



The MSC E-VISORY is an electronic publication which provides information on policies, guidance, available programs and services and training opportunities related to MSC. In order to receive an email notification when a new MSC E-Visory is posted, or to view past issues visit the following link: [MSC E-Visory](#)

ISSUE # 21-15

December 4, 2015

Materials for the December 9, 2015 MSC Supervisors Conference

The MSC Supervisors Conference is being held on December 9, 2015 via videoconference and WebEx from 9:30am-12:30pm. The conference agenda is as follows:

- Residential Request List
- Certified Residential Opportunities Process
- FIDA & Managed Care
- Waiver changes as it relates to Supplemental Group Day Hab, personal care, and clinical services
- Person Centered Planning Regulations
- CAH Waiver

NOTE: The materials that will be referenced during this conference are attached to this MSC E-Visory. There will not be any materials distributed on the day of the conference.

Registration for this conference will close December 6, 2015. Those who have not registered for this conference and would like to can do so at the following link:

http://www3.opwdd.ny.gov/wp/wp_catalogc1310.jsp

Overview of Services for Willowbrook Class Members Training

OPWDD has scheduled a series of training sessions in 2016 which focus on the provision of Medicaid Service Coordination/Case Management by Non-Profit Voluntary Providers to Willowbrook Class members. This training will highlight the requirements for the Willowbrook Medicaid Service Coordination/Case Management services and provide information on fees, entitlements, billing, monitoring and oversight. Medicaid Service Coordinators/Case Managers, MSC Supervisors and district Willowbrook Liaisons are encouraged to attend.

The 2016 schedule for the Willowbrook Overview Training is available in the OPWDD Training Catalog at the following link:

http://www3.opwdd.ny.gov/wp/wp_catalogz2432.jsp

Final Regulations for PPSNA and Reforms to Incident Management

OPWDD has finalized regulations to implement provisions of the Protection of People with Special Needs Act (PPSNA) and make reforms in incident management. The regulations were permanently adopted effective December 2, 2015.

Please click on the link below to see the memo, text and summary on the regulations:

http://www.opwdd.ny.gov/regulations_guidance/opwdd_regulations/Implementation-ofProtectionofPeoplewithSpecialNeedsActandReformstoIncidentManagement%E2%80%9312-2-15



NEW YORK
STATE OF
OPPORTUNITY

Office for People With
Developmental Disabilities

MSC Supervisors Conference

December 9, 2015

December 4, 2015

2

Welcome & Hot Topics

Anne Swartwout
MSC Statewide Coordinator
Anne.Swartwout@opwdd.ny.gov



NEW YORK
STATE OF
OPPORTUNITY

Office for People With
Developmental Disabilities

Agenda

Welcome
Residential Request List
Certified Residential Opportunity
FIDA & MC
Waiver changes: SGDH, personal care, clinical
Person Centered Planning
CAH Home Waiver
Closing



NEW YORK
STATE OF
OPPORTUNITY

Office for People With
Developmental Disabilities

3

HOT TOPICS

- Training on Services for Willowbrook Class Members available in 2016
 - Check the catalog for listings



Residential Request List and Certified Residential Opportunity Process



What Is the Residential Registration List (RRL)?

- The RRL is the list of individuals with developmental disabilities currently registered with OPWDD as having requested residential supports
- It is not the same as:
 - The Certified Residential Opportunity (CRO) process list (formerly called the Vacancy Management list)
 - Any voluntary agency's list of people interested in residential placement

12/4/2015



What Is the RRL Review?

From August – October 2015, OPWDD called individuals or their caregivers to talk to them about:

- The OPWDD services they are currently receiving and
- Whether they continue to express a need for certified residential services now or in the future

12/4/2015



Why Did the RRL Review Happen?

To gather information to:

- Inform planning for development of housing alternatives for individuals with developmental disabilities, and
- To learn more about the service needs of the individuals on the RRL

12/4/2015



Outcomes of the RRL Review

- Contacting individuals & caregivers:
 - Shared information with MSC agencies
 - Requested updated contact information for 8,936 individuals/caregivers from 364 MSC agencies
 - o Got updated information for 5,649 individuals/caregivers
 - Sent more than 20,000 letters to inform people about the survey
 - Made more than 24,000 phone calls to caregivers or individuals
- Total # of completed surveys – 4,462

12/4/2015



What a Service Coordinator Needs to Know About RRL

If someone on your caseload expresses need for residential placement in the future, you add him/her to the Residential Request List:

1. You and individual/family complete DDP4 (Developmental Disabilities Profile Four)
 - In CHOICES or using paper version, depending on requirements of OPWDD Regional Office.
2. You ensure that DDP4 question 14 is answered with either a "1" or a "2."
3. You make sure individual and family understand that:
 - They will get a follow-up telephone call from the Regional Office &
 - When telephone follow-up occurs, individual/family must confirm need for residential placement.



