Joint Advisory Council (JAC) Meeting

Tuesday, September 29, 2020

Webex Meeting Transcription

Roger Bearden: Welcome everyone. This is the meeting of the Joint Advisory Council. I see that there are many of the members of the Council who are enrolled as panelists in this Webex meeting and then I see that there are currently about 90 attendees, so welcome everyone. My name is Roger Bearden, for those of you who don't know me I am executive deputy commissioner at OPWDD.

In the last six months or so, and more at this point, we have all been dealing with the global public health emergency and that has been a primary focus in all of our lives. We, I think, missed our last quarterly meeting as a result of that. But we wanted to try to get back on schedule and working together on advisory council items.

First, just to look at the agenda, we are going to give an update on the SIP-PL public comment. We submitted for further public comment back in February, extended the deadline for comment a couple of times in light of COVID public health emergency and then concluded that mid-to-late June. Allison McCarthy will be taking us through a high-level overview of that.

The second item is the Clinical Advisory Group has continued to meet and review outstantial value-based payment strategies and that will be something that Tamika Black will address.

And then the third item is we have received some consulting assistance from what's called the Medicaid Innovation Accelerator Program, which is a federal opportunity that we were able to avail ourselves of over the last number of months. That is also something Tamika Black has spearheaded.

Certainly as we move through the agenda we would welcome questions, comments from the members of the advisory council, hoping that folks have a facility potentially

with the chat feature, which you can send us a chat either to Josie, who is the meeting host or to the panel. You can also raise your hand; Josie will see that and be able to cue you in. I would like to make this a dialogue not a monologue. And for members of the public who may be participating in the remote Webex, if you include comments in the chat function, we can scrape those, take a look at them and try our best to have those comments be addressed. If those comments are not able to be addressed, we would try to address them subsequently.

Let me move over to Allison McCarthy.

Allison McCarthy: Good morning, everyone. It is nice to be back engaged with you all. It has been quite a last few months of a lot of hard work and attention to the current emergency and it's nice to see your faces as much as we can. Apologies for not having a camera, we are working on that technology and next time I will certainly able to be seen.

Today, we just wanted to take a few minutes to touch on the SIP-PL public comment. As Roger has mentioned, we had released a draft back in August 2018 and then issued another draft this past February. As Roger also mentioned, we did extend that due date for public comment a few times given the COVID emergency. Public comment did close out on June 25th.

And we received many comments. I believe comments and questions came from 125 stakeholders. These included questions or comments from individuals and families, advocacy groups, providers, CCOs and existing Managed Care Organizations, which included the emerging SIP-PLs.

I just wanted to take a couple of minutes to review some of the trends or themes we heard from stakeholders. We heard from individuals and families on a consistent basis that they really just want to understand how managed care will affect their current experience. "What will it mean for me" was the common theme we heard.

In addition, we heard interest in understanding how rate development works. Today we have a cost-based rate methodology and as you transition to managed care you move

to a per-member, per-month capitation payment, and stakeholders expressed an interest in understanding how that works. As many of you know, after we have spent some time with this council, rates for managed care need to be actuarily sound, which means you have independent actuaries. Right now, the state's actuary firm is Duloitte, who work to ensure that as you put a rate out into the market it is an actuarily-sound rate. I think stakeholders are interested in just understanding how that works a little bit more, and also requested that a data book be released for review and used by emerging plans.

We also heard a lot about current crisis. Obviously, we've experienced a workforce challenge. It's likely even worse with COVID-19 and there wants to be an understanding that the implementation of managed care won't impede or make that workforce crisis any worse. We heard from many self-direction stakeholders that their interest in maintaining that full-budget authority as you transition to managed care. And we also heard consistent input on the need for an independent ombudsman. Those are three areas that we heard from several stakeholders around and the ombudsman program, and the availability of that program, on a regional basis was of great interest and they though that should be in place.

Other themes that we heard from stakeholders around included VBP, Value-based payment and quality. I think we have discussed that there is not a tremendous amount of experience nationally in terms of developmental disability measures and measures that are specific to habilitation. That was expressed on a consistent basis. There was a real desire and concern that measures need to align with the traditional goals of developmental disability services in New York State and promote the outcomes that individuals are trying to achieve, which obviously need to be individualized. I think we will hear more from Tamika as this meeting continues around VBP and some important learning that we received nationally through our IAP experience and through recent guidance from Center for Medicaid and Medicare Services. So, more to come on the VBP side.

The concept of medical necessity when it comes to habilitation. It is an area that we haven't spent time with and it's difficult to apply a concept of medical necessity to

habilitative supports and services. That was a common theme we heard from stakeholders, as well.

Two other areas that were expressed through public comment was the transparency of due process rights. I think that continues to be a priority for stakeholders, as it should be. Due process rights are essential and need to be transparent. We also received input that managed care advisory groups should be established and it should include individuals and families to actively solicit feedback from stakeholders so that we ensure that any implementation or development work around implementation is being communicated transparently between individuals who receive services and families who support their loved ones.

What's next? It think that is kind of that million-dollar question. What we can say is that we have the budget process commencing shortly, which will certainly make decisions about what's next for OPWDD and the future of developmental disabilities services relative to managed care. We obviously need to consider both the long- and short-term fiscal environment. As I think you all know, it's a very challenging time. But we are very much encouraged by the continued communication from CMS and our national stakeholders around value-based payment strategies and the opportunities that exist, both in fee-for-service and in managed care. And how an incremental approach to value-based payment strategies is essential. It will be nice to hear from Tamika, who is going to share some of that detail with you all to kind of get a sense of how we can incrementally begin and continue to work towards a VBP strategy regardless of our short- and long-term trajectory for managed care. With that, I am happy to take questions, and we will be hearing from Tamika on the Clinical Advisory Group work as well as the IAP opportunity that Roger spoke of.

Roger Bearden: Let me ask whether there are any members of the JAC that wanted to share a comment or have a question.

