



**Office for People With
Developmental Disabilities**



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



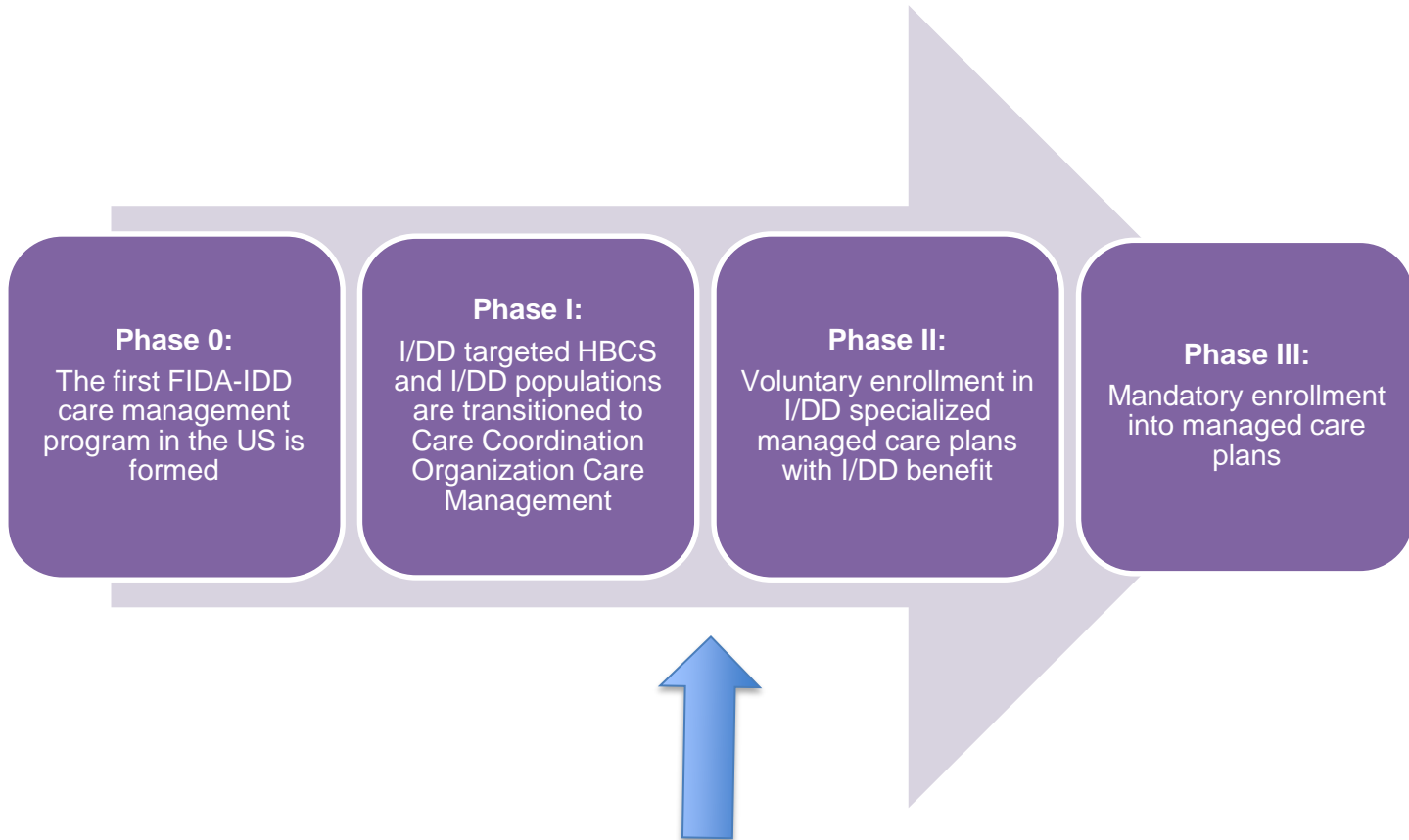


AGENDA

- 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



2022

August 2018



Office for People With
Developmental Disabilities

What is People First Care Coordination?

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

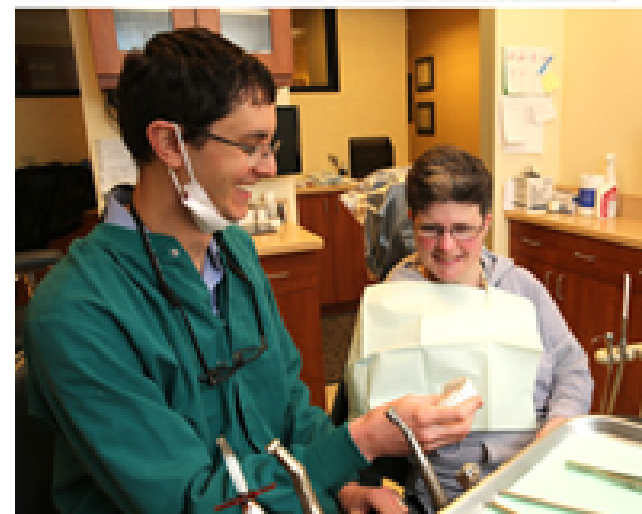
- Care Coordination Organizations (CCOs) are new organizations designed by providers with I/DD experience to:
 - Coordinate services across multiple systems, primary care, behavioral health, community-based services
 - Develop and manage specialized Person-Centered Life Plans, with the individual and 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	<ul style="list-style-type: none"> • Public Comments on Draft CCO Application received • 1115 Waiver Amendment posted for public comment 	✓
Summer 2017	<ul style="list-style-type: none"> • DRAFT State Plan Amendment shared with CMS to add I/DD diagnoses as a single qualifying diagnosis for Health Homes 	✓
October 2017	<ul style="list-style-type: none"> • Final Health Home application released 	✓
December 2017	<ul style="list-style-type: none"> • Designation applications due to OPWDD/DOH, including proposed Care Management Networks • 1115 Transition Plan is published for public comment 	✓
Dec. 2017– Feb. 2018	<ul style="list-style-type: none"> • Review and approval of Health Home Applications by the State; awarding of grants 	✓
Feb. – June 2018	<ul style="list-style-type: none"> • Completion of CCO/HH and network partner readiness review and activities 	✓
July 1, 2018	<ul style="list-style-type: none"> • 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

