Training Wheels Are Off: New York’s Transition to Managed Care for Individuals with I/DD

HCBS Conference
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Today’s Presenters

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Disclaimers

The information provided in this presentation is only intended for NY IDD CCO HHs benchmarking and overall systems improvement purposes. It is not intended for use in clinical decision-making and the findings have not been independently validated. It was generated during the program’s regulatory start up period with policy, technical, and training considerations during implementation. Where noted, data has been self-reported and captured by care managers.
• Overview of Medicaid Redesign in NY
  To achieve more integrated, holistic, and flexible service planning, communication, and monitoring

• Introduction to Advance Care Alliance NY
  Care Coordination Organization / Health Home for Individuals with Intellectual and Developmental Disabilities

• Introduction MediSked
  Health IT Vendor / Partner

• Results from Year 1
• Lessons Learned
• The Road Ahead
New York Medicaid Redesign - IDD Transformation

**Phase 0:**
The first FIDA-IDD care management program in the US is formed

**Phase I:**
I/DD targeted HCBS and I/DD populations are transitioned to Care Coordination Organization Care Management

**Phase II:**
Voluntary enrollment in I/DD specialized managed care plans with I/DD benefit

**Phase III:**
Mandatory enrollment into managed care plans
Waiver Transition and Managed Care Timeline (New York)

Current Phase: Transition to Care Coordination Organizations / Health Homes

- October 6, 2017 - Health Home Application to Serve Individuals with I/DD
- November 30, 2017 - Due Date to Submit Health Home Applications
- December 2017 - February, June 2018 - Health Home Readiness and Approvals
- July 2018 - Health Home Go-Live

Next Phase: Transition to Managed Care

- Office for People with Developmental Disabilities (OPWDD) Managed Care Requirements/Standards (Part I) for Comment (DRAFT)
- Application Submission from Plans Due to NYS
- Onsite Readiness Reviews Begin
- State Announces Approved Specialized I/DD Plans
- I/DD Specialized Managed Care Plans (SIPs-PL) Voluntary Enrollment
- Expansion to Mandatory Enrollment Begins (Downstate then Upstate)
What is People First Care Coordination?

A connected group of health care and service providers for developmental disabilities working together – for individuals and families

- Care Coordination Organizations (CCOs) are new organizations designed by providers with I/DD experience to:
  - Create a more holistic, comprehensive, and person-centered level of service
  - Coordinate services across multiple systems, primary care, behavioral health, and community-based services
  - Develop and manage specialized Person-Centered Life Plans, with the individual and family, based on his/her needs
  - Increase accountability for a person’s well-being by driving valued outcomes
Requirements for CCO/HHs

1. Person-Centered Comprehensive Assessment
2. Integrated CQL Personal Outcome Measures (POMs)
3. Integrated Health and Safety Supports, Individual Protective Oversight Plans (IPOP)
4. OPWDD Integration including Care Coordination Data Dictionary Compliance
5. Use of Electronic Life Plan
6. Electronic Care Coordination System with Communications Among Circle of Supports
7. Meets I/DD Health Home Requirements
8. Data Exchange with Regional Health Information Organizations (RHIOs)
Goals and Core Services of the CCOs

1. Enhance person-centered planning and focus on outcomes
2. Create a foundation of person-centered planning for specialized DD managed care
3. Eliminate conflict of interest
4. Incorporate a person's services in a single Life Plan overseen by a care manager
5. Incentivize performance
6. Keep the same level of family involvement as before
7. Develop/train Medicaid Service Coordinators (MSCs) as Care Managers

Source: [https://opwdd.ny.gov/sites/default/files/documents/MSCInformationalSession1_121317_0.pdf](https://opwdd.ny.gov/sites/default/files/documents/MSCInformationalSession1_121317_0.pdf)
Advanced Care Alliance

- **CCO/HH** that supports 25,000 people with I/DD and their families across New York City, Long Island, and the Lower Hudson Valley

- As the only not-for-profit CCO in New York, ACA is a mission-centered organization dedicated to providing the **support and services** people need to lead an active, healthy, and fulfilling life

- ACA's agencies provide high-quality services to people with I/DD and their families, funded and overseen by NY OPWDD
ACA’s Core Values

**ACA's core values** are grounded in an approach that fosters and encourages:

- Choice and Empowerment
- Active Family Engagement/Circle of Support
- Individualized Supports in a Home of Your Choice
- Access to Successful Employment Opportunities
- Community Involvement and Meaningful Relationships
- A Healthy Lifestyle with Supports to Ensure Personal Safety
MediSked is the leading brand in holistic solutions that improve lives, drive efficiencies, and generate innovations for human service organizations that support our community.
IT Requirements and NIST 800-53 Controls

