially for plans with experience in managed care. The PACE model provides an option to implement managed care in a non-traditional way that is a smaller program and community based.

   a. Improving the current service delivery system to support the aging IDD population through a person-centered, PACE-like approach, would require a shared vision and timely and effective coordination between key community stakeholders and agencies in support of shared goals for the IDD population.

   b. Implementation of a PACE program to include the IDD population would require Federal authorization through amendments to the OPWDD 1915(c) Comprehensive Home and Community-Based Services (HCBS) Waiver and New York State's Section 1115 Medicaid Waiver.

   c. **Core attributes of the PACE model that could be considered for a future delivery system under managed care for people with IDD include:**

      i. An interdisciplinary team of healthcare professionals that provides PACE participants with a fully integrated, person-centered care management experience.

[20] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FQHC-Text-Only-Factsheet.pdf

ii. Full capitation risk for Medicare and Medicaid services, which allows providers to deliver all services that people with IDD need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans.

iii. A comprehensive benefit package that honors personal preferences and enables people to be served in their home and support a person's autonomy, choices, and personal goals.

iv. Operation of a PACE center, where individuals receive medical care and other specialized PACE services.

d. **Limitations of the PACE model:**

i. **Scalability:** PACE plans are required to operate PACE centers that provide a single location for medical and social support. Deviation from the current PACE model requiring the operation of a PACE center to provide services and ensure member choice in all regions of the State could create gaps in service provisions.

ii. **Eligibility:** The current PACE program provides fully integrated care to a limited subset of dually eligible beneficiaries, including individuals 55 years of age or older, nursing home certifiable by the State, and those living within the geographic area served by the program delineated in its state contract. The eligibility requirements of the current PACE program does not present the option to be statewide and mandatory for all.

Health Related Social Needs (HRSN)[21]

1. States Enhancing Contracts with MCOs

a. States are enhancing MCO contracts to promote initiatives related to HRSN. Some of these efforts include:

i. Expanding coverage, as a part of New York's 1115 Health Equity Waiver Amendment, through the nation's largest investment in health-related social care needs (up to $3.2 billion) for food assistance, nutrition programs, housing, brokerage fees and transportation.

ii. Partnering with network providers and local CBOs for more equitable and accessible HRSN initiatives.

iii. Encouraging MCOs to incentivize healthcare providers actively engaged in HRSN initiatives.

iv. Creating performance incentives for MCOs to encourage involvement in HRSN activities.

b. Leveraging performance incentives within MCOs can boost activities related to HRSN and can be incorporated into contracts with MCOs in New York to address the social challenges encountered by many people with IDD in the State. Figure 37 displays the application of these performance incentives implemented by other states.

[21] HRSNs are also called Social Determinants of Health, Social Drivers of Health.

Figure 37: HRSN Performance Incentives

State	Example
New York	• Through the 1115 waiver amendment (New York Health Equity Reform [NYHER]: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic), New York seeks to improve the collective understanding of HRSN across regions and demographic groups.[22] • New York plans to evaluate Social Care Networks (SCNs) on performance metrics including, HRSN Screening.[22] o Member demographics completeness measure (% improvement of incomplete fields, % of members with validated demographic info)[22] o Members screened (#, %)[22] o Screening results (% by HRSN, % by number of needs)[22]**Error! Bookmark not defined.**
California	• Medi-Cal managed care receives incentives for investing in reducing homelessness and creating a stable housing for people. Managed care plans and the local planning body must provide the State with a homelessness plan.[23]
Oregon	• Quality Pool Incentive Payment Program includes an incentive measure for social risk factor screening.[23] • The Performance-Based Reward (PBR) initiative offers incentives to CCOs by offering a higher profit margin when they manage to lower costs, uphold quality standards, and invest in qualified spending on health-related services.[23]

2. Funding the HRSN Initiatives

MCOs have designed initiatives to address the HRSN among their enrollees, but funding is not always available. Recently, CMS has granted states the opportunity to experiment with new HRSN services through 1115 demonstrations and is encouraging more states to apply for these HRSN demonstration opportunities.[23] Section 1115 "gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs."[24] Furthermore, these demonstrations aim to integrate HRSN services by embedding them into capitation rates as benefits. The State can utilize these demonstrations as a platform to finance the MCO efforts related to HRSN.[23]

On January 9, 2024, CMS approved New York's request to amend to its Medicaid section 1115(a) demonstration entitled, MRT. Approval of this demonstration amendment will allow the State to advance health equity, reduce health disparities, support the delivery of HRSN services, and promote workforce

[22] https://sachspolicy.com/wp-content/uploads/2024/01/GO_5002575_fupGOFullPDFUpload.pdf
[23] https://www.chcs.org/media/Financing-Approaches-to-Address-Health-Related-Social-Needs-via-Medicaid-Managed-Care.docx.pdf
[24] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html#:~:text=Section%201115%20of%20the%20Social,objectives%20of%20the%20Medicaid%20program.

development.[25] Figure 38 illustrates the approved HRSN services across states via the 1115 demonstration.

Figure 38: States with Approved HRSN Services

State	Example
New York	• HRSN services for housing, nutrition, transportation, and case management.[26]
Arizona	• HRSN Services: Housing supports, including rent/temporary housing for up to six months post transition from certain settings.[23]
California	• HRSN Services: Recuperative care and short-term post-hospitalization housing (not benefits but provided at the option of MCOs).[23]
Oregon	• HRSN Services: Housing supports (including rent/temporary housing for up to six months post transition from certain settings), nutrition supports, and clinically indicated devices to maintain healthy temperatures and clean air during climate emergencies.[23]

Recent Approval of New York's 1115 Waiver[25]

The overall goals of this approval include:

1. Investments in HRSN via greater integration between primary care providers and CBOs.
2. Improve quality and outcomes of enrollees in geographic areas that have long standing history of health disparities and disengagement from the health system, through an incentive program for safety net providers with exposure to enrollees with historically worse health outcomes and HRSN challenges.
3. Focus on integrated primary care, behavioral health, and HRSN with a goal to improve population health and health equity outcomes for high-risk enrollees including kids/youth, pregnant and postpartum individuals, the chronically homeless, and individuals with SUD.
4. Workforce investments with a goal of equitable and sustainable access to care in Medicaid.
5. Developing regionally focused approaches, including new value-based payment programs, with a goal of statewide accountability for improving health, outcomes, and equity.