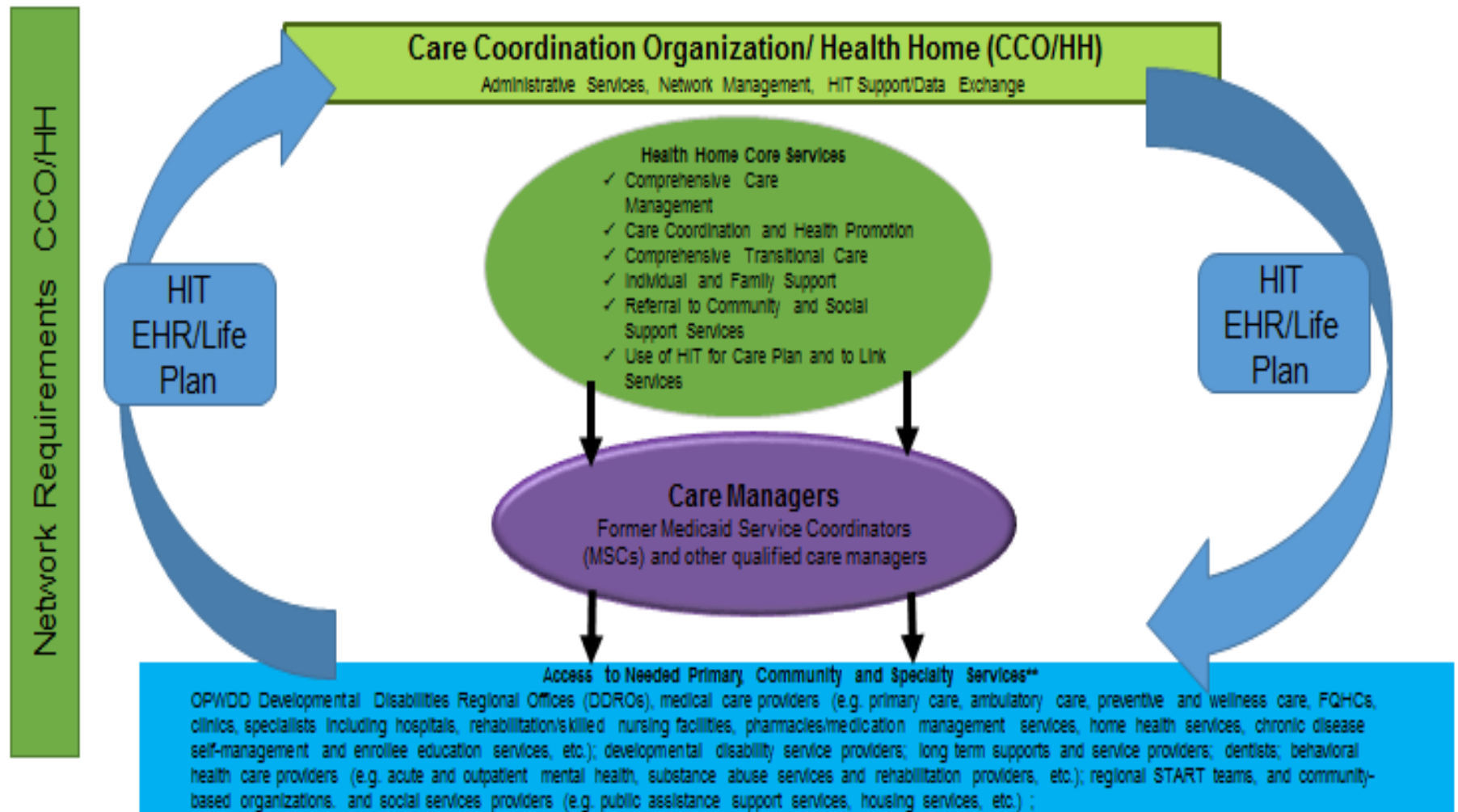
Goal: Improve outcomes (health/personal/social) for individuals with I/DD through care coordination

