

# MSC E-VISORY

Issue # 13-12

May 18, 2012

State of New York Office for People With Developmental Disabilities  
Courtney Burke, Commissioner  
Distributed by: Division of Person-Centered Supports  
Gerald Huber, Acting Deputy Commissioner

The MSC E-Visory is an electronic advisory which provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly. **MSC Supervisors: Please share this issue with all MSC Service Coordinators and others as appropriate.** In order to receive an email notification when a new MSC E-Visory is posted, please sign up for our mailing list (listserv). Listserv information and past issues can be accessed via the OPWDD website at [www.opwdd.ny.gov](http://www.opwdd.ny.gov) or via the following link: [http://www.opwdd.ny.gov/opwdd\\_services\\_supports/service\\_coordination/medicaid\\_service\\_coordination/msc\\_e-visories](http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories)

## In This Issue:

### Materials for the Special MSC Supervisors Video Conference – May 22, 2012

A special session of the MSC Supervisors Video Conference is being held on May 22, 2012 from 9:00 am – 12:00 pm. This session will focus on the “People First Waiver”.

There will be no handouts. The PowerPoint that will be referenced during this video conference is attached to this e-visory.



**PEOPLE FIRST  
WAIVER**

MSC Supervisors Videoconference  
May 22, 2012



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**THE WAIVER – WHERE WE'RE AT**

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**Recent Activities**

- Needs Assessment Tool Selected (interRAI Integrated Assessment Suite)
- Spring Statewide Public Briefings
- Final Steering Committee meeting held March 28, 2011
- CMS Conversation Continues – recent Q&A posted
- Preparation for Case Studies
- Participation in NYS DOH's Integrated Care for Dually Eligible (Medicare & Medicaid)

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## CMS Negotiations

- Regular conference calls occurring since Jan 2012, **Now Weekly!**
- Latest information contained in "Response to CMS" document posted online on 4/6/12
- Recent questions about which authority to use – We will be using 1915 b/c combination.
- The authority doesn't matter: objectives remain the same.
- We are still moving to managed care.

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## 1915 b/c Combination

- 1915 c waiver (Current Home & Community Based Services Waiver) – defines services
- 1915 b waiver – supports managed care service delivery
- So, a b/c combination supports the goals of the People First Waiver.

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## THE WAIVER *WHERE WE'RE HEADED*

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1115 DEMONSTRATION WAIVER

## Main Elements of Reform

- 1. Creating a Person-Centered, Demand-Oriented System**  
Need-focused service planning  
Equity across NYS  
Self-Direction available to all
- 2. Enhancing Care Coordination and Person-Centered Planning**  
Cross system coordination of comprehensive services  
Ready access to one person for all care coordination needs
- 3. Enhancing Community-based Services**  
Supports for higher levels of need in community
- 4. Modernizing the Financial Platform**  
Funding individual's service needs, not service allocations



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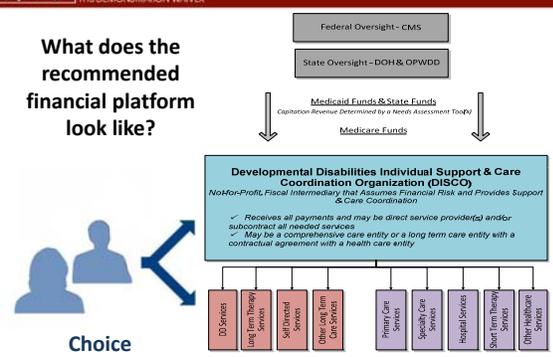
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## What does the recommended financial platform look like?



Choice

DD/Long Term Care Services      All Other Healthcare Services

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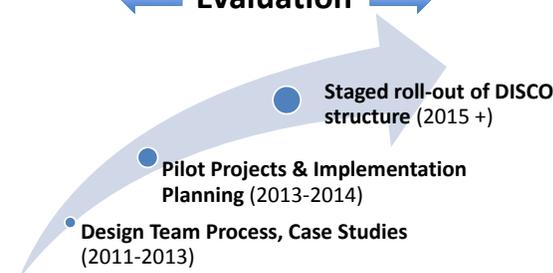
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## A Five-Year Reform Process

← Evaluation →



Staged roll-out of DISCO structure (2015 +)

Pilot Projects & Implementation Planning (2013-2014)

Design Team Process, Case Studies (2011-2013)

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## THE WAIVER

### *HOW WE'RE GOING TO GET THERE*

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## The Waiver's Moving Parts

- CMS Agreement
- Design & Planning Process - continuing from last summer

Access and Choice    Quality    Care Coordination  
Fiscal Sustainability    Services & Benefits

- Case Studies – launching with waiver approval
- NYS Integrated Care for Duals Demonstration
- Pilot DISCO projects – launching late 2013/2014

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## Design & Planning

- First year = 12 months of implementation planning:
  - Work Groups – internal to OPWDD & external
  - Oversight – DD Advisory Council subcommittee
  - Transparency
  - Ongoing opportunities for public input
- End Product = Implementation Plan for CMS

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## Focused Case Studies

**Purpose** – to immediately begin to test key reform concepts on a small scale.

**Tested concepts** – assessment tool, care planning process, documentation practices, new measures of individual outcomes, global budgeting.

**Participating Agencies** – high performing agencies.

**Schedule** - One year of study beginning with CMS approval, formal evaluation.

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## Preparing for Case Studies

- Selecting State Assessment Specialists
- Preparing to train hired staff to implement NY state draft of interRAI tool and conduct interviews
- Working with Westchester Institute for Human Development and Council on Quality Leadership to develop practices for measuring personal outcomes
- Agencies are preparing to use flexible funding & new planning and support models to improve outcomes.

