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Office for People With Developmental Disabilities

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Navigating the Transition to Managed Care for Individuals with Intellectual and Developmental Disabilities (I/DD)

August 30, 2018

HCBS Conference

Disclaimers

The New York Office for People with Developmental Disabilities and MediSked are not engaged in a contractual relationship. OPWDD is the entity driving the transformation in New York State and MediSked, LLC holds contracts with each of the seven CCO/HHs in New York

The opinions expressed in this presentation should not be construed as advice to care for specific individuals

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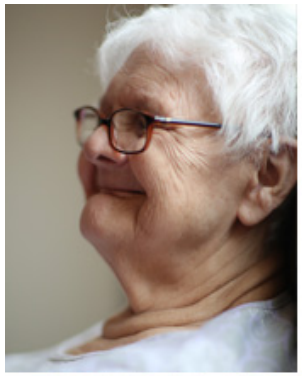
The Office for People With Developmental Disabilities' (OPWDD's) Commitment

- Ensure that people with developmental disabilities receive supports that are person-centered, flexible, easy to access and responsive to individual needs & preferences.
- Advance system to provide high-quality outcomes-based supports that include health and wellness; and prepare for transition to Managed Care.





MediSked Care Coordination Solutions

- Fully Integrated, Patent-Pending Assessment Application for Individuals with I/DD
- Powerful Care Management and Service Coordination Platform
- Person-Centered Portal for the Individual, Providers, and Interdisciplinary Team
- Population Health, Outcomes, and Compliance Reporting and Analytics
- Native OPWDD, SHIN-NY, and Third-Party System Integrations

The leading brand in holistic solutions that improves lives, drives efficiencies and generates innovations for human service organizations that support our community

MediSked Solutions Support:

- Individuals & their Circles of Support
- Provider Agencies
- State & Administrative Oversight
- Care Coordination Organizations

Out-of-the-box Solution include:

- 1115 Waiver Transformation in NY
- Meets all Health Home requirements
- MCO Readiness

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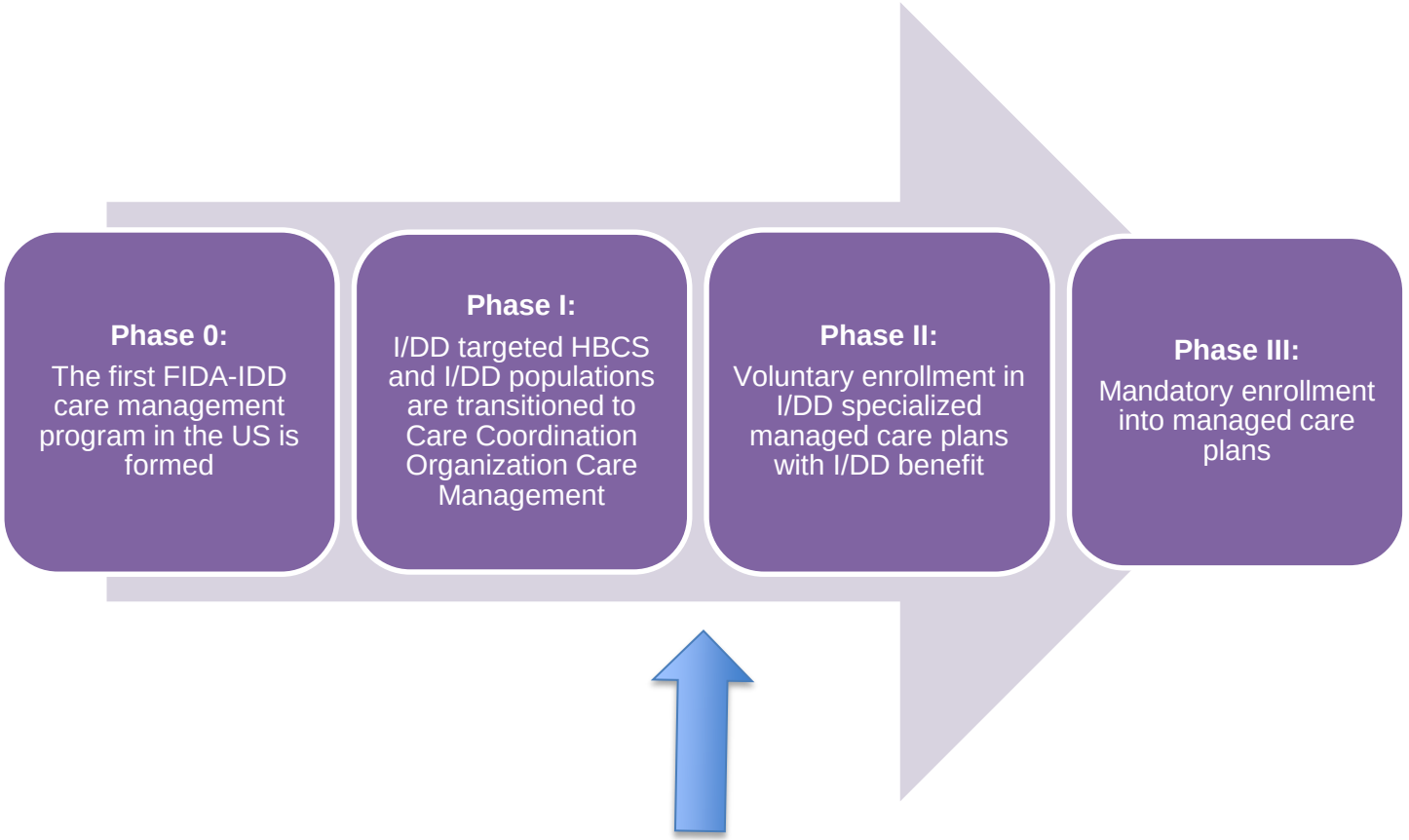
AGENDA

- Overview of NYS' transition plan to achieve more integrated, holistic, and flexible service planning;
- Attributes of the IT system adopted by CCO/HHs, and how elements can be used for planning, communication, and monitoring;
- Best practices and lessons learned from Phase One, including how to successfully introduce IT to care management and habilitation supports, both in New York and other states.

