THE DEVELOPMENTAL DISABILITIES SYSTEM FACES ENORMOUS CHANGES

Discussion  NYC FAIR
May 21, 2019
FOUR MAJOR FOCUS AREAS

• Services for People in Need
• The Workforce
• Financing of the current system
• Impact of Managed Care
Services for People in Need

- **FACTS to be Addressed**
- More than 13,000 people across the state have expressed a need for services
- 6,400 indicate a need for residential supports within the next two years
- NYS has presented an ICF closure plan which will eliminate more than 1600 residential opportunities
Services for People in Need

- OPWDD offers an array of services and supports to help people with developmental disabilities live in the home of their choice; find employment and other meaningful activities in which to participate; build relationships in the community, and experience health and wellness. The various levels and combinations of services and supports mean that OPWDD can accommodate the strengths, needs, and preferences of virtually any person with developmental disabilities.

- People new to the OPWDD system can access services and supports through our Front Door. Those already receiving services can review service and support options, and may want to consider self-direction. If you are interested in changing your services, talk to your care coordinator about the service amendment process and submit a Service Amendment Request Form.

- OPWDD understands that there is no “one-size-fits-all” program that is appropriate for every person. That’s why every person that is receiving OPWDD supports and services undergoes a person-centered planning process. The goal of this process is to discover the particular abilities, wants, goals and needs of each individual served. Person-centered planning helps us turn the input of each individual and his/her caregiver(s) to build a lifestyle suited to his or her unique situation.

- OPWDD is committed to providing a wide variety of support and service options to meet the needs of individuals and their families. OPWDD supports and services include:
  - Help for people to live in a home in the community.
  - Help for families to support their family member to live in the family home with respite and other family support services.
  - Help for people who want to work in the community with employment training and support, volunteer opportunities, and other types of community engagement.
  - And help for people who need intensive residential and day services.
The Front Door is the way OPWDD connects people to the services they need and want. Once you enter, a person-centered planning process begins which helps you learn about and access service options taking your needs and desires into consideration. It will also give you the chance to direct your own service plan or help your family member or loved one as they direct theirs.

The Front Door is based on the understanding that people with developmental disabilities have the right to enjoy meaningful relationships, experience personal growth, participate in their community and live in the home of their choice.

The Front Door staff will guide you through the steps involved in finding out if you are eligible for services with OPWDD, identify your needs, goals and preferences, and help you work on a plan for getting those services.
Services = Front Door

• Where do I begin?

• You can contact the OPWDD regional office that covers your county to access the Front Door, or call the OPWWD Info Line at 1-866-946-9733. To help you get ready to plan for OPWDD services, you will be asked to attend an information session.

• The first step to receiving assistance is to determine if the person seeking services is eligible to receive services and supports. Once someone is determined eligible to receive services, they can begin the planning process. There are many support and service options available, including residential, employment, day habilitation, children’s services and aging services.

• The Access to Services Resource Booklet can also help guide you through the process.
• The Front Door Q&A may also help address some of your questions.
• Download a copy of our brochure How Can I Get Services?
The Eligibility Review process is the gateway to OPWDD services in New York State. An individual who has a developmental disability and lives in New York State can request a basic eligibility review by: calling an OPWDD office directly; asking a local government agency to assist them in accessing OPWDD-funded services; or having a voluntary agency make a request on their behalf. Before receiving Medicaid-funded services through OPWDD, an individual must arrange to have a review of the necessary records that contain evidence of a qualifying developmental disability.

The eligibility review process begins at one of OPWDD’s five Developmental Disability Regional Offices (DDROs) that are located throughout New York State. Each DDRO provides services to a specific county or group of counties. The materials and records that are submitted to the DDRO include reports of assessments prepared by qualified practitioners that support a qualifying diagnosis of “developmental disability.” Depending on the complexity of an individual's condition, the review process for obtaining an eligibility determination may require reports from multiple or specialty assessments. A face-to-face interview may also be part of this process.
Services = Eligibility

- For information on eligibility and applying for services, please contact the [Eligibility Coordinator](#) for the [Developmental Disabilities Regional Office](#) that covers the county where the individual lives.
- For information on assessment services in your area, please see [Finding Testing/Assessment Services](#).
- For information on voluntary providers in your area, please see the [Provider Directory](#) on the Individuals and Families tab on OPWDD’s [home page](#).
Future Services = CAS

• Coordinated Assessment System

• The Role of the Care Manager/Qualified Intellectual Disabilities Professional (QIDP) in the Coordinated Assessment System (CAS) Process

The Care Manager/Qualified Intellectual Disabilities Professional (QIDP) will play a vital role in the assessment process by assisting the assessor with confirming/obtaining contact information, scheduling/coordinating, providing documentation to the assessor for review, and reviewing the Coordinated Assessment System (CAS) Summaries with the person, actively involved family member or LG, and the person’s supports (i.e., residential provider, Consumer Advisory Board (CAB) representative), as appropriate. The Care Manager’s/QIDP’s quick response to an assessor’s request is important because the CAS assessment is a time sensitive process.