Arnold Ackerley: A really quick question: Just in terms of trends, I think a significant topic that is still under discussion, at least amongst stakeholders, is whether managed care in its entirety is really a desirable model to transition to at this point? And I do know that for SANYS we did make that general point that our organization, based on

the fact that we have not been reassured that the cost of operating managed care won't draw from services at this point. And the fact that it is not proven effective in terms of long-term supports and services. Basically, we say we don't support it moving forward until those things become known. We know there are others who feel this way. In terms of the comments that you got back, did you trend that to see how many of the 125 were pro-managed care and how many of those were opposed to managed care?

Allison McCarthy: We did take a look at those trends and it was consistent overall that individuals and families had more concerns and self-advocates had more concerns about the potential for managed care implementation. Overall, similar to your comment, there is a concern about not only what it means for me but how would we fund an endeavor that does cost money upon startup. So, very much so. On the organization, providers, emerging managed care plans, there is generally a more positive perspective in terms of potential implementation. Again, though the same kind of need for transparency, understanding of how capitation rate development works, assurance that funds continue to be supporting services and don't go to administration. From a provider and CCO and managed care organizational perspective, there is a more a positive trend. But similarly, to individuals and families, a need to understand and have transparency and really plan over time that implementation strategy.

Roger Bearden: If I could just throw in, too. It is a little hard to chart it because it wasn't a poll, where there would be a binary choice. A lot of the comments had "I would support if," "I am opposed, but could be supportive…" There were a lot of things where people were sharing analysis or comment. So, it is a little challenging to do straight-up percentages, Arnold. Is that fair, Allison?

Allison McCarthy: Yes, absolutely.

We do have a comment in the chat speaking about a report from Duloitte as well as the data book, communicating that Duloitte did a presentation in Texas on a very similar IDD transition to managed care. I think that is absolutely something that can be looked at. From NYS Department of Health perspective, they do have Duloitte, who is the state's actuarial firm share information to stakeholders upon implementation of such an initiative. Thank you for pointing that out.

Roger Bearden: There is another comment in the chat room. There is not at this point a report on the comment other than the presentation that was just given. It cannot be located because it does not at this point exist. And I saw also a comment posting a link to the meeting materials, which we can certainly supply. Any other questions?

Gail Smith: I thought it was a very informative presentation and I thought also that it was an excellent segue way because one of the areas that was in the presentation was in regard to a Managed Care Advisory group, which would include the participants, stakeholders and their families, which is excellent. And I think having such a group would assist in whatever the concerns are in reference to managed care, in general. So, I think that is an excellent recommendation.

Susan Dooha I am wondering whether you have had a discussion or have material or a report on whether the model can be replicated?

Roger Bearden: I don't understand the question. Or maybe Allison, you do?

Allison McCarthy: When you say model can you explain what you mean by model?

Susan Dooha: I was talking about FIDA-IDD whether you have any discussion anywhere about whether it can be replicated, or will we be expecting that later on in today's presentation?

Allison McCarthy: Thank you for clarifying, that is very helpful. I think we definitely can take a look and do want to draw upon FIDA-IDD. You know one of the differences is that is a model for dual individuals, who have both Medicaid and Medicare, so that certainly is a model we can look at and work with the Department of Health on as we move forward and think about that future. There are individuals who just have Medicaid and it would look a little bit different, but I think our goal is to look at that and outline that. I think recently we have not had a lot of time with the Department of Health who has been very busy along with our team in addressing other priorities. But I think you make a very good point and we want to continue to draw upon the FIDA experience as we move forward.

Elizabeth Benjamin: Will OPWDD have dual jurisdiction with DOH on the plans, as it were. Or can you go talk about the relationship with the DOH. How will it be navigated so that it is successful implemented for the enrollees? It is difficult when you have multiple jurisdiction. We see this in some of the other products out there….like DFS and DOH. Not that everybody is not all trying to work together, but it can be a little difficult for consumers. So, for example, the Department of Financial Services consumer report doesn't include data….just because of the way PHPs grew up different than health plans grew up, so that consumer data and quality and complaint and appeals and external review data that is put in the Department of Financial Services report doesn't include health plans that serve half the individual market. So, for example Fidelis, HealthFirst, MetroPlus, none of those plans' information are concluded in the very consumer guide that is supposed to help people sort of understand what health plan might be most effective for them and to have a better sense of things. So, I think that has sort of been a bit of a hiccup as managed care has evolved over the last couple of decades in New York State. I am just wondering how OPWDD is thinking about navigating those sometimes, choppy waters.

Roger Bearden: I think the intention would be that there would be a joint authority between the two agencies, DOH and OPWDD, in oversight of plans serving individuals with developmental disabilities, and if I am not mistaken the authorizing legislation in terms of the specifics of that, That would probably need to be worked out through MOUs to make sure who was doing what. We haven't gotten there yet.

Elizabeth Benjamin: I think there are certain obvious things that can be tricky -- networks, network analysis, what consumer protections provide for these products. We have been thinking about this through the consumer perspective for decades here, and if it would be helpful, we can talk to at a later meeting when we are further along. I would just love that at the next meeting we could just talk about those streams of authority, who's doing what, so as the population moves in they really have an understanding of if I have a network complaint, where do I go; if I need to do an appeal, which agency do I go to. It can be a little chaotic for people to understand and navigate.

Roger Bearden: To the degree to which your experience in navigating in other sectors and you were to have some thoughts about common mistakes that have been made in the past that could be remedied and addressed on the front end. I think that would be more than helpful and we would look forward to any kind of information, any kind of lessons learned that you would be able to offer from the consumer perspective.

Maxine George: There is so many things up in the air here about how we are going to pull through with managed care and it all seems so confusing and chaotic. But in one of your earlier slides, you mentioned actuarily-sound rates to maintain services. How can we be talking about transitioning to such a complex system as managed care if we have no idea whether or not the rates that are going to be rolled out will sustain some of the core programs of services that our families have come to treasure?

Roger Bearden: I am going to have to defer. I am not a rate setter. Should we take that question back, Allison?

Allison McCarthy: I think to your point, Maxine, it is absolutely critical that we take a step back and consider where we sit today, and what the environment and what providers are experiencing today and what challenges are on the table. As I have mentioned, we will be taking time to asses what our next steps are and what the trajectory looks like and will take into consideration your point. So, I thank you for bringing that up.