NYS IDD Transformation

2014



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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:
  - Coordinate services across multiple systems, primary care, behavioral health, 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

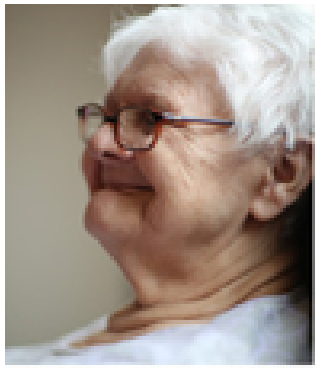
People First Care Coordination =

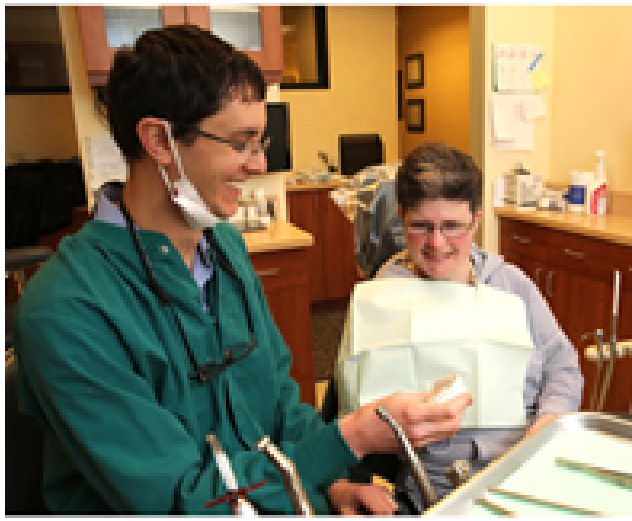
Care Coordination Organizations =

I/DD Health Homes

Follow model of the federal **Health Home** program, tailored for people with intellectual or developmental disabilities

Health Home: **Not a building --** a new organization, a connected team of health and human-services providers that coordinates care for Medicaid eligible people with chronic conditions.





The Goals of People First Care Coordination

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

CCOs are Required to Provide Six Core Services Through Health Home Care Management

How to Get There?

- Communicate early and often
- Listen to, and hear stakeholders
- Provide resources
- Build on the strengths of the current system
- Set forth in governing documents clear and detailed expectations
- Consider both the short and long term goals in the model design
- Commitment

Care Coordination Organization (CCO)/Health Home (HH) Implementation Timeline

August 2017	• **Public Comments** on Draft CCO Application received • 1115 Waiver Amendment posted for **public comment**
Summer 2017	• DRAFT State Plan Amendment shared with CMS to add I/DD diagnoses as a single qualifying diagnosis for Health Homes
October 2017	• Final Health Home application released
December 2017	• Designation applications due to OPWDD/DOH, including proposed Care Management Networks • 1115 Transition Plan is published for **public comment**
Dec. 2017– Feb. 2018	• Review and approval of Health Home Applications by the State; awarding of grants
Feb. – June 2018	• Completion of CCO/HH and network partner readiness review and activities
July 1, 2018	• Transition to I/DD Health Home Care Management

NYS I/DD Transformation Resources

- Background and Policy Information for Serving Individuals with Intellectual and/or Developmental Disabilities
- Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115 Waiver Transition
- State Plan Amendment
- FAQs
- Webinars
- CCO/HH Provider Manual

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm

CCO Education and Outreach

Fall/Winter 2017 & Spring 2018

- **Regional Forums**

Hosted across the state to educate individuals and families about CCOS and the care management services available

Began in December 2017 and Continue Today

- **Information Sessions**

In December 2017, OPWDD began offering webinars as part of ongoing efforts to support the transition

February & April 2018

- **CCO Summits**

Two, two day, summits held in February and April with the CCOs to discuss enrollment and readiness

Care Manager Toolkit Developed

- OPWDD, in collaboration with stakeholders, developed a “Toolkit” for MSCs to use as a resource as they educated individuals and families and assisted them as they transitioned to care management
- The toolkit consists of:
  - CCO Informational Brochure
  - Scripts for MSCs to engage and educate individuals and families
  - Example Individualized Information Letter that will go to individuals and families about transitioning to CCO
  - Documents for the individual’s selection of care management
  - Frequently Asked Questions
- Supplemental Resources:
  - FAQs and Step-by-Step Training Guide

CCO/HH Application Requirement Overview

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)

Electronic Person-Centered Life Plan

- Description of the person and demographic information
- Desired quality of life, health, and functional outcomes
- Safeguard description and supports needed to reduce the likelihood of harm
- Employment status;
- Services, including physical, behavioral health, and HCBS long term services and supports
- Behavioral support needs
- Physical health conditions and treatment information
- Emergency plan