Questions?



OPWDD CERTIFIED RESIDENTIAL OPPORTUNITIES PROTOCOL



Certified Residential Opportunities (CRO) Protocol

- Defines the process and principles for management of certified residential opportunities
- Implemented May 2015, based on vacancy management approaches previously used, creates consistency, defines structure
- Prioritizes collaborative efforts among stakeholders, transparency



Certified Residential Opportunities Protocol

- Supports person-centered planning;
 - ensures people have the right to choose where they live from among setting options including settings that are not disability specific.
- Supports Home and Community Based Settings requirements, ensuring:
 - there is a full exploration of integrated settings,
 - opportunity for self-direction,
 - access to least restrictive settings possible



CRO and RRL

- Separate lists
- RRL = expression of interest
- CRO = needing and actively seeking a residential setting



Protocol Key Elements

- Structure (CRO Team/Department, AROC)
- Priorities: determining, creating the Priority 1 list, tracking
 - District Referral and Placement Tracking Report
- Processes: Anticipated vacancies, referrals, approvals, admission plan, internal moves, cross regional moves
- Performance Standards (due process, timelines)
- Dispute Resolution
- Standardized Forms



Residential Referrals

A residential referral is made on behalf of individuals:

- requesting residential services for the first time, or
- requires a change due to clinical changes/personal goals that can't be accommodated by the current provider



Residential Referrals

Prior to a Referral for Residential Placement

Service coordinator/referral source will first fully explore with individual and family:

- Possibility of remaining where they are with additional supports/services
- Community placement in a non-certified residence with supports/services self-directed or overseen by a voluntary provider
- Interest in self-direction or referral for exploration
- Need for referral to the RO Crisis Team if individual in crisis



Referral Steps

- Submit referral packet to RO by referral source/SC
- RO Reviews packet, assigns priority level
- Information about individual is placed on the District Tracking Sheet
- Screening activity and placements made are documented on the Tracking Report
- P1 Tracking Sheet shared regularly with providers
- Reviewed at AROC and by CRO teams



Referrals and Screening

Screening

- CRO Team sends residential providers the P1 list when a provider announces a vacancy, prior to AROC and as requested by the provider
- Residential providers screen individuals from P1 list who may be appropriate for vacancies

Residential Screening Report

- Following a face to face screening, the provider completes the Residential Screening Report whether or not the provider's vacancy is appropriate for the individual
- If not deemed appropriate, specific information is detailed on the Screening Report form



Referrals and Screening

- Timely screenings by providers will ensure full utilization of beds
- Providers respond to urgent requests by the CRO Team to screen individuals who may be appropriate for the provider's vacancy
- RO CRO Team reviews screening reports, may initiate follow up discussions
- Screening reports are shared at subsequent AROC meetings to assist other providers in evaluating options



Request to Fill

Request for Approval to Fill a Residential Opportunity

If screening results in a successful match, provider completes Request for Approval to Fill a Residential Opportunity and submits to RO CRO Team

- CRO Team forwards to RO Director for final approval
- CRO Team immediately notifies provider and service coordinator/referral source
- Admissions can not occur prior to receiving the RO Director's approval



Admission Plan

Admission Plan

- Is highly recommended to be completed when a residential provider indicates a desire to serve an individual deemed as a Special Population
- Completed collaboratively between the CRO Team and the Residential Provider



Admission Plan

- Details the individual's "above and beyond" needs so the provider is fully aware of these needs. In response, the residential provider will identify how they plan to meet those needs.
- Completed prior to seeking approval from the RO Director for admission.



Director to Director Requests

- Director to director requests
 - Used for individual requests for residential placement that fall outside the catchment area of the individual's home district/region
 - RO staff from home district/region initiate the request
 - For most this will be the district where the individual currently resides, but not so for those attending a residential school



Office for People With Developmental Disabilities

26

Questions?



