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Office for People With Developmental Disabilities

People First Care Coordination
What is a Health Home?
MSC Information Session

MSC Information Session 3

People First Care Coordination – What is a Care Coordination Organization/Health Home (CCO/HH)

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Overview of Session 3

- Purpose
  - Provide an overview of CCO/HHs; how THEY provide coordination services, and how they differ from Managed Care

- Good News
  - Webinars will be recorded and posted on OPWDD website People First Care Coordination page

    https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations

  - Info sessions will count towards the current required annual professional development hours for MSCs

What is a CCO/HH?

- An *optional* Medicaid State Plan benefit authorized under the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have eligible chronic conditions

- CCO/HH will provide care management under the Health Home Care Management model that is designed to provide:
  - Comprehensive, person-centered care planning using a network of care managers and providers (team approach)
  - Enhanced care coordination and integration of primary, acute and behavioral health services, and
  - Linkages to community services and supports, housing, social services, and family services

New York's Health Home Model

- The NYS Health Home Model was launched in 2012 with the approval of the first Health Home State Plan Amendment (SPA)
- The 2012 SPA indicated the State would implement the Health Home program for adults, *and then expand to serve children and then to individuals with I/DD*
- The Health Home model was expanded to serve children in 2016, and now is being expanded to serve I/DD individuals (i.e., referred to as CCO/HHs)
- Currently, to be eligible for Health Home care management, an individual must be enrolled in Medicaid and have two or more chronic conditions or a single qualifying chronic condition of:
  - HIV/AIDS
  - Serious Mental Illness (SMI adults) or Serious Emotional Disturbance (SED children) or
  - Complex Trauma (children)
- There are currently 34 designated Health Homes across NYS (18 serve adults only, 13 serve adults and children, 3 serve children only)

New York's Health Home Model

- NYS submitted, for CMS approval, a State Plan Amendment (SPA) to create CCO/HHs to serve individuals with I/DD and to expand the Health Home eligibility criteria to include I/DD chronic conditions
- Major Category: Developmental Disability Category
  - Intellectual Disability
  - Cerebral Palsy
  - Epilepsy
  - Neurological Impairment
  - Familial Dysautonomia
  - Prader-Willi Syndrome
  - Autism

New York's Health Home Model

CCO/HHs - Adults and children with one of the I/DD HH chronic conditions, have received OPWDD eligibility determination for OPWDD eligibility and meet ICF level of care criteria

HHs Serving Adults – Adults, 21 and over, with at least one of the I/DD chronic conditions, and another qualifying HH chronic condition, and meet the HH appropriateness criteria, *but have not received OPWDD eligibility determination*~~,~~