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## State Assessment Specialists for Case Studies

- State employees, new functional title
- Minimum qualifications:
  - ✓ At least one year experience with individuals with DD
  - ✓ Knowledge of supports & services
  - ✓ Experience conducting interviews/assessments
- Extensive training in administering the interRAI ID/DD Assessment

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 **interRAI Assessment Suite**

- ✓ **Person-centered, strengths and needs-based**
- ✓ **Standardized**
- ✓ **Strong validity/reliability**
  - Each item is highly researched and tested
- ✓ **Comprehensive and holistic**
  - Multiple domains and items, with no need to supplement HRST
- ✓ **Flexibility**
  - Can customize the tool by modifying or adding necessary items per domain
- ✓ **Informs care planning process**
- ✓ **Informs acuity**



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 **The Case studies will tell us:**

- What changes are needed to the assessment process and/or assessment tool?
- What impact does changed funding have on support options and individual satisfaction?
- Does the documentation appropriately identify individual outcomes and support maintaining continuity of services?
- Was greater equity achieved by aligning supports with individual needs?

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 **Pilot Project DISCOs**

**Purpose: to demonstrate effective care coordination models on a small scale prior to statewide reform**

- Most will provide traditional OPWDD services and other long-term supports/services (partial capitation).
- Some may be prepared to provide comprehensive care (fully capitated).
- Enrollment will be voluntary.
- Outside evaluation will occur.
- Pilots will form the basis for statewide roll-out of initial, non-pilot DISCOs beginning in 2014/15.

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## Assessment of System Capacity

- To prepare for pilot DISCOs, capacity assessment will occur this spring.
- We will review our provider capacity in the following areas:
  - Care Coordination**
  - Administrative Capacity**
  - Scope of Services**
  - Financial stability**
  - Regulatory Compliance**
  - Integrated Health Care Systems**
- On-site reviews will occur on a stratified, sample basis.

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## Continuity of Service Provision

- OPWDD will explore and define this during the first year of implementation planning.
- Pilot projects will help us gauge the DISCOs' ability to establish robust provider networks to meet the full range of needs, provide choice of providers, and ensure continuity and quality of care.
- It is our intent that there will be an allowance for the time-limited continuation of current providers during statewide roll out of DISCO services.

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## Getting a Jump Start NYS Duals Demonstration

- DOH initiative to integrate comprehensive care for people eligible for both Medicare & Medicaid
- Will include up to 10,000 OPWDD service recipients
- Phase 1 – OPWDD and other long-term services, 2013
- Phase 2 – Adding medical and behavioral health services, Jan 2014



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## THE WAIVER – CARE COORDINATION

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### Comprehensive Care Coordination within the People First Waiver

Comprehensive care coordination is a person-centered interdisciplinary approach to addressing the full range of a person’s needs, integrating habilitation, medical and behavioral health care and support services.

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### Why change care management?

Currently:

- No single entity is responsible for a person’s entire service plan.
- Service coordination is characterized by person’s “point of entry” to services.
- Different processes, standards and other requirements within different agencies make access to services from multiple systems confusing.

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## Why change care management?

The goal is to:

- Establish “No Wrong Door” access to comprehensive services for people in all parts of the state.
- Be able to identify the need to provide a “light touch” that can meet needs earlier and avoid the need for high cost, intensive services.
- Use a care management model to promote the provision of the right level of support in the least restrictive settings.

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## Transitioning to Care Coordination

Who does which functions?

- DISCO
- State OPWDD
- DISCO Providers
- Independent Providers

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## Key Elements of the Care Coordination Model

- True person-centered tools and methodologies to drive individualized service plans and outcomes
- A strong voice for individuals and family members - care plans will be shaped by their active involvement.
- Required education, training, & demo of competency for care coordinators
- Incorporate benchmarks to assess individuals' progress
- Ready access to care coordination whenever it is needed
- Procedures to access natural & community resources
- Information sharing across systems supported by a People First technology solution

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## Care Coordination vs. MSC

Elements that will be different:

- Working with the individual & family, care coordinators will help identify individual outcomes that are measurable, with benchmarks and progress milestones.
- One-Stop for Services - The care coordination organization will eventually be responsible for coordinating all of the supports and services that an individual receives (e.g. medical, habilitation, and clinical).
- A team approach to care coordination with a strong voice for individuals and family members

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## Care Coordination Team

- Interdisciplinary team for each person
- Ongoing training in person-centered planning & self direction
- Team membership will be individualized, including professionals as determined by the needs of the individual (e.g. nurses, employment specialists)
- Each individual will have a designated care coordination team leader.
- Team members will know the individual.



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## Critical Reform: Care Coordination

***This means:***

- MSC will transition slowly to Care Coordination.
- We will need MSC to continue during the transition.
- Many MSCs will provide care coordination.
- Other functions may be provided outside the DISCO by independent providers.
- Other possible future roles will be determined during implementation planning.
- OPWDD cannot guarantee that each MSC will continue to serve their current individuals.

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## THE WAIVER – NEXT STEPS

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## Next Steps

- **CMS Agreement** - Continued negotiations with the federal government to finalize our plan
- **Statewide Implementation Planning** – Form work groups, DDAC Subcommittee
- **Case Studies** – prepare agencies to implement planned testing
- **NYS Integrated Care for Duals Demonstration** – preparing application with DOH
- **Pilot Project DISCOs** – capacity assessment, create application process

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## How Can I Get More Information?

OPWDD webpage: <http://www.opwdd.ny.gov/>

Email comments and questions:  
[People.First@opwdd.ny.gov](mailto:People.First@opwdd.ny.gov)

View video series on OPWDD's  
 YouTube channel: opwddvideo

Contact OPWDD's information line:  
 1-866-946-9733 or TTY: 1-866-933-4889

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