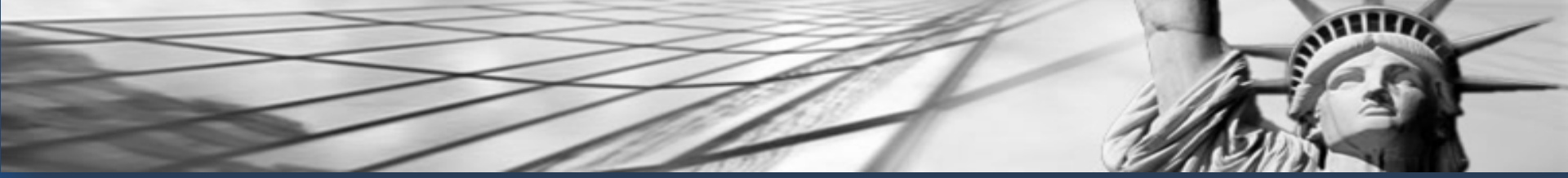

NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals

Public Meetings

Meeting Overview

- Here today to discuss NYSDOH's **revised** demonstration proposal around Integrated Care for Dual Eligible Individuals
- Meeting Agenda:
  - NYSDOH to provide Overview of NYSDOH's demonstration proposal
  - Participants to ask questions and provide comments
  - Wrap-up

Background on NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals

- In March 2011, NYSDOH received a planning grant from CMS to develop a demonstration proposal around integrated care for Dual Eligibles
  - CMS provided NYSDOH $1 Million
  - NYSDOH had12 months to Develop and Submit a Proposal
- In March 22, 2012, NYSDOH published its draft proposal for public comment
- April 20, 2012, NYSDOH received approximately 58 sets of comments

Background on NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals (Continued)

- April 24, 2012 NYSDOH announced 30 days extension granted by CMS
- May 3, 2012, NYSDOH published a second draft proposal for public comment
- May 17, 2012 Deadline for Public Comment
- May 25, 2012 Deadline to submit a final draft to CMS

Important Dates

- May 17, 2012 – 2nd Public Comment period will close
- May 25, 2012 – NYSDOH will submit its draft demonstration proposal to CMS
- June – CMS will publish NYSDOH's draft demonstration proposal for 30 day public comment period
- June – September 2012 - Stakeholder process continues

Demonstration Proposal

- Demonstration proposal can be found here:

  http://www.health.ny.gov/facilities/long_term_care/docs/second_demo_integrate_care_for_dual_elig.pdf

- Instructions for submitting public comment can be found here:

  http://www.health.ny.gov/facilities/long_term_care/dual_elig.htm

Major Changes to Demonstration Approach

- Change FIDA program: only for duals requiring 120 days or more of community-based LTSS – Metro NYC area
- Add small FIDA OPWDD program for OPWDD duals – Statewide
- Add Managed FFS approach – using Health Home for dual eligibles - Statewide

Context of Proposed Demonstration

- The FIDA programs build off the mandatory MLTCP program that is being implemented

- The MFFS program will build off of the Health Home program that is being implemented

Demonstration Proposal - FIDA

- NYSDOH has proposed a capitated model approach to integrating care for full dual eligibles.
  - Currently named “Fully-Integrated Duals Advantage” (although the name may change), this new program would be built of the framework of the MAP program but would provide a more comprehensive package of benefits, improve access, and enhance consumer protections than does the MAP program
  - Provides NYSDOH the opportunity to test and evaluate a model for delivering such fully-integrated care

Proposed FIDA Model Description

- Fully-Integrated Dual Advantage programs
  - Capitated managed care program that provides comprehensive array of Medicare, Medicaid, and supplemental services – including:
    - All physical healthcare
    - All LTSS services currently available through Medicaid Advantage Plus (MAP) program
    - Additional services currently only available through HCBS Waivers
    - Additional supplemental services not currently required in NYSDOH managed care plans
    - All behavioral healthcare
    - For FIDA OPWDD, the program will also include all services currently available in the OMRDD Comprehensive Waiver