• PHI contained in the CCO environment is classified as Medicaid Confidential Data (MCD)
  • Requires NYS Moderate-Plus System Security Plan (SSP) controls
• SSP includes 402 security controls across 18 domains


## IT Requirements and NIST 800-53 Controls

### Security Intelligence & Analytics

**Infrastructure**
- Next Generation Firewalls – Cisco ASA, Palo Alto, Unifi
- Anti-Malware - ProofPoint Email Gateway and Trend Deep Security
- Intrusion Detection & Prevention - Palo Alto / AWS WAF / Trend Deep Security
- Network Advanced Threat Protection - AWS WAF, Palo Alto,
- Web Application Firewalls – AWS & Palo Alto Application Risk Rating Analysis

**Applications**
- Phishing Tests – Auto-generation phishing message and training
- Security Awareness Training – ADP & Restricted Intelligence Videos
- Intranet – Information Security Website with Policies, Procedures, Awareness
- Security Risk Management Services – CORL, JIRA, SharePoint
- Advanced Threat Protection – Microsoft Defender ATP & Trend Deep Security

**Data Loss Protection**
- Full Disk Encryption for Workstations - BitLocker
- Mobile Device Management – Microsoft Intune MDM Platform
- Security Information Event Management w/real-time monitor/alert
- Secure Remote Access – Multi-Factor / 2FA Authentication / Centrify
- Security Vulnerability Assessment Solutions – Qualys and AWS Inspector

### Advanced Threat & Security Research
Trends in MLTSS for I/DD across the US

- 7 states with statewide MLTSS for I/DD
  1. Arizona
  2. Michigan
  3. Wisconsin
  4. North Carolina
  5. Kansas
  6. Iowa
  7. Tennessee

- 3 states in transition to MLTSS
  1. Arkansas
  2. New York
  3. Texas
THE TECHNOLOGY SOLUTION
MediSked Coordinate – Care Management Platform

MediSked Coordinate is the platform dedicated to the daily activities of Care Management and is used daily by Care Managers, along with other CCO/HH employees

Activities include:

• Individual Record Management
• Plan Development
• Event/Contact Logging
• Information Sharing
• Reporting
• Task Workflows
• Note Audit
• Billing
MediSked Coordinate - Life Plan Development

- Medicaid Service Coordination Moved to CCO on 7/1/2018
  - Basic HCBS Care Management
  - HH Comprehensive Care Management

- The provider continues to develop habilitation plan and provide summaries to CCO
  - CCOs create, edit, and review current or past Life Plans and associated service delivery information, including:
    - Personal outcome measures (POMs)
    - Individualized plans of protective care
    - Needed supports and services
    - Plan progress toward goals and valued outcomes
  - Integrated with IAM assessment to dynamically populate Life Plan
  - CCOs document, edit, and review plan meetings, attendance, and minutes
  - CCOs share draft and completed Life Plans with the individual and members of his or her IDT using the MediSked Person-Centered Portal
IAM Assessment

- Determines services to meet people’s hopes and dreams as well as traditional health and safety requirements
- Provides a list of specific goals and actions for natural supports and service providers to follow
- Integrates the Council for Quality and Leadership’s Personal Outcome Measures (CQL POMs)
- Gathers important information into standard printouts
- Provides a list of preferences and supportive routines for individuals with more significant challenges
- Represents the powerful voice of the person with I/DD
Comprehensive IAM Assessments Populate Life Plan

Assessment dynamically populates care management platform to assist Care Manager in:
- Scheduling and facilitating planning meetings
- Life Plan approval process
- Sharing information with service provider agencies
Person-Centered Portal

- Web-based tool that allows people, providers, and any family member a person chooses to get a clear, complete view of life and records to track plans, services, and even message directly with the Care Manager
- List view shares individuals that are associated with that provider/member agency
- Family members/natural supports/other service providers may be granted access
- Securely view and share information (messages, forms, charts, plans) depending on the level of access
MediSked Connect Exchange

A multi-agency business intelligence platform being leveraged to expand the breadth of available data and supercharge traditional care coordination tools and workflows in New York and beyond.

