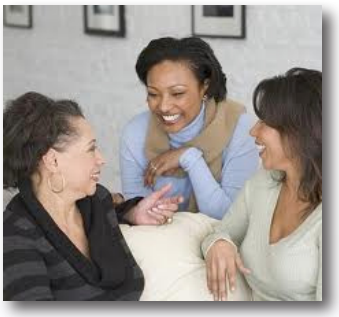
NYS Case Management Coalition

Person-Centered Care Coordination

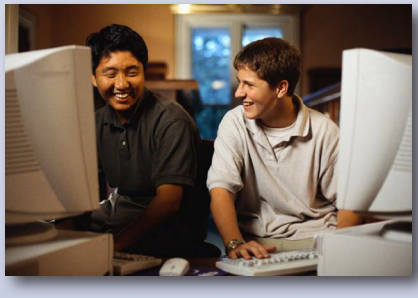


It is the stance of the NYS Case Management Coalition that health homes cannot be effective without incentivizing flexible service delivery that is consistent with the consumer's wants as well as their medical and behavioral health needs. Person-Centered Care Coordination has demonstrated marked results on both quality of life and personal satisfaction measures as well as reduced treatment and other costs (see WNYCCP Care Coordinator Results, 2010, http://www.carecoordination.org/results.shtm). It should be the cornerstone of all coordinated care within the health home. Additionally, the care coordination function of the health home will need to be supported with:

- Multi-Systemic, multi-provider, person-centered service planning process that includes all health providers' developing and adhering to one unified service plan that includes the personal interests of the consumer as well as natural supports and community based resources.
- Financial or regulatory incentives for treatment providers, especially physical health providers, to participate in planning processes, plan monitoring, and ongoing communication with the planning group. This could be accomplished if the care coordination and network services all have the same payer.
- Incentives and/or regulatory relief that will allow and encourage service providers to flex services in a way that accommodates the other goals identified on the unified plan (i.e. substance provider excuses person from treatment on Thursday so person can attend such things as wellness education or a job interview).

Care Coordination Must Be Supported By Adequate Funding to Meet the High Touch Needs of Clients

The Coalition is calling for care coordination rates that will both match and incentivize the "actual [Touch]" level of involvement related to the needs of the individuals whose health is expected to improve as a result of care coordination efforts. To achieve this we believe the State will need to:



- Bring rates for "high touch"/ "high severity," individuals with SMI/SED into alignment with current TCM rates when the needs of the individual will require face-to-face involvement during linkage efforts by the care coordinator two or more times in any given month. This will incentivise care coordinators to continue to provide the hands-on support that individuals with chronic health issues will need.
- To a great degree, effective outreach-based care coordination is related to the ability of the care coordinator to spend face-to-face time with a person with high needs in the community and then upon the level of relationship/trust the care coordinator can develop with that person over time. Lower rates encourage a high volume-based service (high case loads) that will impair the coordinator's ability to be thorough with the individuals who need the most care.
- Establish that when a person has SMI/SED and a chronic health condition, the health home will be required to pay the highest potential rate associated with qualifying conditions. For instance, the SMI/SED rate, and not the lower rates associated with "Pairs Chronic," should be paid for the services provided to the person with SMI/SED and one other chronic condition.

- Establish criteria by which care coordinators and/or providers can qualify and re-establish a person's severity level (low, mid, high) in the event that the person's status changes while in health home care. We believe that the progression to wellness will ebb and flow: in some circumstances a person's condition will worsen while in care before it improves. This will also allow providers to lower intensity of service as severity declines in a set of steps that leads to graduation from health home services.
- Establish an add-on payment or an outreach incentive payment for coordination when a chronic substance use disorder is associated with one or more chronic conditions and/or SMI.
- Chronic substance use complicates coordinated care as significantly as SMI/SED and in many cases degrades a person's physical health more quickly.
- Service Dollars/Client Dedicated Funds must be retained beyond two years and must be a regular part of health home services. We are asking the state to solidify continued use of Service Dollars by direct contribution to care coordination agencies involved in health homes or through managed care and/or health home contracts. Service Dollars are essential to the goals of the health home in that they provide immediate access to housing, medications, emergency supplies, and they can be used to support wellness, education, fitness, occasional transportation to services, and community connection-based activities. Service Dollars also allow for the use of strategic rewards that help to motivate reluctant individuals to embrace their healthcare needs.