Office for People With Developmental Disabilities

27

FIDA-IDD Care Coordination

FIDA-IDD Care Coordination & Medicaid Service Coordination
How will they work



Office for People With Developmental Disabilities

Care Coordination

<p style="text-align: center; margin: 0;">Fee-for-service MSC</p> <ul style="list-style-type: none"> One manager Functional assessments Plan Development and Implementation Follow Up Advocacy Benefit Management 	<p style="text-align: center; margin: 0;">FIDA-IDD Care Coordination</p> <ul style="list-style-type: none"> Team Transdisciplinary environment Connects across various systems Includes Clinical, Medical, Behavioral Health Incorporates care management
--	---

Office for People With Developmental Disabilities
28

FIDA-IDD Care Management Functions Care Managers

- Care Manager qualifications:
 - Must be an RN, Licensed Social Worker or Psychologist, and
 - Have knowledge of physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS), and 1 year experience with IDD population
- Care Managers are the lead members of the IDT. Responsibilities include:
 - Lead the IDT, coordinate/lead IDT meetings (summarizing discussion and any conflicts)
 - Ensure that all IDT responsibilities are being met, assisting the IDT members where possible or necessary
 - Assists with developing, implementing and monitoring the Life Plan
 - Ensure that the Life Plan is updated when necessary
 - Complete the IAM tool

Office for People With Developmental Disabilities

FIDA-IDD Care Management Functions Care Coordinators

- Care Coordinators must be a QIDP
 - o Care Coordinators work more closely with the individuals within the plan to lead the following duties:
 - o Follow Up
 - o Advocacy
 - o Benefit Management
 - o Facilitates IDT activities and communications.
 - o Administers CQL POM interviews when needed
 - o Administers non clinical additional assessment components identified from the plan's comprehensive assessment (IAM)
 - o Assists with Life Plan development and implementation
 - o Educates individuals and families regarding care coordination activities-including access to supports/services, community resources and availability of reasonable accommodations, etc.

Office for People With Developmental Disabilities

MSCs and the Future

- The MSC fee-for-service structure remains in place in a stable environment
 - MSCs are serving over 41,000 individuals in the downstate area
 - Maximum client/Service Coordinator ratio of 40:1
 - Currently there are approximately 1,300 Medicaid Service Coordinators in the FFS program in the FIDA-IDD target area
- Enrollment into the FIDA-IDD will be limited
 - Projected enrollment in year one (SFY 2016/2017) = 2,000
 - Max potential of case managers to be hired by FIDA-IDD in year 1 = maximum of 50 MSCs to be employed by the FIDA-IDD,
 - 50 MSCs = 3% of the current MCS pool



MSCs and the Future

- Upon FIDA-IDD implementation, Medicaid Service Coordinators can choose to:
 - Remain working as an MSC within the FFS system
 - Continue in your role with your current agency within the FFS system. Since enrollment into the FIDA-IDD Plan is limited, the majority of individuals will still receive services through FFS.

OR

- Apply to work directly with/for the FIDA-IDD plan
 - Speak to the FIDA-IDD plan to ascertain your ability to work directly for the plan in a capacity that will benefit yourself, the plan, and individuals with developmental disabilities.



Participation

We have to work together to plan, implement and refine a care coordination model that:

- meets needs of all individuals including those with complex needs, and
- results in quality care with better outcomes
- aligns quality with payment



Next Steps

- FIDA-IDD FAQ for MSCs (attachment)
 - Post to OPWDD FIDA-IDD webpage
 - Share via MSC E-Visory
- Provide training and education at December 9th MSC supervisory training
- Plan outreach and education during pre-implementation and post-implementation periods



Questions



Waiver Service Changes



Today's Topic-Part 1: 10/1/15 Changes

- Changes to Separately Billed Services for People who live in Supervised and Supportive IRAs, CRs, and Family Care Homes.
 - Services continue, but they need to be reimbursed differently.
 - These services cannot be separately billed to Medicaid, these need to be part of the Residential Habilitation funding.
- Services for People who Live in their Own Home, or their Family are not Changing.
- Termination of Individual Day Habilitation.



Today's Topic-Part 2: Changes for Direct Therapies

- Elimination of Direct, Hands-On Therapies provided in Supervised IRAs and Day Habilitation Sites:
 - Physical Therapy (PT)
 - Occupational Therapy (OT)
 - Speech Language Pathology (SLP)
- Establishment of Article 16 Satellite Clinics.
- Implementation of Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD), also known as the Preventive Services state plan option.