Proposed FIDA Service Area

- 8 Counties
  - Bronx
  - Kings
  - New York
  - Queens
  - Richmond
  - Nassau
  - Suffolk
  - Westchester

Proposed FIDA Target Population

- All Full Dual Eligibles in 8 County Service Area
  - Age 21 and Over
  - Not receiving services through OPWDD
  - Not receiving services in an OMH Inpatient Facility

Proposed FIDA Start Date

- Demonstration will begin on January 1, 2014
  - Phase 1 – January 2014
    - Those full dual eligibles in the service area who are enrolled in MLTCP who are receiving community-based long-term supports and services
      - **The proposed "Phase 2" population that was in the first draft proposal (which would have started in January 2015 and would have included all remaining full dual eligibles in the service area) has been eliminated from the second draft proposal**

Proposed FIDA Enrollment Process

- Phase 1 – January 2014
  - In Fall of 2013, the independent Enrollment Broker will contact full dual eligible MLTCP recipients of community-based care and inform them of intention to enroll them into the FIDA Program
    - Dual eligibles will be informed that they will be enrolled into a FIDA plan offered by their MLTCP plan sponsor, if available, or will be contacted to be counseled through a choice of FIDA plan

Proposed FIDA Covered Services

- Comprehensive Benefit Package
  - Includes:
    - All Medicare Physical Health (PH), Behavioral Health (BH), and Prescription Drug services and All Medicaid PH, BH, and LTSS State Plan Services
    - Plus HCBS Waiver services presently available under NHTD, LTHHCP, and TBI Waivers
    - HCSS is included
    - Plus Supplemental Benefits

Proposed FIDA Coordination Model

- Participant-Centered
- Interdisciplinary Care Coordination Team
  - Includes
    - Participant,
    - Designee,
    - Primary Care Physician,
    - Behavioral Health Professional,
    - Care Coordinator, and
    - any other providers
      - as chosen by Participant or
      - as recommended by PCP or Care Coordinator and agreed to by Participant

Proposed FIDA Beneficiary Protections

- Independent Enrollment Broker
- Independent Participant Ombudsman
- Integrated Grievances and Appeals Processes
- Choice of Plans
- Choice of Providers
- Maximum travel, distance, wait, and appointment times
- Continuity of Care
- Single Consolidated Statement of all Rights and Responsibilities
- No Costs

Improving Care for Medicaid Recipients with Chronic Conditions-Health Home MFFS Model

- The Health Home program resulted from an initiative endorsed by Governor Andrew Cuomo's Medicaid Redesign Team to find ways to save money and improve the quality of care within the Medicaid program. This initiative was established in January 2011

- The 2011 NYS Executive Budget provides for the establishment of a model for integrated care coordination and care management services called Health Homes

Improving Care for Medicaid Recipients with Chronic Conditions-Health Home MFFS Model

- Authorization for the establishment of Health Homes is found in the Affordable Care Act, section 2703 (SSA 1945b) and the NYS SSL 365-l entitled "State option to provide Health Homes for enrollees with chronic conditions under the Medicaid State Plan"

- This provision is an important opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use) and long term services and support for persons across the lifespan with chronic illness

State Plan Amendments-Health Homes

- NYSDOH submitted a SPA to CMS on June 30, 2011
- This SPA targeting the Chronic Medical Behavioral Health population (#11-56) and was approved 2/6/12 with an effective date 1/1/12
- The SPA is available on the NYSDOH Health Home website

http://nyhealth.gov/health_care/medicaid/program/medicaid_health homes/index.htm

Definition of a Health Home

- A Health Home is a care management service model where all of the professionals involved in an individual's care communicate with one another so that all of a patient's needs (medical, behavioral health and social services) are addressed in a comprehensive manner

- Coordination is achieved primarily through the care manager who oversees and coordinates a patient's access to needed services

Definition of a Health Home (Continued)

- Health Records are shared among providers so that services are not duplicated or neglected;
- All members of the Health Home team report back to the care manager on patient status, treatment options and needed services