Sankar Sewnauth Thank you for this opportunity. It is always great to have these sessions where you can share information with the field. My interest is as a provider that has been interested in managed care for a long time and operates a managed home care plan in upstate New York, an IDD provider. I was following the presentation and you had talked about the concerns as part of the comment period, the concerns you had from the individuals and families in self-determination and then we talked about next steps and maybe I am jumping ahead, but I was interested to know if OPWDD is having any conversations with any of the individual providers or groups that are thinking about managed care and are maybe operating a managed care plan on behalf of people with IDD. Can you share any information that you might have?

Roger Bearden: I think we have almost daily discussions with some set of stakeholders. Obviously, in the last number of months those discussions have focused on the public health emergency and keeping people safe and healthy. Are there conversations or discussions you think we should be having?

Sankar Sewnauth: I would just urge that maybe we could just include those organizations and see where they are and what information they might provide because obviously there is a lot of concern and a lot of interest as well. My feedback would be that we have some conversation with providers who are thinking about moving to managed care, as well.

Roger Bearden: Arnold, you have a question in the chat, do you want to articulate that?

Arnold Ackerley: Have you examined how to continue conflict-free case management? My understanding is that CCOs in some cases may be able to become SIP-PLs, which means effectively they would be allocating funding to services, which seems to be a significant conflict of interest. And further say, defining the business relationships that they also might form with emerging MCOs would probably be important to look at, as well in terms of conflict. What's been looked at there?

Allison McCarthy: I think it's a good point in terms of needing to be clarified as we engage with Department of Health and look to the future. We will be drilling down a bit more in terms of that specific relationship. I think there are firewalls when you institute an Article 44 plan that requires arms-length and conflict-free. Those firewalls and protections will absolutely be reviewed and identified and established. As we move forward, we will have to be focused on that area specifically.

Roger Bearden: I see some other comments. The SIP-PLs have not been established at this point. There was comment received on the proposed model and that was what was reviewed in the presentation that just occurred. But those entities have not been formally established to provide managed care for developmentally disabilities services. I think people are aware of this. But in the event that it's more fully responsive, there is a current program called the FIDA program for people who are dual eligible, which means they have Medicare and Medicaid and those individuals in the downstate region can

enroll in that program and that's been a program that's been operating for several years now.

I am going to move on to the second item on the agenda without the IDA Clinical Advisory Group and what we will do is take a look at the chat room and I will try to scrape any of the comments that have been made and circle them around to a Q&A section afterwards. So, please keep putting in comments, they will be reviewed, and we will see if we can digest them into a single set of answers as we go through. With that I am going to pivot over to Tamika.

Tamika Black: Good morning everyone. I am giving an updated on the Clinical Advisory Group. I know it's been some time since the JAC has met. Since then the CAG met on July 9, 2020, and our key focus for the CAG meeting was really around clinical quality measurement for I/DD, quality measure use cases, and the measure evaluation framework that the CAG would use in terms of measure selection. We also discussed the next steps for the CAG and I think this dovetails nicely into the point made earlier about their being valid and nationally recognized measures relative to I/DD. And I think this is a great opportunity for us to discuss some of the work that has been underway.

When the Department of Health presented some of the information in the last CAG meeting in July, one of their focuses was really talking about clinical quality measurement goals for I/DD. And for those of you who are not aware, the CAG is co-chaired by Douglas Fish, who is an MD at the Department of Health, and Dr. Jill Pettinger here at OPWDD. And what we try to do is bring together both the DOH perspective as well as the OPWDD perspective in terms of thinking about quality measurement and thinking about ways to leverage DOH's experience around quality measurement.

So, one of the things that became a key focus especially as a result of the COVID-19 public health emergency was the need to really look at quality measurement relative to I/DD. One of the first focus areas was really thinking through whole-person measurement. And that's really where measures of all services that support the overall

health and wellbeing of a person are taken into account and they should include and ensure that individuals receive quality of care and prevent institutionalization.

One of the other key focuses, both of DOH and OPWDD, is making sure that when we think about clinical quality measurement, we are looking at disparities in care. And the goal is to use standard measures across populations, as well as to identify gaps in care so we can address those through quality improvement mechanisms.

One of the final areas that we think we will be able to really leverage is building on the use of clinical quality measurement in managed care. Irrespective of what the ultimate service delivery model is, there is tremendous experience that the Department of Health has regarding quality measure. New York State assess health plans on these quality measures, and they are useful for comparing health plan performance. But they also give us a real historical perspective of the use of measures over time, the validity of those measures and the reliability of those measures.

When we also think about using measures, we also want to look in the frameworks from which they have been applied. And there are four major frameworks where measures have been used, so far. Clearly, one of the more robust areas for the Department of Health really is managed care. And in that regard state assesses plan performance on care processes, outcomes or patient experience of care. CMS is also responsible for overseeing states' managed care program.

There is also experience with VBP in managed care and using measures in that framework. And that is where plans pay their contracted providers based on performance and specific quality measures. That is essentially incentivizing quality of care and there are a variety of payment mechanisms to do so. In this arrangement, CMS is also responsible for overseeing states' VBP managed care program.

We also have our current system which consists of waiver programs – that's our fee-for-service area. And CMS and states assess waiver program performance or evaluate enrollees; experience in receiving Home and Community-Based services. Measures may be included in states' waiver agreements with CMS.

And finally, we have been looking at a newer area as CMS has been assisting states with technical assistance, of which New York State has been part of that process in the IAP or the Innovation Accelerator Program, of really looking at ways in which states states have been able to use VBP for waiver services – and that's value-based payments. In that arrangement, waiver programs pay contracted HCBS providers based on performance on specific quality measures. And the measures used in VBP may be included in the state's waiver agreements with CMS.

So, these are four different frameworks and what it does illustrate is that VBP approaches can be used in a variety of ways, in a variety of structures. So, when we think about VBP, we're looking at the quality measurement in and of itself and not necessarily the service-delivery system in which it is embedded.

One of the things we have been exploring with the I/DD CAG is really, quality measures and use cases. Essentially, quality measures are tools that help measure or quantify care processes, outcomes, patient perceptions, and organizational structure and/or systems. It is essentially how good are we doing at delivering services or care and are individuals achieving the health outcomes or the habilitative outcomes that they desire.