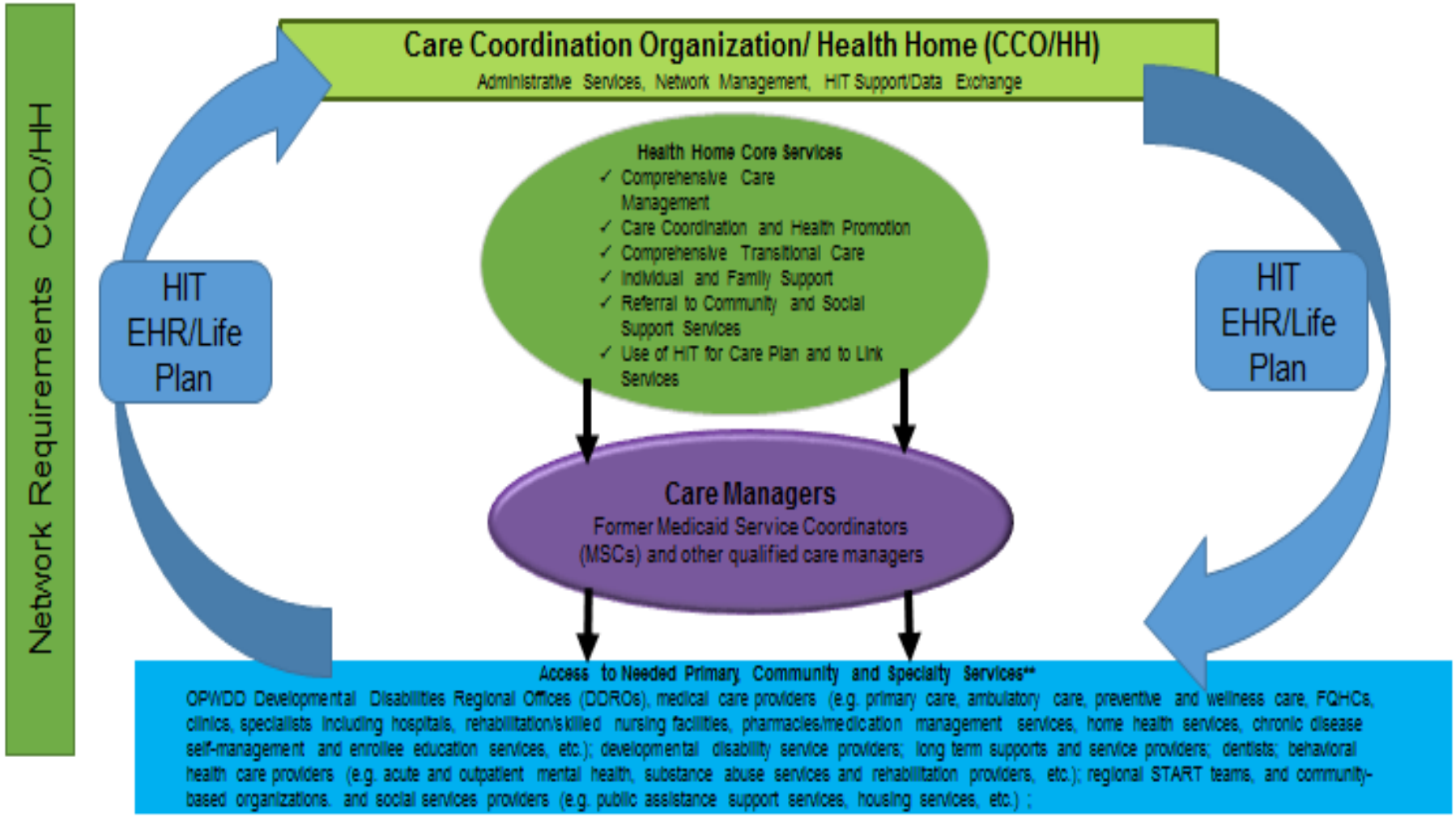
I/DD Tailored Quality Measures

Goal: Improve outcomes (health/personal/social) for individuals with I/DD through care coordination

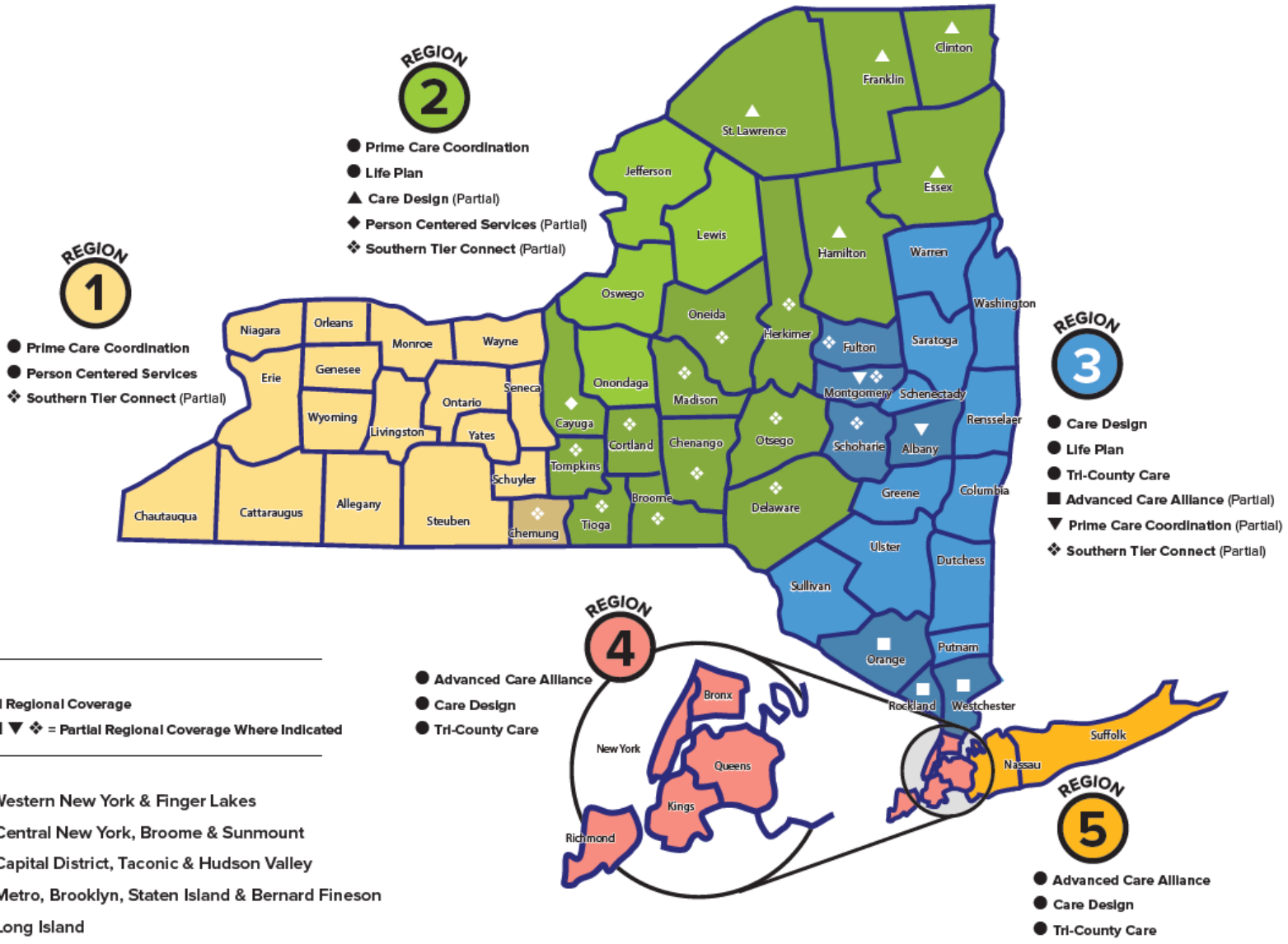
Measures	Data Source	Measure Description
Implementation of Council on Quality Leadership (CQL) Personal Outcome Measures (POMs)*	CCO Reporting	Percentage of Life Plans that have minimum of two POM measures. CCO must record in Life Plan Personal Outcome Measures(POM) drawn from CQL reporting guidelines. Life Plan must reflect at least three personal goals, of which two must be POM directed.
Implementation of personal safeguards	CCO Reporting	Percentage of Life Plans that reflect personal safeguards for all enrollees. CCO must record personal safeguards in Life Plan
Transitioning to a more integrated setting	Claims TABS	Of those enrollees who are in a 24-hour certified setting, the number/percentage of enrollees who move to a more integrated setting
Employment	CCO Reporting	Of those enrollees who indicate in their Life Plan they choose to pursue employment, the number/percentage of individuals who are employed (compared to the previous reporting period). CCO will record enrollee progress and verify support to find and maintain community integrated employment in Life Plan.
Self-direction	Claims	Of those enrollees who select self-direction as indicated in the Life Plan, the number/percentage of individuals who enroll in self- direction) compared to the previous reporting period). CCO will identify those who choose to self-direct their supports and services with either or both employer authority and budget authority in the Life Plan

Attachment C

New York State Health Home Model for Individuals with Intellectual and/or Developmental Disabilities



CCO Regional Coverage Map



Health IT Requirements

Highlighting the Information Technology Requirements

Each Care Coordination Organization Must:

- Adhere to all State & Federal legal, statutory & regulatory requirements
- Have structured information systems, policies and practices to electronically create, document, execute and update a Life Plan for every enrollee
- Have an electronic record system to allow each enrollee's information to be shared among the team of providers
- Use health technology and a health record system that's qualified under the national HITECH Act
- Commit to joining regional health information networks for data exchange & data sharing
- Support the use of evidence-based decision-making tools & consensus guidelines to achieve optimal outcomes

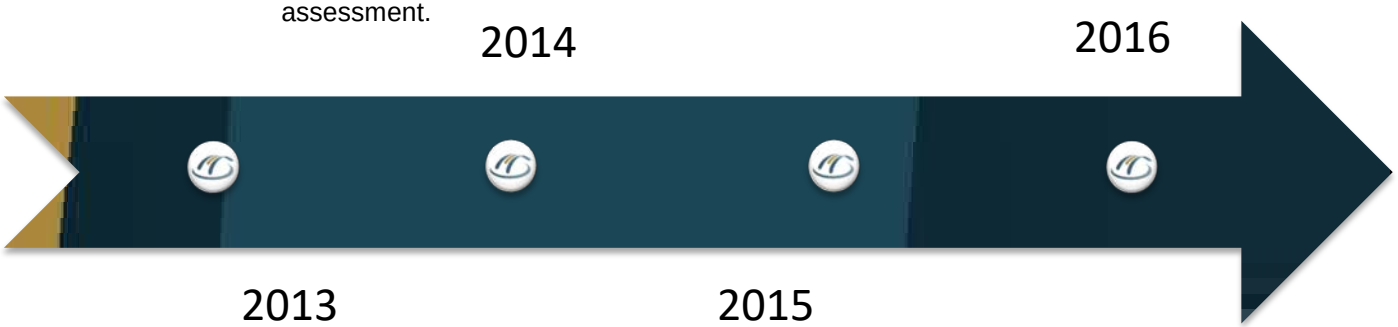
Preparing for NY Transformation

2014: OPWDD **Care Coordination Pilot** begins with MediSked, PHP, and five providers

- "It's All About Me Assessment" first OPWDD approved comprehensive assessment.

2014-2015: PHP Approved by CMS to as only FIDA-DD in the US. Model of Care receives score of 95% from CMS. MediSked systems used throughout.

2016: PHP began enrolling first ever OPWDD dual eligible members in Managed Care on 4/1/2016 through FIDA.



MediSked continues to host the Care Coordination platform for Partner's Health Plan's FIDA-IDD Care Complete Plan.

2012-2013: Partnership with PHP and five providers to design and implement care coordination data dictionary and model of care

- Comprehensive Assessment
- CQL Valued Outcomes/Health and Safety Supports
- Life Plan/ISP
- Hab Plan/Active Treatment Plan Goals, Supports, Tasks
- Observation Charts
- Monthly Summaries
- Notification of Change

2015: MediSked Care Coordination Stack **passes CMS/DOH/OPWDD review**

CMS | New York State Department of Health

2015: Coordinate Life Plan approved to replace ISP requirements

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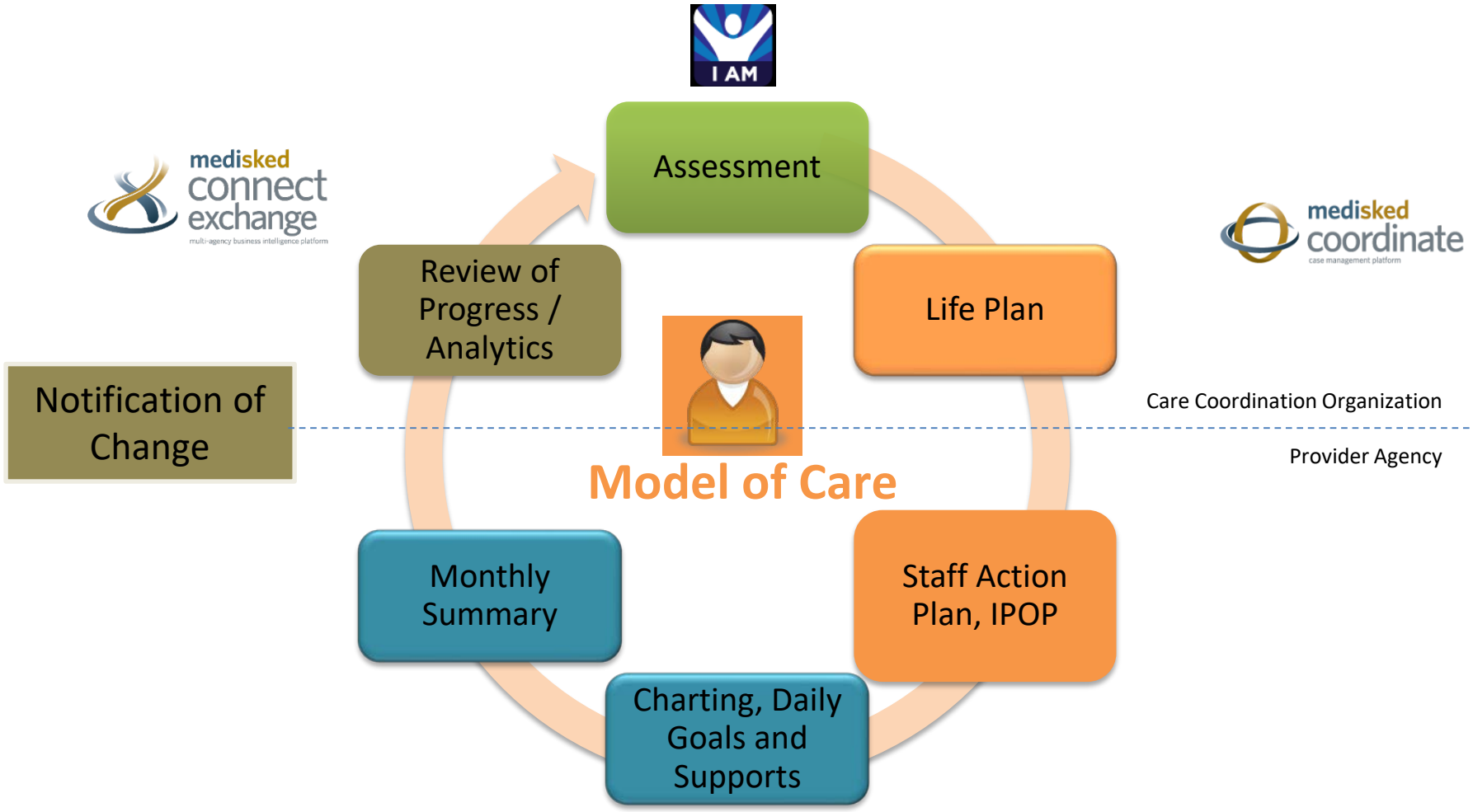
Partners Health Plan