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

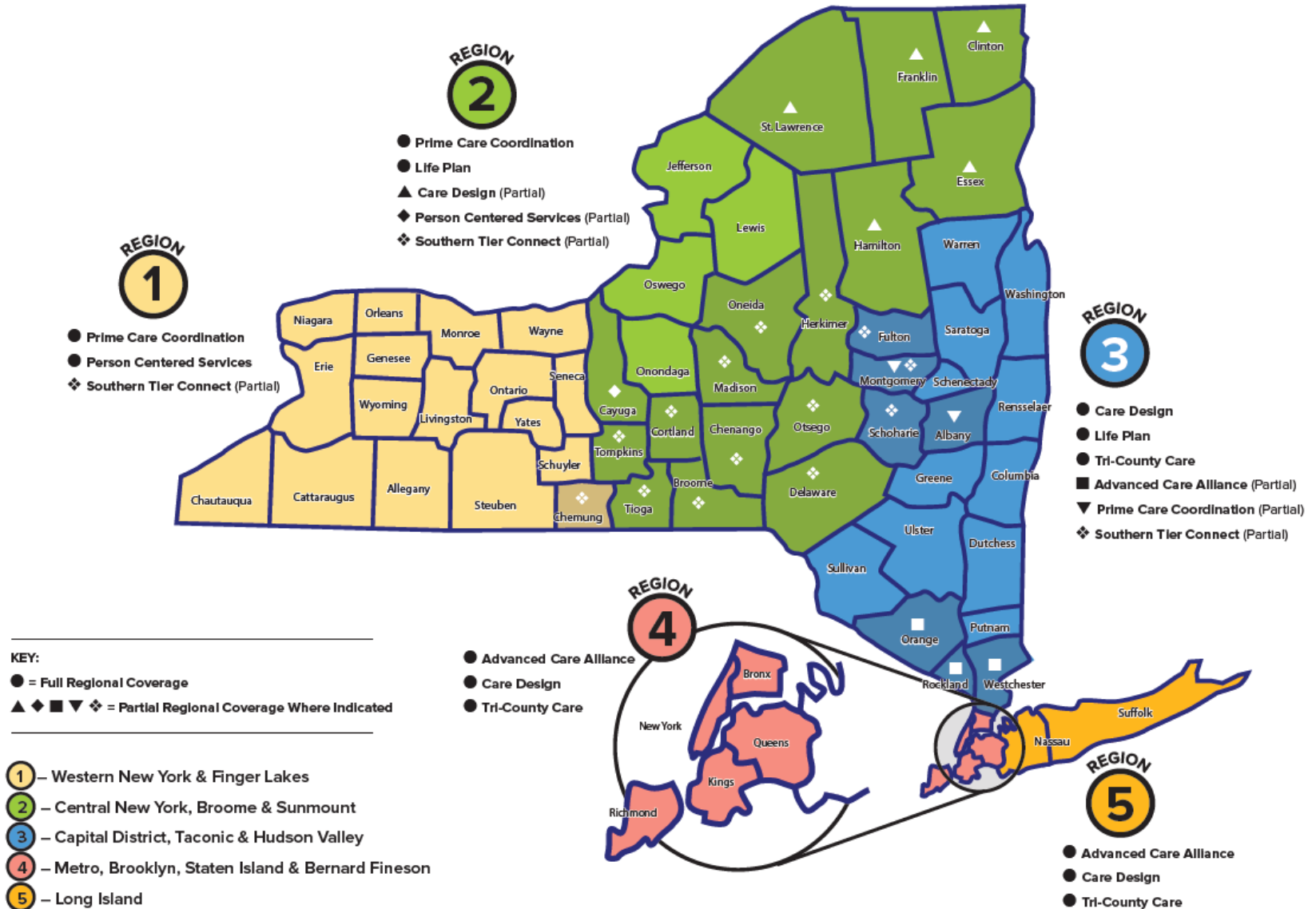


Attachment C

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



CCO Regional Coverage Map



Health IT Requirements

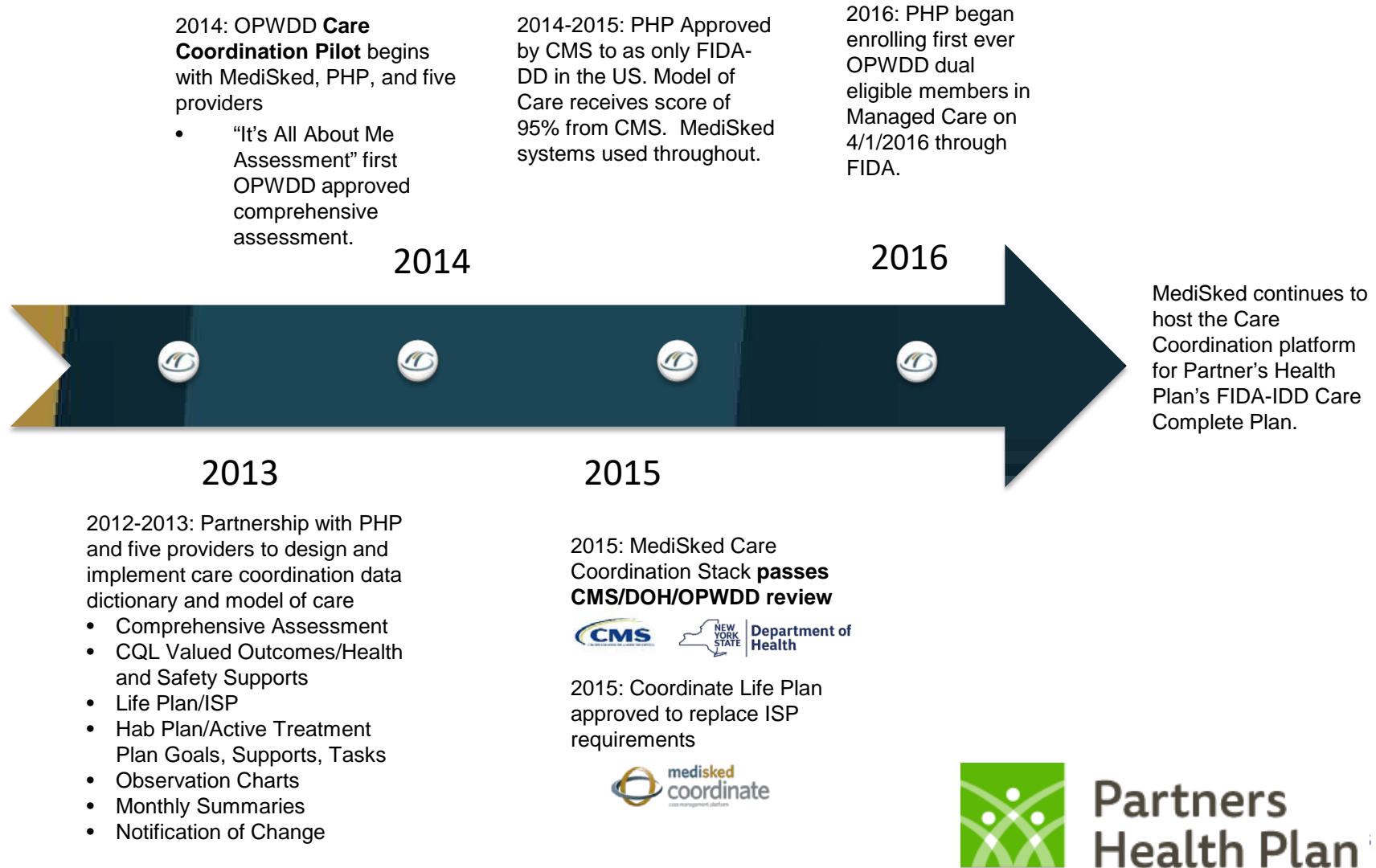
Highlighting the Information Technology Requirements

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



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



Comprehensive Care Management Tool

Care Management

Care Coordination

Transitional Care

Individual Family Support

Social Service Referral

Health Information Exchange / Healthcare Information Technology

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

The screenshot displays the MediSked Coordinate web application interface. At the top, there is a navigation menu with options: People, Planning, Billing, Calendar, Reporting, Messaging Center, Setup, Admin, and Add Care Coordination Note. Below the navigation, there are tabs for 'My Home', 'My Direct Reports', and 'Tina J. Parker'. A 'Welcome back, Carrie Manager' message is displayed. The main content area is divided into two sections: 'My Caseload' on the right and a calendar/agenda view on the left. The 'My Caseload' section shows a grid of member profiles with names like Matthews, Edyth; McDowell, Robert; Avalon, Ella; Smith, Katherine; Carter, Jake; Allen, Barry; Martin, Mary; and Timmons, Helen. The calendar view shows a list of events for the week of August 25-31, 2017, including meetings and assessments.

