New York DISCOs: Managed care plans for people with developmental disabilities - Critical factors for financial viability

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The model for delivering care to the developmentally disabled (DD) population is likely to undergo fundamental change, which could have significant financial impact on the agencies and healthcare providers serving this market. New York, similar to many other states, is looking to improve the quality of care and reduce the costs of care delivered to this population and is driving a shift away from a fee-for-service (FFS) payment approach that rewards volume to alternative payment approaches that reward improved outcomes. In this paper, we will describe the upcoming changes to the Medicaid benefit framework and some of the challenges facing the managed care organizations and providers serving this population. While this paper focuses on the changes taking place in New York, similar changes are occurring in other states as well, and the financial and design considerations presented here will be relevant elsewhere.

New York's People First Waiver demonstration, a managed care framework for the intellectually and developmentally disabled, was unveiled in early 2011. The state's primary goals for this initiative are to:

- Improve care coordination among the many state agencies that provide Medicaid services
- Replace institutional care with a broad array of community-based services
- Develop a financial framework that will work toward achieving these goals and improving quality of life

With more than 90,000 Medicaid beneficiaries with developmental disabilities statewide, annual Medicaid costs, excluding acute care benefits, were approximately $5 billion in 2011, or about $55,000 on a per-beneficiary-per-year basis, according to the New York State Office for People With Developmental Disabilities (OPWDD) Regional Databook.[1]

One of the strategies the state is developing in response to the high cost of benefits and the desire to improve quality for DD beneficiaries is the establishment of licensed managed care organizations that will coordinate care for this population on a capitated basis. These organizations will be called Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs). A draft request for application (RFA) was issued in September 2012, and 36 organizations across the state submitted letters of intent. Issuance of the final RFA has been delayed many times, and as of the publication of this report, has yet to be released. Based on the latest information from the state, it is currently negotiating with the the Centers for Medicare and Medicaid Services (CMS) to modify its existing waiver agreements and reform the current payment rate methodology for certain residential services. After these negotiations are complete, the state will release a final RFA and begin the process of licensing DISCOs.

1 New York State Office for People With Developmental Disabilities. NY OPWDD Regional Databook. Retrieved from http://www.opwdd.ny.gov/node/4033.

BACKGROUND: TRANSFORMING THE MEDICAID SYSTEM

The Americans with Disabilities Act (ADA) of 1990, later amended in 2008, is a federal law that prohibits discrimination against people with disabilities. In 1995, two women with mental illness and developmental disabilities brought a suit against the state of Georgia claiming that their confinement in a mental institution was a form of discrimination and violated the ADA. The U.S. Supreme Court decision of this case in 1999, known as the Olmstead Decision, states that a public system that results in people unnecessarily living in institutions rather than being integrated into the community is unlawful. As a result, many states began the process of transitioning people with DD out of state-run institutions into alternative community residences.

In many areas of the country, this transition has been slow to progress. Programmatic changes to state Medicaid benefits, including the expansion of community housing and other support services, are necessary. New York has made significant progress in reducing the number of DD individuals living in state-run institutions. Through the People First Waiver, the state hopes to restructure Medicaid benefits and care coordination to make it possible for even more people to be integrated into the community.

TODAY'S MEDICAID FRAMEWORK

In New York, Medicaid beneficiaries with DD currently receive benefits through several different state agencies:

- The Department of Health (DOH)
- The Office for People with Developmental Disabilities (OPWDD)
- The Office of Mental Health (OMH)
- The Office of Alcohol and Substance Abuse Services (OASAS)

The DOH pays for beneficiaries' acute care health services, such as hospital stays, emergency room visits, physician services, and prescription drugs. Certain individuals may also qualify for the DOH long-term care services, such as personal care and home health visits, if the individual requires more than 120 days of long-term support services. The OPWDD covers day habilitation, supportive employment, and residential services. The OMH and the OASAS cover additional behavioral health and substance abuse services beyond what is covered by the DOH.

This fragmented system makes it difficult for DD beneficiaries and their families to understand the benefits and eligibility requirements and likely leads to duplication and waste. In addition, the set of prescribed benefits may not be ideal for each individual. Many advocates believe that offering alternative benefits, such as additional financial support for living independently in the community, could lead to improvement in quality of life and possibly lower costs.

According to the state's databook released in April 2013, the average annual cost of Medicaid benefits for DD beneficiaries statewide was about $55,000 in 2011, not including acute care services. There is significant cost variation by geographic region and among individuals within a particular region. The most significant factor affecting the benefit costs for a particular individual is residential setting. Table 1 shows the variation in average annual benefit costs for DD beneficiaries by residential setting.

DISCO PROGRAM FACTS

The proposed DISCO demonstration seeks to develop managed care plans that will coordinate all Medicaid, and eventually Medicare, services for their members. There have been many revisions to the program parameters since its initial unveiling. Table 2 outlines the major provisions based on the original draft RFA and more recent presentations by the state.