To assist the Care Manager/QIDP in understanding his/her role, the Care Manager/QIDP will be provided the following documents: CAS Brochure, Documentation Review List, and The Coordinated Assessment System (CAS): Summary Guidance Document for the Person/Family and Supports Conversation.

• Initial Care Manager/QIDP Contact
• The CAS assessor will contact the Care Manager/QIDP to verify/obtain the following information:
  • Person’s contact information
  • Identification of knowledgeable individual(s)
  • Identification of Legal Guardian (LG) and/or actively involved family member/key staff
  • Communication/language access needs
Future Services = CAS

- Care Manager’s/QIDP’s Role in the Assessment Process

  - The assessor will contact the person and schedule an interview.
  - The assessor will communicate to the Care Manager/QIDP the date and time of the interview.
    - If the Care Manager/QIDP learns that the person is experiencing a change in his/her life that requires the assessment to be rescheduled (i.e., hospitalization, unexpected emergency/crisis, etc.), the Care Manager/QIDP will contact the assessor as soon as possible.
  
  - The assessor will inform the Care Manager/QIDP, if the person has identified an individual that he/she would like to have present at the interview for support.
  - The Care Manager/QIDP will be asked to inform the individual identified for support, the location and time of the interview.
  
  If the Care Manager/QIDP is aware of other key individuals in the person’s life that he/she would want to have at the assessment interview, the Care Manager/QIDP will be asked to inform the individual(s) of the location and time of the interview.

  - The Care Manager/QIDP will ensure that all obtainable and requested documentation be available for an assessor to review on the assessment date.

  - The assessor will need to review certain documents, in order to complete the assessment (refer to the Documentation Review for the Coordinated Assessment System (CAS) document for guidance.
Future Services = CAS

- CAS Summaries

The CAS Summaries and Summary Guidance Document will be available 24 hours after the CAS is finalized (Note: Finalization of the CAS could take up to three days from assessment reference (interview) date).

The CAS Summaries and Guidance document can be found in the “Supporting Documents” section of the person’s file in CHOICES.

The Care Manager/QIDP is responsible for sharing, reviewing, and discussing the CAS Summaries with the person, actively involved family member/LG, and the person’s supports (i.e., residential provider, Consumer Advisory Board (CAB) representative), as appropriate, within 30 days from availability. The CAS Summaries should not be distributed without having a proper review and discussion of them. The Care Manager/QIDP should utilize the Summary Guidance Document to facilitate the discussion of the summaries. In addition, the Care Manager/QIDP should document the discussion, as well as any issues or concerns that result from it.

The Care Manager/QIDP should ensure that any new information found in the CAS Summaries is addressed with the person’s supports, as appropriate, and documented in the monthly note and/or Life Plan.

- Questions and/or concerns regarding CAS Summaries should be emailed to: coordinated.assessment@opwdd.ny.gov

- Additional Documents & Guidance:
  - Coordinated Assessment System (CAS): Concerns Response Guidance
  - How to View CAS Assessment Completion (Finalized) Dates by Care Manager Program
Future Services = CAS

- **Documentation Review for the Coordinated Assessment System (CAS)**
- As part of a person-centered approach, the CAS assessment process requires assessors to have access to records and documentation that are pertinent to the person’s care planning process. With the partnership of the Care Manager/Qualified Intellectual Disabilities Professional (QIDP), assessors review documentation that, along with the rest of the CAS assessment process, allows for a more comprehensive understanding of the person’s strengths and needs. In this context, the documentation needed for each person may vary according to his or her unique characteristics. Since the CAS is a time sensitive tool, it is crucial that assessors have access to the documents on the day of the interview with the person and/or the knowledgeable individual(s).
- The role of the Care Manager/QIDP is extremely valuable as they will assist in identifying the documents needed for review and will facilitate the access to such documents. There are several methods Care Managers/QIDPs can use, in order to provide assessors with access to the documents. Some of these methods are: having the person’s record/chart onsite on the date of the interview, sending documents via secure email, or faxing the documents. In addition, assessors may review documentation that has been previously uploaded to OPWDD’s CHOICES portal; however, it is NOT advisable to upload documents to CHOICES with the sole purpose of being reviewed by the assessor.
- The collaborative effort between CAS assessors and Care Managers/QIDPs will reflect the ongoing goal of utilizing a person-centered functional needs assessment in the development of a care plan inclusive as required by the Person-centered Planning Regulations.
Future Services = CAS

