



Office for People With Developmental Disabilities



People First Care Coordination MSC Information Session



Info Session Updates

- Sessions 1-6
 - Posted on the OPWDD Website.
- Session 8 – March 28, 2018
 - ***Cultural Competency: Why It's Important for Care Managers***
- Session 9 – April 11, 2018
 - ***Topic - TBD***

For viewing or registration go to the OPWDD website at:

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

Information sessions count towards current annual MSC professional development hours.



MSC Information Session 7

MSC Next Steps: Updates on CCOs, Training, and Enrolling Individuals

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Today's Webinar

- Updates on Educate to Enroll Training for Medicaid Service Coordinators (MSCs)
- Review of Toolkit for MSCs
- Questions from the Field
- Introduction of Care Coordination Organizations (CCOs)

Updates

- Follow-up from Feb. 28 Webinar
 - Training on Enrollment and Consent coming for MSCs on Statewide Learning Management System (SLMS)
 - Available in late March
 - All MSCs must take that training to be equipped to provide continuity of service coordination for individuals
 - Training can be used toward MSC Professional Development hours



Transition Activities and Milestones

Late
March

SLMS
Enrollment
Training
available
for MSCs

3/28/18

OPWDD
sends MSC
Toolkit with
personalized
letters to
MSC
providers

Starting
4/1/18

MSCs
conduct
education
for distri-
bution of
information
packet and
identify
program
choice

4/15/18-
6/30/18

Choices
selection
screen
available in
CHOICES
for MSCs
to record
individual
selection of
Health
Home or
Basic
HCBS Plan
Support

No later
than
5/1/18

OPWDD
sends two
monitoring
reports
each week
to CCOs
and MSC
providers to
assist in
verifying
enrollment



MSC Toolkit

- CCO Informational Brochure to give to individuals/families
- Scripts to help you know what to say to engage and educate individuals
- A sample Individualized Information letter that you will be giving to individuals and families about transitioning to CCO
- Documents to support the individual's selection of care management
- Frequently Asked Questions

How To Access the Toolkit

- You will be able to access the Toolkit materials:
 - On the OPWDD website
 - Via the MSC provider agency in which you are employed
 - In the SLMS resource section of the enrollment training

Informational Brochure



- Benefits of Health Home Care Management
- What is a Care Coordination Organization
- What is a Care Manager
- Why OPWDD is transitioning from MSC to Health Home Care Management
- What individuals must do to continue receiving Care Management services
- What is a Life Plan

Scripts for MSCs to Educate Individuals

- You will be responsible for communicating the system changes that will take place in July 2018 with all the people you currently support
- These scripts will help you know what to say to individuals and families as they make choices about care management options

Individualized Information Letter

- The Individualized Information Letter will help you review with families the decisions that they must make to complete the enrollment process
- The Individualized Information Letter outlines
 - The transition to Care Coordination Organizations
 - The CCOs available in their Region
 - The CCO his/her current Medicaid Service Coordination provider/coordinator will be joining
 - The care management options

Questions



What is Basic HCBS Plan Support?

- The Basic care management option is a limited option that is most similar to Plan of Care Support Services (PCSS)
- It offers less than the current Medicaid Service Coordination
- The frequency of self-direction planning meetings and the need for plan updates may not be comprehensively supported in the Basic HCBS Plan Support option which will require a minimum of 2 annual contacts and a maximum of 4 annual contacts
- There are no limits to the Basic option caseloads
- The holistic, wellness focus of the Health Home Care Management core services are not part of the Basic HCBS Plan Support option

Benefits of Health Home Care Management

Health Home Care Management

- Develops Care Plan and Reviews Bi-Annually
- Monitors Health and Safety
- Coordinates Access to Behavioral Health Services
- Coordinates Access to Medical and Dental Services
- Identifies and facilitates connection to Community-Based Resources
- Uses Technology to Link Services
- Connects Care Providers
- Works collaboratively with Individuals and Families to Navigate Systems

Basic HCBS Plan Support

- Develops Care Plan and Reviews Bi-Annually
- Monitors Health and Safety



Does an individual need to choose Health Home Care Management or Basic HCBS Plan Support to receive HCBS waiver services?

- Yes, in order to receive Waiver services, an individual must receive either Health Home Care Management or Basic HCBS Plan Support Services

How will the implementation of Care Coordination Organizations affect self-direction?

- The current self-direction model will not be impacted by the implementation of CCOs
- The CCOs and Care Managers are required to help people self-direct their services, if they so choose
- The current Broker and Fiscal Intermediary services are part of the waiver service system and will remain in place
- Personal Resource Accounts will continue to be set by the state as we shift to CCOs and also into a managed care environment

Benefits of Health Home Care Management for people who self-direct their services

- People who choose to self-direct their services will benefit significantly from the Health Home Care Management Service; it will add a layer of support, monitoring and assistance to help people receiving services and their families coordinate their self-direction plan and other cross systems or future planning needs
- The Health Home Care Manager role should reduce family member concerns. The Care Manager will play an active role and will help with the navigation and monitoring of the self-direction plan
- Feedback has told us that self-direction works best with a strong coordinator involved
- Health Home Care Management strengthens the Circle of Support



If a family member does this, why is there need for a Care Manager?