Today's Topic-Part 3: Impact on MSC's Role

- With the changes that are taking place, changes may need to be made to the:
 - Planning of services to meet individual's needs
 - Options Available
 - Individualized Service Plan (ISP)



10/1/15 Changes



Office for People With
Developmental Disabilities

Rationale for Changes

- The policy regarding 10/1/15 changes reflects CMS' view that Res Hab services should fully meet the care needs of residents while they are in the residence and also meet all habilitative, recreational, and community integration needs of the residents during weekends and on weekday evenings.



Office for People With
Developmental Disabilities

Supportive IRA/CR & Family Care Changes: Aide Services

- After 10/1/15, Residential Habilitation Provider must pay for all Aide Services in the Residence:
 - Personal care services
 - Home health aide services
 - Homemaker services
 - Consumer directed personal assistance programs.
- Aide services may continue during weekday/ day time outside the residence.
- Exception - for weekend or weekday evening services related to employment.



Office for People With
Developmental Disabilities

**Supportive IRA/CR & Family Care Changes:
Day Habilitation & Community Habilitation Services**

- After 10/1/15, Residents of Supportive IRAs and CRs and Family Care Homes can continue to attend Supplemental Day Habilitation services, but the service must be reimbursed by the Residential Provider.
- Similarly, Residents of Supportive IRAs and CRs and Family Care Homes can continue to receive Community Habilitation Services on weekends and weekday evenings, but the service must be reimbursed by the Residential Provider.



SUPERVISED IRA/CR CHANGES: 10/1/15

- Effective 10/1/15 Supervised IRA and CR providers are responsible for paying for and providing the following services that are related to Residential Habilitation:
 - Nutrition
 - Psychological Services (Behavioral Intervention and Support Services delivered by a Licensed Psychologist, Licensed Clinical Social Worker, or Behavioral Intervention Specialist)
- No separate Medicaid billing allowed for these services when it is related to Residential Habilitation.



**INDIVIDUAL DAY HABILITATION
TERMINATION: 10/1/15**

- The termination of IDH is necessary due to the recent expansion of Community Habilitation services.
- IDH is duplicative of two other Home and Community Based Waiver services available: Community Habilitation and Group Day Habilitation.
- An individual can choose to receive either CH or GDH or a combination of both services in order to meet their service needs.



Changes For Direct Therapies



Rationale for Changes:

- The policy regarding these changes reflects CMS' view that direct provision of therapy services funded in Supervised IRA rates or in Day Habilitation sites must be provided either in a certified Article 16 satellite clinic, main clinic, or through the new Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD), state plan option.



Therapy Services NOT at a Main Clinic or Satellite :

Two Options:

1. Provision of clinical services moves to certified on-site Article 16 clinic --satellite or main.
2. Provision of clinical services transitions to Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD), Preventive Services state plan option.



Impact on MSC Responsibilities



Impact on MSC Responsibilities:

- Changes to Supplemental Group Day Habilitation (SGDH) and Personal Care for people who live in Supervised and Supportive IRA's, CR's, and Family Care Homes were effective October 1, 2015.
- Agencies who have individuals that receive SGDH or personal care will no longer be able to bill these services separately to Medicaid. These services are the responsibility of the Residential Habilitation Provider.



Individualized Service Plan (ISP) Changes:

- Changes to the ISP need to be made at the next ISP review.
 - Up to 6 months time frame to implement changes.
- As SGDH is no longer billed separately to Medicaid, it needs to be removed from the "HCBS Waiver Services" Funded Services section. If an individual chooses to continue receiving Supplemental Group Day Habilitation (SGDH), the service should be reflected under the "Other Services or 100% OPWDD Funded Supports and Services" section.



**Individualized Service Plan (ISP)
Changes:**

- Changes to the ISP need to be made at the next ISP review.
 - Up to 6 months time frame to implement changes.
- As Personal Care is also no longer billed separately to Medicaid, it needs to be removed from the "Medicaid State Plan Services" Funded Services section and if the individual continues to receive personal care, the service should be reflected under the "Other Services or 100% OPWDD Funded Supports and Services" section.



52

**Individualized Service Plan (ISP)
Changes:**

- ISP needs to be updated with termination of Individual Day Habilitation (IDH) by removing IDH from the plan.
- An individual can choose to receive Community Habilitation, Group Day Habilitation or a combination of both; this needs to be updated and reflected in the ISP.



