



PEOPLE FIRST
1115 DEMONSTRATION WAIVER

Care Coordination Design Team Meeting

Wednesday, July 13, 2011



Courtney Burke
Commissioner



Andrew M. Cuomo
Governor



Nirav R. Shah, M.D.
Commissioner



Care Coordination Design Team Agenda July 13, 2011

- **Review minutes & confirm agreement** 10:00-10:10
- **Update from other Design Teams** 10:10-10:20
- **Review of Design Team parameters** 10:20-10:45
- **Examine & discuss care management models** 10:45-12:00
- **Lunch** 12:00-12:45
- **Continue to examine & discuss care management models** 12:45-2:15
- **Discuss Charter questions 4 and 5** 2:15-3:45
- **Identify action items and next steps** 3:45-4:00



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Review meeting minutes & confirm agreement



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Update from other Design Teams



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Review of Design Team Parameters



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Examine & Discuss Care Management Models



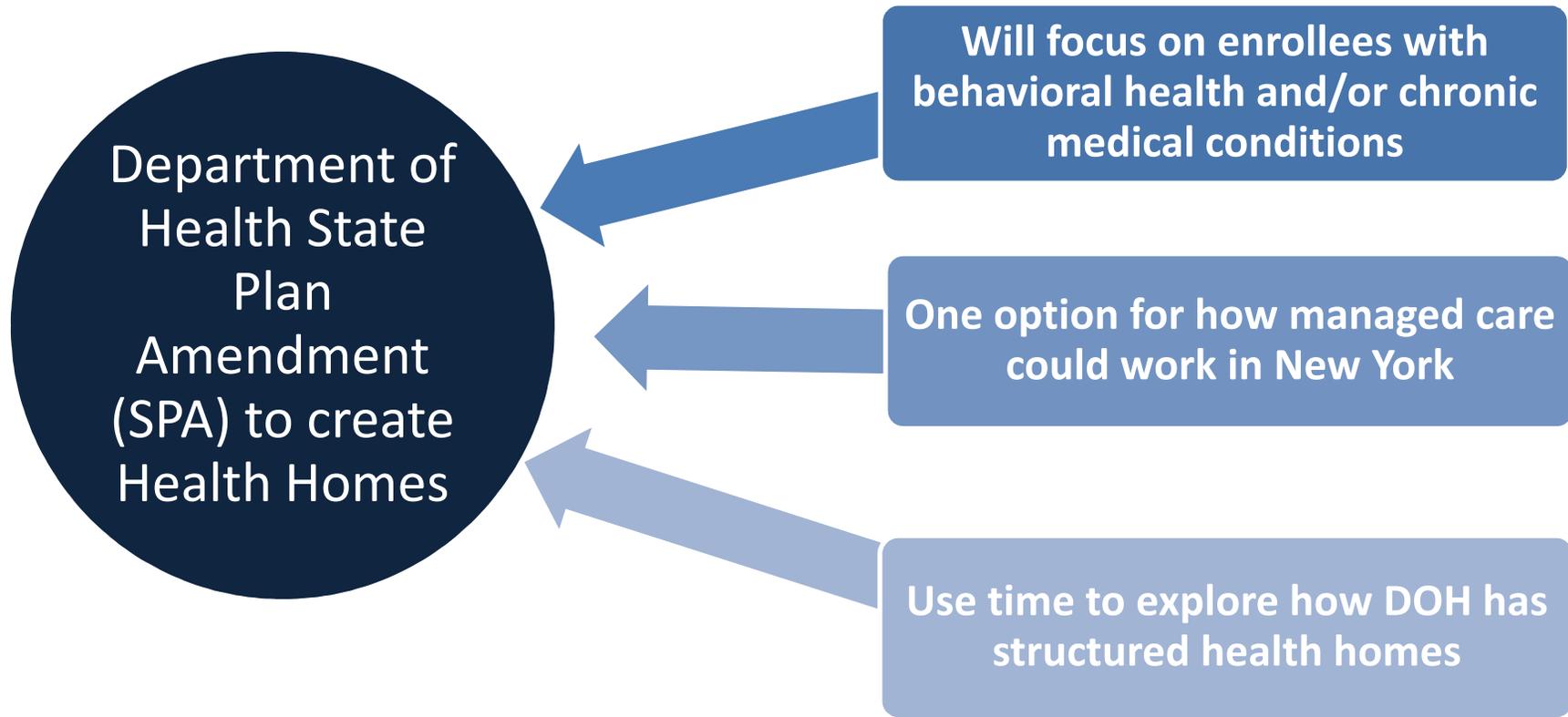
Design Team Parameters

CARE COORDINATION

- There will be comprehensive care coordination for all individuals in the People First Waiver. For the purpose of the work of the People First Design Teams, comprehensive care coordination is defined as a person-centered, interdisciplinary approach to integrating health care and habilitation and support services in which:
 - A comprehensive care plan is developed based upon a standardized needs assessment that incorporates the person's strengths, needs, and preferences, and
 - Services are managed and monitored by an identified care management organization.
- This care coordination may be provided through the managed care organization or contracted to another provider through the managed care organization. The transition will likely take two to five years.



DOH State Plan Amendment (SPA)





Background on Health Home SPA

PURPOSE:

HIGH COST

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness.

IDENTIFIED GROUPS

These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions.