TABLE 1: 2011 AVERAGE ANNUAL BENEFIT COST BY RESIDENTIAL SETTING* STATEWIDE, ALL AGE GROUPS, DUAL AND NON-DUAL ELIGIBLES

RESIDENTIAL SETTING	2011 AVERAGE ANNUAL BENEFIT COST PER BENEFICIARY
Intermediate Care Facility (ICF/DD)	$175,487
Individualized Residential Alternatives (IRAs)	$120,496
Community (Non-Residential)	$23,932

**Based on DISCO Databook released April 2013; does not include acute care services.*

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TABLE 2: DISCO PROGRAM FEATURES

PROGRAM FEATURE	DISCO PROGRAM FEATURE
Eligibility	All beneficiaries of OPWDD Adults and children Both Medicaid-eligible only and dually eligible (Medicare and Medicaid)
Start Date	Voluntary enrollment initially Mandatory enrollment beginning at a later date
Covered Benefits	Current OPWDD covered services Long-term care support and services, currently provided under the state's Managed Long-Term Care program (includes custodial home health and personal care services) Behavioral health services currently provided by OMH Substance abuse services currently provided by OASAS Alternative benefits – plans may provide other benefits that help support the transition of individuals to less restrictive settings Acute care services currently covered by DOH may be included at a later date
Care Coordination*	Annual assessments performed by DISCOs and lead care coordinators Individualized plans are key components Interdisciplinary teams (IDTs) ensure that services are appropriate for identified needs

**Source: New York Office for People with Developmental Disabilities and New York Department of Health (March 2013). Strengthening Services for the Future: Understanding the People First Waiver and Managed Care. Retrieved from http://www.opwdd.ny.gov/sites/default/files/documents/waiver301_march_2013.pdf.*

FINANCIAL STRUCTURE OF THE DISCO PROGRAM

There has been much speculation about the financial structure of the DISCO program, and the state has not released many details. One possibility, consistent with New York's other Medicaid managed care programs, is a system of capitation payments. Capitations are predetermined amounts paid to the managed care plans to cover the full amount of benefits, regardless of the amount of services a particular individual uses. These capitation payments are often risk-adjusted based on risk-assessment tools, in the case of the Managed Long-Term Care (MLTC) program,[2] or based on members' health claim diagnosis codes and other data, in the case of the Medicaid Managed Care program.

Although the state has been testing various risk-assessment tools over the past few years, there is currently no risk-adjustment mechanism for DD Medicaid beneficiaries in New York. Without a proven risk-adjustment tool, DISCOs may incur a great amount of risk because benefit costs vary widely among individuals, as seen in Table 1. Until such a mechanism can be developed, some experts suggest that DISCO premium rates should be based on member characteristics such as age, residential needs, and other factors that will more accurately predict their benefit costs. A major drawback of this approach, however, is that too many premium variations (or rate cells) could provide little incentive for DISCOs to truly transform the system.

A risk corridor program is another approach that could mitigate the risk for DISCOs until a risk-adjustment mechanism is in place. This approach has been used as part of the New York's MLTC program for new members under mandatory enrollment. CMS is also using risk corridors as part of the individual and small group exchange programs in the commercial market. A typical risk corridor program establishes a per-member-per-month (PMPM) budget, and if a plan's actual costs are less than the budget, the plan retains a percentage of the savings, and the remainder is paid back to the state (or CMS). If actual costs are greater than the budget, then the state (or CMS) will share a portion of the losses with the plan.

Capital requirements for DISCOs are also a matter of speculation, given the high average cost of benefits per member. In New York, both start-up and ongoing capital requirements for Article 44 managed care plans are based on a percentage of premium or capitation revenue. In the case of MLTC plans, the capital requirement is set at a fixed rate of 5% of premium. However, other managed care plans are required to hold 5% of premium in the initial year of operation, and the required percent of premium increases by one percentage point each subsequent year until reaching 12.5%. The state has hinted that the capital requirement for DISCOs may be less than other types of managed care plans, but actual details have not been released.

2 The Managed Long-Term Care (MLTC) program is New York's Medicaid managed care program for beneficiaries in need of long-term support services.

TABLE 3: EVOLUTION OF NEW YORK MEDICAID PROGRAMS

MEDICAID PROGRAM	CHANGES OVER TIME
Managed Long-Term Care (MLTC)	Started as voluntary enrollment in the New York City region; mandatory enrollment was implemented starting November 2012 MLTC members will soon be transitioned to FIDA plans, which will cover the Medicaid LTC benefits as well as Medicare benefits
Fully Integrated Duals Advantage (FIDA)[3]	According to the recently released memorandum of understanding (MOU) between New York and CMS, the Medicaid portion of the capitation rates will be based on a limited number of rating categories to ensure that plans are financially incentivized to keep as many members as clinically appropriate in less expensive community settings instead of institutional settings Goals of less expense and higher member satisfaction Requirement that FIDAs develop alternative to fee-for-service payment methodologies Future FIDA program for DD members
Medicaid Managed Care	Trend toward covering all benefits under one umbrella - Pharmacy benefits were carved in starting October 2011 - Behavioral health benefits are expected to be carved in starting January 2015

EVOLUTION OF OTHER NEW YORK MEDICAID PROGRAMS

Many lessons can be learned from the evolution of other New York Medicaid programs, and it is possible that the state will follow similar approaches for the DISCOs.