- The list below represents a sample of documents that may be relevant for the assessor to review. If the documents cannot be available on the date of the interview, Care Managers/QIDPs should notify the assessor, prior to the assessment interview and make the appropriate arrangements to ensure the assessor can review the documents in a timely manner.

- **Example List of documents for CAS review:**
  - Annual Physical Exam, including recent medical appointment consultations/notes
  - Current medications – Medication Administration Record (MAR) or medication list
  - Most recent Psychological Evaluation (IQ testing)
  - Current Person-Centered Service Plan, such as the Individualized Service Plan (ISP) (with attachments, including Individual Plan of Protective Oversight and Habilitation Plans), or the Life Plan (with attachments, including Individual Plan of Protection (IPOP) and Staff Action Plans)
  - Current Comprehensive Functional Assessment for people residing in an Intermediate Care Facility (ICF) setting
  - Current Individualized Education Program (IEP), if the person is attending school
  - Current Behavior Support Plan/Guidelines, if applicable
  - Most recent clinical evaluations (e.g., Speech, Physical Therapy, Occupational Therapy, Psychiatry)
  - Risk assessment, if applicable
  - Most recent Psychosocial Evaluation, if available
Actions to Present

• NYS needs to rethink its ICF closure plan-to insure that the plan does NOT eliminate current capacity

• Current plan will dramatically affect the current small regional homes for the medically involved-these homes were established as an alternative to nursing homes and as a result of Olmstead requirements
Actions to Present

• Backfills will NOT address this need. The rate of growth for people who need residential supports outweighs the typical vacancies.

• NYS is advocating that Self Direction can help yet, individuals with complex needs have not been able to receive the supports that are needed.

• Individuals with complex needs may not be best supported in their family home.
The Workforce

• **FACTS to be Addressed:**

  • Support system that helps more than 125,000 people must have a stable, quality workforce.

  • People with disabilities who require supports will be competing with the baby boomers who are advancing into a period where they require supports.
Actions to Present

• Establishing and Maintaining a strong and stable workforce requires funding. While the current budget recognizes the Minimum wage increases – it does not support a COLA-compression is major issues and concern for long term employees.

• Recognition and credentialing of the DSP’s are key elements in ensuring the continuity of care the people we support requires.
Financing of the Current System

- **Facts to be addressed:**
  - Rate Rationalization cannot be created based on the stresses of yesterday
  - Financing structure cannot use arbitrary neutrality measures
  - The continuing uncertainty surrounding the State’s fiscal policy in general and provider reimbursement specifically undermines any real progress toward transformation
Actions To Present

• The rate structure needs to reflect the projected workload

• The rate structure needs to create fiscal incentives that reward lower cost options such as community habilitation, supported employment, day habilitation without walls and personal care

• The system and the rate structure needs to ensure an emergency response mechanism to address people and families in crisis.
Managed Care

• The system of supports for people with developmental disabilities has evolved over the years from an institution-based system to a community-based support system based on meeting the needs of each person. This evolution was brought about by the people that we support, their family members, providers and our staff all working together.

• Managed care is the next step in this important evolution, strengthening the coordination of each person’s supports, ensuring quality and challenging providers to deliver outcomes by helping people achieve their goals.

• View a forum presentation about the Evolution of Supports and Services from family forums being held across the state. Download our brochure, Managed Care: The Evolution of Supports and Services.

• To learn more about the progression of managed care for people with developmental disabilities, visit the Care Management Development page.
Managed Care

The Evolution of Supports and Services

Office for People With Developmental Disabilities
Table of Contents

- Managed Care –
- The Evolution of Supports and Services
- Table of Contents
  - What exactly is managed care? .......................................................... 3
  - Why is OPWDD moving to managed care? ......................................... 4
  - How will managed care work? ............................................................ 4
  - How is managed care different from care coordination? .................. 5
  - Will my services change? ................................................................. 5
  - When do the changes take place? ...................................................... 6
  - What happens if I am not satisfied with my services? ...................... 6
  - Are people with developmental disabilities enrolled
    - in managed care today? .................................................................... 6
  - Managed care case studies ................................................................. 7
  - What changes in managed care? ......................................................... 9
  - How will supports be monitored and evaluated in managed care? ...... 9
  - Where can I learn more? ..................................................................... 9
Managed Care – The Evolution of Supports and Services

People with developmental disabilities and their families want services that meet their needs and that they can rely on to be there when they need them.