CCO/ HH Health IT Implementation Milestones

Model of Care Using MediSked Software Stack



All Seven Regional Groups Use MediSked Care Coordination Suite for NY IDD CCO HH

https://www.businesswire.com/news/home/20180621005186/en/New-York-Intellectual-Developmental-Disability-Care-Coordination

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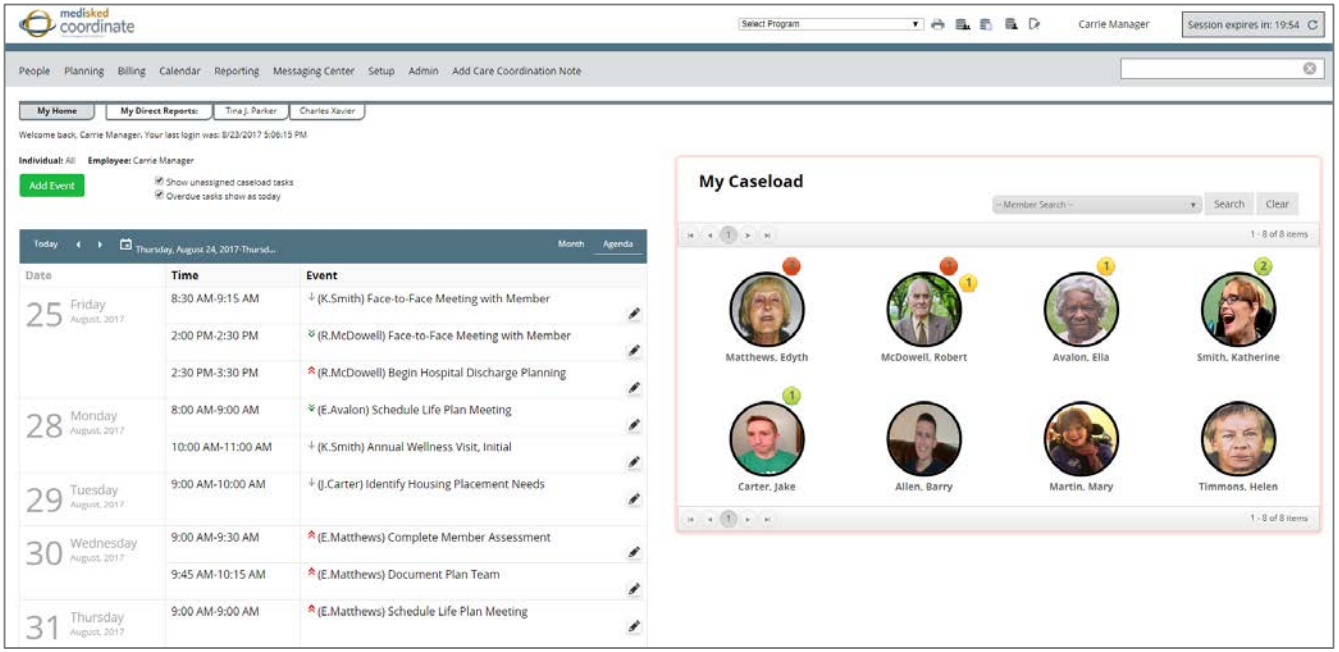
Comprehensive Care Management Tool

MediSked Coordinate – Care Management Platform

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

Activities include:

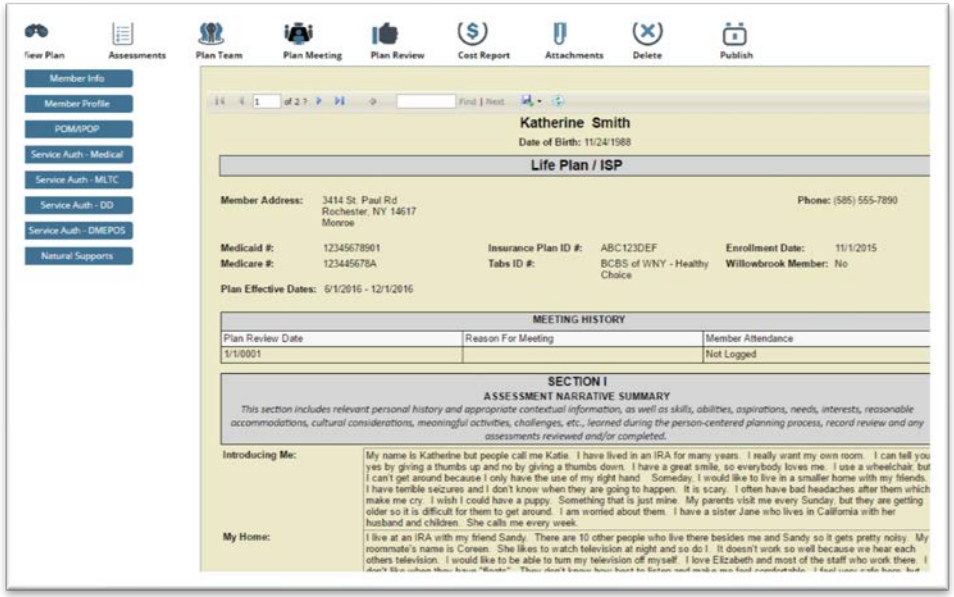
- Individual Record Management
- Plan Development
- Event/Contact Logging
- Information Sharing
- Reporting
- Task Workflows
- Note Audit
- Billing



medisked coordinate
care management platform

MediSked Coordinate – Life Plan Development

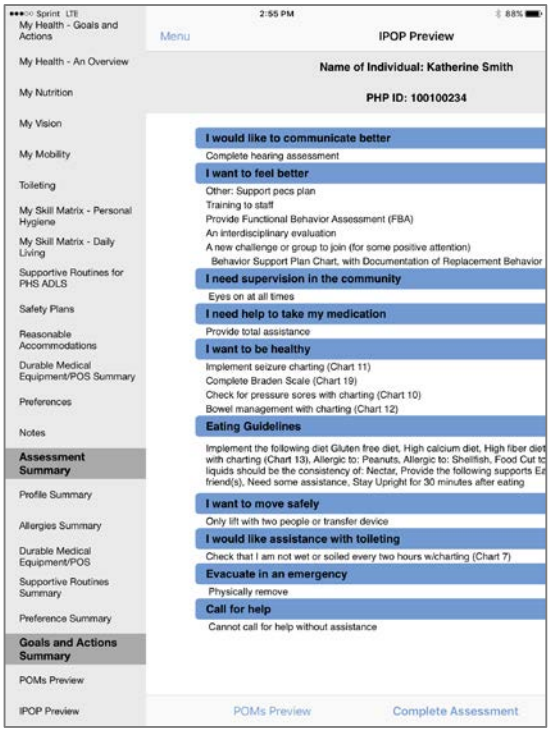
- CCOs create, edit and review current or past Life Plans and associated service delivery information, including:
  - Personal outcome measures (POMs)
  - Individualized plans of protective care
  - Needed supports and services
  - Plan progress toward goals and valued outcomes
- Integrated with IAM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