Rationale

As of March 2024, approximately 38,615 people[5] with IDD are served by MMC, which is a managed care service delivery system for medical and/or behavioral health services.

1. **Stakeholder engagement** revealed that people with complex needs have a more challenging time accessing and coordinating services in the current service delivery system than others. Managed care may provide improved case management and care coordination for people with complex healthcare needs, including people with IDD. MCOs with extensive experience and expertise in providing services to people with IDD have the potential to better connect people with IDD to needed physical and

[25] https://www.medicaid.gov/sites/default/files/2024-01/ny-medicaid-rdsgn-team-appvl-01092024.pdf
[26] https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2024-02-16_nyher_overview_slides

behavioral health services. Additionally, MCOs have the potential to strengthen provider networks requiring all contracted providers to serve all members to participate in the network.

2. **Performance data** indicates a necessity for a change in the current service delivery system, given New York's performance below the weighted national average in the 24 indicators assessed. Two of the three states with relatively higher scores on these indicators have managed care for physical and behavioral health. However, as mentioned above, there are limitations preventing conclusions on whether FFS or managed care models perform better. Other factors that could impact NCI-IDD IPS data outcomes are the intentionality and policies of the states, the involvement of the state agencies, and the oversight and enforcement of managed care.
3. **Dual Eligibles** are not included in this recommendation. Although some people with IDD needs are dually eligible for both Medicare and Medicaid, and are already receiving services in other plans, including MLTC and FIDA-IDD plans. Dual eligibles are typically medically complex with multiple chronic conditions and comorbidities, and MLTCs have the expertise to serve these individuals effectively. To minimize disruption to the existing service delivery system, dual eligibles should continue to be served in their current Medicaid Managed Care plans covering institutional and community-based long-term services.

   When a person with IDD becomes Medicare eligible or meets the MLTC enrollment criteria, he or she may transfer from a managed care plan (e.g., MMC) to an MLTC plan. While existing MMC plans already cover physical and behavioral health benefits there is room for improvement. Greater coordination and specialization (e.g., providers who understand IDD needs) is needed to strengthen care coordination and provider networks, and to create stronger linkages between community-based organizations and CCOs for non-dual eligibles.

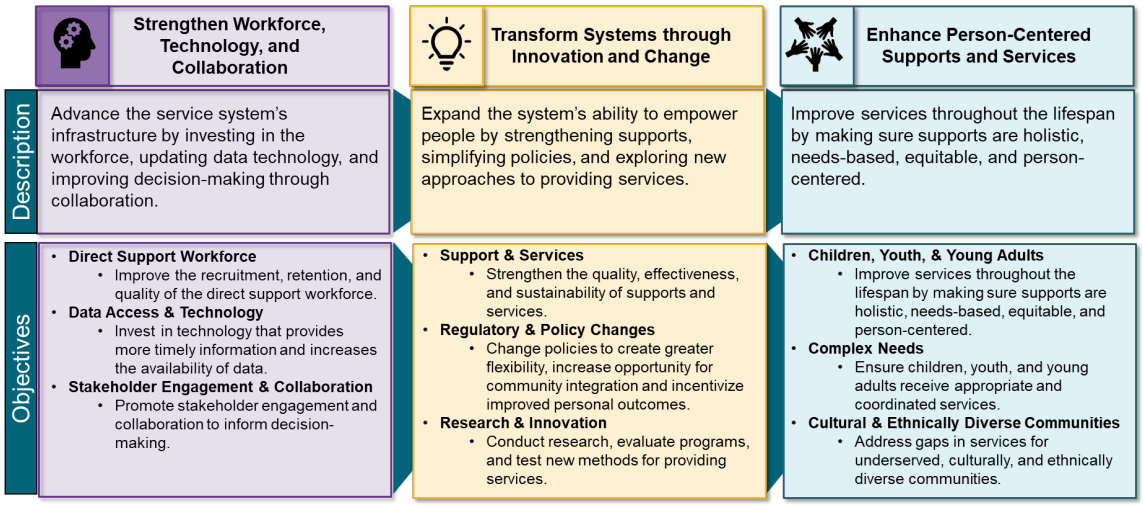
Using today's existing MMC infrastructure, improving enrollment pathways to other programs like MLTCs with DOH to better serve newly dual eligibles in long-term care plans would be the least disruptive way to transition people with IDD to managed care. This would also allow non-dual eligibles to keep some of their current benefits while "testing the waters" for managed care in an enhanced care coordination model for physical and behavioral health services. As explained in Figure 36, OPWDD could initiate a secondary transition overtime to provide people with IDD in MMC the option to change to the new managed care plans that would be created for this recommended model for physical and behavioral health services only.

This transition to managed care also leverages New York's existing framework for physical and behavioral health managed care. Several states only enroll people with IDD in managed care for physical and/or behavioral health services, such as Delaware, Illinois, Louisiana, New Jersey, New Mexico, Pennsylvania, and Virginia.

Final Takeaways

1. For any change to the current OPWDD system, stakeholders (people with IDD, their families, providers, etc.) need to be involved in the decision-making processes and have the opportunity to provide input as these changes impact their daily lives.
2. There are current challenges in the current OPWDD system (e.g., workforce shortages, access to services, etc.). Implementation of managed care is not a cure-all for addressing current system challenges. OPWDD should continue to improve current program fundamentals.
3. If managed care is implemented with thoughtful program design, managed care can support improved care coordination for physical and behavioral health services, integrated with continued FFS for waiver services.

