Joint Advisory Council (JAC)

Care Coordination Organizations (CCOs)
Development & Transitioning to Specialized Managed Care

03/23/2017
Agenda Highlights

• Welcome/Introductions & Role of the JAC

• Care Coordination Organizations (CCOs) Development & Transitioning to Specialized Managed Care

• Review of RFQ Elements
  – Principles of Care Coordination Organizations and the Person-Centered Life Plan
  – Quality Measures

• FIDA-IDD Updates
Welcome New Members

• Antonia Ferguson, Willowbrook Consumer Advisory Board (CAB)
• Brad Pivar, Statewide Advocacy Network of New York (SWAN-NY)
• Bridget Bartolone, Person Centered Supports of Western New York (PCSWNY)
• George Contos, Young Adult Institute (YAI)
• Mike Rogers, Self-Advocate
• Nick Cappoletti, Advocates Incorporated
• Dr. Alice Stratigos, GROW
Role of the JAC

• To ensure care improvements for people and their families, and a thoughtful transition to new paths for receiving services, OPWDD has convened this Council to provide input and make recommendations.

• The purpose of the Joint Advisory Council is to advise regarding the design of managed care models that will provide services to individuals with developmental disabilities (per legislation).

• This group began meeting in 2013; its expanded membership is especially important now as OPWDD embarks on a new initiative of care coordination and, ultimately, to managed care.
2017-2018 Executive Budget

- Governor Cuomo reaffirmed that the OPWDD system will transition to managed care.
- Regional Care Coordination Organizations (CCOs) are being developed to deliver care coordination services.
- Any savings resulting from care coordination organizations and managed care will be reinvested in the OPWDD system.
IDD Specialized Managed Care

• OPWDD is committed to developing a model of managed care designed around the unique needs of individuals with developmental disabilities.

• Performance measurement and value-based payments are tools to advance this vision.
Work Groups

Phase 1: CCO RFP/RFQ/RFA Development

1 – Defining Care Management Functions & Tiers*

2 – Legal & Organizational Requirements

3 – Regional Roll-out, Transition Planning, Special Pops*

4 – Readying the Current MSC & New Team Workforce

5 – HH / IT Specifications

6 – Quality & VBP Measures

*Includes meeting WB injunction

Communications Plan

OPWDD Operational Planning/Implications
Recap: CCO Request for Qualification (RFQ) Application Schedule

Phase 1: Winter 2016/17
- Internal workgroups convene and produce initial deliverables for RFQ

Phase 2: March 2017
- Draft RFQ under review at OPWDD

Phase 3: April 2017
- Publish DRAFT RFQ for public comment

Phase 4: June 2017
- Release RFQ to interested applicants
Building toward IDD Specialized Managed Care

- Regional Care Coordination Organizations (CCOs) will prepare for the move to a person-centered system of managed care for people with developmental disabilities in New York State.
- CCOs will be developed by existing developmental disability provider agencies with experience in coordinating services for people with developmental disabilities.
- Benefits of this approach include:
  - Providers have knowledge and experience serving individuals with disabilities and their families
  - Individuals and families have existing relationships with IDD providers and confidence in their abilities
Care Coordination Organizations (CCOs)

• CCOs will be designed as specialized Health Homes, with their focus on coordinating care for people with developmental disabilities.

• CCOs will operate under the 1115 waiver.

• CCOs may subcontract with existing IDD MSC provider agencies for a period of time before being directly employed by the CCO.
Care Coordination Organization Activities

• OPWDD intends to publish a draft CCO Request for Qualification (RFQ) for a 30 day public comment period in the coming month

• OPWDD continues to work in partnership with DOH to amend the NYS 1115 Waiver and revise the Health Home State Plan Amendment for submission to CMS in June of 2017

• The transition of Targeted Case Management (TCM) to approved CCO entities is anticipated to begin January 2018
## CCO/IDD Health Home Next Steps