Date	Time	Event
25 Friday August, 2017	8:30 AM-9:15 AM	↓ (K.Smith) Face-to-Face Meeting with Member
	2:00 PM-2:30 PM	↻ (R.McDowell) Face-to-Face Meeting with Member
	2:30 PM-3:30 PM	↻ (R.McDowell) Begin Hospital Discharge Planning
28 Monday August, 2017	8:00 AM-9:00 AM	↻ (E.Avalon) Schedule Life Plan Meeting
	10:00 AM-11:00 AM	↓ (K.Smith) Annual Wellness Visit, Initial
29 Tuesday August, 2017	9:00 AM-10:00 AM	↓ (J.Carter) Identify Housing Placement Needs
30 Wednesday August, 2017	9:00 AM-9:30 AM	↻ (E.Matthews) Complete Member Assessment
	9:45 AM-10:15 AM	↻ (E.Matthews) Document Plan Team
31 Thursday August, 2017	9:00 AM-9:00 AM	↻ (E.Matthews) Schedule Life Plan Meeting

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

The screenshot shows the MediSked interface for a Life Plan / ISP. The top navigation bar includes icons for New Plan, Assessments, Plan Team, Plan Meeting, Plan Review, Cost Report, Attachments, Delete, and Publish. The left sidebar contains a menu with the following items: Member Info, Member Profile, POM/POP, Service Auth - Medical, Service Auth - MLTC, Service Auth - DD, Service Auth - DMEPOS, and Natural Supports.