Appendix A: OPWDD 2023-2027 Strategic Plan Goals and Objectives



Appendix B-1: Peer States Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another service delivery model that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight on various provider's operations and delivery of service to people with IDD.

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s), responsibilities, and division within STATE. How long have you been in role? 2. What do you perceive as your greatest barriers to success (within your portfolio and more broadly for STATE)? 3. Are there other STATE agencies that you work with on a regular basis? What is their role in relation to you?
Current Service Delivery Model and IDD Services	1. What types of IDD services are provided in your state? For example, acute care service, behavioral health etc. 2. Do you have funding sources other than Medicaid? 3. What are the eligibility criteria and what is the process for individuals to access IDD services in your state? 4. Are there waiting lists for IDD services? If yes, how long are they? 5. What is the role and eligibility criteria of family members and/or caregivers in the provision of IDD services in your state? 6. Do non-MLTSS MCOs also serve the IDD population? Are there separate MLTSS MCOs? 7. Do the MCOs that serve the IDD population have HCBS services included? 8. In considering people with IDD and their families, do you believe your current service delivery model meets their needs? Why or why not? 9. What led you to determine the service delivery model for those with IDD? 10. How are IDD service providers selected and monitored in your state? 11. What partnerships and/or collaborations does your state have with local agencies and organizations to support people with IDD and their families? 12. How is comprehensive transitional care addressed through your STATE program? 13. How is your state addressing the Home and Community-Based Services (HCBS) settings rule, the HCBS Quality Measure Set and Electronic Visit Verification (EVV)?

	14. What are the strengths of the current IDD service delivery model? 15. What is your satisfaction rate with your current service delivery model? 16. What are targeted areas of opportunity within the current IDD service delivery model? 17. Has your State considered moving to MLTSS? If so, what are the reasons for this consideration. If not, are there reasons against implementation?
Data, Reporting, and Monitoring	1. What quality measures are in place to ensure that IDD services are effective and meet the individual's needs? 2. How do you track the quality measures stated above? 3. Does the state track pre-qualitative and quantitative data comparisons? (Critical incidents, complaints, ER utilization etc.) 4. What data/reports do you use to make decisions to inform policy/program development?
Interviewee Specific Questions	1. [TBD]
Next Steps	

Appendix B-2: National Experts Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another service delivery model that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight on various provider's operations and delivery of service to people with IDD.

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role at ANCOR and experience with MLTSS and the IDD population. 2. What do you perceive as the greatest barrier(s) to success to the highest quality care for people with IDD?
MLTSS and IDD Service Delivery	1. Can you describe some successes you've observed with MLTSS and IDD service delivery? 2. What are some of the main difficulties in advancing MLTSS for IDD service delivery? 3. Can you describe some innovations in services that you have seen to enhance care for IDD. 4. Can you describe some of your findings related to value-based payment methods? 5. What would you tell states who are considering transitioning to managed care for their IDD population?
Next Steps	1. TBD

Appendix B-3: Providers Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another service delivery system that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight on various provider operations and delivery of service to people with IDD.

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s) and responsibilities. How long have you been in the role? 2. What do you perceive as your greatest barriers to serving people with IDD? 3. Tell us about your understanding of how managed care impacts people with IDD. 4. Tell us about your current billing practices for people with IDD.
Experience with People with IDD	1. What experience do you have with caring for people with IDD? 2. What types of specialized services or supports do you provide for people with IDD, such as behavioral therapy or social skills training? 3. How do you ensure a person-centered planning approach in the provision of services, including personal outcomes based on an individual's life goals, interests, strengths, abilities, desires, and preferences? 4. How do you accommodate the unique needs of people with IDD, such as communication or sensory issues, in your clinical practice (Clinical Practice Only)? 5. What continuing education training do you receive on best practice service delivery for people with IDD? 6. What accommodations do you provide for people with IDD during appointments, such as longer appointment times or visual aids (Clinical Practice Only)? 7. How does your practice or agency screen for Social Drivers of Health (SDOH)? a. Tell us about your referral process for SDOH. 8. How do you address issues of discrimination or stigma that people with IDD may face in accessing healthcare services? 9. How do you modify the planning process to account for an individual's cultural preferences? 10. Should states consider managed care or an alternative model for the system of services for people with IDD?

Data, Reporting, and Monitoring	1. What quality measures are in place to ensure that IDD services are effective and meet the individual's needs?
	    a. How do you track these quality measures? Do you use any technology for tracking?
	    b. How do you use this data in your practice or agency?
	2. Do you conduct ongoing quality reviews and if so, how are those reviews incorporated into plan of care adjustments? Is there a feedback mechanism in place?
	3. How do you assess potential risks within the planning process, including identifying barriers, challenges, and obstacles for an individual?
	4. Do you have experience with participating in surveys? Do you have ongoing (annual, quarterly, etc.) participation in these surveys?

Interviewee Specific Questions	1. [TBD]
Next Steps	

Appendix B-4: MCOs Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another service delivery system that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight in managed care organization operations and delivery of service to people with IDD.

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s) and responsibilities. How long have you been in the role? 2. Please describe your MCO's experience working with the IDD population. 3. What do you perceive as your greatest barriers to success in serving the IDD population within your MCO, considering your experience with other special needs populations? 4. What are the primary ways managed care can improve service delivery to the IDD population? 5. Are there specific benefits of managed care for the IDD population? 6. Are there specific downsides of managed care for the IDD population?
Experience with people with IDD	1. What types of providers and services are included in the people with IDD provider network? 2. How do you identify the needs of a person with IDD and work with these individuals and their providers to develop a comprehensive care plan? 3. Do you provide any type of specialized services or supports for people with IDD? a. If yes, what specialized services and supports does the MCO provide? b. Do you provide any specialized services that address Social Drivers of Health (SDOH) or Health Equity? If so, what are these specialized services? 4. How do you address issues of discrimination and stigma that people with IDD may face in accessing healthcare? 5. How do you ensure that people live in the most integrated community settings? 6. How do you ensure that services are delivered in a culturally sensitive manner? 7. How do you involve people with IDD and their caregivers/families in their own care and decision making?