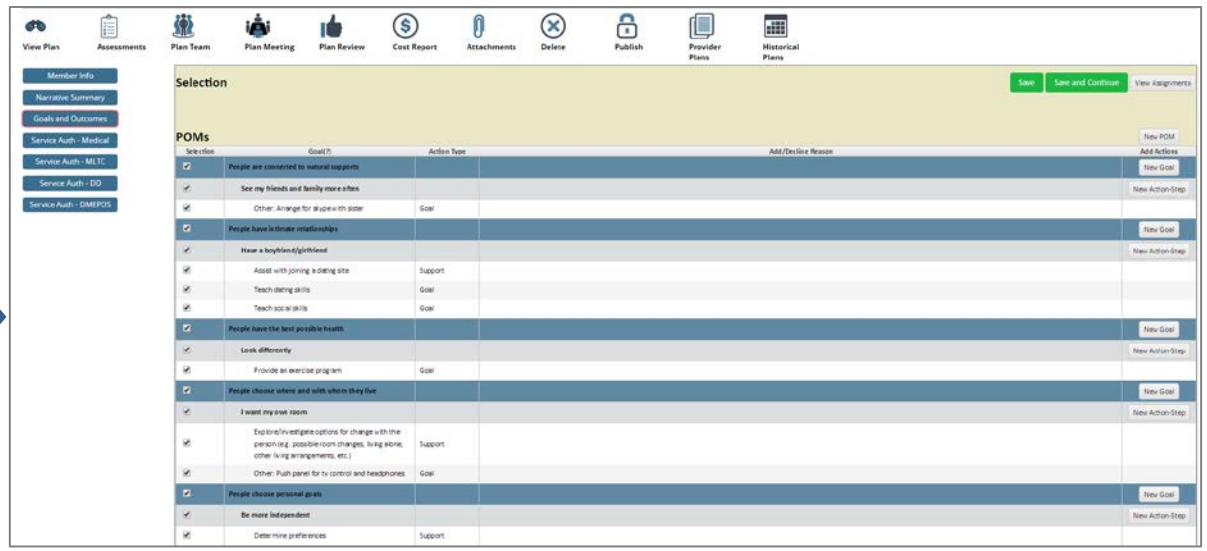


Assessment Development

- Crafted to ensure people are living richer lives
- Questions are written so that everyone can have their voice heard
- Experienced psychologists collaborated with individuals and their families to develop an extensive assessment
- Input from CQL, Self Advocacy Association (SAANYS), providers, and industry thought leaders

Comprehensive Assessments Populates Life Plan





Assessment dynamically populates care management platform to assist Care Manager in:

- Scheduling + facilitating planning meetings
- Life Plan approval process
- Sharing information with service provider agencies

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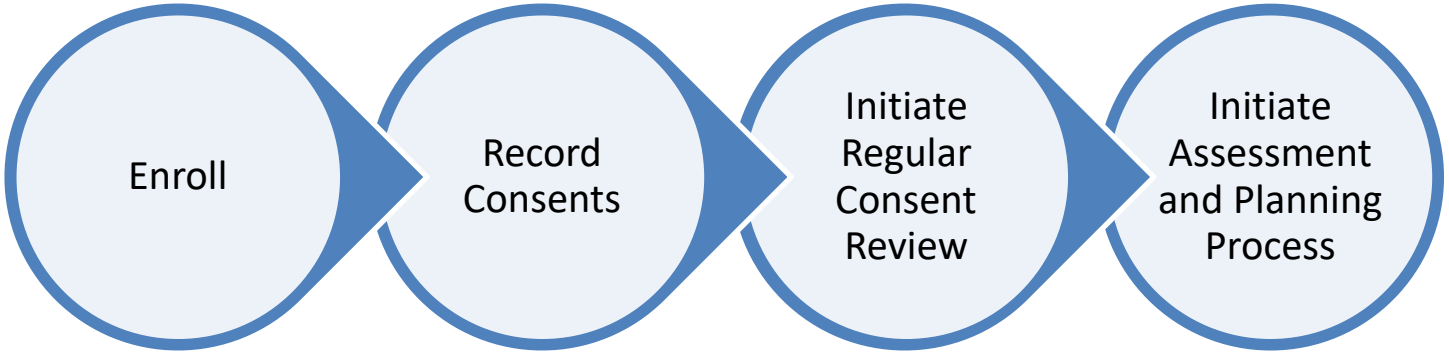
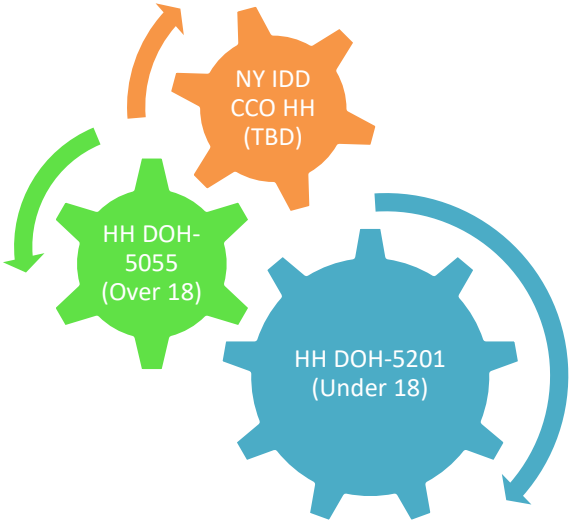
Consent

MediSked Coordinate drives timely collection and review of Member consent documentation through the use of structured workflows