53

Habilitation Plan Changes:

- To reflect these changes Residential Habilitation providers may also find that they need to update habilitation plans to reflect the personal care and SGDH services that a person receives.
- Medicaid Service Coordinators should receive a copy of any updated plans.



54

Advisory Memo

- On Wednesday November 25, 2015 a memo was sent to all MSC's providing instructions for Recognizing "Outside Services" After 10/1/15.



Office for People With
Developmental Disabilities
55

Questions?



Office for People With
Developmental Disabilities

57

Person Centered Planning Regulations

12/4/2015



Office for People With
Developmental Disabilities
57

OBJECTIVES (can't)

- Highlight how these principles foster independence as well as interdependence.
- Inspire and motivate participants via interactive group conversations
- Feature real examples and strategies that support culturally spiritual environments that honor people's desired outcomes.



59

Person Centered Planning

Shelly M. Okure, Statewide Coordinator
Person Centered Practices
Division of Person Centered Supports



Person Centered Planning is

A process that seeks to:

- Listen to the **individual**
- Understand what **they** feel is important
- Discover how and where **they** want to live, volunteer, work and participate in the community
- Strategize with **individuals and those they choose** to identify the supports and services needed to achieve their personal outcomes.



Person Centered Planning

- Builds on **the individual's** abilities, strengths and interests
- Considers of **their** health and/or behavioral concerns

It is a process that guides the development of an individualized service plan.



Person Centered Planning isn't...

- focused on deficits, diagnoses, or disabilities., or
- focused on fixing or changing a person;
- a "one size fits all" process



System Centered to Person Centered

FROM



- Treatment and programmatic focus
- Segregated Programs
- Focus on filling slots, beds and residential placements
- People with disabilities are often stereotyped and "placed" with other who have the same diagnoses or challenges
- Regulations, Policies and Rules are used to govern people's activities

- Individualized plans based individual's strengths, interests and needs,
- Help people be members of their communities
- Support people to live as independently as they are able
- Help people to develop friendships



64

Person Centered Planning Federal Regulations



HCBS Settings Final Rule Key Elements

- The final rule was effective March 17, 2014
- Defines consistent definition of community settings across all HCBS Medicaid authorities
- Final rules apply to all settings
- **Also defines person centered planning requirements/regulations**
- Is based upon the “nature and quality of participant’s experiences”



Person Centered Planning: Element in Regulation

- The PCP process is led by the individual
- It includes people chosen by the individual
- Individuals are supported to direct the process and make informed decisions about supports & services
- Records the alternatives that were considered by the individual
- The process is timely and occurs at times and locations convenient to individual



PCP in the Final rule

The Federal Government has defined Person Centered Planning in regulation; with similar expectations for states

Outcomes of Person Centered Planning in Regulation should lead to:

- Integration and full access to the community
- Selection of service and setting options by the individual
- Individuals' rights to privacy, dignity and respect
- Freedom from coercion and restraint
- Optimizing autonomy and independence in life choices
- Facilitating choice of services and who provides them
- Strategies for solving conflict or disagreement



Person Centered Planning: Element in New York Regulation

- The planning process applies to service coordinators and habilitation providers.
- Individuals must receive notice regarding their right to participate in a person centered planning process.
- The plan will reflect cultural considerations and is conducted in language or communication styles that is accessible and understandable to the individual.
- Strategies in place for Individuals to request updates to the plan
- Procedures are in place and made known to individuals to address conflict of interest and/or due process if they don't agree with their service plans.



The Person Centered Service Plan (ISP)

1. May be an Individualized Service Plan (ISP) or an Individualized Habilitation Plan.
2. Reflects the services and supports that are important for the individual to meet their personal outcomes and needs that are identified through an assessment of functional need
3. Reflects what is important to the individual with regard to preferences for the delivery of such services and supports
4. Commensurate with the scope of services and supports available under the HCBS waiver



The Person Centered Service Plan (ISP)

5. Identify the individual and/or entity responsible for the monitoring of the plan
 - i. The Medicaid Service Coordinator (whether ISP or Habilitation Plan)
6. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
7. Be distributed to the individual and other people involved in the plan
8. Must prevent the provision of unnecessary or inappropriate services and services:



Person Centered Service Plan (ISP or Habilitation Plan)

9. Must be understandable to the individual
10. Must be written in plain language
11. Must take in to account cultural considerations important to individual's
12. Must be in a manner that is accessible to individuals with disabilities
13. Must be accessible to individuals who have limited English proficient or use of other modes of communication.