The main content area is for **Katherine Smith**, with a Date of Birth of 11/24/1988. The title is **Life Plan / ISP**. The member information includes:

- Member Address: 3414 St. Paul Rd, Rochester, NY 14617, Monroe
- Phone: (585) 555-7890
- Medicaid #: 12345678901
- Insurance Plan ID #: ABC123DEF
- Enrollment Date: 11/1/2015
- Medicare #: 12345678A
- Tab ID #: BCBS of WNY - Healthy Choice
- Willowbrook Member: No
- Plan Effective Dates: 6/1/2016 - 12/1/2016

Below the member information is a **MEETING HISTORY** table:

Plan Review Date	Reason For Meeting	Member Attendance
1/1/0001		Not Logged

The **SECTION I ASSESSMENT NARRATIVE SUMMARY** includes a description of the section's purpose and two narrative entries:

Introducing Me: My name is Katherine but people call me Katie. I have lived in an IRA for many years. I really want my own room. I can tell you yes by giving a thumbs up and no by giving a thumbs down. I have a great smile, so everybody loves me. I use a wheelchair, but I can't get around because I only have the use of my right hand. Someday, I would like to live in a smaller home with my friends. I have terrible seizures and I don't know when they are going to happen. It is scary. I often have bad headaches after them which make me cry. I wish I could have a puppy. Something that is just mine. My parents visit me every Sunday, but they are getting older so it is difficult for them to get around. I am worried about them. I have a sister Jane who lives in California with her husband and children. She calls me every week.

My Home: I live at an IRA with my friend Sandy. There are 10 other people who live there besides me and Sandy so it gets pretty noisy. My roommate's name is Coreen. She likes to watch television at night and so do I. It doesn't work so well because we hear each other's television. I would like to be able to turn my television off myself. I love Elizabeth and most of the staff who work there. I don't like when the house "blacks out". Their don't know how hard to get on and make a new bed uncomfortable. I feel very safe here, but



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

Sprint LTE 2:55 PM 88%
My Health - Goals and Actions

Menu IPOP Preview

Name of Individual: Katherine Smith

My Nutrition PHP ID: 100100234

My Vision

My Mobility

Toileting

My Skill Matrix - Personal Hygiene

My Skill Matrix - Daily Living

Supportive Routines for PHS ADLS

Safety Plans

Reasonable Accommodations

Durable Medical Equipment/POS Summary

Preferences

Notes

Assessment Summary

Profile Summary

Allergies Summary

Durable Medical Equipment/POS

Supportive Routines Summary

Preference Summary

Goals and Actions Summary

POMs Preview

IPOP Preview

I would like to communicate better
Complete hearing assessment

I want to feel better
Other: Support pocs plan
Training to staff
Provide Functional Behavior Assessment (FBA)
An interdisciplinary evaluation
A new challenge or group to join (for some positive attention)
Behavior Support Plan Chart, with Documentation of Replacement Behavior

I need supervision in the community
Eyes on at all times

I need help to take my medication
Provide total assistance

I want to be healthy
Implement seizure charting (Chart 11)
Complete Braden Scale (Chart 19)
Check for pressure sores with charting (Chart 10)
Bowel management with charting (Chart 12)

Eating Guidelines
Implement the following diet Gluten free diet, High calcium diet, High fiber diet with charting (Chart 13), Allergic to: Peanuts, Allergic to: Shellfish, Food Cut to liquids should be the consistency of: Nectar, Provide the following supports Eat (friend(s)), Need some assistance, Stay Upright for 30 minutes after eating

I want to move safely
Only lift with two people or transfer device

I would like assistance with toileting
Check that I am not wet or soiled every two hours w/charting (Chart 7)

Evacuate in an emergency
Physically remove

Call for help
Cannot call for help without assistance

POMs Preview Complete Assessment



View Plan Assessments Plan Team Plan Meeting Plan Review Cost Report Attachments Delete Publish Provider Plans Historical Plans

Member Info Narrative Summary Goals and Outcomes Service Auth - Medical Service Auth - MLTC Service Auth - DD Service Auth - DIMEPOS Save Save and Continue View Alignments