Measures are developed for distinct purposes and those are what we call use cases. And that is essentially to assess performance of specific entities. And there is a particular level of analysis or unit of analysis: It can be at the health plan level or at the provider level or it can be at the whole health care system level.

The originally intended use cases are important to consider when evaluating quality measures. So, for example, you wouldn't want to apply a health care delivery system measure to individual care. You want to keep it at right unit of analysis. So, there are a lot of things to consider when we think about quality measures, how they are used and what perspective or entity they apply to.

Here is an example of use cases by measure set. And we really wanted to begin to ground this in the I/DD system. One of the major use cases is: Do we have any kind of experience with measures for HCBS for the I/DD system? And here we list a few of those: we have the National Core Indicators, we have Care Coordination Organization

Health Home measures, we have Personal Outcome Measures, we have Home and Community Based Services or CAHPS measures, and 1915c HCBS waiver performance measures. There is experience with measures around I/DD.

I do want to add something about the National Core Indicators, which really is a new development which I think is really very helpful to moving us forward when we think about a reliable and valid measure set. New York State has been reporting measures on the Department of Health side in the adult core measure set. The core set they have been reporting for over 10 years, and the measures are compiled from a variety of sources including data from plans via QAR or the quality assurance reporting requirements data set from the AIDS Institute, as well as district data. So, there is experience with this core measure set.

National Core Indicators as of 2020 has been included in this core measure set with CMS, which has been great news for us. New York State on the I/DD front has been participating in National Core Indicators for over 10 years, also. So, having the I/DD measures around National Core Indicators included in the adult core measure set is a move towards that reliability and valid measure set that we have been looking for. When we think about National Core Indicators – and for those of you who had a chance to either look at the public-facing website or the New York Profiles for National Core Indicators – they get at those measures, which I think are very important to the I/DD population. Anywhere from “do you have a job in the community,” “do you have a choice of roommate,” “what are the quality of your services.” They have also added measures around care management. So, there is a lot of opportunity around NCI for further development. We have also been engaged with HSRI, who helps administer the National Core Indicators, in developing new measures. So, if there are areas that we want to collect data on, we have the ability as a state to provide that input. And OPWDD has been engaged in that process.

As we move forward from the HCBS or the I/DD system measures – and I just want to make sure that I illuminate where some of these measurements are for the care coordination measures – those are in the CCO application, which I believe are available through the DOH website – the CQL POMS, the Council of Quality Leadership Personal

Outcome Measures, I think have been sort of embedded in the I/DD system for New York State and I think everyone is pretty familiar with those. As similar to the CAPs measures, which are a very common measure set that's used. And for those of you who don't know, we are required to report annually to CMS on HCBS waiver performance measures.

The next use case is around long-term care services and supports. And we have some experience in that around the NCQA L-TSS data set, the New York Managed Long-Term Care measures, the LMTC potentially avoidable hospitalization measures. With those we have been working with the Department of Health to really underscore their experience with those measure sets and can they be applied to the I/DD population.

And similarly, clinical measures – and again, there is familiarity with those where we are looking at HEDIS or the Health Care Effectiveness Information Data Set, as well as CAHPS again for Consumer Assessment of Health Care Providers and systems programs.

We have a variety of opportunities to look at these measures which are considered I think are the more again reliable and valid measure sets for opportunities to advance I/DD system measures.

As we proceed with the CAG, and for many of you who already know, the I/DD CAG, as well as all the other clinical advisory groups, are outlined in the New York State Department of Health Value-Based Payments Road Map. We work in collaboration with the Department of Health to administer, direct and facilitate the CAG, and as part of that we are also using New York State DOH's criteria for measures. There are four key things that we are looking for when the CAGs are reviewing and selecting measures. One is the relevance, the second is the validity of the measure, the third is the reliability and the fourth is the feasibility of the measure.

So, in terms of relevance, and I think again this hearkens back to what was said earlier, we are really looking for measures that are useful for quality reporting and decision making. We are also looking at the level in which the measure has been applied – has it been plan specific, has it been applied to a provider, are the data collected at the

individual level or the health record level. How are we getting the information and who does it apply to? The other thing we also looking for is does the measure make sense when applied to I/DD. And again, these are the things that are considered: Is the measure actually relevant?

For both validity and reliability, we want to make sure that the measure and data is correct and they're free from error so that it's measuring what it is intended to. We want to make sure that they're well defined, that there is no confusion around the specification of the measure and that we can collect data accurately and really reflect quality. And also, too, that we can actually make the distinctions in performance. For example, when results of a measure cluster closely together, so everyone gets a 99.9.8.7, that's not really telling us maybe in a measure where someone is at 70 percent – and I am using this as an arbitrary –and someone is at 90 percent. When we want to think about measure, we want to be able to distinguish performance level. And we don't want people clustering around a particular performance standard.

For reliability, we want to make sure, that again, it is well defined to allow consistent implementation. If everyone interprets the measure differently, you'll collects different types of data, and there won't be reliability in the data that's reported.

We also want to make sure that it is specifies from data elements and it's repeatable, so that anybody having the same information and the same specifications could repeat the data collection and the calculation of any measures. There is also needed testing of all intended levels of analysis to make sure again that they are reliable.

Finally, one of the most important that it is actually feasible. That the data is actually there, it can be collected, it can be aggregated without an undue burden. We want to make sure that we can actually collect information and report on it in a way that is feasible and again, does not require a huge resource strain on the field, on providers to be able to report.

One of the things we are also looking at is how the CAG will work in terms of leveraging measure specifications. We are really looking at how that measure is defined, the numerator and the denominator, and what it really means, what data is collected, where

is that information coming from. And if that specification is clear, we move forward into looking at the four conditions that are the next steps for us to be evaluating measures and looking at those very carefully. And again, that is the work the CAG will be doing as we move forward.

In terms of next steps for the CAG and the recommendations we have from the July meeting, we are really going to be focusing on evaluating and recommending specific HCBS and/or LTSS measure sets and measures. The I/DD CAG will assist OPWDD and the Department of Health with providing an I/DD perspective on clinical quality measures. And CAG members can help identify implementation and reporting challenges, which I think are very important, that may be faced when implementing clinical quality measures for I/DD.

