NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Waiver Transition Workgroup Meeting

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Office of Health Insurance Programs

New York State Department of Health

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Agenda

- HCSS in CFCO – definition and scope of services
- Role of RRDC –service assessment/ reassessments; development of recommendations; provider relations
- Comparison and coordination of Service Coordinator and Care Manager
- Other discussion on Transition Plan draft

- ***Notice:*** *The February 17th Waiver Transition Meeting has been rescheduled to Friday, February 19th from 12:00 p.m. – 2:00 p.m.*

Home and Community Support Services (HCSS)

- **Definition of "Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLS, and health-related tasks"**
  - The State will cover services and supports related to assistance with functional skills training through hands-on assistance, supervision, and/or cueing to accomplish the ADL, IADLs, and health-related tasks. Services will be specifically tied to the functional needs assessment and person-centered service plan and are a means to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement.
  - These services include: assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, life safety, medication management, communication skills, mobility, community transportation skills, community integration, reduction/elimination of maladaptive behaviors including inappropriate social behaviors, problem solving skills, money management, and skills to maintain a household, as it relates to the provision of ADLs, IADLs, and health-related tasks.

Role of Regional Resource Development Center (RRDC)

- Address referrals for Service Assessment(s)
- Resource for the managed care organizations (MCOs)
- Identify needed services
- Provide recommendations to MCOs
- Assist with provider selection in conjunction with care manager
- Reassess as needed

Health Home Care Management

Health Home is a care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical, behavioral health and social service needs are addressed in a comprehensive manner.

The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays, and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

FIDA Care Management

FIDA Care Management — A collaborative process that assists each Participant in accessing services as identified in the Participant's Person-Centered Service Plan. The Care Management process assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet a Participant's needs across the continuum of care. It is characterized by communication, and resource management to promote quality, cost effective, and positive outcomes.

The Care Management process also provides referral and coordination of other services in support of the Person-Centered Service Plan. Care Management services will assist Participants to obtain needed medical, Behavioral Health Services, prescription and non-prescription drugs, Community-based or Facility-based Long Term Services and Supports (LTSS), social, educational, psychosocial, financial and other services in support of the Person-Centered Service Plan, irrespective of whether the needed services are covered under the capitation payment of the Three-way Contract.

Mainstream Managed Care

Mainstream Managed Care administered care management is defined as a comprehensive assessment of a member's needs with an individualized care plan carried out through specific interventions designed to provide coordinated, efficient, quality care to achieve the care plan goals and optimize health outcomes for people with complex health issues.

For people in Medicaid managed care (MMC), health plans are required to provide case management and disease management services for individuals (adults and children) with chronic health conditions or complex health issues or situations. Plan care managers collaborate with the member and the health care providers to conduct interventions to address the member's individual needs and promote optimal outcomes.

Service Coordination

- **Service Coordination** will be a collaborative service between members and their care managers to assist with activities not provided by the care manager or cannot be provided with the required frequency, duration or intensity available through the care manager.
- Care managers are responsible for the ongoing monitoring of the provision of services included in the participant's service plan and/or participant health and welfare.
- Service Coordinators will work with the Care Manager to ensure services are sufficient to allow the person to remain safely in the community. They will provide ongoing coordination and communication with service providers.

Additionally the Service Coordinator will:

- Assist with Problem Solving (directing participants to the services and supports they need to resolve issues).
- Ensure assessment(s) are completed.
- Ensure that the participant has the opportunity for ongoing community integration.
- Assist with applying for and maintaining all benefits (Medicaid, Food stamps, SS, Section 8, Medicare).
- Assist with locating housing that is safe and accessible. Ongoing monitoring of living environment to ensure health and safety.
- Setting up Medicaid/Social transportation (or identifying someone [paid or natural support] to assist with this).

Additionally the Service Coordinator will:

- Address as the point of contact any health and safety issue (bed bugs, loss of power, lack of adequate food, emergency situations).
- Complete additional home visits and supervision visits as needed.
- Complete health and safety assessments as needed.
- Visit day program sites to assess member progress.
- Supplement the role of the care manager in procuring needed services.
- Work with the care manager in team decision making on behalf of the member.

For Discussion

- Brainstorming list of all open issues

Contact Us:

Transition questions:

waivertransition@health.ny.gov

MRT 90 website:

http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/