Selection

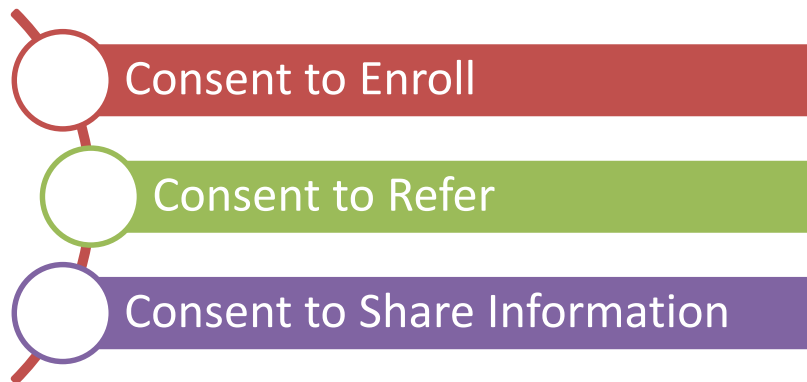
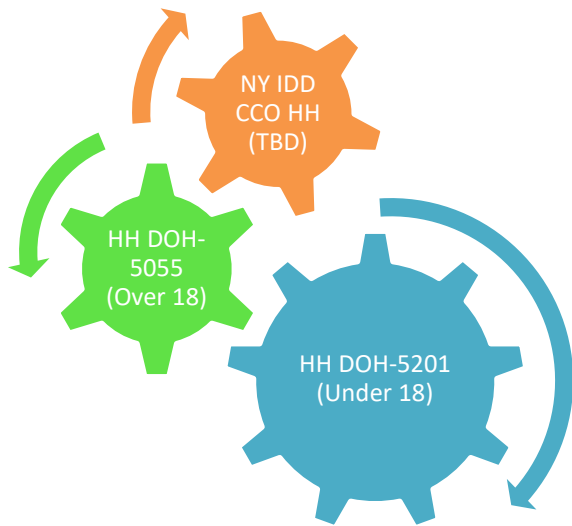
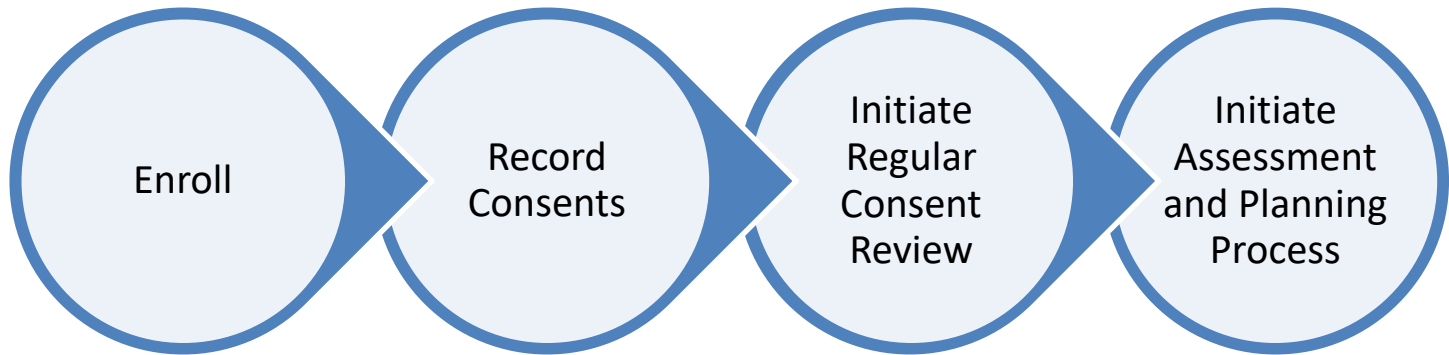
Description	Goal?	Action Type	Add/Delete/Revis	New POM
<input checked="" type="checkbox"/> People are connected to natural supports				Add Action
<input checked="" type="checkbox"/> See my friends and family more often				New Action-Step
<input checked="" type="checkbox"/> Other: Arrange for skype with sister	Goal			
<input checked="" type="checkbox"/> People have intimate relationships				New Goal
<input checked="" type="checkbox"/> Have a boyfriend/girlfriend				New Action-Step
<input checked="" type="checkbox"/> Assist with joining a dating site	Support			
<input checked="" type="checkbox"/> Teach dating skills	Goal			
<input checked="" type="checkbox"/> Teach social skills	Goal			
<input checked="" type="checkbox"/> People have the best possible health				New Goal
<input checked="" type="checkbox"/> Look differently				New Action-Step
<input checked="" type="checkbox"/> Provide an exercise program	Goal			
<input checked="" type="checkbox"/> People choose where and with whom they live				New Goal
<input checked="" type="checkbox"/> I want my own room				New Action-Step
<input checked="" type="checkbox"/> Explore/investigate options for change with the person (e.g. possible room changes, living alone, other living arrangements, etc.)	Support			
<input checked="" type="checkbox"/> Other: Push panel for tv control and headphones	Goal			
<input checked="" type="checkbox"/> Private choose personal goals				New Goal
<input checked="" type="checkbox"/> Be more independent				New Action-Step
<input checked="" type="checkbox"/> Determine preferences	Support			

