Medicaid Redesign Team Waiver Webinar

New York's Reinvestment Strategy Bending the Cost Curve and Improving Patient Outcomes

July 3, 2012

Program Agenda

New Care Models

Greg Allen

Health Home Development

Greg Allen

Medicaid Supportive Housing Expansion

Liz Misa

Redesign Medicaid in New York State

New Care Models

New Care Models

- ***Waiver funds may be used to launch new partnerships to develop, plan, and/or test new models of care that:***
  - ✓ Break down traditional healthcare delivery silos;
  - ✓ Fully integrate and coordinate physical and behavioral health services and other services for which the model is not at risk;
  - ✓ Provide care management teams responsible for person centered assessment, care plan development, and implementation and monitoring;

New Care Models

- ✓ Evaluate outcomes to determine the extent the model has achieved goals of increased access, integration of care and improved health outcomes;
- ✓ Reduce disparities and avert preventable events and hospitalizations while reducing costs;
- ✓ Provide technical assistance to develop new models of care;
- ✓ Provide funds for regional planning.

New Care Models

Potential characteristics of new models of care:

- ✓ Adoption or expansion of evidence-based practices.
- ✓ Co-location of providers and services – integration of physical and behavioral health.
- ✓ Expansion of primary care and use of screening tools.
- ✓ Consumer centered access points that provide comprehensive information and linkage to services (i.e., NY Connects).

New Care Models

Potential characteristics of new models of care:

- ✓ Early identification and management of risk factors and disease (i.e. SBIRT).
- ✓ Effective management of chronic and pre-chronic conditions.
- ✓ Effective coordination of Medicaid and Medicare.

New Care Models

Examples of New Models of Care:

- ✓ Patient Centered Medical Homes (PCMHs)
- ✓ Provider Based Integrated Delivery Systems
- ✓ Accountable Care Organizations (ACOs)
- ✓ Special Needs Plans (SNPs)

Additionally, funds may be available for:

- ✓ Technical Assistance for developing new models of care
- ✓ Regional Planning

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Health Home Development

Challenges/Opportunities

- Of the 5.4 million Medicaid enrollees (FFS and MC), 975,000 (including dual eligible's) have been identified as high cost/high need enrollees
- A Health Home is a care management service model to assure 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 with the goal of improved health and reduction of unnecessary emergency department visits and inpatient stays

Challenges/Opportunities

Health Home Opportunities

- 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.

Challenges/Opportunities

Health Home Challenges

- Create shared learning and connections across the silos of behavioral, physical/social and community care delivery systems.
- Need to leverage the power of IT solutions – access to IT and resources to implement are uneven.
- Workforce training (and re-training) and support to empower providers to deliver truly integrated care and access to needed patient resources such as supportive housing, and other social supports.
- Building care delivery networks (capacity for primary care, specialty care) in underserved areas.

Challenges/Opportunities

HIT Infrastructure

- Fully-integrated, transformative care models cannot be created without real-time electronic linkages between medical, behavioral and community-based providers.
- Behavioral and community-based providers have not been well resourced to implement EHR and connectivity with regional and State-wide electronic networks.
- Funds could be used to develop capacity for integration across the continuum of care and to support the RHIOs in integration efforts, including operationalizing a multi-party consent.

Challenges/Opportunities

Prioritized Supportive Housing

- Stable housing is integral to improving health outcomes and lowering costs for high-needs, high cost Medicaid members.
- Health Home care management will support members to transition to and maintain stable housing by coordinating needed behavioral, social and medical services.
- Funds could be used to support housing projects that target Health Home members; opportunities to match funding with other housing initiatives will be explored.

Challenges/Opportunities

Workforce Development

- Care managers and other providers will need retraining to function effectively in a fully-integrated system and break down the existing silos of behavioral and medical care.
- The skills and talents of individuals and organizations providing community-based services and peer supports should be developed and strengthened.
- Funds could be used for training, retraining and continuing education and to develop resources to support the integrated care workforce and attract providers to underserved areas.

Challenges/Opportunities

Health Home Structure and Governance

- The NYS model of Health Home services delivery requires forging new partnerships across a wide-ranging network of diverse providers.
- Integrating and standardizing care models across these networks requires leadership and investment to develop the means to effectively manage fiscal, clinical and quality data.
- Funds could be used for organizational development, data management resources, accounting and actuarial support, leadership and management training, and for collaborative learning opportunities to identify other funding gaps.