	8. What kind of training or support do you provide healthcare providers in working with people with IDD? 9. Tell us about the referral process, starting with the identification of a service to the delivery of service. 10. What is the process for obtaining authorization for services and treatments for people with IDD? 11. How do you ensure that services and treatments are appropriate and effective for people with IDD? 12. Should states consider managed care or an alternative model for the system of services for people with IDD?
Data, Reporting, and Monitoring	1. How do you determine what a meaningful outcome measure is for the IDD population? 2. What quality measures are in place to ensure that IDD services (or other services if you do not serve the IDD population) are effective and meet the individual's needs? 3. Do you have measures that are more important than others? Are these measures more focused on the individuals that you serve? 4. How do you track the quality measures stated above? Do you use any technology with tracking? 5. Do you use any value-based reporting metrics? a. If yes, what criteria is used to determine these measures? b. How do you use this data in your organization?
Interviewee Specific Questions	1. Tell me about your interest in serving the IDD population. 2. How does serving the IDD population fit into your strategic plan?
Next Steps	

Appendix B-5: OPWDD Internal Staff Interviews

Overview and Purpose

OPWDD has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another model that meets OPWDD's strategic goals and objectives. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders who work within OPWDD. Answers to the questions below will allow Guidehouse to gather insight into OPWDD's operations and current model and identify the best service delivery model for OPWDD to consider moving forward.

Please note that interview responses are anonymous and will not be attributed to an individual.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s), responsibilities, and division within OPWDD. How long have you been in role? 2. How do you currently measure success (within your portfolio and more broadly for OPWDD)? 3. How is the respective division working on the goals of 5.07 strategic plan? What's working and what could work better in that regard? 4. What do you perceive as your greatest barriers to success (within your portfolio and more broadly for OPWDD)?
Partners and System Strengths / Opportunities	1. What internal OPWDD individuals or teams do you regularly interact with? a. What is working well that you can build on? b. Are there any opportunities to improve? 2. What individuals, entities, or teams external to OPWDD do you regularly interact with? a. What is working well that you can build on? b. Are there any opportunities to improve? 3. Who else, if anyone, needs to be involved to improve management of your area/function on a go-forward basis? 4. From your perspective, what are OPWDD's biggest strengths? 5. What I/DD programmatic gaps exist in the community that OPWDD is not addressing? Why do you think these gaps exist? What can or should OPWDD be doing to address these gaps?
Data, Reporting, and Monitoring	1. Do you think OPWDD is a data driven organization? 2. Do you have the data/reports you need to make decisions to inform policy/program development?
Workforce and Access	1. Can you describe the current skillset of the staff within your organization? a. What services are they equipped to provide? b. What gaps and vacancies do you have within your organization?

	2. What additional resources or organizational changes would allow you, and your team, to be more successful in your current role?
Managed Care and Service Delivery	1. Please describe your current interaction with managed care as a service delivery model for New Yorkers with I/DD (MMC, CCO, FIDA-IDD). 2. In your opinion, what are the best elements of the current service delivery model for people with I/DD in New York? 3. What are the key areas of focus for a service delivery model for people with I/DD in New York? 4. How would you assess OPWDD's performance in those areas? 5. What are the barriers to improvement? 6. What processes within the current service delivery model for people I/DD need the most improvements? What processes work best? 7. What are the biggest challenges with participants being able to access services included in the FIDA/IDD? 8. What feedback have you heard about the FIDA/IDD service delivery model? 9. What do you think will be the biggest challenge switching from the current service delivery model to managed care? 10. How often do people with IDD utilize additional services such as housing, day services, employment?
Interviewee Specific Questions	1. [TBD]
Next Steps	1. Who on your staff would you recommend we connect with for an interview? 2. What additional questions should we ask other stakeholders, both internal and external?

Appendix C-1: Focus Group Questions – People with IDD, their Family Members, and Other Natural Supports

Below are the focus group questions used to guide conversations with individuals, families, and natural supports.

1. What is working well with the services and supports you and/or your loved one receives?
2. What would you change about the Long-Term Services and Supports you and/or your loved one receives?
    a. Long Term Services and Supports include:
        i. In-home help with getting dressed.
        ii. In-home help with bathing
        iii. In-home help with cooking
        iv. In-home help with cleaning
        v. Help with finding a job
        vi. Help with finding rides to work
3. What would you change about the Medical Care you and/or your loved one receives?
    a. Medical Care includes:
        i. Primary Care (Finding doctors to meet you or your loved one's needs; making doctors' appointments; attending doctors' appointments)
        ii. Special Care for illnesses (For diabetes, high blood pressure, or cholesterol)
        iii. Getting help when you or your loved one has a health emergency
4. What would you change about the Non-Medical Services you and/or your loved one receives?
    a. Non-Medical Services include:
        i. Mental Health services (For anxiety, depression)
        ii. Dental Services
        iii. In-home Nursing Care
        iv. Getting wheelchairs, walkers and/or other medical equipment
        v. Case Management services (Care Coordination Organizations)
        vi. Respite Care (A break from taking care of your loved one while someone else takes care of them)
5. What would you change about the Basic Needs you and/or your loved one receives?
    a. Basic Needs include:
        i. Transportation
        ii. Housing
        iii. Food
6. Please tell us how much you know about managed care.
7. If you are comfortable sharing, what are strengths and opportunities for improvement of Managed Care?
8. Is there anything else you want to tell us about how you or your loved one receive services?