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

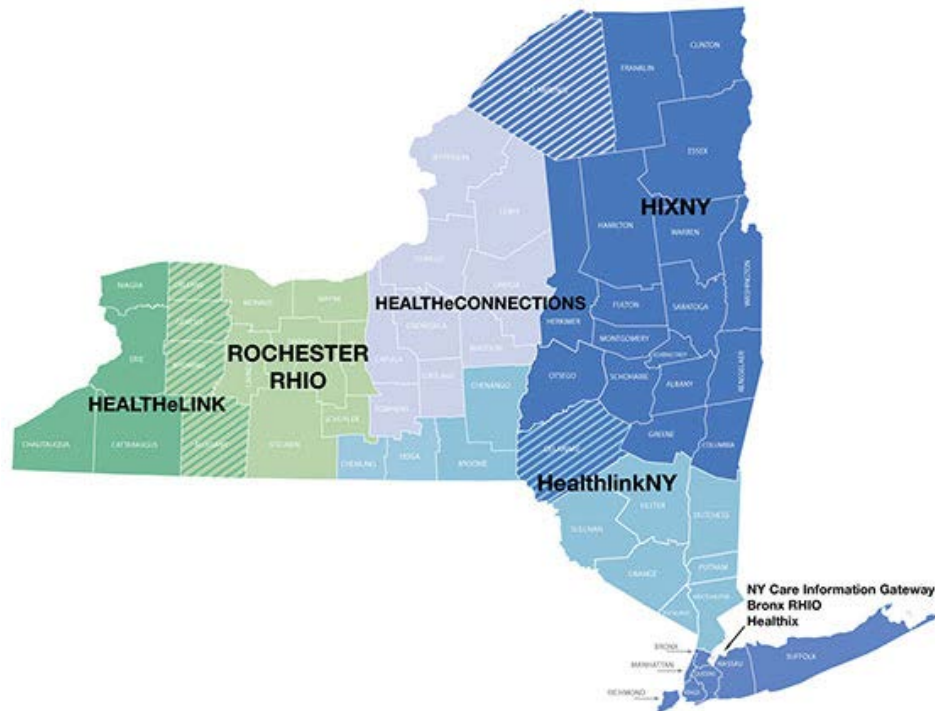
Consent

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



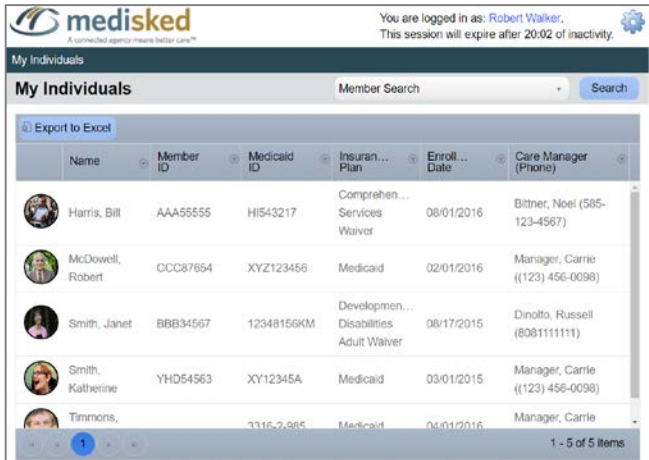
Regional Health Information Organization (RHIO) Overview

- 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

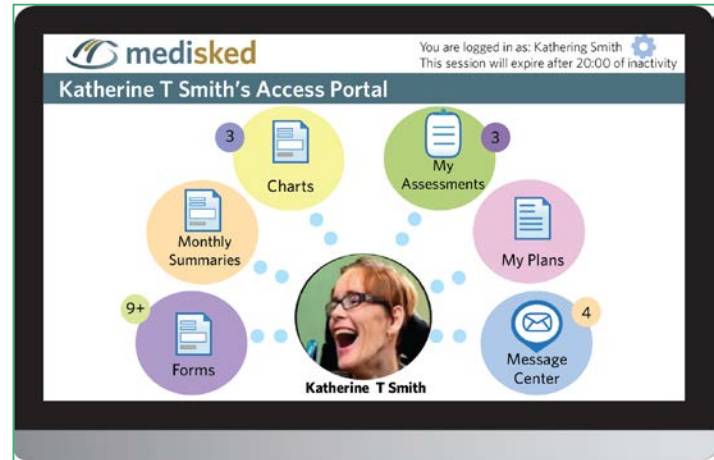


Individual and Family Access

MediSked Portal – *Person-Centered Platform*



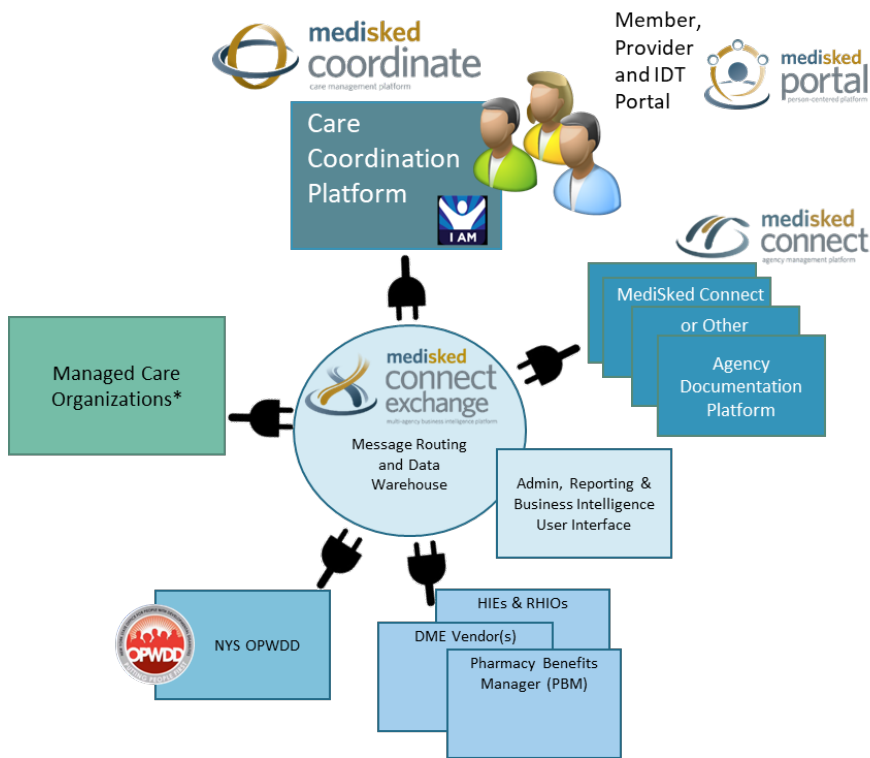
Name	Member ID	Medicaid ID	Insuran... Plan	Enroll... Date	Care Manager (Phone)
Harris, Bill	AAA55555	HIS43217	Comprehen... Services Waiver	08/01/2016	Bittner, Noel (505-123-4567)
McDowell, Robert	CCC87854	XYZ123456	Medicaid	02/01/2016	Manager, Carrie ((123) 456-0098)
Smith, Janet	BBB34567	12348156KM	Developmen... Disabilities Adult Waiver	08/17/2015	Dinolfo, Russell (8081111111)
Smith, Katherine	YHD54563	XY12345A	Medicaid	03/01/2015	Manager, Carrie ((123) 456-0098)
Timmons,	3316-2-985	Medicaid		04/01/2016	Manager, Carrie