The plan needs to reflect:

- that the setting in which the individual resides is chosen by the individual
- the individual's strengths and preferences
- clinical and support needs as identified through an assessment of functional need
- individually identified goals and desired outcomes
- risk factors and measures in place to minimize them including individualized back-up plans and strategies.



- the services and supports (paid and unpaid) that will assist the individual to achieve identified goals
 - include those services, the purpose or control of which the individual elects to self-direct.
- the providers of those services and supports, including natural supports.



73

Rights Modifications

- Rights modification must be supported by a specific assessed need and justified in the person-centered service plan. Requirements must be documented and are described on the next slide.
- Guidance to where the requirements should be documented. Depending on the modification, it may be appropriate to document it in:
 - The ISP
 - The Behavior Support Plan
 - A nursing plan
 - Etc.



74

Plan Reviews

The Person Centered ISP or Habilitation Plan must be reviewed at least twice yearly and revised when the individual's circumstances or needs change significantly, or at the individual's request.



75

What does this mean for you

- Evaluate your current guidance and trainings to see where they can be clarified and/or improved
- Plan more outreach, communication, and training to the field regarding elements of person centered practices.
- OPWDD is including elements of person centered practices into survey protocols.



What does this mean for you

- Despite the fact that this may sound a little daunting; OPWDD has been promoting person centered approaches to service delivery for over 15 year. Yes, we now have regulations; but most of us have already understood that this is just the RIGHT WAY to support people, to their fullest extend possible to have lives they consider to be meaningful and full of purpose.



For Additional OPWDD Resources Related to PCP and the PCP Regulations:

- Our website contains information on HCBS Settings and Person Centered Planning Regulations
- There is a webpage specific to Person Centered Planning. Includes basic information on PCP and PCP methodologies as well as
 - CQL Personal Outcome Measures
 - Strengths and Risks Inventory Tool
 - Information on Self Direction
- CMS Exploratory Questions for Residential Settings



79

OPWDD's Care at Home Waiver(s)

Presented by Lynda Baum-Jakubiak
Statewide CAH Coordinator
lynda.baum-jakubiak@opwdd.ny.gov



About CAH

CAH provides services to children, living at home, who have a developmental disability and complex medical needs. The services under the CAH Waiver(s) include:

- Case Management
- Respite
- Assistive Technology (Adaptive Devices) and Environmental Modifications (Home Accessibility)



CAH Eligibility

- OPWDD Eligibility
- Under the age of 18, living at home
- Complex health care needs
- Level of Care
- Home Health Assessment
- Medicaid eligibility



For further information, refer to
http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/Care_at_Home

General inquiries can be addressed to
careathome@opwdd.ny.gov



NEW YORK STATE
Office for People With
Developmental Disabilities
52

Wrap Up

- Next MSC Supervisors Conference Schedule for 2016:
 - March 9
 - June 8
 - September 14
 - December 7
- Registration will be available through the catalog



NEW YORK STATE
Office for People With
Developmental Disabilities
53

Fact Sheet & Frequently Asked Questions Related to FIDA-IDD Implementation and the MSC Program

The Medicaid Service Coordination (MSC) Program plays an integral part in the coordination of supports and services delivered to individuals with developmental disabilities within the Fee for Service (FFS) program. As the State's Care Coordination models evolve for the DD population, front line staff are key players in the movement to deliver better health outcomes and needed care services to OPWDD's individuals.

In particular, Service Coordinators begin working with individuals as they enter the developmental disabilities system, supporting the DDROs in conducting the OPWDD eligibility determination and service authorization processes. MSC's use the Preliminary Individualized Service Plan (PISP) to develop a full Individualized Service Plan. They work with individuals and their circle of supports to make informed choices regarding services; help to locate and access supports and services; monitor the person's progress; and assist the individual in a way that leads to outcomes or results in areas of the individual's life that are most important to him or her.

The FIDA-IDD (Fully Integrated Duals Advantage-Intellectual and Developmental Disabilities) Program is scheduled to begin implementation in April 2016, through a partnership with the OPWDD, NYSDOH, CMS, and Partners Health Plan. The FIDA-IDD demonstration is limited to operating in 9 downstate counties. Through the FIDA-IDD program, a select segment of adult individuals eligible for Medicaid and Medicare (dual eligibles) will have more opportunities to direct their own services, be involved in care planning, and live independently in the community. Individuals' existing Medicare and Medicaid benefits will be provided through an integrated benefit design that would also include a dedicated interdisciplinary team (IDT) to address each individual's medical, behavioral, long-term supports and services, and social needs. This IDT, which will include a lead care manager and support team, will provide person-centered Care Management to participants through a Life Plan.