Appendix C-2: Focus Group Questions – Providers and CCOs

Below are the focus group questions used to guide conversations with providers and CCOs.

1. What barriers does your organization experience in serving people with IDD?
2. Which of these program elements are most important/least important to you?
    a. Ability to take care of the people your organization cares for
    b. How much providers are paid for the services they provide.
    c. How easy it is for providers to do business (administrative burden)
    d. Availability of support to providers to help coordinate care for the people their organization cares for
3. What do you think about managed care?
    a. What opportunities do you think managed care can offer that the current service delivery system does not offer?
    b. Do you have any concerns?
4. Do you think managed care has the potential to impact (positively or negatively) the following?
    a. Managed LTSS
    b. Person-centered care and integrated case management
    c. Medical social services
    d. Prevention and wellness programs
    e. Education and outreach
    f. Quality standards and programs
    g. Reimbursement
    h. Improved access
    i. Retention of qualified providers
5. Is there anything else you want to tell us about your experience as a provider/CCO and the people your organization cares for?

Appendix D-1: Survey Questions – People with IDD and their Family Members

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery system and provide recommendations regarding a potential transition to managed care or another service delivery system that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse is conducting a survey. Answers to the questions below will allow Guidehouse to gather insight in the current service delivery system and your thoughts on managed care.

Section 1: This section will ask you to tell us a little about yourself.

1. **Who are you?** (Select all that apply)
    a. Person receiving services
    b. Family member of a person receiving services
    c. Caregiver of a person receiving services
    d. Other: _____ (Open response)

2. **How would you describe your racial/ethnic background?** (Open Response)

3. **What OPWDD Region are you located in?**
    a. Region 1 – Finger Lakes and Western NY
    b. Region 2 – Broome, Central NY, and Sunmount
    c. Region 3 – Capital District, Hudson Valley, and Taconic
    d. Region 4 – Bronx, Brooklyn, Manhattan, Staten Island, and Queens
    e. Region 5 – Long Island

Section 2: This section will ask you to tell us more about the services you or your loved one currently receive.

4. **How are you or your loved one's services paid for?** (Select one)
    a. Fee-for-service (FFS)
    b. Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)
    c. I'm not sure
5. **Which services or supports help you or your loved one meet daily goals and needs?** (Select all that apply)
    a. Residential
    b. Day Services
    c. Community Habilitation or Personal Care
    d. Employment
    e. Self-Directed Services
    f. Family Support Services
    g. Other: _____ (Open Response)
6. **How often do you or your loved one use OPWDD services to help with the following?** (Check one box for each area)

	Never	1 to 3 days a week	3 to 6 days a week	Every day

Bathing				
Cooking				
Cleaning				
Getting to work				
Getting to the grocery store				
Getting to community activities like the movies				

7. **See below for question 7:**
    a. **Do the services you or your loved one receive now meet your needs?** (Select one)
        i. Yes
        ii. Sometimes
        iii. No
        iv. I'm not sure
    b. **Please explain your response.** (Open Response)
8. **Does your staff provide you or your loved one services when you need them?** (Select one)
    a. Yes
    b. Sometimes
    c. No
    d. I'm not sure
9. **Do your caregivers provide you or your loved one services when you need them?** (Select one)
    e. Yes
    f. Sometimes
    g. No
    h. I'm not sure
10. **Do you or your loved one have problems accessing or receiving the following?** (Check Yes/No/I'm not sure for each service)

Service	Yes	No	I'm not sure
Medical Care			
a. Primary Care (Finding doctors to meet you or your loved one's needs; making doctors' appointments; attending doctors' appointments)			
b. Specialty Care for illnesses (For diabetes, high blood pressure, or cholesterol)			
c. Emergency Care for Getting help when you or your loved one has a health emergency			
Non-Medical Services			
a. Mental Health Care services (For anxiety, depression)			
b. Dental Care and Services			
c. In-home Nursing Care			
d. Wheelchairs, walkers and/or other medical equipment			
e. Care Management services (Care Coordination Organizations)			
f. Self-Direction (Hiring and Retaining Staff)			
Basic Needs			
a. Transportation			
b. Housing			
c. Food			

Section 3: This section will ask you/your loved one about what is most important to you in a service delivery system.

11. What is most important to you? (Check all that apply)

a. Living as independently as possible
b. Having the same social opportunities as anyone else
c. Being a part of my community
d. Maintaining my current services
e. Having better access to health, dental, and mental health services
f. Access to meaningful employment
g. Being able to choose who I live with, who my staff are, who I get services from
h. Having (insert something around 1 or 2 people to help with service coordination/less administrative burden/more easily navigated services)
i. Being able to reach my personal goals

j. Other (open response)

Section 4: This section will ask you about your thoughts on regarding Managed Care. Please continue with the survey.

12. See below for question 12:

a. **Please tell us how much you know about Managed Care?** (Select one)
   1. I understand nothing at all about how Managed Care works
   2. I understand very little about how Managed Care works
   3. I have a moderate understanding about how Managed Care works
   4. I understand many things but not all about how Managed Care works
   5. I understand how Managed Care works

b. (For those who answer 1-3) **What information would you find most helpful to learn more about managed care?** (Open Response)

13. Please choose the statement that comes closest to your own views on managed care:

I am: (Select all that apply)

a. Excited
b. Nervous
c. Worried about money being spent on administration instead of on services
d. Concerned about care or services being denied
e. Worried about my organizations ability to meet administrative requirements necessary to participate in managed care.
f. I do not know enough to have feelings about Managed Care
g. Other (Open Response)

14. Thank you for your time and thoughtfulness in completing this survey. Are there other improvements or needs you want to tell us about? Are there aspects of you or your loved one's care that is working well? (Open Response)

Appendix D-2: Survey Questions – Providers

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery system and provide recommendations regarding a potential transition to managed care or another service delivery system that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse is conducting a survey. Answers to the questions below will allow Guidehouse to gather insight in the current service delivery system and your thoughts on managed care.