- 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

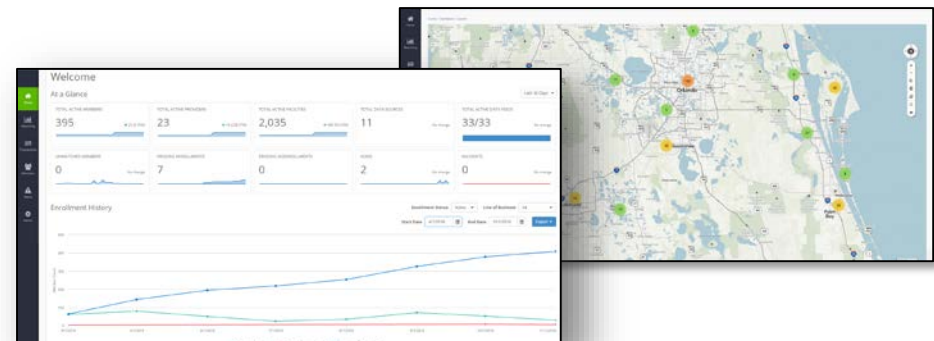
Population Data Collection and Business Intelligence Tool

MediSked Connect Exchange – Multi-Agency Business Intelligence Platform



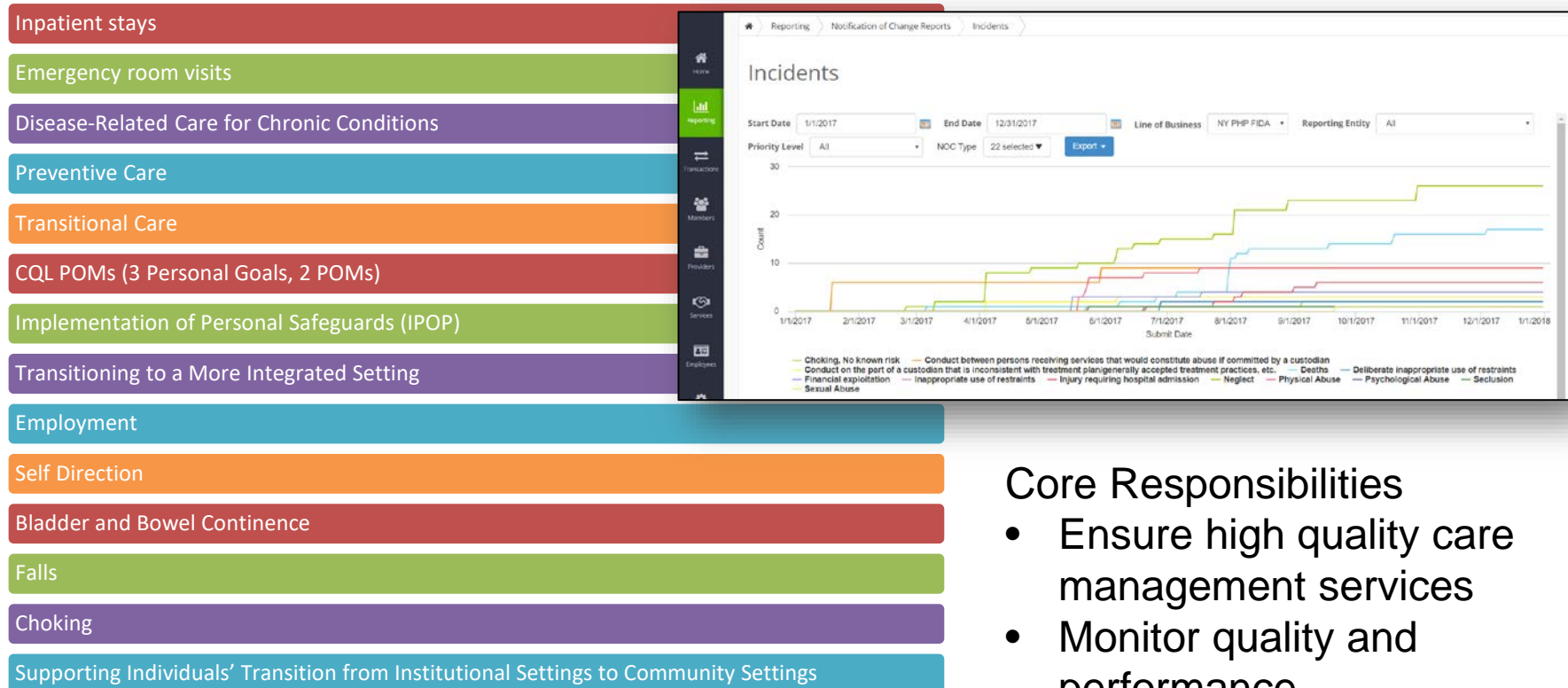
A multi-agency business intelligence platform, MediSked Connect Exchange is being leveraged to expand the breadth of available data and supercharge traditional care coordination tools and workflows in New York

- 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



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



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?