CREATE HEALTH HOMES

One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.



Background on Health Home SPA

PROVIDER PARTNERSHIPS:

“The NYS Medicaid program plans to certify health homes that build on current provider partnerships. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty and behavioral health care that support the integration and coordination of all care. . . Approved health homes will directly provide, or contract for, **health home services** to the identified eligible beneficiaries. To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services. “



Background on Health Home SPA

INDIVIDUAL ASSIGNMENTS:

Individuals eligible for health home services will be identified by the State.

Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition.

Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home.



Background on Health Home SPA

HEALTH INFORMATION TECHNOLOGY (HIT):

NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS.

Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

Health home providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs).

Health home providers will be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient.



Background on Health Home SPA

POPULATION CRITERIA:

The State elects to offer Health Home Services to individuals with:

- Two chronic conditions
- One chronic condition and the risk of developing another
- One serious mental illness

from the list of conditions below:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

- HIV/AIDS
- Hypertension



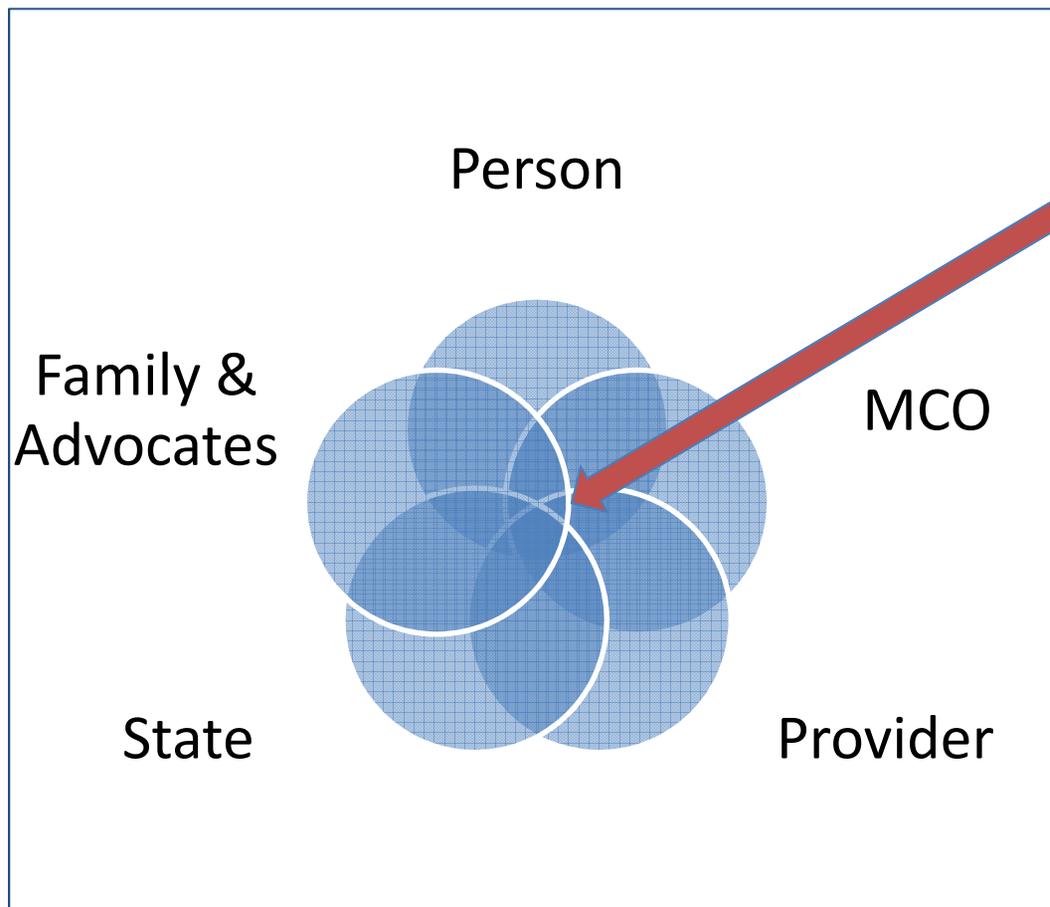
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Discussion Question:

Based on information presented at Design Team meetings so far, what should the roles of stakeholders be in care coordination under the People First Waiver?



Roles within the System



CARE COORDINATION

Within a managed care environment, what are the roles of each stakeholder?

How does care coordination occur?

What are the standards for accountability in care coordination? Who monitors those standards?



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Discuss Charter Questions



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Charter Question 4

How can comprehensive care coordination enhance person-centered planning, individual responsibility, and self-determination (also relates to the Benefits Design Team)?



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Charter Question 5

How can we better incorporate the strengths of the family in the development of the comprehensive care plan?



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Identify Action Items and Next Steps



Participation in Technical Workgroups

Individual Budgets in Managed Care

- Work with Fiscal Sustainability Design Team
- Recommend how an individualized budget fits within the parameters of a managed care system

RFP for Managed Care

- Sub-group of the care coordination design team
- Based on conversation today, recommend elements that should be included in any RFP for managed care organizations



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Next Meeting

- Date: Wednesday, July 27, 2011
- Time: 10:30am – 4:00pm
- Place: OD Heck, Schenectady

Contact Maria Bediako with questions at Maria.X.Bediako@opwdd.ny.gov or 212-229-3331