Section 1: This section will ask you to tell us a little about yourself.

1. **Provider Type** (Select all that apply)
    a. Medical
        i. Primary Care
        ii. Specialty Care
    b. Behavioral Health
    c. Dental
    d. Community-based long-term services and supports (LTSS)
    e. Residential LTSS
    f. Care Coordination
    g. Transportation
    h. Family Support Services
    i. Other: _____
2. **Please provide additional details on the services your organization delivers.** (Open response)
3. **Role of individual (e.g., Executive Leader, Supervisor, Physician, Psychiatrist, LCSW, Direct Service Provider, etc.) completing the survey.** (Open response)

Section 2: This section will ask you to tell us more about your organization and the services your organization provides to people.

4. **Is your organization currently serving individuals with intellectual and developmental disabilities (IDD)?**
    a. Yes (continue to question 5)
    b. No (continue to question 8)
        i. Please explain why your organization is not currently serving people with IDD
5. **See below for question 5:**
    a. **Does your organization ensure a person-centered planning approach in the provision of services?**
        i. Yes
        ii. No
        iii. Not Applicable
    b. **Does your organization provide continuing education and training opportunities for staff on best practices for serving people with IDD?**
        i. Yes
        ii. No
        iii. Not Applicable
    c. **Are accommodations made during appointments such as longer appointment times or visual aids for those with IDD?**

i. Yes
ii. No
iii. Not Applicable

d. **Is guidance/input for people being served integrated into the written policies at your organization for screenings, referrals, and data sharing?**
i. Yes
ii. No

6. **Does your organization experience barriers in serving people with IDD?** (If yes, check all that apply)
   a. Yes – What barriers does your organization face?
      i. Reimbursement
      ii. Administrative burden
      iii. Complexity of regulations
      iv. Trained/qualified staff
      v. Physical Environment (e.g., individual's home, etc.)
      vi. Other – Describe (Open Response)
   b. No – Please describe what your organization has done to prevent or eliminate barriers to serving people with IDD. (Open Response)
7. **Does your organization have the capacity to identify and track meaningful outcome measures for the IDD population?**
   a. Yes – Please describe how you measure and track outcomes (Open Response)
   b. No – Please describe what additional supports or technical assistance your organization may need to measure and track outcomes (Open Response)
8. **See below for question 8:**
   a. **Please rank the below items from most important to least important to you or your organization:**
      i. Ability to take care of the people your organization cares for
      ii. How much providers are paid for the services they provide
      iii. How easy it is for providers to do business (administrative burden)
      iv. Access to additional supports to providers to help coordinate care for the people they care for
   b. **Are there other program elements, not listed above, that are important to you?** (Open Response)

Section 3: This section will ask you about your thoughts on regarding Managed Care. Please continue with the survey.

9. **See below for question 9:**
   a. **Please tell us how much you know about managed care?** (Select one)
      i. I understand nothing at all about how managed care works
      ii. I understand very little about how managed care works
      iii. I have a moderate understanding about how managed care works
      iv. I understand many things but not all about how managed care works
      v. I understand how managed care works
   b. (For those who answer i-iii) **What information would you find most helpful to learn more about managed care?** (Open Response)

10. **Please choose the statement that comes closest to your own views on managed care:**
    I am: (Select all that apply)
    a. Excited

b. Nervous
c. Worried about money being spent on administration instead of on services
d. Concerned about care or services being denied
e. Worried about my organizations ability to meet administrative requirements necessary to participate in managed care.
f. I do not know enough to have feelings about Managed Care
g. Other: _____(Open Response)

11. See below for question 11:

a. **Do you think managed care has the potential to impact (positively or negatively) the following?** (Check all that apply)

Topics	**Positive**	**Negative**
i. Managed LTSS		
ii. Person-centered care and integrated care management		
iii. Medical social services *(Definition: Services that address social and emotional concerns related to the patient's illness and care; counseling for the individuals and their family)*		
iv. Prevention and wellness programs		
v. Education and outreach		
vi. Quality standards and programs		
vii. Reimbursement		
viii. Improved Access		
ix. Retention of qualified providers		

b. **Please explain your responses.** (Open Response)

12. Thank you for your time and thoughtfulness in completing this survey to help inform the best way to serve the IDD population and their families, is there any other information you would like to communicate to OPWDD staff? (Open response)

Appendix E: Select NCI-IDD Survey Questions

Domain: Individual Outcomes

Sub-domain:

1. *Choice and Decision Making*
    a. Life Decisions Scale (Includes choice of residence, work, day activity, staff, and roommates)
    b. Everyday Choices Scale (Includes choice of daily schedule, how to spend money, and free time activities)
    c. Person can hose staff or were aware they could request to change staff
    d. Person can change their case manager/service coordinator if wants to
2. *Community Inclusion and Belonging*
    a. Person gets to do things they like to do in the community as much as they want
    b. Person does things in the community with the people they want
3. *Employment*
    a. Person has a paid community job
    b. Person has community employment as a goal in their service plan
4. *Access*
    a. Has a way to get places needs to go (like work, appointments, etc.)