• Enables real-time population management and enterprise reporting for CCO/HH across their membership

• Includes powerful reporting tools and a custom report builder to allow CCO/HH entities to view trends and outcomes across the state
NY IDD CCO HH Quality Measures

- Inpatient stays
- Emergency room visits
- Disease-Related Care for Chronic Conditions
- Preventive Care
- Transitional Care
- CQL POMs (3 Personal Goals, 2 POMs)
- Implementation of Personal Safeguards (IPOP)
- Transitioning to a More Integrated Setting
- Employment
- Self Direction
- Bladder and Bowel Continence
- Falls
- Choking
- Supporting Individuals’ Transition from Institutional Settings to Community Settings
DATA FINDINGS
Emergency Room (ER/ED) Visits

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Visits</td>
<td>Number of people enrolled that were at the Emergency Room 1, 2, 3, or 4 or more times in the last 12 months</td>
</tr>
</tbody>
</table>

Most enrollees have not been hospitalized in the past 12 months

- 19.7% were admitted to the ED in the last year, but of those 61.2% only had to do so once
Top Reasons for ER/ED Visits

Psychiatric/behavioral episode
Illness
Fracture

Source: NY IDD CCO HH – results have not been formally validated
Tops Reasons for ER/ED Visits

Top Reasons for ER Visits - General Population

1. Stomach and abdominal pain, cramps, spasms
2. Chest pain
3. Fever
4. Cough
5. Headache


Top Reasons for ER Visits - ACA

1. Illness
2. Psychiatric/Behavioral Episode
3. Fracture
4. Seizure
5. Fall

Source: NY IDD CCO HH – results have not been formally validated

Self-reported
Data Powered by
Hospitalizations

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations</td>
<td>Number of people enrolled that stayed overnight in the hospital in the last 12 months</td>
</tr>
</tbody>
</table>

Most enrollees have not been hospitalized in the past 12 months
- 11.4% have been hospitalized at least once
Top Reasons for Hospitalizations

Self-reported Data Powered by
# Top Reasons for Hospitalizations

<table>
<thead>
<tr>
<th>Top Reasons for Hospitalizations</th>
<th>General Population</th>
<th>Top Reasons for Hospitalizations</th>
<th>ACA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Liveborn</td>
<td></td>
<td>1. Illness</td>
<td></td>
</tr>
<tr>
<td>2. Septicemia</td>
<td></td>
<td>2. Psychiatric/Behavioral Episode</td>
<td></td>
</tr>
<tr>
<td>3. Osteoarthritis</td>
<td></td>
<td>3. Fracture</td>
<td></td>
</tr>
<tr>
<td>4. Congestive Heart Failure</td>
<td></td>
<td>4. Surgery</td>
<td></td>
</tr>
<tr>
<td>5. Pneumonia</td>
<td></td>
<td>5. Seizure</td>
<td></td>
</tr>
</tbody>
</table>

Source: AHRQ, Healthcare Cost and Utilization Project
https://www.hcup-us.ahrq.gov/faststats/NationalDiagnosesServletvisits,

Source: NY IDD CCO HH – results have not been formally validated

Self-reported Data Powered by
Choke Risk Analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choke Risk</td>
<td>Number of people at risk for choking</td>
</tr>
</tbody>
</table>

Choke risk = 13.5%

Once identified as choke risk, Life Plans are updated to include safeguards (modified consistency of foods, additional supervision, etc.)
Work or Day Situation

Type of Work for Tier 1-4 Enrollees at ACA

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
<th>Self-reported Data Powered by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Work or Day Situation</td>
<td>Number of people in each work/day category</td>
<td></td>
</tr>
</tbody>
</table>
Desire to Change Work or Day Status

Tier 1-4 Enrollees Who Want to Change Their Work or Day Situation at ACA

17.9% of people indicate a desire to change their work status for different reasons including:
• Desire for a real job
• Want to earn more money
• Want to explore available options
• Want to participate in integrated employment or volunteering

Self-reported Data Powered by
Living Situation Satisfaction

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Situation</td>
<td>Number of people who like/dislike where they live</td>
</tr>
</tbody>
</table>

14.2% indicated they would want to improve their living situation

• ACA identified 12 individuals that:
  • Live in a supervised group home setting
  • Have indicated they want to change their living situation
  • Can reportedly be left alone for 4+ hours

• Although this is a small number of individuals, the cost of residential services for these 12 people is approximately $1.8M/year
Exercise Assistance

Assistance Desired by Tier 1-4 Enrollees with Exercise at ACA

<table>
<thead>
<tr>
<th>Desired Assistance with Exercise</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisting me if I decide to go to a gym or exercise program</td>
<td>Number of people who may or may not require assistance with exercise</td>
</tr>
<tr>
<td>Assisting me in doing ___ minutes of exercise at home or my treadmill or other equipment (Specify daily, weekly, etc.)</td>
<td></td>
</tr>
<tr>
<td>Doing all you can to allow me to be sedentary</td>
<td></td>
</tr>
<tr>
<td>Encouraging me to go for walks and engage in active recreational activities</td>
<td></td>
</tr>
<tr>
<td>Giving me the opportunity to independently go to a gym (YMCA, Curves, etc.) when I wish</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

Self-reported Data Powered by
BMI by Living Situation

Counts by BMI for Tier 1-4 Enrollees at ACA

- **Living Independently**
  - Obese: 2.8%
  - Overweight: 25.4%
  - Normal: 41.2%
  - Underweight: 30.5%