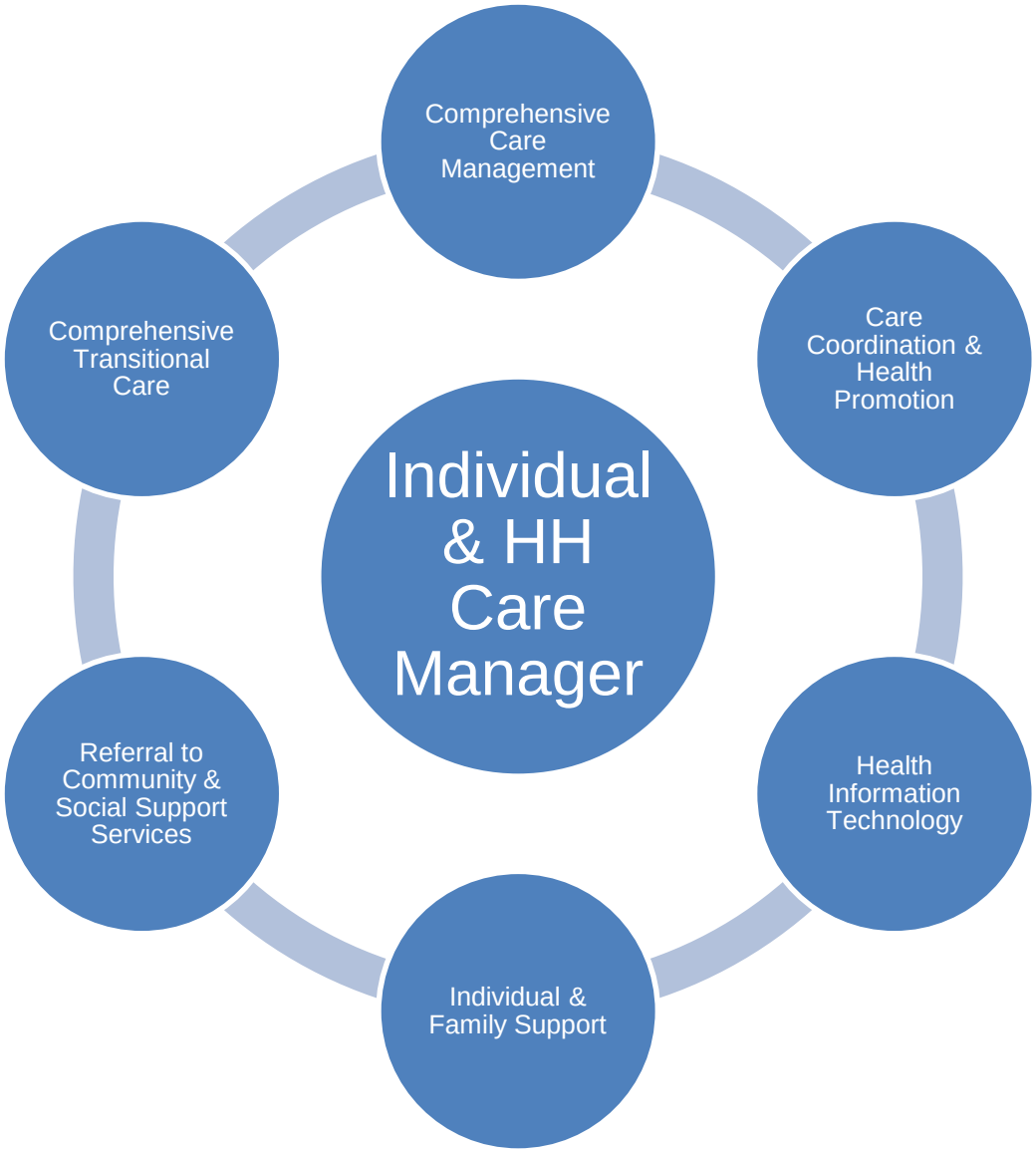
HHs Serving Children – Children, under 21, with at least one of the I/DD chronic conditions, and another qualifying HH chronic condition, and meet the HH appropriateness criteria, *but have not received OPWDD eligibility determination*

Note: Children will be served by HHs Serving Children when the 1915(c) Care at Home OPWDD and DOH waivers, and B2H Waiver for I/DD Foster Care transitions to 1115

Opportunities to Improve Health and Outcomes for People with Developmental Disabilities

- The HH model **provides:**
  - **Person-centered comprehensive care management**
    - Care management expertise of MSC provider agencies and MSC Service Coordinators play an important role
  - An opportunity to establish critical linkages & break down silos of care by linking systems & programs to comprehensive care planning
    - Care manager, person & family at the center with a multi-disciplinary team of working to coordinate disability, long-term services and health-care services
    - Regionally based to provide expertise in community resources
    - Use IT systems to allow accessibility to service & health information that is confidential, accurate & secure – including individual/family portal

Health Homes Provide Six Core Care Management Functions



Six Core Services of Health Home

- **Examples were shared during the December 27, 2017 Webinar – "What is Comprehensive Care Management and How is it Different From the Work of Today's MSCs?**

- View the Webinar: https://www.youtube.com/watch?v=Ozi7jsYL6jw&feature=youtu.be

- PowerPoint: People First Care Coordination MSC Informational Session 2

How Do Services Get Coordinated?

Through the delivery of the six core Health Home Services, a Care Manager (e.g., former MSCs):

- Will provide person-centered planning that coordinates the provision of all service needs (not solely OPWDD HCBS) across multiple systems (i.e. habilitation, medical, & behavioral health);
- Develop a Health Home care plan, called a Life Plan, that is developed & managed with the individual, family & multi-disciplinary care team;
- Communicates, through a computer network, with the individual, family & care team about changes or updates to individuals needs.