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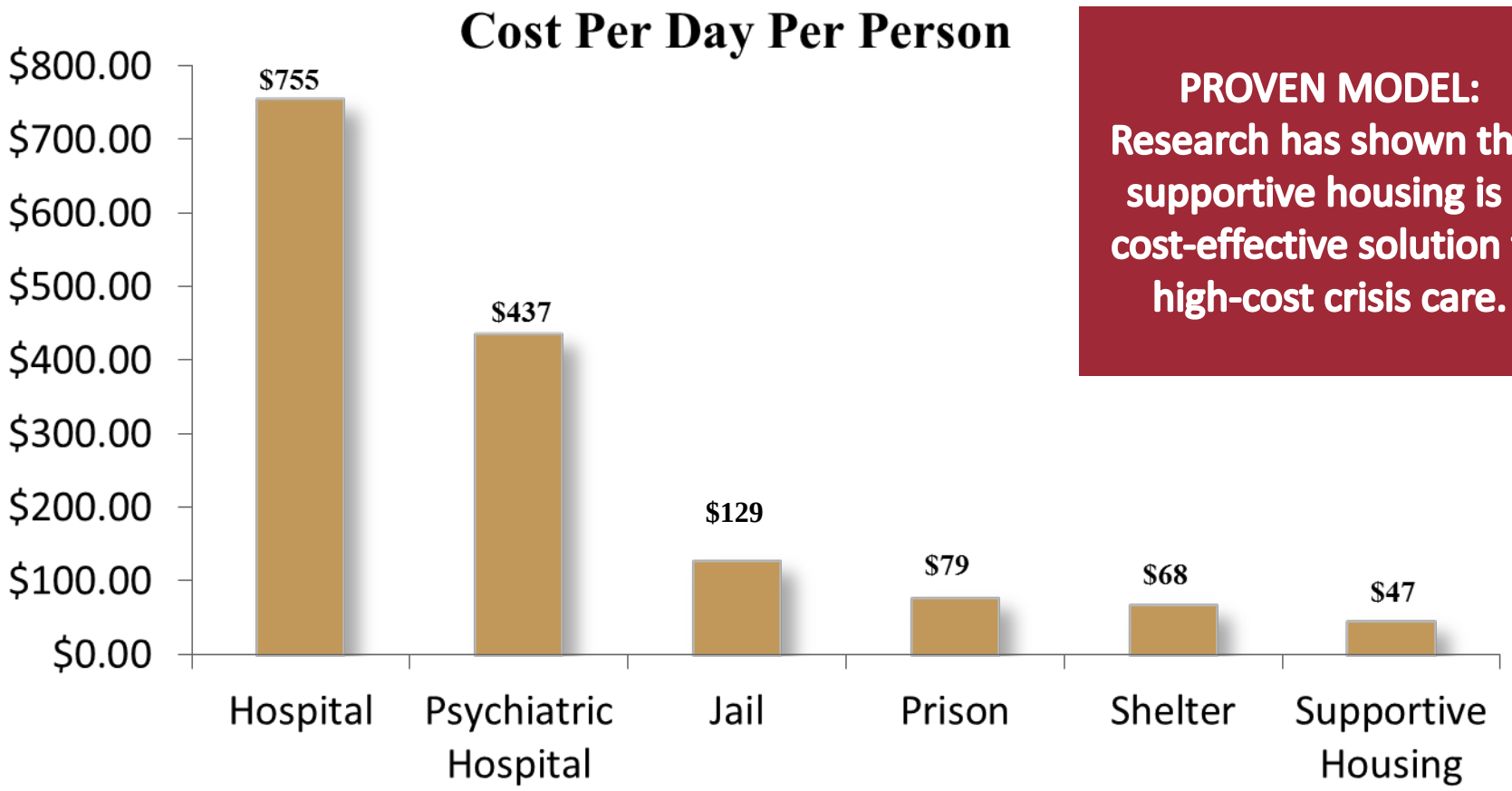
Supportive Housing Expansion

Program Overview

- **Supportive Housing:** Permanent, affordable housing with on-site services.
- **GOAL:** Expand access to supportive housing for high cost Medicaid users.
  - ✓ ***Target populations with particularly high healthcare costs.***
  - ✓ ***975,000 patients with multiple chronic illnesses eligible for health homes.***

Supportive Housing



PROVEN MODEL:
Research has shown that supportive housing is a cost-effective solution to high-cost crisis care.

Goals/Opportunities

Supportive Housing Opportunities

- Reduce Medicaid spending.
- Improve quality of care for vulnerable populations.
- Improve health home care management.

Program Components

- **Beneficiaries**
- **Eligible Applicants**
- **Program Design**
  - Capital
  - Rental subsidies
  - Support services
- **Accountability**

Contact Information

We want to hear from you!

MRT Waiver Website:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

This website includes the documents referenced in this presentation, e-mail address and form to submit feedback, as well as instructions on how to enroll for the MRT listserv.

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