

Achieving Conflict Free Case Management Across OPWDD Service System

**Division of Person Centered Supports
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**NEW YORK
STATE OF
OPPORTUNITY.**

**Office for People With
Developmental Disabilities**

Transformation Panel & Managed Care

- Transformation Panel Legislative Report
 - Of 59 recommendations, ten related to managed care, care coordination and assessment

- Goals of Recommendations:
 - Transform the provision of care & finances for IDD from disjointed FFS to comprehensive, person-centered system
 - Design and deliver managed care for persons with IDD – in a thoughtful way
 - Provide better outcomes and value



Conflict-Free Case Management (CFCM) Transition Plan

- Federal Home and Community-Based Settings rule, as described in 42 CFR 441.301(c)(1)(vi), requires states to separate case management from service delivery functions (March 2014).
- CMS specified that OPWDD submit a transition plan to comply with conflict free standards for service coordination by October 1, 2016.
- The same organization shouldn't deliver both **case management** (person-centered service plan development) and **HCBS services** to the same person.



Intent of 2014 HCBS Final Rule – A Fundamental Shift in Orientation

- Better align HCBS Medicaid funding and program requirements with civil rights protections afforded under ADA.
- Foster genuine person-centered planning and individual choice concerning provision of services.
- Address concerns that in some states HCBS is used to fund “institutional-style” settings lacking opportunities for people to engage meaningfully in their communities.
- Ensure that individuals have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate to their needs.



OPWDD Implementation

- Primary goal is to strengthen the holistic approach to organizing services and supports.
- CFCM is a foundational element in improving Care Coordination.
- Multi-phased approach spanning over several years.
- Allowing OPWDD to transition into a CFCM system that can operate in both the fee-for-service system and in Managed Care



Conflict Free Case Management (CFCM) Timeline

- **Phase One – 2016:**
 - Communication with stakeholders on the concept of CFCM - set a foundation for understanding necessary changes
 - CMS and the State publish a plan for stakeholder input (October)
- **Phase Two – 2017:**
 - OPWDD will use a competitive procurement/ bidding process to ensure individuals and families have choice of new conflict free case management organizations
- **Phase Three – 2017-18:**
 - The award of contracts will begin during this phase and may be 'rolled out' on a regional basis



What is a CCO?

- Care Coordination Organizations (CCO), a new organization to be approved by OPWDD
- To provide enhanced care coordination services
 - Level of service tailored to individuals' needs
 - Regionally based / community resources expertise
 - Personal choice
 - Build on traditional MSC role
 - IT enabled
 - Conflict free
- Foster HCBS Rule attainment



OPWDD CCOs Will Be Established Under the Health Home Authorization

- The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions.
- Health Homes are used in serving other Medicaid populations in New York State
- CMS expects health home providers to operate under a "**whole-person**" **philosophy**. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion and prevention
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