Domain: Health, Wellness, and Rights

Subdomain:

1. *Safety*
    a. Person feels afraid in their home, neighborhood, transport, workplace, day program/at other daily activity and/or other places
    b. Person has someone to go to for help when they feel afraid
2. *Health*
    a. Has a primary care doctor or practitioner
    b. Has completed a physical exam in the past year
    c. Had a routine dental exam in the past year
    d. Had a flu vaccine the past 12 months
    e. Went to the emergency room for any reason to get care for themselves in the past 12 months
3. *Wellness*
    a. Exercises or does physical activity at least once per week for 10 minutes or more at a time

Domain: System Performance

Subdomain:

1. *Service Coordination*
    a. Person was at last service planning meeting, or had the opportunity to be but chose not to
    b. Service plan includes things that are important to person
    c. Person has met or spoken with case manager/service coordinator
    d. Case manager/service coordinator knows what is important to person
2. *Workforce*
    a. Staff treats person with respect
    b. Staff have the right training to meet the person's needs
    c. Person can talk or communicate with staff in their preferred language

Appendix F: Additional NCI-IDD Information

NCI-IDD are standard measures used across states to assess the outcomes of services provided to people with IDD and their families. Indicators are organized across domains: Individual Outcomes; Health, Welfare and Rights; and System Performance. Each domain is categorized into sub-domains. In-Person, Family, and State of the Workforce (formerly Staff Stability) Surveys are data sources used to assess outcomes.

The NCI-IDD In-Person Survey (IPS) is an interview-based survey of individuals who are 18 years of age or older and receiving at least one paid service from the State (in addition to case management). Before the survey, Background Information (BI) is collected using state and Care Coordination Organization / Managed Care Organization administrative records. BI includes data such as demographics, personal characteristics, health data, and data on employment status and wages.

The face-to-face portion (Sections I and II) of the IPS is conducted in-person or through a secure video meeting. IPS Section I can only be answered by the person receiving services — no proxy responses are allowed. IPS Section II, however, may be conducted in the presence of and with the assistance of a proxy respondent (family member/friend or staff) if deemed appropriate by the interviewer.

Appendix G-1: Provider Interview Guide

Provider Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another service delivery system that meets OPWDD's strategic goals and objectives in serving the needs of individuals as effectively as possible. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight on various provider operations and delivery of service to individuals with IDD.

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s) and responsibilities. How long have you been in the role? 2. What do you perceive as your greatest barriers to serving people with IDD? 3. Tell us about your understanding of how managed care impacts people with IDD. 4. Tell us about your current billing practices for people with IDD.
Experience with People with IDD	1. What experience do you have with caring for people with IDD? 2. What types of specialized services or supports do you provide for people with IDD, such as behavioral therapy or social skills training? 3. How do you ensure a person-centered planning approach in the provision of services, including personal outcomes based on a person's life goals, interests, strengths, abilities, desires, and preferences? 4. How do you accommodate the unique needs of people with IDD, such as communication or sensory issues, in your clinical practice (Clinical Practice Only)? 5. What continuing education training do you receive on best practice service delivery for people with IDD? 6. What accommodations do you provide for people with IDD during appointments, such as longer appointment times or visual aids (Clinical Practice Only)? 7. How does your practice or agency screen for Social Drivers of Health (SDOH)? 8. Tell us about your referral process for SDOH. 9. How do you address issues of discrimination or stigma that people with IDD may face in accessing healthcare services? 10. How do you modify the planning process to account for a person's cultural preferences? 11. Should states consider managed care or an alternative model for the system of services for people with IDD?
Data, Reporting, and Monitoring	1. What quality measures are in place to ensure that IDD services are effective and meet the person's needs? 2. How do you track these quality measures? Do you use any technology for tracking? 3. How do you use this data in your practice or agency?

	4. Do you conduct ongoing quality reviews and if so, how are those reviews incorporated into plan of care adjustments? Is there a feedback mechanism in place? 5. How do you assess potential risks within the planning process, including identifying barriers, challenges, and obstacles for an individual? 6. Do you have experience with participating in surveys? Do you have ongoing (annual, quarterly, etc.) participation in these surveys?
Interviewee Specific Questions	1. [TBD]
Next Steps	

Appendix G-2: Managed Care Organization Interview Guide

Managed Care Organization Interview Guide

Overview and Purpose

OPWDD (Office for People With Developmental Disabilities) has requested Guidehouse, a global consulting firm with national and state healthcare and intellectual and developmental disabilities (IDD) experience, to evaluate OPWDD's service delivery model and provide recommendations regarding a potential transition to managed care or another model that meets OPWDD's strategic goals and objectives. To support the creation of well-informed recommendations, Guidehouse will interview key stakeholders. Answers to the questions below will allow OPWDD to gather insight in managed care organization operations and delivery of service to people with IDD (Intellectual and Developmental Disabilities).

Please note that interview responses are anonymous and will not be attributed to an individual or organization.

Questions

Background, Roles, and Responsibilities	1. Please describe your role(s), responsibilities. How long have you been in the role? 2. Please describe your MCO's experience working with the IDD population. 3. What do you perceive as your greatest barriers to success in serving the IDD population within your MCO, considering your experience with other special needs populations? 4. What are the primary ways managed care can benefit service delivery to the IDD population? 5. Are there specific benefits of managed care for the IDD population?
Experience with People with IDD	1. What types of providers and services are included in the people with IDD provider network? 2. How do you identify the needs of people with IDD and work with them and their providers to develop a comprehensive care plan? 3. Do you provide any types of specialized services or supports for people with IDD? 4. If yes, what specialized services and supports does the MCO provide? 5. Do you provide any specialized services that address Social Drivers of Health or Health Equity? 6. How do you address issues of discrimination and stigma that people with IDD may face in accessing healthcare? 7. How do you ensure that people live in the most integrated community settings? 8. How do you ensure that services are delivered in a culturally sensitive manner? 9. How do you involve people with IDD and their caregivers/families in their own care and decision making? 10. What kind of training or support do you provide healthcare providers in working with people with IDD? 11. Tell us about the referral process, starting with the identification of a service delivery provider. 12. What is the process for obtaining authorization for services and treatments for people with IDD? 13. How do you ensure that services and treatments are appropriate and effective for people with IDD?