Care Manager Responsibilities Will Continue to Include:

- Developing the Life Plan using a PCP Process
- Writing the Life Plan
- Monitoring and implementing the Life Plan
- Inviting the circle of support and providers to Life Plan ~~(ISP)~~ review meetings and working with them when they cannot attend to ensure services are coordinated
- Ongoing Monitoring of Life Plan Reviewing and revising the Life Plan twice annually or when a change is needed, or when the individual requests one
- Following up to ensure that all needed attachments are received
- Ensuring meetings occur when & where it is convenient to the individual
- Following up to ensure that the Life Plan is being implemented as written
- Ensuring that federal laws concerning privacy are honored. The sharing of the Life Plan, in whole or part, is based on the needs of the individual, the scope of the services and supports being provided, & any applicable state and confidentiality requirements

Care Management: Now And Future Focus

Current MSC

1. Strong emphasis on advocacy – actively supporting, encouraging, and/or negotiating on behalf of the individual

2. Required Professional Development Training/Courses – 10 to 15 hours of additional professional development training to enhance ability to service individuals with developmental disabilities

3. Care planning focused on OPWDD service provision

1. Coordinate and arrange provision services

2. Support adherence to treatment recommendations

3. Monitor and evaluate individual's needs

4. Identify community based resources

CCO/HH Care Management

1. Use of Health Information Technology – to link services, and enhance communication between the team

2. Coordinate and provide access to wellness support for individuals and families

3. Coordinate access to mental health and substance abuse services, and all needed services in one comprehensive Life Plan

4. Establish continuous quality improvement program – to ensure quality outcomes for members served

Is a CCO/HH Managed Care?

- A CCO/HH is **not** the same as managed care
- Through CCO/HHs OPWDD is developing a framework for service delivery that is focused on I/DD & person-centered planning as networks of providers are being developed.
- CCO/HHs will initially function in fee-for-service, but can also continue to serve individuals who are enrolled in managed care.

How is a CCO/HH Different from Managed Care?

Managed Care Organization

A health insurance plan or health care system that coordinates the provision, quality and cost of care for enrollees, designed to coordinate care effectively and provide better access to services and supports.

- Payments to service providers come from funds managed by the Managed Care Organization (MCO)
- Services are authorized by MCO
- Individual typically chooses from providers within the managed care network

CCO/HH

Care Management Program

- Payments will only be provided to CCO/HHs for service coordination
- Service authorization continues to come from the OPWDD Regional Offices
- Individual may choose any service provider, even if it is not affiliated with the CCO/HH

CCO Implementation Timeline

✓ Draft application for CCO/HHs designation was released June 2017 for stakeholder comment

✓ The final application was released in October & applications due November 30, 2017

✓ Review applications (underway).

✓ Designations expect to be made by early February 2018

✓ CCO/HHs will begin operations July 1, 2018

✓ OPWDD released a CCO/HH Transition Plan in November, open for 30 day public comment – now assessing comment

From MSC Service Coordinators to CCO/HH Care Managers

CCO/HH Care Managers who serve adults & children with I/DD must have qualifications:

- A Bachelor's degree with two years of relevant experience, or
- A License as a Registered Nurse with two years of relevant experience, which can include any employment experience & is not limited to care management/service coordination duties, or
- A Master's degree with one year of relevant experience.

Care Manager qualifications will be waived by OPWDD for existing MSC Service Coordinators who apply to serve as Care Managers in CCO/HHs.

- Documentation of prior status as MSC Service Coordinator may include a resume or other record created by the MSC agency or CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.

Care Manager Training

- Existing MSC Service Coordinators have many elements of required CCO/HH training – e.g., person-centered services

- CCO/HHs will be required to provide Health Home services training for all current MSC Service Coordinators who transition to the Health Home program.

- The CCO/HH will be responsible for ensuring that all “grandfathered” MSCs are adequately trained for Care Management responsibilities.

Session 4: January 24, 2018

What is a Life Plan and How Does it Compare to an Individualized Service Plan?

- Overview: An Introduction to Life Planning Elements

- Registration https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/msc_webinars

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Thank you – Questions?

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Detailed Description of Health Home Core Services

- Detailed Core Service Description available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf
- In Application – pages 10-16.