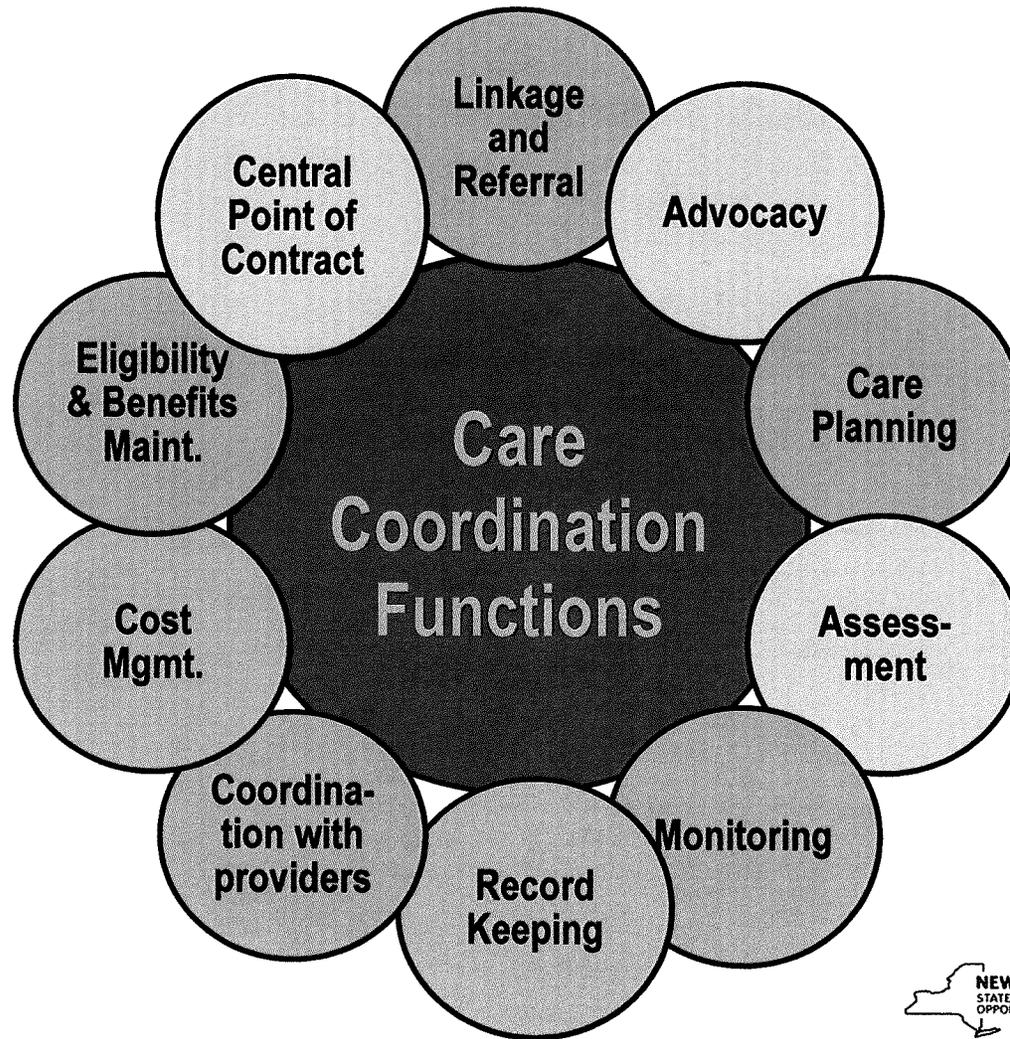


Functions of Health Homes

- **Improve Access:** Coordinate and provide access to:
 - Long-term supports and services;
 - Health care and behavioral health services;
 - Preventive care and health promotion services;
 - Comprehensive care coordination for services within the OPWDD system and across other systems;
 - Chronic disease management, including support to individuals and their families to help them manage chronic conditions; and,
 - Individual and family supports, including referrals to community and social supports.
- **Integration of Healthcare:** Develop person-centered plans that coordinate and integrate all clinical and non-clinical health related needs and services
- **Improved Use of Technology & Data:** Use Health Information Technology to link services, facilitate communication among team members and between the health team, individuals and family; provide feedback to providers
- **Continuous Quality Improvement**



Care Coordination is Teamwork



MSC Responsibilities Continue to Include

Developing the
ISP using a PCP
Process

Writing the ISP

Monitoring
and
implementing
the ISP

Inviting the circle of support and
providers to ISP review meetings
and working with them when
they cannot attend to ensure
services are coordinated

Reviewing and revising the 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 and
where it is
convenient to
the individual;

Following up to
ensure that the
plan is being
implemented as
written

Ensuring that the individual has determined who receives the whole plan or parts of the plan, based on the level of need of the individual, the scope of the services and supports being provided, and any applicable state and federal laws concerning privacy and confidentiality