I think that is the end of that portion of the presentation. I don't know if we want to stop for questions at this point, Roger or wait until the end?

Roger Bearden: Tamika, I don't know if you can see in the chat room. There was a series of questions, I will let you sort of browse them for a minute while I am asking the question of whether panel members and members of the JAC have any questions, comments at this point on the CAG read out that Tamika was able to provide.

Tamika Black: So, I will try to generalize comments. We have quite a few comments here so it's great to see that everybody is engaged in the conversation when we think about measures and that is a wonderful thing. I am always interested in debate and deliberation and really thinking through a mindful and thoughtful approach as we move forward.

I think we gotten quite a few comments from Ralph Laurent, who a panelist. We see here there is an ongoing problem going back more than one year on the I/DD CAG use of the POMs and the CAG I think he is saying it is inconsistent and illogical in the use of measurement standards among the POMs. In other words, some POM items were picked, and others were omitted without regards to strict measurement standards DOH uses in other CAGs. I think again this CAG has been reconvened from the original CAG. The original CAG that occurred, I believe it was in 2016, did identify initial measures.

Some of them were clinical measures and some of them, I believe, were related to the POMs. We have started from a different collaborative framework for the second round of the I/DD CAG and are really trying to look at it more thoughtfully around the selection of measures. And we are using a great amount of assistance from the Department of Health in thinking though the applicability and consistency across the CAGs. We are using the complete DOH framework, which includes the VBP Steering Committee review. Doug Fish operates and oversees all of the clinical advisory groups, so his work in bringing in the I/DD CAG along with the other CAGs is creating that level of consistency and that framework. We are working together and developing the expertise as we go and are leveraging the existing expertise of the Department of Health.

I think there was interest in actually knowing what specific measures we are recommending. The CAG is going to be embarking on that process. We are not recommending any measures at this point, we are telling you the framework we're using to begin measure selection, the importance of the selection criteria, and the work that we're doing to ensure that we are selecting measures appropriately.

Roger Bearden: Thanks, Tamika. I believe those meetings, similar to this one, are held publicly so folks have the opportunity to participate as we look into the fall and the winter in those discussions. Am I correct in that?

Tamika Black: The Clinical Advisory Group is not a public meeting. However, the information and the PowerPoints are posted on the DOH website. So, if anyone is interested at looking at the work the CAG has done so far, the information can be found on the Department of Health website.

Roger Bearden: And I am glad you mentioned that because there was a request for a link to that information so we can find that and throw that into the chat room.

Donna Colonna: I actually participated in the recent CAG. It was some really good conversations in terms of looking at different measures and improving care. The one thing that strikes me though is integration with healthcare and flexibility with the platform for that. I know that we are actually talking about crafting the future, so to speak. I think it is really important that with whatever platform we create we need to be able to bring in

Health. I think our experience in COVID and sort of trying to push and work with the healthcare side our challenges and some of our standards and some of the standards the Department of Health are looking at. Without a real integrated approach and a flexible approach, it is really important to have to a whole-person approach for the people that we serve. How do we get there? Because I think that's how we started the joint advisory council – I couldn't believe it was like 2013 when we started. We have to get to a whole-person approach, at least in my view.

Roger Bearden: Tamika, do you see any other questions or comments?

Tamika Black: I think there have been questions again about the reliability and validity of the measures set and how we are approaching that. Again, I think that is the continued work of the Clinical Advisory Group and I think after our next set of CAG meetings we will have a greater opportunity to update the JAC on the direction we are taking. When we also think about reliability and validity, we also are working with the Department of Health, Office of Quality & Patient Safety (OQPS), which has a substantial research and data infrastructure underneath it. And we are using again their calculation of measures and their approaches. And we are making sure it fits the I/DD system. It's not simply taking a measure and copying it over to the I/DD space. But we are looking at it very thoughtfully from a variety of perspectives: clinically, methodologically as well as programmatically. There is much more work to be done. What I also want to say is that this is a foundation. The perfection is not going to be achieved in the first round, we will not isolate every perfect measure. But what we will do is start on a process of refining, of getting data, of using data and getting better at it over time. As a result of that, getting more reliable and valid information. I think everybody wants to start off with this sort of Holy Grail. The I/DD arena is very new; we are at the forefront of this conversation. Concerns about measures are absolutely true. You do not want to go out with anything that is arbitrary and does not measure what's intended. At the same time, we have to begin the process somewhere and there needs to be that conversation about how do we begin to build capacity. How do we understand data literacy and how do we move forward with using measures, refining them and building on experience and being a leader in that regard. So, because it hasn't been done before doesn't mean it's impossible, what it means is that we have to be thoughtful

and really mindful of our approach. But we also have to be willing to have some opportunities to be successful in areas and also work in some areas to do better. I just wanted to put that out there.

We have some questions around social determinants of health, which is also another key area that we are looking at through the CAG and that does factor in. We are continuing to develop that approach and that framework with the Department of Health.

I think I have done largely some justice to some of these comments. There is much more here. Hopefully, Josie you are tracking questions and comments for me so I can look back at it.

Roger Bearden: We can pivot to the next item on the agenda, which is a read out -- and I don't believe we previously discussed this program because it is an opportunity that came about rather quickly and a short turnaround for the consultants to be able to provide assistance to us. And obviously, this is highly related to achieving valued outcomes for our payment methodologies. With that let me pivot back to Tamika to take us through some information on the Medicaid Innovation Accelerator Program.

Tamika Black: Thank you, Roger. This is another initiative that we have been participating in. We were awarded an opportunity to receive technical assistance from CMS as part of the Innovation Accelerator Program. Select states are offered this opportunity to join their various team of consultants to work through approaches towards value-based payments. The IAP team that we participated in ran from February to August 2020. It included the Department of Health and OPWDD.

One of the things I did want to mention is that while we were very excited about our IAP opportunity, we had a very ambitious agenda. We encountered some key challenges during the progress. Clearly, we had the COVID-19 public health emergency, which changed the nature of the focus, as well as our ability to participate at the level that is usually needed through the IAP. It consists of usually weekly and bi-weekly meetings and a tremendous amount of work and effort. The original team was moving towards fiscal modeling and financial simulations and developing complex approaches to thinking about VBP. That didn't happen in the same way that we had initially intended.

