NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

Transformation Agenda Update – People First Care Coordination

September 18, 2017

JoAnn Lamphere, DrPH
Deputy Commissioner
OPWDD Division of Person Centered Supports

OPWDD's Commitment Moving Forward

- Ensure that people with intellectual and developmental disabilities (I/DD) receive supports that are person-centered, flexible, easy to access and responsive to their needs and preferences.

- Advance our system to provide a high-quality outcomes-based system of supports that includes health and wellness, preparing for a transition to Managed Care.

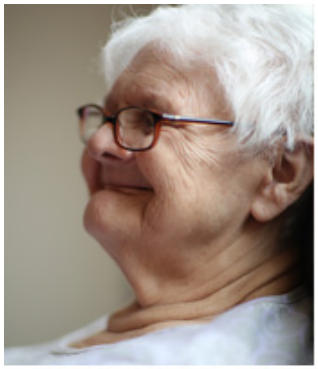
People First Care Coordination =

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.





What is People First Care Coordination?

A connected group of health care and service providers for developmental disabilities working together – for individuals and families. It is not a physical location.

- Coordinates services across multiple systems, connected to each other and individuals by a real-time computer network
- Develops and manages a specialized Life Plan, with significant input from the individual, based on his/her needs
- Integrated, holistic, person-centered and conflict free
- Increases accountability for the person's well-being by driving valued outcomes
- Becomes the care management entity through delegation by a MCO when the system moves to Managed Care

Care Coordination Organizations (CCOs)

- ✓ Care Coordination Organizations (CCO), a new organization to be approved by OPWDD
- ✓ CCOs being designed as specialized Health Homes, with focus on coordinating care for people with I/DD
- ✓ CCO essentials: teams, conflict free, holistic, & integrated
- ✓ CCOs may subcontract with existing I/DD MSC provider agencies for a period of time for staff
- ✓ For existing Health Home to be considered CCO, must have 51% governance I/DD and meet additional qualifications
- ✓ DD Regional Offices will continue to authorize Medicaid services and assess eligibility for waiver

CCO / HH Implementation Timeline

June 2017	• Draft Designation Application published for public comment; comments due 8/4/2017
Summer 2017	• Submit revised State Plan Amendment to add I/DD diagnoses as a single qualifying diagnosis for Health Homes; Submit 1115 Medicaid Waiver Amendment
September 2017	• Final Health Home Application released, along with information about potential start-up grants
December 1, 2017	• Designation Applications due to OPWDD / DOH, including proposed care management networks
December 2017 – February 2018	• Review and approval of Health Home Applications by the State and awarding of grants
February 2018 to June 2018	• Completion of CCO / HH and network partner readiness review & activities
July 1, 2018	• Transition to I/DD Health Home Care Management

Comprehensive Care Management Includes

- Use of care **teams** comprised of individuals receiving support and services and their representative/circle of support, developmental disability service providers, and medical, behavioral health providers, social workers, nurses and other care providers, as appropriate
- **Conflict-free** care management services must be person-centered and person-driven
- Comprehensive care coordination that addresses the individual's needs **holistically,** including better access to physical, behavioral health services, and wellness
- Support and care is detailed and monitored through the use of the OPWDD defined Life Plan that is **integrated** and electronic

Six Core Health Home Services

1. Comprehensive care management -- initial & ongoing assessment and care management services – to support individual outcomes & **integration** of habilitation, primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan called a Life Plan
2. Care coordination and **health promotion** — implementation of the Life Plan and its continuous monitoring
3. Comprehensive **transitional care** from inpatient to other settings, including appropriate follow-up
4. Individual and **family and caregivers support**
5. Referral to **community and social support services**, to ensure that community resources are utilized, as individuals pursue meaningful activities consistent with their Life Plans and
6. The use of **health information technology** to link services, as feasible and appropriate

Person-Centered Life Plan

- Supports and services are detailed and monitored through the use of OPWDD's Life Plan, an integrated and person-centered electronic service plan
- Care Coordination Organizations (CCO/HHs) will be responsible for the development & monitoring of the Life Plan
- The Life Plan must include specific domain areas and be accessible electronically to all authorized members of the care team

How Will the Transition Take Place?

- People receiving OPWDD services will transition to a CCO in their region.
- All people receiving services will have a Care Manager and a team to rely on from the start.
- We expect no interruption to the services individuals receive during the transition.
- OPWDD Regional Offices will continue to authorize Medicaid services, including the Health Home.

Helping People We Serve Transition Well

- Provider agencies and OPWDD will work with individuals & families to help them see the benefit of CCO / HH enrollment.
- If an individual does not want People First Care Coordination, s/he will enroll in a CCO / HH but will receive service coordination solely for developmental disability services.
- All providers are expected to become part of CCOs.

Positioning Providers for the Future

- OPWDD is conscientious about the sustainability of our providers as this transition occurs.
- All providers must affiliate with one or more CCO / HHs operating in the region to continue to deliver services in the OPWDD system.
- Providers should immediately begin work to affiliate with CCO / HHs forming in their region.

Five-Year Transformation for I/DD Service System has Four Phases

1. Transfer care coordination responsibility from existing, agency-based Medicaid Service Coordinators (MSCs) to conflict-free Care Coordination Organizations (CCOs), which will function as state designated Health Homes, under federal law.

2. Develop specialized Medicaid Managed Care Organizations (MCOs) that have responsibility for planning, arranging and financing a full array of Medicaid services for individuals with I/DD.

3. Ensure voluntary enrollment in specialized MCOs until such time as two or more MCOs are available in each region of the State.

4. The State will begin mandatory enrollment into MCOs. MCOs will delegate their care management responsibilities.

1115 Waiver Amendment

- Amendment to current MRT 1115 Waiver allows creation of a model of care that enables qualified Managed Care Organizations (MCOs) in:
  - Mainstream Medicaid Managed Care (MMMC)
  - Managed Long Term Care Plans (MLTCP) and
  - Specialized I/DD plans

  throughout the State to meet needs of individuals with I/DD, including those enrolled in the OPWDD 1915c HCBS Comprehensive Waiver
- Transition to managed care to be initiated with enrollment of individuals with I/DD into Health Homes in 2018, expanding on a voluntary enrollment basis with establishment of Specialized I/DD MC plans

Transition to 1115 Waiver

- August 31, 2017: State submitted request to CMS to approve amendment to the MRT 1115 Demonstration Waiver seeking a January 1, 2018 effective date
  - I/DD population
  - I/DD services, including HCBS Waiver services
- Specialized I/DD managed care plans & schedule for moving the I/DD population into managed care are summarized in the amendment
- Care management services provided by a I/DD Health Home will meet Conflict of Interest (COI)
  - People First Care Coordination
- The 1115 Waiver will provide the authority for Care Coordinating Organizations/Health Homes, managed care, shared savings arrangements (VBP), and increased flexibility

What Do I Need To Do?

- Attend upcoming OPWDD Webinars offering additional details
- Read the draft & final designation Application to learn more about CCOs and Health Homes
- Connect with potential CCOs in your geographic region
- Reach out to OPWDD with questions
- Check OPWDD's & DOH's website frequently for updates and new materials
- Learn about health & behavioral health sectors

Transitioning to Future

- OPWDD continues to work in partnership with DOH to amend the NYS 1115 Waiver and revise the Health Home State Plan Amendment
- Extensive implementation & operational details to be worked through & resolved
- OPWDD will continue to regulate and oversee I/DD services
- With move to 1115 Waiver, potential for greater regulatory flexibility, including service design

Contact Us

Care.Coordination@opwdd.ny.gov