Goals of Health Home Program

- Reduce avoidable hospital admissions and readmissions;
- Reduce avoidable emergency room service;
- Provide timely follow up care;
- Reduction in health care costs;
- Less reliance on long term care facilities and
- Improved experience of care and quality of care outcomes for the individual

NYS Health Home Population Criteria

At least two chronic conditions, HIV/AIDS, or one serious and persistent mental health condition. Chronic conditions include:

- mental health condition
- substance abuse disorder
- asthma
- diabetes
- heart disease,
- being overweight (BMI over 25)
- HIV/AIDS
- Hypertension

Health Home Population in NYS

- More than five million Medicaid members in New York State.
- At least 975,000 meet the federal criteria for Health Homes.
- Nearly 130,000 duals are eligible for the current Health Home model

Health Home High Risk Population

Chronic Episode Diagnostic Categories
Health Home Eligibles Adults 21+ Years
With a Predictive Risk Score 75% or Higher (n=27,752)

Percent of Adult Recipients with Co-Occurring Condition

Condition	Total	Severe Mental Illness	Mental Illness	Substance Abuse	Hypertension	Hyperlipidemia	Diabetes	Asthma	Congestive Heart Failure	Angina & Ischemic Heart Disease	HIV	Obesity	Osteoarthritis	COPD & Bronchiectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	**74.7**	**77.2**	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	**70.4**	100.0	**70.9**	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	54.4	61.9	60.3	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0
Total	**100.0**	**43.5**	**46.2**	**54.4**	**37.6**	**29.8**	**27.8**	**28.3**	**13.4**	**12.2**	**8.3**	**12.7**	**22.1**	**15.5**	**13.5**	**41.9**	**18.8**

Note: Diagnosis History During Period of July 1, 2010 through June 30, 2011.

Demonstration Proposal – MFFS Health Home Model

- The proposed MFFS model is the Health Home model
- Managed FFS dual eligible Health Home members are eligible for Medicare (Part A, B and D) all Medicaid State Plan services provided via FFS and other programs in which a beneficiary might be enrolled
- Care managers with expertise in the unique needs of the dually eligible population will coordinate access to these services to provide dual eligibles meeting Health Home selection criteria with access to an integrated continuum of physical, medical, behavioral health services, rehabilitative, long term care and social service needs

Demonstration Proposal - MFFS – Health Home Model

- Care managers with knowledge of behavioral health, aging and loss, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias and will enhance the Health Home's ability to work effectively with the Health Home's dual eligible population
- The Health Home program will serve dual eligibles statewide beginning in July 2012

Proposed Health Home Enrollment and Start Date

- Demonstration will begin on July 1, 2012, once Health Homes have been designated Statewide

- Dual eligibles will be passively assigned to a Health Home with an opportunity to opt-out

Proposed Health Home Model

- Fully coordinated care for dual eligibles
- Service Area: Statewide
- Target Population:
  - Not requiring 120 days or more of LTSS
  - Not receiving services through OPWDD
  - Not receiving services in an OMH Inpatient Facility

Provider Qualification Standards

- Health home providers will be required to provide the following Health Home services in accordance with federal and State requirements:
  - **Comprehensive care management**
    - *An individualized patient centered care plan based on a comprehensive health risk assessment – must meet physical, mental health, chemical dependency and social service needs.*
  - **Care coordination and health promotion**
    - *One care manager will ensure that the care plan is followed by coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The Health Home provider will promote evidence based wellness and prevention by linking patient enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on need and patient preference.*

Provider Qualification Standards

- Comprehensive transitional care
  - *Prevention of avoidable readmissions to inpatient facilities and oversight of proper and timely follow-up care*
- Patient and family support
  - *Individualized care plan must be shared with patient enrollee and family members or other caregivers. Patient and family preferences are considered*
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services

Health Homes

Applications reviewed for:

- Meeting Provider Qualifications and Standards and providing adequate choice within Health Home partnerships
- Care Management "Bandwidth" - ability to meet needs of all facets of complex populations (e.g., Mental Health, Housing, Substance Use Disorder, etc.)
- Promoting the State vision - minimize silos and concentrate volume over a few rather than many Health Home networks/systems to assure a more limited accountability structure and more financially viable Health Homes
- Creating choices, where applicable, between institutional led and community based led Health Homes

Proposed Health Home Covered Services

Health Home Participants will have access to:

- All Medicare PH, BH, and Rx services and All Medicaid Physical Health, Behavioral Health, and LTSS State Plan Services – through the FFS systems, as facilitated by the Participants' Health Homes
- Comprehensive Care Planning and Care Coordination
- Targeted Case Management(TCM) programs will transition to Health Home services-participants (including dual eligibles) currently enrolled in TCM can continue to receive services from their existing TCM provider

Assignment - New Referrals

New referrals (via HRA, county, SPOA, care management agency, practitioners, hospital, prisons, BHO, etc) meeting Health Home criteria must be assigned to Health Homes to ensure access to care management.

Demonstration Proposed - OPWDD FIDA

- Target Population
- OPWDD FIDA – Care Model
- Care Coordination Model
- Duals Initiative & People First Waiver

Proposed OPWDD FIDA Target Population

- Up to 10,000 Dual Eligibles statewide (1 to 3 qualifying plans to be selected)
  - Age 21 and Over
  - Eligible for OPWDD Services
  - Are not receiving services in an OMH facility

Proposed OPWDD FIDA Care Model

- Fully-Integrated Dual Advantage programs
  - Capitated managed care program that provides comprehensive array of Medicare, Medicaid, and supplemental services – including:
    - All physical healthcare
    - All LTSS services currently available through Medicaid Advantage Plus (MAP) program
    - Additional services currently only available through HCBS Waivers
    - Additional supplemental services not currently required in NYSDOH managed care plans
    - All behavioral healthcare
    - All OPWDD People First Waiver Services

Proposed OPWDD Care Coordination Model

- Comprehensive care coordination is a person-centered, involving professionals from many disciplines based on the needs of the person.

- Person-centered planning is at the center of service delivery.

- Care plans will be shaped by individual, family and advocate involvement.

Duals Initiative & People First Waiver

- Discussions with CMS and NYS occurring to establish OPWDD People First Waiver. Key elements include:
  - Broader more flexible range of community-based service options.
  - Life plan with self-direction opportunities through real and ongoing person-centered planning for all enrollees.
  - Encouraging employment, citizenship, life-long learning.
- Duals Initiative and People First Waiver have same objectives and common elements for specialized managed care.

Public Comments

- Input Welcome
  - During this Public Meeting
  - Please submit comments:
    - Submit written comments to mltcworkgroup@health.state.ny.us;
    - Mail your comments to:

      Mark Kissinger
      New York State Department of Health
      Empire State Plaza, Corning Tower, 14th floor
      Albany, New York 12237
    - Submit your comments by fax to: (518)486-2564
    - For those unable to submit comments by e-mail or fax, please call: (518)402-5673

Proposed Stakeholder Process

- June 2012-September 2012 – A Stakeholder process continues around key issues.
- June 2012 through December 2013
  - Quarterly Stakeholder Meetings
  - Written notices, Outreach and Education Campaign
- During Implementation
  - Annual Quality Surveys
  - Participant Advisory Committees
  - Participant Feedback Sessions
  - Stakeholder Quarterly Meetings

Assistance Needed

- At this time, NYSDOH needs Stakeholders to
  - Share the Draft Proposal with Your Networks
  - Submit Comments on the Draft Proposal by 5/17/12
  - Encourage Others to Submit Comments by 5/17/12
  - Provide Letters of Support:
    - Submit by e-mail to: mltcworkgroup@health.state.ny.us;
    - Submit by mail to:

      Mark Kissinger
      New York State Department of Health
      Empire State Plaza, Corning Tower, 14th floor
      Albany, New York 12237

Questions or Comments?