It is important to note that the implementation of voluntary enrollment into the FIDA-IDD in the downstate area (NYC, LI, Westchester and Rockland Counties) by no means diminishes the need or importance of the MSC Program in the FFS system. This Q&A clarifies how MSCs will work with the FIDA-IDD program.

1. If an individual chooses to enroll into the FIDA-IDD, will the individual still have me as his/her service coordinator?

An individual enrolled in the FIDA-IDD will not receive Medicaid Service Coordination. She/he will receive Care Coordination through the FIDA-IDD.

2. Am I still able to provide MSC services through the FFS program for individuals that choose not to enroll in the plan?

Yes. Your agency is able to continue to provide services for FFS individuals that choose not to enroll in the FIDA-IDD. As a voluntary program, enrollment into the FIDA-IDD is expected to be a proportionally small group as individuals are not mandated to join. The majority of the IDD population will remain FFS at this time.

3. What are my options as a Service Coordinator for providing services after the FIDA-IDD is implemented?

- a. Continue in your role with your current agency within the FFS system. Enrollment into the FIDA-IDD Plan is limited to dual eligible individuals only and therefore the majority of individuals you work with will still receive services through FFS.

- b. Speak directly to the FIDA-IDD plan to ascertain your ability to work directly for the plan in a capacity that will benefit yourself, the plan, and individuals with developmental disabilities. There are various care management functions within in the FIDA-IDD operations that present more than one type of opportunity for supporting individuals within the FIDA-IDD.

1. What are the care management functions within the FIDA-IDD that as a Service Coordinator, I may be eligible to perform?

There are two potential areas within the FIDA-IDD plan;

- **Care Managers** must be an RN, Licensed Social Worker or Psychologist and have knowledge of physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS). They must have at least one year experience working with individuals with IDD. Care Managers are the lead members of the IDT. Responsibilities include:
 - Lead the IDT, coordinate/lead IDT meetings (summarizing discussion and any conflicts)
 - Ensure that all IDT responsibilities are being met, assisting the IDT members where possible or necessary
 - Assist with developing, implementing and monitoring the Life Plan.
 - Ensure that the Life Plan is appropriate and updated as needed
 - Complete the IAM tool
- **Care Coordinators** must be a QIDP. They work closely with the individual within the plan to perform duties as follows:
 - Follow Up
 - Advocacy
 - Benefit Management
 - Facilitate IDT activities and communications.
 - Administer CQL POM interviews when needed
 - Administer non clinical additional assessment components identified from the plan's comprehensive assessment (IAM)
 - Assist with Life Plan development and implementation
 - Educate individuals and families regarding care coordination activities-including access to supports/services, community resources and availability of reasonable accommodations, etc.

2. How else will my responsibilities as an MSC change beginning in April 2016, when individuals are able to choose to enroll in the FIDA-IDD?

Beginning in April, 2016 when the FIDA-IDD enrollment begins, Service Coordinators will responsible for providing the following information to their clients:

- a. Advise individuals who meet the eligibility requirements of the availability of the FIDA-IDD Plan and their options for enrolling into the FIDA-IDD or remaining in Fee-for-Service (FFS);
- b. Inform individuals that FIDA-IDD is voluntary and their right to exercise changes in choice of managed care or FFS at any time;
- c. Provide the State's enrollment broker FIDA-IDD brochure;
- d. Refer interested individuals to the State's enrollment broker for education and potential enrollment into the FIDA-IDD Plan; and when they have questions about which providers in their geographic location are available to them through the FIDA-IDD Plan.

OPWDD will be monitoring both enrollment into the FIDA-IDD and plan capacity of affiliated providers to assess the impact of the FIDA-IDD program on MSC providers in the FIDA-IDD service area. OPWDD will ensure that MSC staff are supported and retain capacity to continue to provide needed service coordination to the FFS population.

Questions for the Office for People with Developmental Disabilities (OPWDD).

If you have questions about FIDA-IDD, please email OPWDD at: FIDA-IDD@opwdd.ny.gov or visit www.opwdd.ny.gov or call (518) 402-2830.