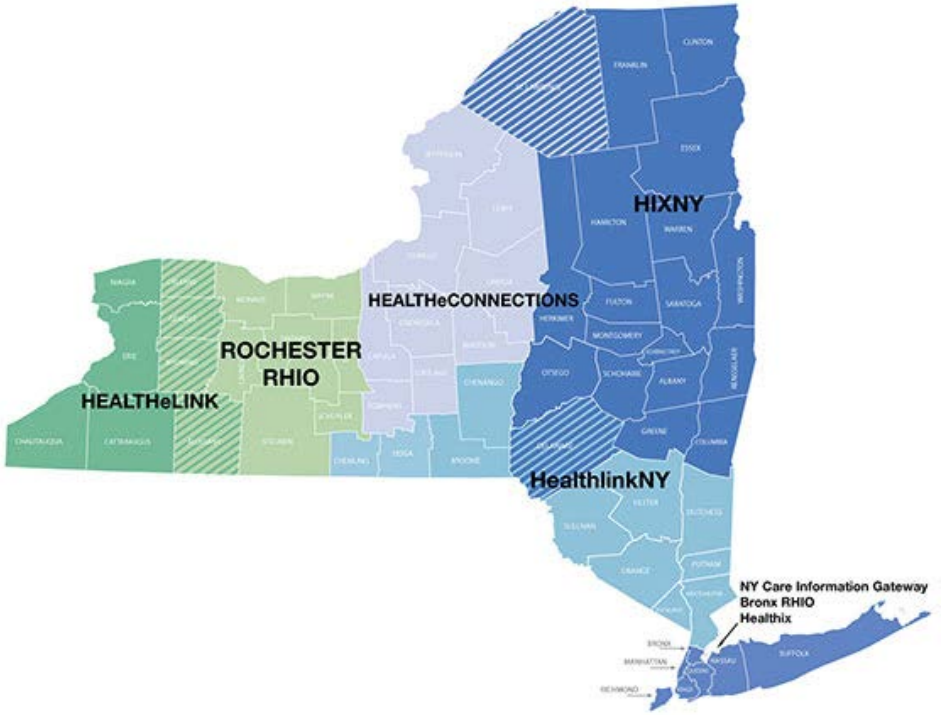




- Consent to Enroll
- Consent to Refer
- Consent to Share Information

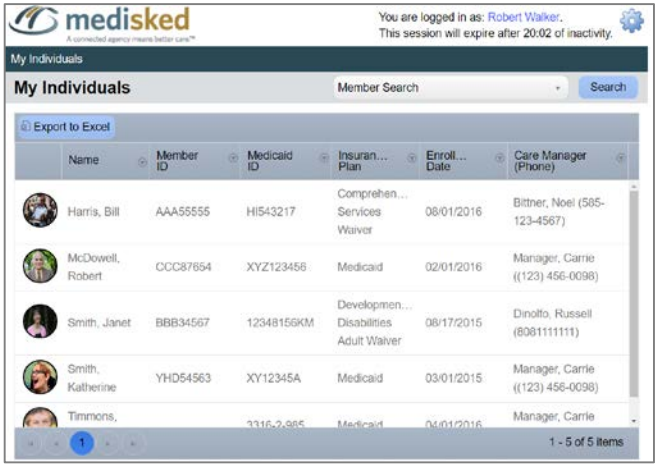
Regional Health Information Organization (RHIO) Overview

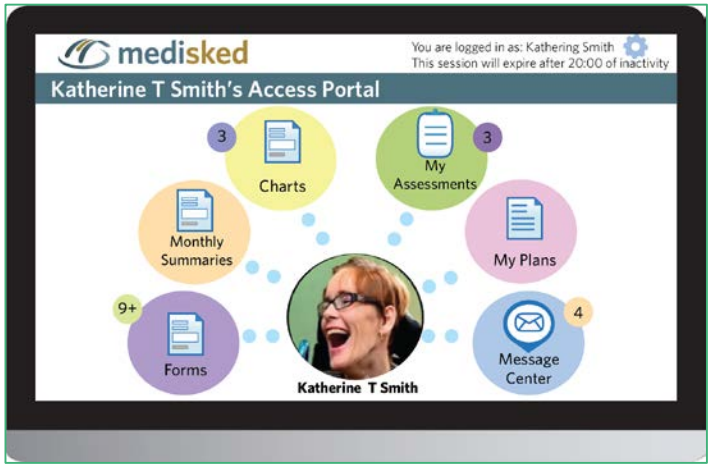
- Regional Health Information Organizations (RHIOs) bring together health care stakeholders within a defined geographic area and govern health information exchange among them
- New York is served by eight RHIOs across the state, all connected to SHIN-NY
- Traditionally, RHIOs have focused on aggregating traditional clinic health data



Individual and Family Access

MediSked Portal – *Person-Centered Platform*

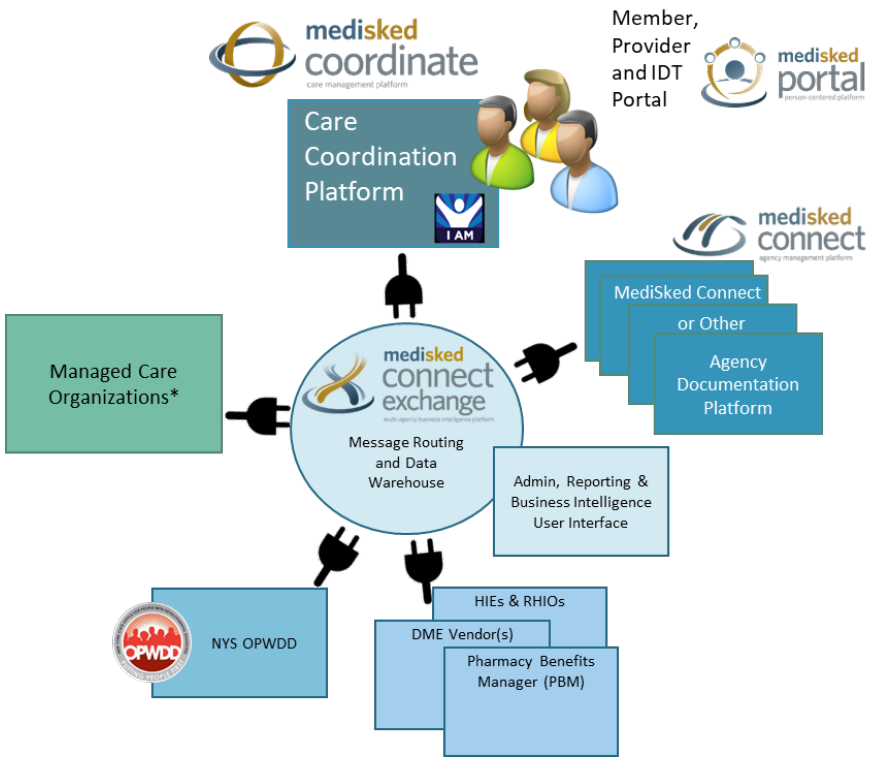




- The Portal is a web-based tool that allows people, providers and any family member a person chooses to get a clear, complete view of life and records to track plans, services, and even message directly with the Care Manager
- List view shares individuals that are associated with that provider/member 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