MSC Now and Future Focus

MSC Current Approach

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

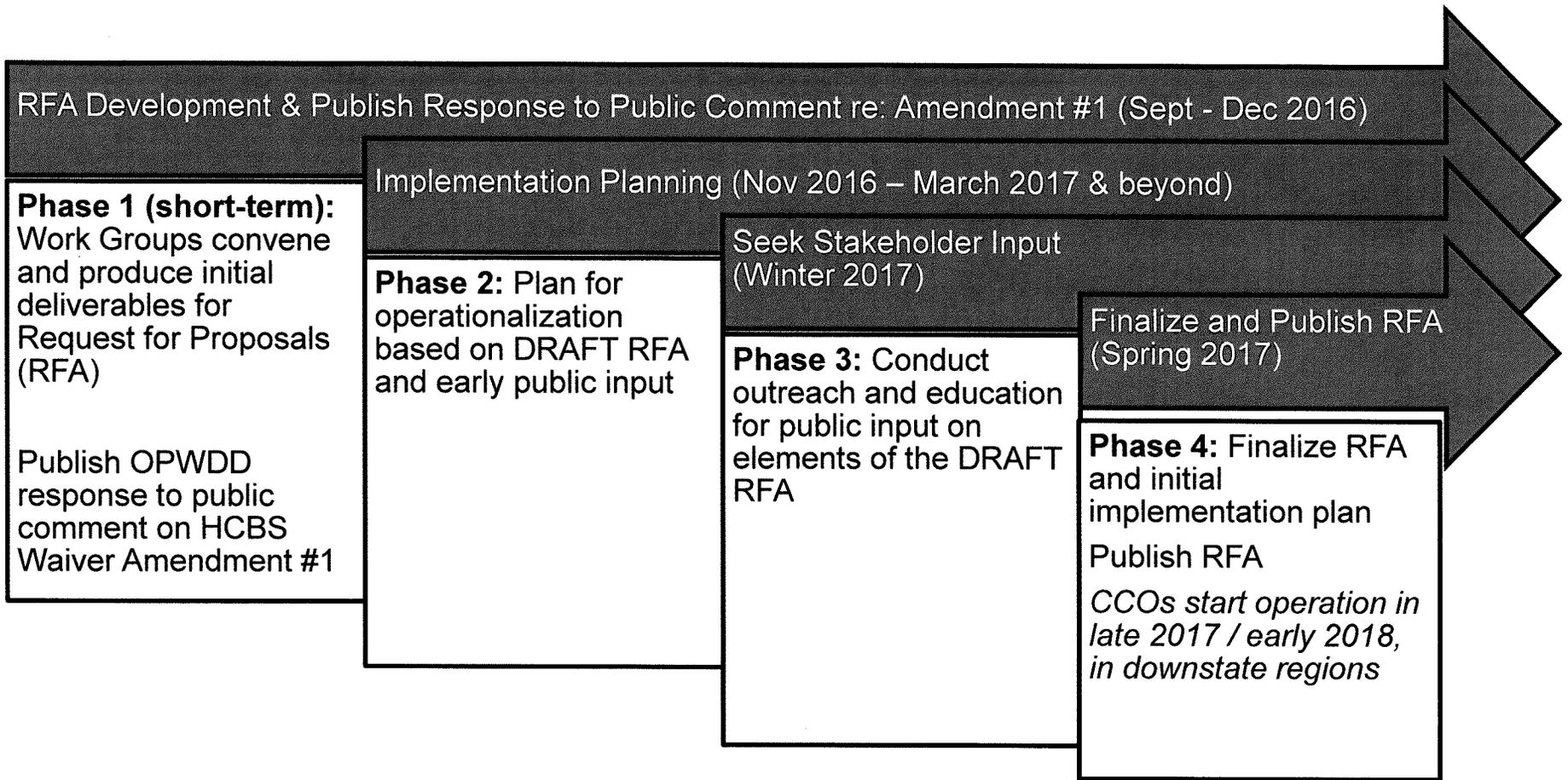
1. Coordinate and arrange provision of services
2. Support adherence to treatment recommendations
3. Monitor and evaluate individual's needs
4. Identify community based resources