- **Living with Others in a Community Setting**
  - Obese: 13.7%
  - Overweight: 24.7%
  - Normal: 27.5%
  - Underweight: 34.1%

- **Group Residences**
  - Obese: 3.7%
  - Overweight: 31.2%
  - Normal: 34.7%
  - Underweight: 30.8%
CQL Personal Outcome Measures

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People are treated fairly
6. People exercise rights
7. People are respected
8. People use their environments
9. People live in integrated environments
10. People interact with other members of the community

Source: https://c-q-l.org/the-cql-difference/personal-outcome-measures

11. People participate in the life of the community
12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles
17. People choose where and with whom they live
18. People choose where they work
19. People choose their services
20. People choose personal goals
21. People realize personal goals
CQL Personal Outcome Measures (cont.)

Count of Tier 1-4 Enrollees with each POM at ACA

- People perform different social roles: 281
- People live in integrated environments: 379
- People experience continuity and security: 255
- People exercise rights: 266
- People decide when to share personal information: 26
- People choose where and with whom they live: 194
- People are treated fairly: 143
- People are respected: 355
- People are free from abuse and neglect: 81
- People are connected to natural supports: 289

ACA Scale Range:

0 - 400
LESSONS
LEARNED
Lessons Learned

Looking back on the first year, we know that most of the turbulence is behind us and that with teamwork and perseverance the obstacles can be overcome, and the envisioned transformation can be achieved.

- Things may take more time than expected
- The individuals we support come first – everything else comes second
- The state has been flexible
  - Portal, security controls, and consent controls require more time to codify
  - The state has given flexibility on roll-out dates and has been very supportive in the planning and consideration process
Lessons Learned: Policy

• Include all stakeholders (individuals, families, providers, care coordinators, payors) in planning and communication

• Keep an active forum for dialogue and partner with the state agencies regulating policies

• Circumstances will come up that are not explicitly predetermined in existing regulations that need to be worked out together

• Ongoing guidance and clarification is necessary to ease the transition
Stakeholders

CCOs
- Individuals & Circles of Support
  - Change management is ongoing and adds time to this process
- Oversight: DOH & OPWDD
- Providers
  - No interruption to billing
  - Concern over compliance
  - Adapting to new ways of doing things
  - It's not just care management and CCOs
    - For example, providers not accepting plans

NY has over 700 well-established HCBS waiver providers with a strong history of supporting individuals and circles of support.
Lessons Learned: Technology

• Security Requirements
• Internet Connectivity
• Pilot to help with learning and fine tuning the end solution
• Have a troubleshooting team on standby
• Be prepared for disruption and a learning curve to get to the ‘new norm’
• Allow adequate time for testing
• Communicate frequently, but also target communication for needed information to the right people
• Cultural Competencies
• Having a vendor that is a subject matter expert on core program functions
Lessons Learned: Training

• Change management needs to be an active and ongoing undertaking
• Be flexible during times of change and keep an eye towards getting to the future goal
• Be prepared for disruption and a learning curve to get to the ‘new norm’
• Provide educational resources for individuals, care management staff, provider staff, and families
ACA Staff Onboarding and Training

1. Values, Person Centeredness & Communication
   - Building Relationships and Establishing
   - Communication within Care Coordination Team & Among Providers

2. Promoting Community Orientation
3. Cultural Competency
4. Knowledge of Developmental Disabilities, Chronic Disease & Social Determinants of Health
5. Knowledge of Community Supports and Services, New Models of Care, and Healthcare Trends
6. Understanding Ethics & Professional Boundaries
7. Promoting Quality Improvement
8. Understanding Health Information Technology
9. Proficiency in Documentation & Confidentiality

**ANNUAL**
- PRAISE
- Tuberculosis
- Fire Safety
- Personal Allowance, training presented by OPWDD
- Benefits & Entitlement, training presented by OPWDD
  - Medicaid
  - Medicare
  - Social Security
  - Supplemental Security Income

**ONCE**
- Foundations of OPWDD
- Prevention of Choking and Aspiration

**AS NEEDED**
- Overview of Services for Willowbrook Class Members, training presented by OPWDD

**EVERY 3 YEARS OR WITH REGULATORY CHANGES**
- Supplemental Nutrition Assistance Program - SNAP, training presented by OPWDD
- Liability For Services Trainings, training presented by OPWDD
The Road Ahead
The Road Ahead

Strategies ACA is looking towards in the next quarters:

• Utilize RHIO alerts to improve linkages to Primary Care Physicians
• Use the data collected during the first year to establish a baseline upon which we can conduct CQI projects
• Access additional sources such as claims data to get to know our population even better and improve the quality of services
THANK YOU
QUESTIONS?

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