CRITICAL FACTORS FOR FINANCIAL VIABILITY

DISCOs will need to assess the financial risk of the program based on the state's final RFA, the covered benefits, and the capitation or payment structure. DD provider organizations that contract with DISCOs must be equally diligent in assessing this risk. The following are some key elements that all risk-bearing entities will need to consider.

ASSESSING THE MEMBER DEMOGRAPHICS AND COSTS

DISCOs will need to consider the following important questions:

- What population (key characteristics) does the DISCO's provider community currently serve?
- Who is likely to enroll in the DISCO based on the plan's provider community and the benefits available through the DISCO?
- Under voluntary enrollment, what is the motivation of individuals to enroll in a DISCO?
  - Are there currently waiting lists for certain services or residential options?
  - Will the "alternative benefits" available under the DISCO attract particular individuals?
- What are the gaps in the DISCO provider network? Will a large number of certain services be provided outside the core provider organizations? How does that impact the cost of services and coordination of services?
- Will the access to new benefits for the DD population, primarily the MLTC benefits, be an additional cost to the DISCO? Or will these benefits replace more costly services that are provided under the current framework?

FINANCIAL MODELING

Perhaps the most systematic approach to assessing risk is developing detailed financial projections. These financial projections will likely be required as part of the state's RFA and application process. In addition to a best-estimate scenario, a good financial model will allow for sensitivity testing of key variables. This can indicate how widely the gain or loss will vary as certain assumptions are changed and can predict how much capital will be required under each scenario. Based on our analysis of the state's databook, we believe some of the key variables that should be considered are the number of members enrolling, the proportion of residential and non-residential members, the demand for new or alternative benefits, and administrative and care coordination costs.

Another modeling tool that will be critical for DISCOs to measure performance will be detailed utilization and PMPM cost targets. DISCOs will need to monitor actual performance against these budgets and make adjustments as needed to minimize losses.

3 A FIDA plan is an integrated Medicare-Medicaid managed care plan for dual eligible beneficiaries requiring long-term care services. The program is scheduled to begin on July 1, 2014.

REFORMING PROVIDER PAYMENT SYSTEMS

One of the key factors that will determine the success or failure of the DISCO demonstration will be the ability of DISCOs to transform the current fee-for-service system to a payment system that pays providers based on performance and quality. Under FFS, providers are rewarded for providing more services, and it is generally accepted in the healthcare community that these payment systems neither control costs nor promote quality outcomes.

The DISCO program revenue will likely be based on the government's current FFS costs and will likely not support the full cost of a plan's administrative and care management functions if the overall cost of benefits is not reduced. DISCOs will need to establish contracts that incentivize their providers to transition DD members to less restrictive settings, while scoring high in member satisfaction and delivering services within a target budget. DISCOs will need to borrow payment mechanisms from the acute healthcare community, such as bundled payments, risk-sharing arrangements, global budgets, and other incentive programs, and apply these concepts to DD services.

DESIGNING THE BENEFIT PACKAGE

In order to transform the current system, which is heavily dependent on residential services, DISCOs will need to design a benefit package that supports the transition of residential members to less restrictive settings. The benefit package will need to be flexible enough to meet each individual's unique needs by allowing for alternative benefits such as long-term care benefits and assistance with expenses that are not reimbursed today. New benefits, however, must be viewed as alternatives to existing benefits, and DISCOs will need to develop a system for authorizing and establishing budgets for these services.

SUMMARY

New York has the very big challenge of transitioning DD beneficiaries out of institutions and improving the coordination of services provided by a multitude of agencies, while controlling costs and improving quality. In order to accomplish these goals, the state needs to transform the DD service delivery system and payment methodology. DISCOs will be at the center of this transformation and will be asked to take on considerable financial risk. Therefore, plans will need to carefully assess all potential risks and develop budgets to monitor performance.

DD providers that partner with managed care organizations to form a DISCO will be equally challenged. The DISCO will likely seek to share financial risk with the providers in the form of capitation payments or other risk-sharing arrangements. The successful provider organization must view itself as a risk-bearing entity and perform the same financial analyses that we have described in this paper.

QUALIFICATION STATEMENT

Melissa Fredericks, Rob Parke, and Jane Suh are employed by Milliman. Melissa Fredericks and Rob Parke are members of the American Academy of Actuaries and meet the qualification standards to render the actuarial opinions contained in this report.

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