

## Joint Advisory Council (JAC) July 24, 2015

### Excerpts from the Draft Document Describing the Care Management Policy for Fully Integrated Duals Advantage Plans for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)

The FIDA-IDD is a fully voluntary Managed Care Program for individuals who are dually covered by Medicaid and Medicare. The program includes all services (Health Care, IDD Services, and other services like Personal Care). The FIDA-IDD expands on the original NYS FIDA Demonstration (implemented in January 2015) and focuses on individuals who receive IDD services. The intended start date for the FIDA-IDD plan is January 1, 2016. This document presents excerpts from the draft Care Management policy document. It describes the roles and responsibilities of the *Interdisciplinary Team* (IDT) that works with the enrolled person to develop and manage a Life Plan.

### IDT Policy Pending final policy decisions related to CMS approval & Comparability to Primary FIDA IDT Policy (Not For Distribution)

#### **FIDA-IDD PLAN RESPONSIBILITIES**

FIDA-IDD must establish, implement, & maintain written policies/procedures for operation of Interdisciplinary Teams meeting the requirements of this document. Specify, but not limited to:

- 1) Mechanisms, tools, and timeframes for IDT interactions and
- 2) Policies and procedures necessary for permitting the exchange of information between the IDT, providers, and Participants and their caregivers/guardians or designees in a manner consistent with confidentiality requirements.

#### **COMPREHENSIVE SERVICE PLANNING ASSESSMENT OF FIDA-IDD PARTICIPANTS**

##### **Comprehensive Service Planning Assessment Required**

Participant will receive and actively participate in, a timely Comprehensive Service Planning Assessment including their:

- Medical health
- Behavioral health,
- Long-term services and supports (LTSS), and
- Social needs

The Assessment shall be completed by a RN on staff, or under contract with, the FIDA-IDD Plan.

## **Assessment Tool**

### **Assessment & Initial Enrollment in the FIDA-IDD Plan**

FIDA-IDD Plan RN must use the results of the provided OPWDD Approved Assessment. This Assessment will be the person's most recent results of either:

- Developmental Disabilities Profile (DDP2 tool in use at the time of publication of this policy), or
- Comprehensive Assessment System (CAS)

FIDA-IDD Plan will complete additional Comprehensive Service Planning Assessment, which will be used as the basis for developing the integrated, Person-Centered Life Plan called the Life Plan (LP) must cover at least the following domains:

- social,
- functional,
- medical,
- behavioral,
- wellness and prevention,
- caregiver/guardian or designee status and capabilities, and
- participants' preferences, strengths, and goals.

### **Timing of the FIDA-IDD Plan's Comprehensive Service Planning Assessment**

- FIDA-IDD Comprehensive Service Planning Assessment to be completed no later than 30 calendar days from the individual's enrollment effective date.
- FIDA-IDD Comprehensive Service Planning Assessment must be performed by a FIDA-IDD Plan or contract Registered Nurse (RN) in the location of the individual's choice.

## **INTERDISCIPLINARY TEAM**

### **Interdisciplinary Team / Authority and Decision-Making Role**

- IDT approach provides each Participant with an individualized, comprehensive care planning process to maximize and maintain every Participant's functional potential and quality of life.
- An individually tailored IDT, led by an accountable Care Manager at the FIDA-IDD Plan, will ensure the integration of the Participant's medical, behavioral health, community-based or facility-based LTSS, and social needs.
- IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.
- The IDT members should be identified no later than 30 days from the individual's enrollment effective date.

## Timing

- Care Manager must review the Participant's Life Plan at least every six months from the previous Life Plan review.
- Life Plan review must coincide with a meeting with the IDT at least annually (no more than twelve months from the previous IDT meeting).
- IDT meetings may occur more frequently, as the IDT must reconvene after a Reassessment.

## Interdisciplinary Team Composition

### ***A Participant's IDT MUST be comprised of the following individuals:***

- Participant and/or his or her caregiver/guardian or designee;
- Participant's primary providers of Developmental Disability services, who have knowledge of the Participant's desired outcomes and service needs;
- Primary Care Provider (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant;
- FIDA-IDD Plan Care Manager.

