**Possible Innovations for the Transition to Value-Driven Care**

**Summary**

The Developmental Disabilities Service Alliance of Western New York (DDAWNY), in coordination with its Member Agencies, wishes to develop an **alternative payment demonstration project** in partnership with the New York State Office for People with Developmental Disabilities (OPWDD). A demonstration would test multiple (1) service delivery, (2) administrative / regulatory, and (3) service payment innovations during a two-year period.

This document includes an initial menu of innovations and strategies. Some of these changes could occur quickly, while others would require a year or more to implement. Regardless of which innovations and strategies are chosen, a resulting alternative payment demonstration could offer a compelling alternative to the SIP-PL model.

1. **Current impediments to cost reduction**

The DDAWNY Member Agencies identified and classified multiple challenges to controlling Medicaid expense associated with Western New York’s I/DD population. The current fee-for-service model created and perpetuates many of these challenges.

* Service delivery: excessive segmentation of service lines; duplication of services and associated support capacity across many providers; little service continuity with other points of care (e.g., primary care, behavioral, inpatient); multiple assessments capturing duplicative information; default ‘heads-in-beds’ mentality that effectively discounts individuals’ pursuit of independence
* Administrative and regulatory: burdensome DDRO service authorization driven by volume of units; inordinate approval delays for certain services (e.g., modifications, technologies) that would obviate more costly services over time; over-investment of time, effort, and other resources to supporting legacy services; no cost and little quality data shared by OPWDD or DOH; unwillingness / inability to accommodate regional variations in infrastructure
* Payment: no projection of cost impact when providers request services or DDROs make authorizations; constant re-basing of highly segmented rates; insufficient effort to shrink / close / repurpose service lines that do not deliver high value to taxpayer or individual; myopic assumption that providers must launch Article 44s to transition to VBP

1. **Innovations to contain and drive down cost**

The DDAWNY Member Agencies propose a menu of innovations that could streamline service delivery, address administrative burden and duplication, and reduce the total cost of care for the targeted population.

1. **Delegate specific regional oversight and management functions to the CCO**

CCOs maintain two important characteristics for the transition to value-driven services: (1) a hub-and-spoke relationship to providers in the region and (2) a shared governance apparatus. As de facto network heads, CCOs should assume the following responsibilities on behalf of their participating providers:

* Service payment and billing
* Data aggregation and service reporting
* Utilization management and service authorization
* Rate negotiation
* Certain human resources functions

The CCO could operate as a management services organization (MSO), although application and approval for other provider network arrangements would, over time, allow groups of providers to enter risk-bearing contracts. Additionally, OPWDD should seriously consider sharing cost data for lives attributed to the CCO; this information is essential to curbing cost and enhancing services for individuals. Finally, there are unavoidable upfront costs associated with the CCO assuming the above-listed functions. OPWDD and providers could, however, carefully tie these costs to long-term return on investment benchmarks.

1. **Shift from volume to value by bundling complementary services and payments**

OPWDD could incentivize value by bundling services and corresponding payments across a population. Bundling would require stratifying the population by risk/acuity groupings and then offering tiers of capitated monthly payments. OPWDD and providers would collaboratively score risk/acuity, and, while OPWDD remains the single payer, OPWDD and providers would jointly negotiate rate tiers within each bundle. Possible value-driving bundles could include the following.

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| **Community Living Bundle** | **Social Integration Bundle** | **Health Stability Bundle** |
| *Value Pathway:* Transition a portion of population into non-certified settings; retain youth in community longer | *Value Pathway:* Developing innovative initiatives with employers and other private entities | *Value Pathway:* Preventing / managing avoidable acute events and returning people to community |
| *Could include:*  - Individual Residential Alternatives (IRAs)  - Community Transition Services  - Live-in Caregiver  - Family Support Services  - Community Habilitation | *Could include:*   - Day Habilitation  - Pathway to Employment  - Prevocational Services  - Supportive Employment  - Respite | *Could include:*  - Intensive behavioral health  - Telehealth / telemonitoring   - Modifications   - Family support and education  - Specialized acute stabilization services |

1. **Promote a Centers of Excellence model and allow service flexibility**

Services for individuals with I/DD in Region 1 are currently replicated across many providers. This distribution partly reflects geography, variety of services, and the need for consumer choice. However, some providers deliver specific services because rates for other certain services do not cover costs. Providers could cross-contract with each other and gauge success against value based measure sets. With the introduction of bundles noted above, OPWDD should also allow providers to work collaboratively in teams and specialize in the delivery of specific types of services. While such activity will disrupt the status quo, more flexible service delivery would promote innovations in service delivery and payment structuring.

1. **Transition some individuals on CRO list to non-certified settings with safety net funding**

Individuals with I/DD stagnate on DDRO waitlists for years hoping for placement in an IRA. A percentage of these individuals could thrive in non-certified, community-based settings. Moreover, these individuals could (1) be placed in the community immediately and (2) at considerably less expense than an IRA placement. OPWDD should view this challenge as an opportunity to spur residential innovation:

* + 1. Impose a level of need restriction on who from the CRO list can move into an IRA.
    2. Those on the CRO who do not qualify for an IRA should be immediately transitioned into the community.
    3. Each person moved into the community represents a long-term savings; they’re not in the more expensive IRA setting.
    4. If that savings is $100 (hypothetically), pay $40, in the form of one-time safety net funding, to the provider(s) overseeing the transition. The taxpayer retains a $60 savings.

Over time, a similar model could be used to transition a portion of the *existing* IRA population into the community. Such an initiative would require substantial planning. Furthermore, OPWDD would have to invest time and money in outreach and education to individuals and families who currently believe IRAs are the best residential option for all individuals with I/DD.

1. **Explore areas of administrative and regulatory flexibility**

DDAWNY Member Agencies appreciate that OPWDD is a state agency that must adhere to laws and regulations established by the legislature and interpreted by the courts. However, certain regulations and guidelines have so burdened service delivery that only suboptimal care and excessive cost result. Examples include: impediments to funding non-certified housing; duplicative assessments, eligibility requirements, and documentation requirements; deficit-based approaches to quality of care determinations; DSP evaluation requirements; etc.

OPWDD, DOH, and DDAWNY Member Agencies could form a collaborative working group to identify and address areas of potential regulatory and administrative reform within Title 14 Part 600. The *State Administrative Procedure Act* – specifically Section 202-b, Regulatory Flexibility – may offer useful tools for this exercise.

1. **Next steps**

The transition of the I/DD population to managed care, and associated adoption of value-based contracting, should not require that CCOs form Article 44s. DDAWNY’s Member Agencies are ready to discuss with you alternative approaches to this transition, including the innovations outlined above. Please contact us at any time to begin the process.