Our technical assistance ended on August 31st, so we had a very limited timeframe between February and August and there wasn't an ability to extend the IAP. And so, as a result of that it changed the trajectory from the initial aim of having a deliverable based focus to more about consulting and learning as we worked with our partners at CMS. The team that participated with included NORC at the University of Chicago, Rand ARC, which was an actuarial company, Stratus Health and others.

What it did lend itself to was a large-scale sort of opportunity for OPWDD, which was phenomenal. We had the ability to access expertise in resources. We really had an opportunity to assess our current state and think about leveraging capacity of our existing system towards VBP. We could support the continued focus on data. We could gain a further understanding of VBP arrangements and alternative payment models. We had the opportunity to identify foundational steps and considerations for the I/DD system, irrespective of funding or service delivery models. We learned from other state experience and we had an opportunity to review our OPWDD stakeholder engagement process. So even despite having a limited resource available to us at this point, relative to the state capacity to participate, we came away with a lot from the experience.

In terms of current state initiatives, again many of you are familiar with this, we have talked about these. We have the VBP roadmap, which is available on the Department of Health website. It was part of the 1115 delivery system reform initiative, the DSRIP. And the goal, when the VBP roadmap was first drafted was a payment reform goal to reach 80 percent value-based payment arrangements. Provider-stakeholder standards and guidance for creating VBP payment arrangements were really specified in that document.

We also have the I/DD Clinical Advisory Group, which was part of that VBP roadmap and we talked about the update just a few minutes ago. We began the process in 2019 and we've been using clinical expertise and industry knowledge to try to move forward in looking at measure sets for I/DD services and the population. The goal of the CAG is also to make recommendations and to provide feedback on quality measure sets.

We also have the experience of the FIDA I/DD demonstration, which has been very important to us. This is a five-year demo for the fully integrated, dual advantage plan

program. And is an ongoing partnership between OPWDD, DOH, CMS and Partners Health Plan. Someone had mentioned earlier about replicating the model. We would refer to it more as leveraging the model – learning from that experience. They are not exactly the same, as Allison pointed out, this is for dually eligible individuals. However, there are things that we can learn about the measurement process, about the measures that the FIDA has to report, that data collection and the reliability and the validity of those measures. And so PHP is also part of the I/DD CAG and they have shared their insights around data collection, around measures and that was on one of the earlier CAGs and I believe that PowerPoint is on the DOH website.

In addition, we also have I/DD Health Homes, which again has been a key part of our service system, effective July 1, 2018. The goal of the CCO is to deliver person-centered planning and care management services and cover over 100,000 individuals with I/DD.

Opportunities for aligning the IAP with state initiatives and goals. We want to be able to use these pieces that we have available to us and think about how do we move forward. Someone commented about the JAC forming in 2013. Again, change and developing a service delivery system or transitioning to managed care is a long road. One of the things we wanted to do with the IAP experience was figure out how we can leverage, how can we get there?

One of the things we discussed in the IAP around the I/DD health homes was thinking about ways to enhance capacity to measure quality outcomes and support VBP models through a more integrated and person-centered care management process. Another way we were looking at it is how we think about the quality measures that we were recommending through the I/DD CAG to support VBP, including for HCBS; how to leverage managed care to build on the experience that we already have, both in the FIDA I/DD as well as mainstream; and think about ways that helps us leverage opportunities for VBP design and HCBS; looking at waiver redesign and as we think forward after the public health emergency, looking at flexibility, looking at equity, sustainability, those key principles and looking at the Waiver Design Process and how

we can create and look at measures through the waiver and how do we support education, life-long learning and helping adults engage in citizenship.

We also want to look at incentives and measures in that space. And again, we want to also update the VBP roadmap to reflect any new directions and DOH is fully informed about that and wants us to update the roadmap as we continue to refine the direction that OPWDD is headed.

One of the things that became very important to us in understanding the move to VBP is the importance of data. And so, I just want to reiterate OPWDD's data strategy initiative, because at the foundation of any quality measurement system is actually having access to the information, having systems, IT systems, having the ability to analyze, collect report effectively, both on the provider side, but also for OPWDD. One of our goals at OPWDD is really to promote accountability and transparency for individuals, families, providers, employees and our stakeholders. It has been an aim we have been focusing on for the past year and a half. We want to be able to provide accurate, timely and actionable data to support decision making, as well as look at the IT systems and the data as the source.

We also want to balance the quality and performance reporting with assurances that person-specific confidential data will be handled appropriately. Privacy and security are one of the key focus areas as we seek to be more data driven.

In terms of our data strategy, and we have talked about this in the JAC before, but it is coming together under the context of the VBP, is that we have developed a high-level roadmap for milestones for achieving our data strategy. We have instituted data governance to ensure that we have accurate and reliable sources for our data and that we are safeguarding that data. We are looking at data sharing and looking at DUAs and how we can actually share data and also looking at open data, which is one of our key initiatives to expand on. And also developing our quality strategy and the Clinical Advisory Group is part of that quality strategy. As well as exploring development of new quality measures and monitoring service delivery and provider performance.

In terms of the VBP roadmap, it is a highly technical document. But this distills down the six major pieces of that roadmap. The first thing is the outcomes that we expect to achieve; who actually is the target population; what are the quality measures that we intend to use; what is the data and the information systems that support the VBP model; what are the services to support our strategy – waiver and non-waiver services included in the model; and the payment method used to incentivize quality and effectiveness.

One of the other things that we need to really talk about is the target population and there is also attribution – who is ultimately responsible for delivering those services and who would be the beneficiaries of any VBP strategy or incentive.

One of the three key areas we discussed with the CMS IAP team are the key goals that are proposed for our VBP model. The first one is how to best support people to live in the most integrated setting, how do we incentivize employment first, and how do we continue to incentivize comprehensive care coordination. We went into the IAP experience with those three major system goals.