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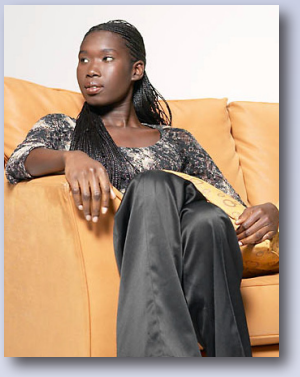
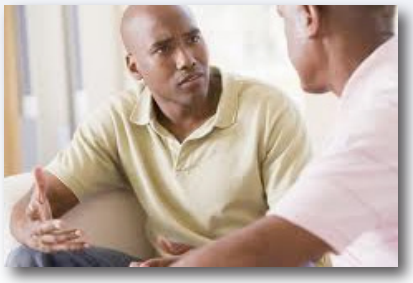
Outcome Measurement



- The Coalition supports health home outcome measurement that is sensitive to the complexity of helping individuals with variant motivations and variant conditions move toward wellness. It is the experience of the agencies within the coalition that recovery and wellness is not a linear process, it ebbs and flows. Individuals will generally progress and relapse over time in route to wellness. Moreover, coordinated care for some may not bear significant savings and could even increase cost in some cases when the cost of treating known conditions is ongoing and high and when other conditions are discovered and treated as a result of improved care. Therefore, the state should have a criteria for health home providers to identify these highly complex persons of chronic health conditions and tie outcome measures to the proportion of highly complex persons the health home serves in relation to the over all health home population. This would mean that health homes with disproportionate numbers of highly complex persons will not be penalized or considered inefficient if they serve more of those who need help the most. Outcome measures should also include those identified by the state as part of health homes as well as make provisions for measuring:
- Client Self Satisfaction Assessment completed at intervals (Intake, 90,120, 180, 365 days, etc.)
- Stage-Based Intervention: Includes 'Stage of Change' (i.e. Motivation) based assessments at specific intervals (Intake, 60, 90, 120, 365 days, etc.) that measure for increased client motivation, related to each specific health condition.



- Ratio of outpatient treatment and/or medical visits to inpatient/ emergency days, related to each specific condition.
- Increased Medical/ Behavioral Health involvement associated with conditions discovered as a result of improved care coordination.
- Evidence of stabilization/increased functioning (i.e. days in safe housing, consistent pharmacy patterns, reductions in outpatient medical and/or behavioral health treatment days/visits, connections to community, etc.).
- Effective Transition to chronic or long term care services when a person's medical and other conditions warrant a higher level of care.

TCM Transition to Health Home Must Be Supported and Funded

- Allow TCMs to keep excess Medicaid Revenues for years one and two of the transition to health homes provided that revenues are targeted for specific transition based activities (i.e. upgrades to IT systems, developing data expertise, staff training, business model development, marketing, and contracting.

- Adjust regulations to allow TCMs to operate under health home regulations prior to the full transition to health homes even if those they are serving are considered original TCM clients and are not part of health home expansion slots. This provision will reduce vulnerability to Medicaid audits and allow agencies to begin transitioning traditional TCM services to health home services at a manageaeble pace.

A good example of regulatory relief that is necessary is that there are regulations that don't allow TCMs to bill for service visits while adults 18-64 are hospitalized or in institutions (especially State Facilities) but effective coordination in health homes will require care coordinators to start transition planning the day a person enters an institutional setting. This will require visits in institutions that, although considered the optimum thing to do now, will not be billable and therefore negatively affect agency budgets while opening the agency for audit risk should care coordinators mistakenly bill for services as health home when the person is actually a traditional TCM client.

Care Coordination Staff Training is Essential for Positive Outcomes

- Additional resources to train staff in motivational approaches that are adjusted to integrate medical, psychiatric and substance use care coordination to compensate for staff turnover and encourage retention must be supported
- Staff will require additional training to enable them to conduct more sophisticated medical assessments
- Such training needs to be provided to care coordination staff during the transition period to meet health home requirements.

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