New Paradigm Includes

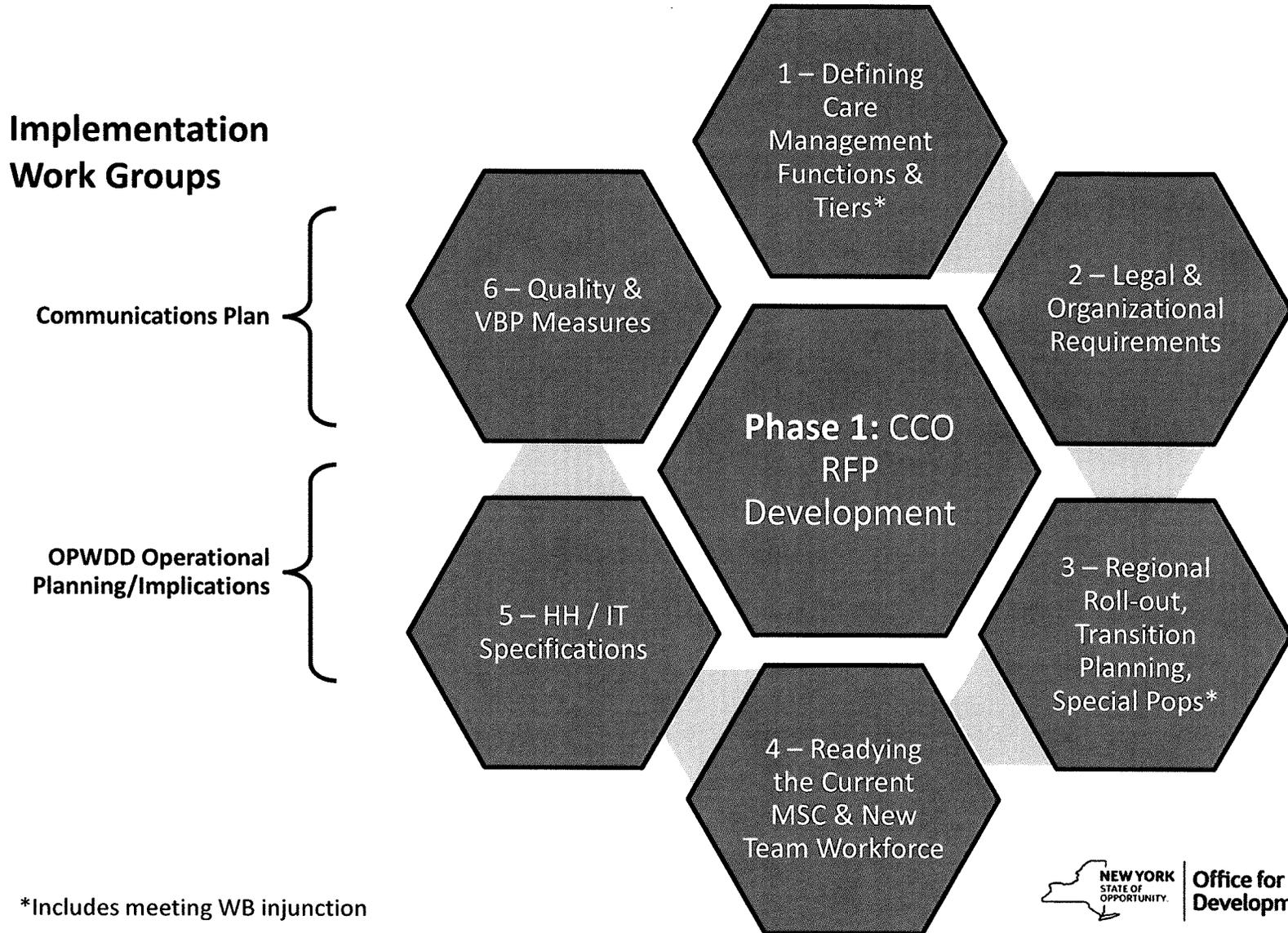
1. Use of Health Information Technology – to link services, and enhance communication between providers
2. Coordinate and provide access to wellness chronic disease support to individuals and families
3. Coordinate access to mental health and substance abuse services
4. Establish continuous quality improvement program – to collect and report on data that permits an evaluation of increased coordination of care



CCO Implementation Timeline



RFA Development Work Groups



*Includes meeting WB injunction

OPWDD's Commitment to Delivering Improved Coordination & Better Outcomes

- Strive to develop service that is person-centered and person driven
- In designing CCO approach, OPWDD will address policy objectives:
 - Meet and maintain federal requirements
 - Minimize service disruption to individuals and families
 - Support the establishment of a system transitioning to managed care, quality monitoring and value-based payments, and
 - Maintain individual choice, to the maximum extent possible
- Design improved career path for service coordinators
- All phases of the CCO plan development will include stakeholder involvement, outreach and planning
- CFCM is the action step, enhanced care coordination is the goal