- Many families and individuals worry about managing a self-direction plan if their support system changes. A Care Manager will provide the ongoing monitoring and planning needed to ensure a person's needs are met and his/her Life Plan is being carried out
- The needs of people receiving services can change and family circumstances change – the safety net of a strong Care Management service is very important to those who choose to self-direct

What if an individual has a health care provider and doesn't have behavioral health needs?

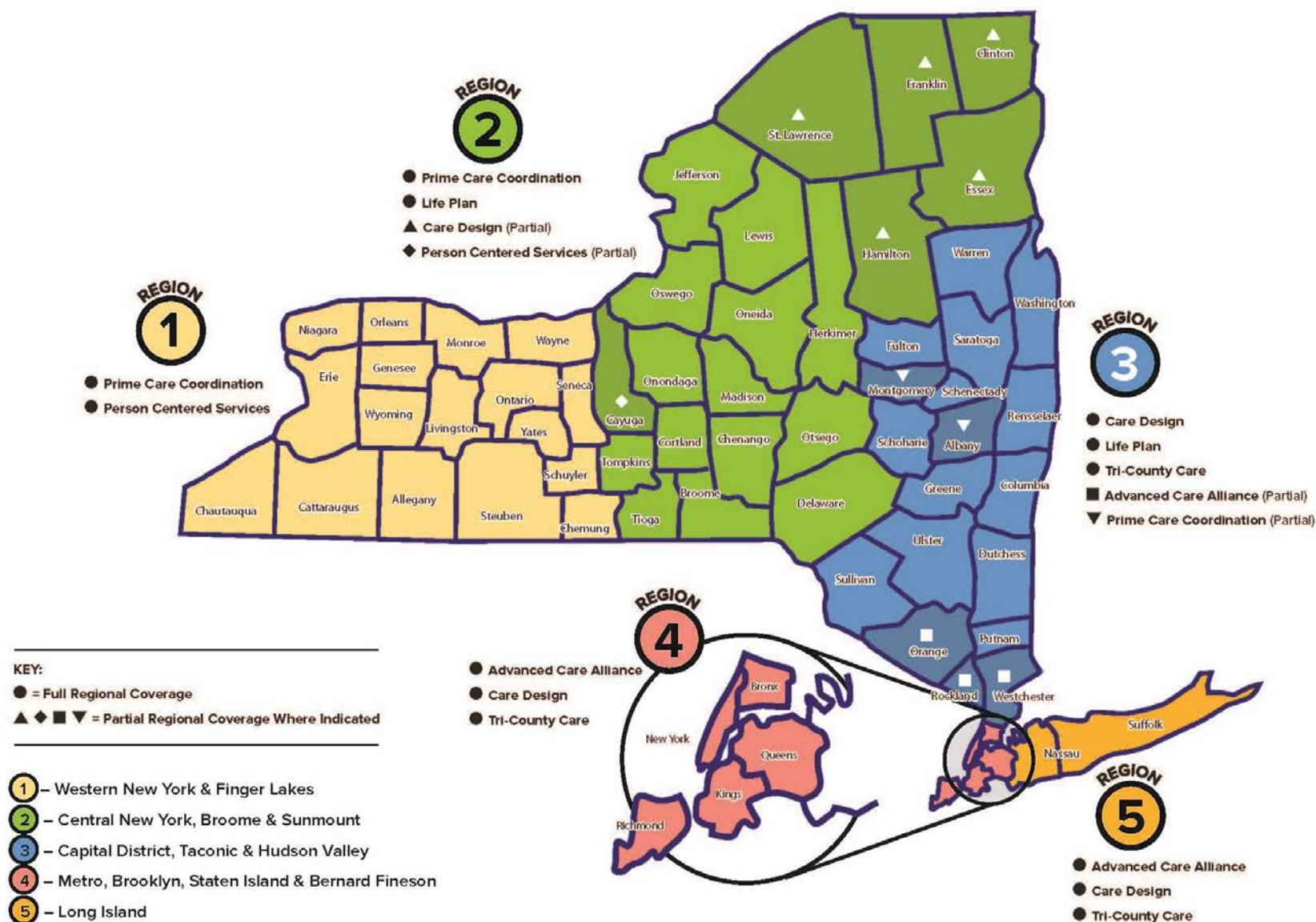
- An individual does not need to have complex or unmet needs to benefit from Health Home Care Management. The core services also include social supports, education, and general wellness planning that benefits everyone
- An individual's health care provider becomes a member of the team so that health needs are considered and planned for in the Life Plan

Care Coordination Organizations

- [Advance Care Alliance](#)
- [Care Design NY](#)
- [LIFEPlan](#)
- [Person Centered Services](#)
- [Prime Care Coordination](#)
- [Tri-County Care](#)



CCO Regional Coverage





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Thank you – Questions?
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