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>April 2017</td>
<td>Issue Designation Application published for public comment</td>
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<tr>
<td>June 2017</td>
<td>Issue Designation Application to initiate submission process</td>
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<tr>
<td>June 2017</td>
<td>Submit revised State Plan Amendment to CMS to add IDD diagnoses as a single qualifying diagnosis for Health Homes</td>
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<td>August 2017</td>
<td>Designation Applications Due to OPWDD/DOH including proposed case management networks (i.e., MSC providers associated with the IDD HH)</td>
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<td>November</td>
<td>Designate IDD/HH and complete Readiness Review and initiate</td>
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<tr>
<td>Jan 1, 2018</td>
<td>Initiation of HH services</td>
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Request for Qualification (RFQ) - Principles of Care Coordination Organizations (CCOs) and the Person-Centered Life Plan
CCO Benefits/Goals

• Provide care coordination and planning that is family-and-individual driven and which is responsive to the unique needs of each individual
• Use a “Life Plan” for individual service planning
• Adopt individual-specific and nationally recognized measures to monitor quality and outcomes
• Track clinical and functional outcomes using standardized, validated assessment tools
CCO Benefits/Goals

- Enhance training in supporting individuals with unique, complex health needs
- Provide conflict-free comprehensive care management services
- Ensure a smooth transition from the current care management programs to CCOs, including a transition plan for care coordination payments
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 (CCOs) will be responsible for the development of the Life Plan.

• The Life Plan must include specific domain areas and be accessible electronically to all authorized members of the care team.
Life Plan Domain Areas

- Description of the person
- Desired health, functional, and quality of life outcomes
- Observable/measureable action steps to achieve outcomes that will be taken by the person, paid and unpaid service providers, and other persons who will support the individual
- Pertinent demographic information
- Employment status
- Services the individual will receive (both HCBS waiver services and non-waiver services)
- Expectation of how goals and outcomes will be achieved
- Safeguard description and supports needed to keep the individual safe from harm
- Detailed back up plan for situations in which regularly scheduled HCBS waiver providers are unavailable or do not arrive
- Relevant information pertaining to behavioral support that is needed
- Relevant information regarding physical health conditions and treatment
- Frequency of planned care manager contacts needed
Request for Qualification (RFQ)-Quality Measures
Quality Measures

The State Plan and Health Home Core Sets of Quality Measures will be the basis for developing CCO/IDD HH quality measures.

- Statewide Health Home Quality Measures PDF: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Additional, developmental disability focused quality measures will be developed by the State to track performance and help CCOs, care managers and Managed Care Plans manage to quality outcomes.

- The list of quality measures will continue to evolve over time.
Health Home Quality Measures

Goal-based quality measures:

Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays

Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits

Goal 3: Reduce utilization associated with short term NF and ICF stays

Goal 4: Improve Outcomes for persons with IDD through care coordination (health as well as personal/social)

Goal 5: Improve Disease-Related Care for Chronic Conditions

Goal 6: Improve Preventive Care
Goal 4: Improve Outcomes for persons with IDD through care coordination (health as well as personal/social):
Goal 5: Improve Disease-Related Care for Chronic Conditions
Goal 6: Improve Preventive Care
FIDA-IDD Update
FIDA-IDD Update

- United Cerebral Palsy (UCP) of NYC has joined the five Downstate ARCs as a governing partner of Partners Health Plan
- PHP Network update:
  - Contract with OPWDD State Operation providers
  - Contract with Montefiore Medical Center
  - Reviewing physician & hospital contracts with the Mt. Sinai system
FIDA-IDD Update

• PHP’s MSC incentive program. Program was developed to make a smooth transition for individuals with IDD from FFS to PHP’s FIDA-IDD plan.
  – MSC agencies are paid a fee when they meet the criteria of assisting in the 90 day transition process for new PHP participants.
  – First payments were made to 9 MSC agencies for 21 participants
• 31 Willowbrook class member enrolled in PHP effective 3/1/2017
FIDA-IDD Update

• OPWDD website has been updated to include Managed Care

  – https://opwdd.ny.gov/opwdd_services_supports/managed_care/faq
  – https://opwdd.ny.gov/providers_staff/managed_care/faq

• FIDA-IDD question email:
  – FIDA-IDD@opwdd.ny.gov