As part of the IAP work, we went through the alternative payment framework – and we will talk a little bit more about that framework in future slides. Our IAP focus really was —and this was counter to what we initially expected – meeting states where they are. Many of the states, based on our work with the IAP, were very aspirational in the directions where they were headed. The IAP allows you to leverage and look at where the system currently is, and what are the opportunities in the current space, as well as in the future space. Identifying building blocks, leveraging a continuum of progressive steps, and promoting value and quality through existing system capacity. I think that was a great framework for OPWDD, as we are starting this sort of foundational walk towards more complex payment arrangements.

Here is the alternative payment framework. It starts off with fee-for-service arrangements with no link to quality and value and often this is where many states have started. And then they move on to Category 2, which what was what we spent a lot of our time in the VBP IAP talking about. And that was linking fee-for-service to quality and value and using foundational payments for infrastructure and operations, pay-for-

reporting and pay-for-performance arrangements and how could those be operationalized, potentially for New York State.

We also talked about Category 3 and Category 4 to also provide some examples of how we might transition from the Category 2 to ultimately 3 and 4 payment arrangements. And again, those are the ones you are more traditionally familiar with for VBP. Most often, specifically category 3 B and 4 A, B, and C, moving forward in a managed care arrangement. We ran through the gamut of this and really talked about where New York State is now and where we ultimately want to be.

As a result of that conversation, the consulting team was able to identify a few states that are walking or have walked a similar trajectory as New York State. What they did is actually identify where we have a baseline system of health homes and how they have been able to use the health home framework to begin to develop VBP arrangements. In the District of Columbia, they have two health home programs and they were able to use Category 2A, foundational payments. They were also able to incentivize health homes to make greater use of data. The state created a VBP structure to actually support the transformation of the process to being more data driven. They used a pay-for-performance model and they were reimbursed for meeting quality metrics and that was actually an example of a category 2C pay-for-performance payment.

We also learned about South Dakota that was also able to use its health home model to target both individuals with chronic medical conditions, as well as those with serious mental illness. We talked a lot about being able to further cross-system collaboration and integration for OPWDD and our health system. There was an opportunity there to look at foundational 2a payments, also to continue to support health homes with smaller caseloads. They were also able to look at quality measures in the context of pay-for-performance arrangements, and using statewide averages, using quartiles to be able to assess performance, using 2c pay-for-performance payments.

We also had an opportunity to explore California's experience and the IAP thought there was an interesting amount of opportunity here to think about this context also for New York State, not necessarily in terms of housing navigation, but the opportunity to build into the care management process, key areas where the state would like to see some of

its VBP goals being met. In the case of California, they focused on a housing navigator program and were able to use VBP arrangements to allow individuals who may be at risk for homelessness to be able to find housing and partner and create a supportive network to be able to find housing. Their structure was also using foundational payments with options for pay-for-performance and reporting.

Finally, we looked at Tennessee and the specificity of their arrangements where they were in a more complex 3a savings arrangement. They have moved on in their trajectory and their health homes are overseen by their MCOs, which also set the health home rate. We looked as their use of the state's use of HEDIS and so they elected to use HEDIS because it could be calculated using claims data. Again, this is VBP, this is what the incentives or the payments are based on. It is not an assessment of their whole system. Oftentimes, states use a variety of measures and measure sets to look at the quality of their overarching system. It's about looking at this perspective of what are we creating the incentives on, what do we want to promote and what do we want to pay on as a system. And those are sometimes a little bit different. They are the same as a subset of the overall quality oversight.

For Tennessee, the MCOs track home health performance on the quality and efficiency metrics. The high-performing health homes are eligible for outcome payments, if they of-course improve quality. The MCOs are responsible for producing quarterly cost and quality performance reports for the health homes. So, the MCOs and the health homes work in tandem and in partnership.

Now we are at the future of VBP or the present of VBP, depending on how you look at it. On September 15, 2020, CMS released the state Medicaid Director Letter, #20-004. It is a pretty lengthy letter, it's very interesting. What it does is it reaffirms the HCL-LAN framework, which is the alternative attainment framework that I just went through in the slide deck. It supports opportunities to expand VBP in Medicaid, including within fee-for-service, which is a great expansion. It identifies ways that the states can support the shift to VBP, including innovative payment strategies. What is interesting is the work of the IAPs and I mean IAP process has been going on for a number of years, actually informs CMS's guidance. So being part of the process, at least for OPWDD and DOH,

allowed us to get a lot more information and understanding of where CMS's guidance was going, how it was going to support VBP and that we were right on the correct trajectory for how to incorporate VBP in the I/DD landscape.

I think that concludes my slides. Roger, I will turn it over to you in terms of time. If we have time for questions or for chat or how you would like to move on.

Roger Bearden: I am going to first ask members of the JAC if they have any questions or comments.

Michelle Juda: Tamika, in one of the early slides that you had an opportunity to learn something more about was through the stakeholder engagement process. Can you speak a little specifically about what was learned around that?

Tamika Black: I think one of the things that we have been doing – and this is more internal work in OPWDD and Allison, if you are still on the call, please feel free to weigh in, is really understand how to communicate effectively the various initiatives, the timing of communication, how to engage our stakeholders and bring them in the conversation. It's some of the tools that we have used, as well as some new tools like focus groups, other types of avenues for engaging stakeholders. I don't know if I answered the question or if there was something more specific you were alluding to?

Michelle Juda: Was there anything specific from any of the other states that are best practices or things we should be thinking about?

Tamika Black: What we did is we worked with Stratus Health, who has worked with other states. So, in the process, just like the alternative payment framework, they provided a framework for us to work through, almost like a workbook, of beginning to look at in a value way of how we engage stakeholders. I think it was more of a reflection process and understanding the timing and the approaches that were necessary. I don't know if there was more or less any sort of best practices, other than that their framework is a compilation of best practices and they have you work through that framework to make sure that you are catching all of the underlying concerns, that we understand the perspective of our stakeholders, that we are engaging our stakeholders

at the critical point in time as we move through initiatives and we're doing that in a holistic way, not in a siloed way.