### ***A Participant's IDT MAY be comprised of the following individuals:***

- Behavioral Health Professional, if there is one, or designee with clinical experience from the BH Professional's practice who has knowledge of the Participant's needs;
- Participant's home care aide(s), or designee with clinical experience from the home care agency who has knowledge of the Participant's needs (if receiving home care);
- Participant's Intermediate care facility (ICF) representative who is a clinical professional, if receiving ICF care; and
- Other providers either as requested by the Participant or his/her designee; or as recommended by the IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee

The FIDA-IDD Plan Care Manager is the IDT lead and facilitates all IDT activities.

- CM may request information from the Plan's Utilization Management (UM) staff, such as information about medical necessity, clinical guidelines, or evidence-based best practices.
- The UM staff may not participate in IDT meetings, and should not be deemed members of the IDT.

The IDT must at all times meet the minimum requirements outlined above.

- Clinical staff such as physician specialists, may be added to the IDT as appropriate.
- IDT members may also be added or dropped from the IDT as the Participant's needs require.
- An IDT member may drop from the IDT once they no longer have any current goals or objectives related to the Participant.

## **IDT Meetings, the Decision-Making Process, and Standards of Practice**

- All current IDT members must actively participate in the IDT service planning and care management process.
- IDT members must attend the meeting in person, or via means of real-time, two-way communication (such as by telephone or videoconference).
- The Primary Care Provider (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant must participate in IDT meetings when there are changing medical service needs to be discussed by the IDT.
- IDT must meet to create the Life Plan within 30 days (or sooner if required by the circumstances or clinically indicated) of the initial Assessment.

### **Responsibilities of IDT Members**

The IDT is responsible for coordinating care for the Participant.

- Responsibility is continuous and independent from their authorizing authority.
- Remains applicable even when a different entity is responsible for authorizing particular services.
- IDT must maintain regular communication as and when required and agreed upon by the other members, and must participate in service planning and oversight.
- Each IDT member is responsible for:
  - regularly informing the IDT of the medical, functional, and psychosocial condition of each Participant;
  - remaining alert to pertinent input from other team members, Participants, and their caregivers/guardians or designees; and
  - documenting changes of a Participant's condition in the Providers' own medical record for the Participant consistent with policies established by the FIDA-IDD Plan.

Implementation of the Life Plan requires that the IDT members must either directly deliver services (or arrange and confirm delivery of services) required under the Life Plan.

### **Participant Involvement on IDT**

- Participants shall be involved in care planning.
- Participants must be asked to express their preferences about care, and his or her expression must be respected and incorporated into care decisions, as appropriate.
- Providers on the IDT must work with the Participant (and his or her Designee and/or his or her Authorized Representative) and consider his or her preferences in making care decisions.

To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the Life Plan must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are obtained as called for in the Life Plan.

## **Care Manager Qualifications**

- Must be a licensed professional such as an RN, Licensed Clinical Social Worker or Psychologist,
- Have knowledge of physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS), frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate,
- Required to have a Bachelor Degree and one year experience working with individuals with IDD.

## **Care Manager Responsibilities**

As the lead member of the IDT, the Care Manager has many responsibilities, including:

- Ensure that all IDT responsibilities are being met,
- Must assist the IDT members where possible or necessary.
- The precise tasks involved with carrying out the Life Plan will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager.
- Upon the occurrence of a trigger event, as described in Section X, the Care Manager must notify the IDT, and ensure that a Reassessment will be conducted within the appropriate timeframe.

## **Timing of Person-Centered Service Plan**

A Life Plan must be completed for each Participant by and with that Participant's IDT within 60 days of the FIDA-IDD Plan completing the Comprehensive Service Planning Assessment and within 30 days of the FIDA-IDD plan completing Reassessments. The initial Assessment must be completed within 30 days after enrollment into the FIDA-IDD Plan. Prior to the initial care planning meeting, service authorizations related to new needs for service may be made by, and only by, the FIDA-IDD Plan.