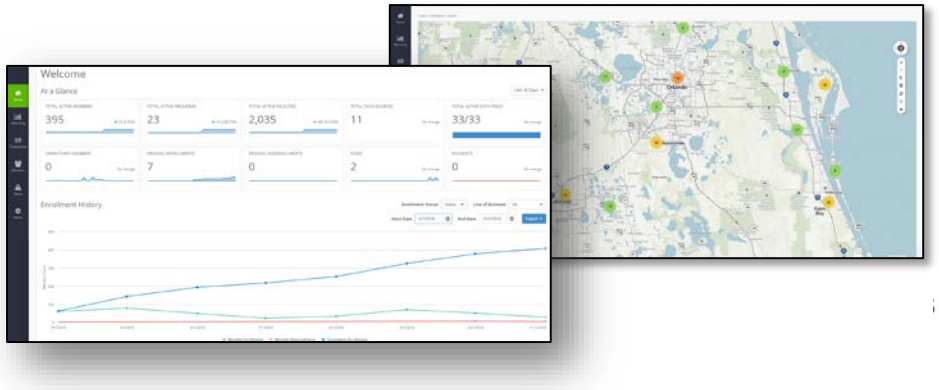
Population Data Collection and Business Intelligence Tool

MediSked Connect Exchange – Multi-Agency Business Intelligence Platform



A multi-agency business intelligence platform, MediSked Connect Exchange is being leveraged to expand the breadth of available data and supercharge traditional care coordination tools and workflows in New York

- Enables real-time population management and enterprise reporting for CCO/HH across the state
- Includes powerful reporting tools and a custom report builder to allow CCO/HH entities to view trends and outcomes across the state
- Comprises tools to perform quality oversight and performance management



NY IDD CCO HH Quality Measures

DD-focused quality measures were developed to track performance and help manage quality outcomes using stakeholder engagement

- 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

Core Responsibilities

- Ensure high quality care management services
- Monitor quality and performance
- Track and report key performance measures to CMS and stakeholders

Best Practices and Lessons Learned

Individuals Enrolled July 1, 2018

Total Enrolled: 99,287

96.77% of total population

Health Home Care Management:

97.04% of total enrolled

Basic HCBS Plan Support:

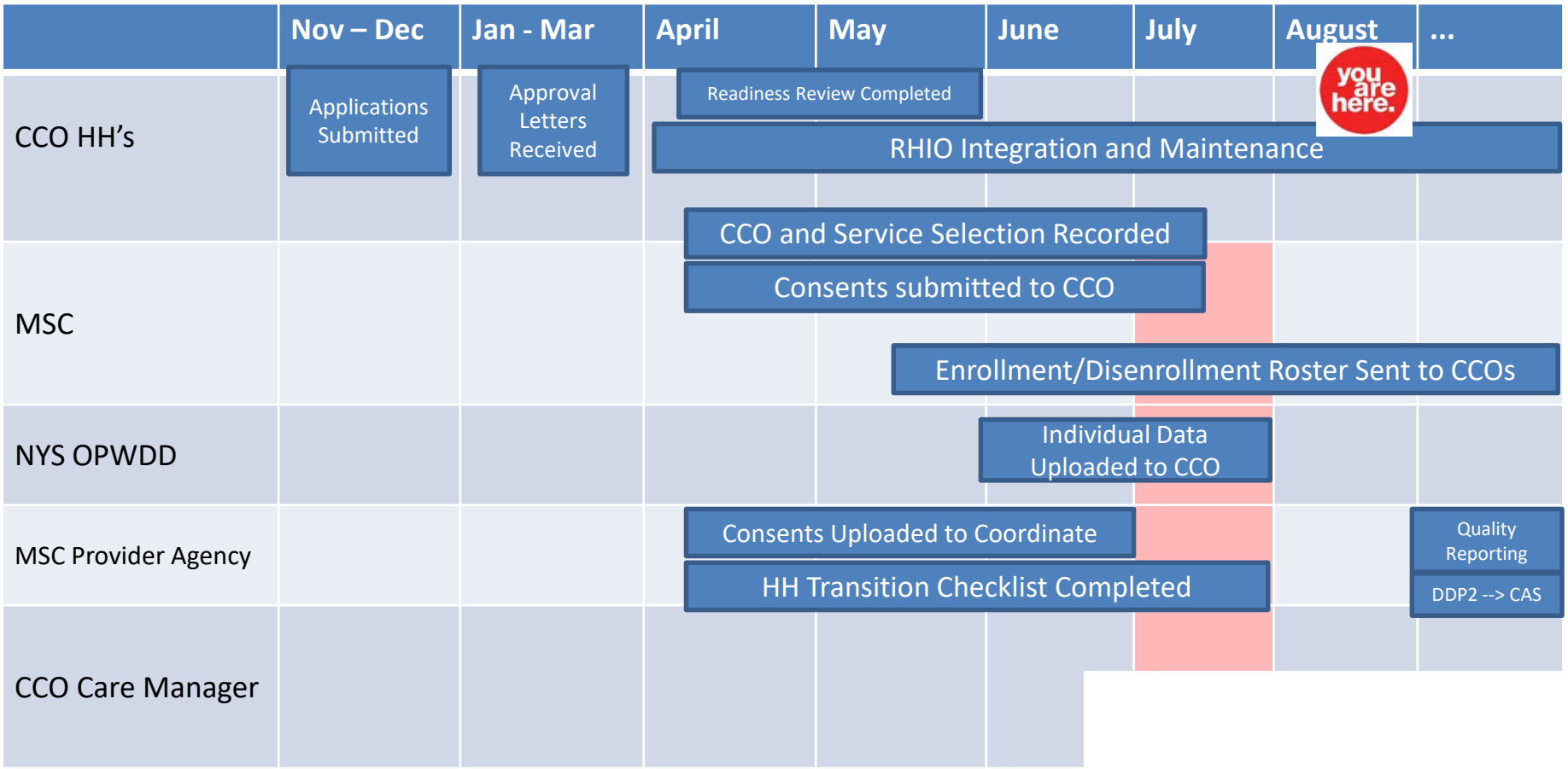
2.96% of total enrolled

Bringing it All Together

- To be successful, strong stakeholder collaboration is vital
- Ensuring the tenants of person-centered approach in implementing managed care
- Early investment and piloting helps achieve incremental change
- Choosing a vendor with the ability and flexibility to meet the requirements

NY IDD CCO/HH Timeline

The CCO enrollment process began in April and ran through July 2018. This process required coordination across the Individuals' existing MSCs, the MSC Provider Agencies, OPWDD and the CCOs.



How to Ensure a Quality Transition

- Be an active participant implementing in these changes
- Communicate. Communicate. Communicate.
  - Across all levels of your organization
  - With colleagues and families
- Help families and everyone who has contact with them understand what to expect
- Learn to articulate the “value proposition”
- Articulating value and be accountable for outcomes – culture, data, HIT systems, etc.

Thank You
Questions?