Roger Bearden: And I can maybe pitch in something there. There is ongoing stakeholder engagement to try to understand the most critical and kindly question right in front of us which is, as people know, the Appendix K allows for certain flexibilities within the waiver that weren't present, but those expire at the end of March 2020, absent further action. That's the maximum extension under current policy for an Appendix K. We are looking very critically at what was successful, what was successful, but could be improved, to be more successful, but was not successful in terms of the Appendix K flexibilities. The thinking being within the next month or so we need to be submitting something to CMS in order to extend those flexibilities as far as the permanent waiver That's a product of the maximum extent of an Appendix emergency waiver of one year, this March to next March. That is a process that has been ongoing through multiple mechanisms. What we are hoping to do once those set of questions are answered is to be able to dive a little deeper into some further stakeholder questions, trying to sequence things in a way that makes sense. Looking, say early November or late October depending on when we can do the work on the flexibilities waiver we will be asking our various stakeholders how we vision the system moving forward in the medium term. That is something that we learned about. It is always good to have somebody take a look at what you have been doing – clearly you do the things, you believe are going to be helpful and useful or else you do other things and then give us a critical eye on that. I think it is more about taking this what we have done traditionally, taking a critical eye at it and saying are there areas where we can do better.

I see in the chat box some questions around benefitting from the FIDA experience to help inform larger programmatic transitions with respect to managed care. Tamika or Allison, do you want to address that question. I know that we are taking a critical look at the FIDA experience so that we benefit from that trial run, if you will, as we look at the broader initiative. Is there anything more specific?

Tamika Black: I don't think there is anything further at this point. But I think PHP did a great job presenting at the Clinical Advisory Group that we had some months ago, explaining some of the challenges with measurement – DOH was there, OPWDD and all the participants on the CAG – in understanding some of those lessons learned as well as opportunities to enhance the way we look at quality measures. I think we continue to look at that expertise and that experience to determine where we go next and I think we are going to be doing that more as we move forward with the CAG.

Roger Bearden: I see a request from a self-direction stakeholder that we engage them in looking at a potential VBP approaches as they would apply to HCBS services before we would float such approvals. I think that makes all the sense in the world. What our thought is that we would be benefitting from the analysis given to us, to the degree to which it is worthwhile to explore those approaches as part of the next iteration of our next HCBS conversation. We would absolutely intend to engage as many stakeholders as we can to try to see what proposals have merit, and which ones have less.

Susan Dooha: I am curious about equity – the discussion about equity that appears on the first slide. What is meant by that in this context?

Tamika Black: I think when we are thinking about equity, we are thinking about not only the ability to access services, but to ensure that individuals who have a disproportionate impact related to access to services or health outcomes are also being served. I think it is both a combination of everyone having services that meet their needs, but also making sure that individuals who disproportionately been impacted also are taken into account.

Roger Bearden: And we have talked in different forums about sustainability, equity and access. Thinking about those as themes that kind of guide really any system of public supports. Sustainability meaning not spending more than you have, or not spending more than you have in the future, so that the system is sustainable. Equity we tend to think about as a more distributional idea, which is to say those who are comparatively more needy would have greater command on resources than those who are comparatively less needy. So, you have an equitable distribution of the available resources. And then access: Once you kind of figure out what do you have with a

reasonable distribution of resources, taking into account need, then access is making sure you have a system that quickly and efficiently gets those services to the people in a way that helps them and is meaningful to them. We have looked at a variety of issues though that lens to try to enhance each one of those. With equity we have tended to use as a distributional lens, people who are more needy ought to command more resource than people who are relatively less needy.

Susan Dooha: Does that analysis encompass identifying and addressing disparities based on race and ethnicity, for example?

Roger Bearden: It certainly could. The contention is that equity – when you are talking about publicly funded supports that are meant to sustain individuals with developmental disabilities lead meaningful lives – the relevant consideration when you are trying to determine access to resources is what types of supports, predicated on need, does that individual require in order to achieve those life outcomes. So, there are other types of characteristics of the individual besides the need for support, would and should not be relevant to that determination. And obviously to the degree that there are confounding factors that might include race, ethnicity, gender, etc., class, one would look to combat those components and have them not implicate the distribution of resources.

Arnold Ackerley: At least one of the states had linked value-based payments to health care savings. I am just curious how much you have thought about health care savings vs. heath care outcomes? Many people served in the system have chronic either health or psychiatric conditions. Their health care costs may not be able to be managed even if their program supports are really are of quality. I just worry that if health care savings becomes a measure coupled with the recent reductions and retainer payments, that it could really incentivize cherry picking and really a preference for not serving people with either significant psychiatric or chronic health needs.

Roger Bearden: I am not sure I have an answer. I think what you are talking about, Arnold that to the degree to which certain costs are unavoidable, as opposed to avoidable, the inclusion of those costs as part of the value-based payment structure might disincentivize higher need individuals – did I get it more or less right?

Arnold Ackerley: Yes.

Roger Bearden: I think that it can certainly be addressed through benefit design. And I also think that – let me ask Tamika, do you have a response to that? Or should we take that one back?

Tamika Black: We definitely need to take that one back. As I mentioned, Arnold – and that is a very, very good question – the intention of our IAP experience of what we intended and what actually happened were two different things. One of our goals initially was to do some financial modeling and looking at quality measures and trying to identify certain types of simulations on approaches that the state could use. We didn't get into that point in our IAP simply because of the public health emergency. We are hoping that as we move forward, we can take some of the initial thinking, some of the other states' experiences and approaches we have been formulating and take that back and identify opportunities to move forward. So unfortunately, we didn't get there yet, but I understand your question and the need to make sure that one is not being sacrificed for the other. We don't want to focus on savings and sacrifice outcomes. But also have to make sure that as we look at outcomes, that the system still remains sustainable and we're looking at it in a more comprehensive way. I understand your question, we just need a little more work on that.

Roger Bearden: I am looking at the chat line. There are several comments that are looking for information being sought around three items. One is the Duloitte analysis regarding cost and there was a point that Texas had published some Duloitte information and requests that we do the same. There is a second regarding any analysis with the FIDA program, and the third having to do with the consultant to OPWDD to assist with – it's called the resource balancing model. None of those are to do with questions but are more requests for information that we can certainly take back and see what can be shared. I have a note that there is a request that at the next JAC meeting that we include information about the DOH and OPWDD and potentially other state entities' rules with respect to oversight. I see a follow up on the conflict-free care coordination and the relationship to that and managed care entities.