

Care Coordination Design Team Charter

The purpose of the Care Coordination Design Team is to make reform recommendations that will result in comprehensive care coordination within a care management environment for all people with developmental disabilities. The recommendations of this team will ensure that individualized and person-centered principles (goals, choice, rights, self-determination) direct how Medicaid and non-Medicaid primary and acute health care, behavioral health care, and long-term care services will be planned and coordinated between multiple service systems through “No Wrong Door” and with an effective and flexible comprehensive written care plan to coordinate and monitor quality of services.

Through its work, the Care Coordination Design Team will answer the following questions:

1. What is not working in the current service coordination model(s) for people with developmental disabilities?
2. Under the People First Waiver the current service coordination model will be transitioned to one or more comprehensive care coordination/case management models in a care management environment. What considerations should be integrated into any model of comprehensive care coordination/case management for people with developmental disabilities (and various subpopulations, e.g., children, aging, forensic/risk, medically involved, medically frail, etc.) in a care management environment?
 - Consider whether the person’s needs assessment should correlate to the type/intensity/level/model of comprehensive care coordination.
 - What choices should the individual have (e.g., choice of care coordination providers; choice of services provided under the care coordination model; choice of health, behavioral health and/or long-term service providers; and choice of specific services and resulting outcomes to be delivered through the People First Waiver)?
 - Consider roles and responsibilities of the care coordination provider and person(s) delivering the service (must address assurance and monitoring of health and safety (a component of the HCBS quality framework)).
 - What are the components of the system that should be independent from comprehensive care coordination (e.g., service authorization, resource allocation, service delivery, etc.)?
 - Given that advocacy is an important component of the current service coordination model, how should this function be addressed in a comprehensive care coordination model?
3. In conjunction with the Fiscal Sustainability Design Team, how should care coordination reimbursement be structured/compensated (e.g., provider based regional care management/coordination models that specialize in the needs of people with developmental disabilities and take responsibility for managing care and are reimbursed on an individual budgeting, global budgeting, or capitation basis)? How could OPWDD



establish pilots and demonstrations such as a Program for All-Inclusive Care for the Elderly (PACE) capitation model?

4. How can comprehensive care coordination enhance person-centered planning, individual responsibility, and self-determination (also relates to the Benefits Design Team)?
5. How can we better incorporate the strengths of the family in the development of the comprehensive care plan?
6. What are quality and individual outcome measures that could be used to demonstrate effective comprehensive care coordination (also relates to the Quality Design Team)?