Data, Reporting, and Monitoring	1. How do you determine what a meaningful outcome measure is for the IDD population? 2. What quality measures are in place to ensure that IDD services (or other services if you do not serve the IDD population) are effective and meet the individual's needs? 3. Do you have measures that are more important than others? 4. How do you track the quality measures stated above? Do you use any technology with tracking? 5. Do you use any value-based reporting metrics? 6. If yes, what criteria is used to determine these measures? 7. How do you use this data in your organization?
Interviewee Specific Questions	1. Tell me about your interest in serving the IDD population 2. How does serving the IDD population fit into your strategic plan?
Next Steps	

Appendix H: Guidehouse Subject Matter Experts

1. **Hanford Lin – Engagement Executive and Former Deputy Secretary of the Kansas Department of Health**

A longtime New Yorker, Hanford leads engagements with state health and human services agencies, hospitals and health systems, and health plans to design, implement, operate, and evaluate programs and delivery models including alternative payment, value-based payment, and pay-for-performance models for states, commercial payers, and providers to drive quality, access, and cost-of-care improvements.

The former Acting Deputy Secretary for the Kansas Department of Health and Environment (KDHE) – Medicaid, he worked closely with Medicaid leadership, the Kansas Department of Aging and Disability Services (KDADS), Governor's Office, the State Legislature, and numerous patients, Medicaid members, and advocacy groups to assess, design, and implement program initiatives, including the successful CMS approval of Kansas's 1115 waiver and SUD waiver and Kansas' Medicaid MCO procurement. He also supported development of organizational policies and procedures to improve coordination and collaboration between KDADS and the Kansas Medicaid Agency.

2. **Mark Thomas – Engagement Director and Former Deputy Secretary of the Louisiana Department of Health**

Mark is the former Deputy Secretary of the Louisiana Department of Health and Immediate Past President of the National Association of State Directors of Developmental Disabilities (NASDDDS). He previously served as the Assistant Secretary for the Office for Citizens with Developmental Disabilities, a role he held since 2013 before becoming Deputy Secretary in 2018. He brings more than 30 years of experience in the field of developmental disabilities. Prior to serving as the Assistant Secretary for OCDD, Mark joined the Department as Executive Director of Community Services for the Office for Citizens with Developmental Disabilities in 2006 and has served as Deputy Assistant Secretary for OCDD beginning 2009. Mark has prominently participated in successful statewide transformational activities in the areas of resource allocation, public facility downsizing and closure, waiver waiting list reduction/tiered waiver and cross-government agreements for supporting persons with IDD.

Before joining the State office, Mark delivered community-based disability services for 15 years for several nonprofit organizations and consumer advocacy groups before joining state government, including Community Opportunities for East Ascension.

3. **Camille Dobson – ADvancing States Deputy Director and New York State Medicaid / Managed Care Subject Matter Expert**

At ADvancing States, Camille serves as the subject matter expert on MLTSS, providing intensive technical assistance to states seeking to implement or improve their MLTSS programs on topics as diverse as stakeholder engagement, care management, MCO oversight mechanisms and quality measurement. She also assists states in translating 1915(c) waiver assurances to managed care delivery systems. She provides consultation to states operating 1115 demonstration programs, advising on CMS policies and approaches to approvable demonstration amendments. Camille worked at Center of Medicare and Medicaid Service (CMS) for 10 years where she served as a Senior Policy Advisor and Technical Director for Medicaid Managed Care and was the project officer on both Vermont and Tennessee's 1115 demonstration project.

4. **Andrew Segal – New York Long Term Care Subject Matter Expert**

Andrew is an experienced executive leader and leading subject matter expert in long-term care and health policy. He is currently serving as the Chief Innovator and CEO of ANSEGA Health Solutions, a health management consulting firm that combines deep industry knowledge, meaningful insights, and expertise for healthcare organizations. ANSEGA guides both payers and providers to transform how they serve their customers and address their most pressing challenges using bold ideas that matter.

Andrew formerly served as an appointee to Governor Andrew Cuomo as the Director of the Division of Long-Term Care for the New York State Department of Health. In that role, he led the strategic oversight and regulation of 58 Managed Long-Term Care (MLTC) plans for over 250,000 LTSS beneficiaries throughout the State of New York. This included the oversight, planning, and implementation of the Partially Capitated Plans, Fully Integrated Dual Advantage (FIDA) demonstration program, Medicaid Advantage Plus (MAP), and the Program of All-inclusive Care for the Elderly (PACE). In 2018, he generated $350M in Long Term Care savings under the Medicaid Global Spending Cap for the $12.4B Long-Term Care program.

In partnership with CMS and the Office for People with Developmental Disabilities (OPWDD), Andrew also oversaw New York's State Department of Health's demonstration to test a new model for providing more coordinated, person-centered care for Medicare-Medicaid enrollees with Intellectual and Developmental Disabilities. The program demonstration, knowns as Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), provided Medicare-Medicaid enrollees with a better, more integrated care experience. Andrew was involved in a comprehensive evaluation of the benefits and services of the program, ongoing regulatory oversight, and critical decisions involving the Interdisciplinary Care Team and model of care.

Prior to his tenure with the State, Andrew worked for the largest non-profit home and community-based organization in the country, the Visiting Nurse Service of New York (VNSNY), where he served as Vice President of External Affairs and Government Relations. In that role, he oversaw the legislative and policy activities for the enterprise, including the Managed Long-Term Care plan, the Medicare Advantage plan, and the Certified Home Health Agency. Prior that, he served as Director of Product Management for VNSNY CHOICE Health Plans, the largest MLTC in the State

5. **Karen Blount – Clinician and Managed Care Quality Subject Matter Expert**

Karen is an experienced healthcare professional with more than 30 years of hospital and health plan experience, including experience in compliance with the Joint Commission and National Committee of Quality Assurance (NCQA) Standards. She supports clients with Medicaid redesign, care management, operational turnaround, and improving care for the behavioral health population. She has held previous leadership positions at academic medical centers, women and children's hospitals, and health plan facilities, including former Hospital President, Magnet Chief Nursing Executive, and Health Plan Vice President.