OPWDD, with the help of providers, families and the people we serve, is taking steps to make that possible.

As the first step, Care Coordination Organizations were established to help people develop a Life Plan and coordinate all of a person’s developmental disability, medical and behavioral health services.
The next step is to transition services to operate in managed care. The new managed care system will be designed for people with developmental disabilities and use service providers with experience in supporting them.

Managed care will coordinate and arrange for the delivery of all of a person’s services, including OPWDD-funded services, healthcare, behavioral health and medication management, improving access to services and ensuring that people are reaching their goals.

**What exactly is managed care?**
Managed care is a payment system in which a Managed Care Organization receives money that will be paid to a group or network of providers for the delivery of all of a person’s medical, behavioral and developmental disabilitiy services.
**Why is OPWDD moving to managed care?**

Managed care makes it easier for OPWDD to ensure that services are helping people. Managed care gives OPWDD a way to measure how well a provider meets a person’s needs (their outcome) rather than just measuring that a service was delivered. It also helps people receive services they need from OPWDD and other important health and behavioral health services.

**How will managed care work?**

Just like the current system, people with developmental disabilities who are new to services will work with OPWDD Regional Office staff to determine their eligibility for Medicaid Home and Community Based Services (HCBS) Waiver services and supports, and to select a Managed Care Organization (MCO). A care manager will assist the person with developmental disabilities and their family and/or advocates in the person-centered assessment and planning processes.

After the assessment is complete, they will develop the Life Plan. The Life Plan serves as the basis for outlining the supports a person needs and his or her desired outcomes.

The Managed Care Organization then offers the person access to a network of providers who will deliver the services. The MCO will also provide opportunities for self-direction.
How is managed care different from care coordination?

Care Coordination Organizations (CCOs) provide care management services including person-centered assessment of a person’s needs and choices, and assist in the development of a Life Plan that identifies the supports a person needs and their desired outcomes.

Managed Care Organizations (MCOs) will authorize a person’s services and provide access to a network of providers responsible for the delivery of the services in the Life Plan.

Managed Care Organizations (also called Plans) must—

• Have a full network of providers to serve individuals and families
• Ensure that individuals and families will have input and a strong voice in their supports
• Address health, safety and clinical needs
• Meet performance and quality management standards
• Secure private information
Will my services change?

The person-centered planning process identifies the supports and services a person needs, and that doesn’t change in managed care. Under managed care, Continuity of Care Provisions will ensure that a person’s current level of supports remain in place when they enroll in managed care.

The person centered planning process, with individuals and families fully involved, will continue to drive a person’s services.

In addition, people can choose to enroll in a managed care plan that includes their current providers. If they require services from a provider not in the plan’s network, the Managed Care Organization can authorize that service to continue from the current provider.
When do the changes take place?

Initially, people will enroll in managed care on a voluntary basis, meaning a person chooses whether they would like to be enrolled in managed care. Beginning in 2021, everyone receiving OPWDD services will need to choose a Managed Care Organization to provide their services.

To ensure a smooth transition, OPWDD will monitor the progress of managed care plans and make adjustments as needed before making enrollment mandatory.

What happens if I am not satisfied with my services?

If a person is not satisfied with their services, they can speak with their care manager and review their Life Plan to determine if a change is needed. If they are not satisfied with their provider, they will have a choice of providers within their managed care plan’s network. If a person is not satisfied with their managed care organization, they can choose another. Individuals enrolled in managed care can also file complaints with the managed care organization and appeal decisions about their care.
Are people with developmental disabilities enrolled in managed care today?

Yes. The Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration in the New York City metropolitan area provides managed care for 1,800 people.

There is also a Program of All-Inclusive Care for the Elderly (PACE) that provides services to elderly people with and without developmental disabilities.

Both of these managed care plans are run by organizations with experience serving people with intellectual and developmental disabilities.

In addition, there are currently over 25,000 people with developmental disabilities enrolled in the New York State mainstream managed care program for their non-OPWDD services.