COMPLEX CARE SUBCOMMITTEE-AUGUST 24, 2012

Kate McEvoy reported discussions with CMS:

Authority under which state could operate Health Neighborhood—Not yet finalized;; likely to be combination of state plan PCCM authority (with discussion of coordination and monitoring with PMPM and performance incentives as part of this) along with waiver authority re limitation in geographic access.

MA only state approved so far—are a managed care state. 26 states have applied; 5 are for fee for service models like CT.

Shared savings models nationally still under discussion. Mercer has mapped set of decisional questions that will be provided at next meeting re shared savings.

Platform on best practices, structure and leadership of health neighborhoods. Will be seeking formal comment on more developed planning. Staging of implementation:

- Research into best practices and discussions with CMS;
- Outline format of Health Neighborhoods;
- Scope of initiative—should Health Home model be included in Health Neighborhoods, especially for those with SMI or should it be pursued separately as a stand-alone model? BHP subcommittee looking at essential elements of care mgt/care coordination for people with serious mental illnesses.
    - Additionally, will the HNs be expanded to single eligibles? This is less likely decision.

Next steps much more detail on leadership, structure, providers, and care mgt model, as well as on performance measures. September and October development and presentations on detail.

Sheldon asked why PCCM is the Medicaid authority for Health Neighborhoods. What is best fit under Medicaid law? PCCM can encompass care coordination and some supplemental services; discussion with CMS is how broad that authority can be. Supplemental services are being conceptualized as only part of HN. Shared savings discussions with CMS are in line with the mutual decision of DSS with MAPOC. Discussions with CMS are much broader than CT specific, and are not to the point of tailoring to CT.

Rivka Weiser developed paper on best practices on care coordination for MMEs. Exhaustive review of literature with attention to well researched practices. Preferred definition focuses on person-centeredness with specificity to populations. Must be able to measure outcomes and also that is replicable and shows impact. Key effective factors and components of care coordination were reviewed. Successful programs incorporated face to face contact. Size of caseloads greatly varied based on populations and settings. Focus on member and family/significant others care givers central to assessment, along with using motivational interviewing. Key to have access to data regarding client's full medical needs and treatment. Self management key to success. Transition post hospitalization most often discussed.

Ellen Andrews: How is it decided about who gets care management and at what level of intervention. How to assure real engagement of care plan that client owns? Will signature be required? Rivka said there is wide variation on how "stratification" is done regarding who gets what kind of care mgt/care coordination intervention. No "best practice" identified so a hybrid model of using claims and client identification about those at risk, those with high utilization, those with under utilization. Ellen suggesting that system has many doors so that self-referrals can be made. Tracy Wodatch said that providers need major education in order to change current practice; 90% are not client centered. Lori Szcygiel said there are initiatives in behavioral health on partnering with clients. Alicia referred to BHP subcommittee working on Health Home and engagement. Also terminology re care management and care coordination will be standardized for purposes of duals demonstration. Application discusses intensive care management and then more concrete Care coordination.

Molly Gavin referenced ACCESS agency and its 13,000+ clients. Three legged stool: preparing client and family for care assessment/pre-screening—discussing on the phone, e-mail whatever method works for them. E. g., collect all medications they are taking to show person who will be working with them. 2nd stage is training person doing assessment—must be culturally sensitive, able to communicate in client's language. Actual assessment process that engages individual in on-going basis with individual key to process. Reimbursement for model will be central in terms of what actually happens. Molly commented that in caseload size must work on task delineation—time consuming telephone calls, eg, do they require highly credentialed person or should they be done by other trained staff? CCCI formula is related to so many Access Coordinators to each Care Manager. Critical to define credentials and licensing and certification programs re who is deemed a Care Manager.

Sheila commented that the culture change needed in practice about engagement and person-centeredness is huge and must be addressed not just in learning collaboratives but also in reimbursement. What will process now be for developing actual Care Management requirements in terms of credentials, structure, process, levels of care and intervention. DSS will pull together working group to develop model addressing all aspects, including role of key community adjunct providers, like homeless providers who know those who are "outside" the care system. Physicians must be included. Work force development also may be needed.

Quincy Abbott indicated that Long Term Care Plan in CT and in 2013 will have Long Term Life Supports Plan. We need to be focusing on "life plans", not just medically focused care. Must also recognize that some individuals may not want to engage in certain treatments, and if they are well informed, then this is their choice, even if there is "risk."

Mary Ann Cyr acknowledged hundreds of physicians involved in developing Primary Care Medical Homes.

Sheldon suggested that individuals would have some choice over who their care managers are and Kate acknowledged this is the case.

Kate introduced Mercer staff on the phone. "Health Neighborhood Design" and another paper on North Carolina was reviewed. States vary in how specific their requirements are. North Carolina is a managed

fee for service state; very few other states doing this. North Carolina approach is multi-disciplinary as well, and took a more incremental approach, not at first including people with SMI. North Carolina also pays its providers under Medicaid the Medicare rate, which CT does not. No. Carolina provided original technical assistance and then on-going assistance on "learning collaboratives." Data sharing and analytics is given to providers for their care management (e.g., CHN as ASO in CT). Value of central source of support for all entities in the state with resource support and TA. Need clinical champions who are thought leaders in their areas of state.

Sheldon asked if state is thinking of another entity other than CHN for "the central source of support." Mary Ann pointed out that for some aspects of model, CHN will provide some information, but state is also contracting directly with HNs. Kate indicated claims and contracting will be central office; ASOs will be doing predictive modeling. Jennifer Hutchinson asked if DMHAS could provide information about states that are integrating the medical and behavioral health areas. Jen also said intense work going on with care management planning and will bring information to the CCC. Missouri and RI had implemented specific Behavioral Health Homes. BHP planning is developing model that will be applicable to dual and single Medicaid eligible individuals.

Performance Measure sets are limited in "measuring" integration of Medicare and Medicaid. Also outcome measures focus on disease or settings, rather than multiple conditions, transitions, or on "maintenance" of a condition. Sets of measures being used nationally are: ACO measures and domains within them and also CMS draft guidance which established 6 domains which will be their focus. States will be required to report on process measures: # of care plans with documented person centeredness (no benchmarks established yet by CMS). Sheila commented that National Quality Forum Performance Measure Reports had focus on clinical depression and substance use core measures. It also pointed out no agreed upon performance measures related to nursing home diversion, discharge, or care. Rifka Weiser also doing cross walks among different measure sets in CT (NCQA, NQS, HEDIS, CMS, ASO, etc).

Next Steps: Kate distributed an outline for ICD Operations Plan Outline for Health Neighborhoods. Major issues to be addressed in a linear path for RFP. Early 2013 will be new target date for RFP. Italicized questions were issues raised in CCC but not in application or note for additional detail. How will Neighborhoods form? What Administrative structure and requisites for Leads? Financing models to be presented at next meeting. Kate asked if there are questions that are missed that should be addressed. This is outline for much more detailed review by CCC.