

COMPLEX CARE SUBCOMMITTEE—October 26, 2012
MINUTES

Kate McEvoy commented this is the first stage of working agreements between DSS and DMHAS. DSS will also present this to BHP Health Home Work Group. Will then also have formal comment period. (See attached document describing Lead Agency for Health Neighborhoods, the BH Partner agency, and provider composition of HNs)

Three operational issues: Lead and health neighborhood characteristics, care management model, and financial model. These aspects after presentation and comment and with approval by CMS will be in RFP in 2nd quarter of next year. State of Washington just approved for fee for service model. There are 19 managed care proposals, 6 fee for service models, and one public managed care entity in Vermont. Still looking for guidance from CMS on outcomes and financial model.

Next presentation to committee will be on care coordination/care management, using principles from White Paper. Financial model will be presented in December or later.

DSS will be the entity with which Leads sign contract. DSS/DMHAS will work together on performance. Only DSS will be the supervising entity.

CMS has had a much longer approval process with duals issues than with other proposals.

Kate presented overview of Leads and Health Neighborhoods.

Administrative Lead is responsible for establishing an integrated service network within its geographic area, and coordinating care with its BH Partner Agency (BHPA). DSS will specify template for care coordination agreement, with Lead establishing standards (building on what is outlined in RFP), especially to show innovations. Lead works in partnership with BHPA in quality, consumer surveys, etc. Lead also carries fiscal responsibility. Also Lead should provide or contract for supplemental services. State will see a core curriculum for Health Neighborhoods, and admin lead expected to develop local curricula for its own Neighborhood.

Matt Katz said he thought state would develop care coordination standards, and not set mandatory contract language. Will state dictate the payout formulas, limiting innovating practices to incentivize providers? If Lead is not fully responsible for what happens in Neighborhood, how can they enforce contracts? Matt also asked about consumer health equity. Kate said Admin Lead assures that each provider member will have contract that spells out terms of participating—DSS will outline process and protocols not strategies for care coordination. Kate said she can circulate a sample contract. Kate indicates Lead decides how supplemental services are provided and represent in application how that happens. State should establish performance measures and benchmarks for payments and what % must be attained? State wants to be sure there is a way of recognizing the contributions of all

providers, regardless of size and influence. Admin Lead does administer all financial payments. Kate said they would add health literacy and equity for consumers.

Karyl Lee said she doesn't see a problem with one lead as long as there is full partnership. She does see a problem with a medical model as opposed to a person centered model. Jennifer Hutchinson says that DMHAS sees Behavioral Health Partner as playing a significant role in the Neighborhood. BHP will be a co-signatory to RFP, must be identified by the Lead in the RFP. Also BHPA must be co-signatory to contract with DSS. All functions for BHPA are spelled out "in partnership" with Admin Lead. Fiduciary and data management is under Admin Lead, and also has responsibility for care coordination contracts; BHPA responsible for educating and developing care coordination with BH providers in Neighborhood. Jill pointed out that definition of "partnership" is vague; currently have bifurcated system with primary care and behavioral health. DMHAS' vision was co-signatory and shared decision-making with Lead on all other functions except for those specified; two partners who apply and sign contract with DSS together, and will have to define their mutual roles. Sheila commented that you have to define the administrative roles that everyone is performing and how the partnership is carried out. She also indicated that there must be room for innovative practice once the partnership parameters are outlined. Matt said outline in application that these are the working components for the BHPA and the relationship with Admin Lead, including admin payment to BHPA. (If BHPA is identified as care manager for client, then they might do care management also based on client choice.)

Karyl Lee thought there should be an independent reviewer of the Demonstration. Kate said they have considered consumer focus groups, tracking of outcomes, but we have very few measures about "integration" across various practice areas. DSS is looking at possibly developing some measures.

Single point of contact for consumer is Lead Care Manager. Enrollment information will be developed for consumers and supported through enrollment process with Lead developing education process for consumer members in HN. Quincy said how people work together at local level will determine success.

Jill said there are shared roles between Lead and BHPA so should there be an outcome measure(s) to how care is being integrated and coordinated across sectors. How does communication care and when, how do transitions take place? A BH agency can apply to be the Lead Agency. Sheldon cautioned that in this partnership must be cautious about finger pointing about whose responsibility various care functions, but incentives should promote best practices with all partners. Buck still stops with the Admin Lead.

Kate outlined what requirements they are considering for leads. "Must be a community based, non-institution provider of health care services..." Deb Polun asked what "stand alone" hospital is? A Hospital on its own can't be the applicant. What if a provider has a system of care that includes nursing homes? DSS wants providers providing care in the community-which entities are best positioned to provide primary preventive care, and who have the most day to day

contact with MMEs. DSS wants an independent organization who can carry out the requirements. Many hospitals now own physician practices who serve the community. Matt Katz stated that all institutions are moving towards hospital systems. Alicia said she thought the goal was to reduce the most expensive services. Meg pointed out that Masonic Health Care, eg., has the largest home care system in the state in addition to a nursing home. Matt's concern is that we would eliminate small hospitals from participating who are the core of health systems in their areas. Sheila suggested that DSS be explicit that larger hospital systems' components that are community based could be the Lead applicant, rather than the hospital itself.

Quincy looked at competencies re person-centered since in long term services and supports these are what help people live successfully in the community. Sheila also asked that we have explicit presentations on how the HN related to people with intellectual disabilities and their waiver providers, as well as waiver providers to the elderly.

Karyl Lee said applicants for Lead must demonstrate success with what is being sought in the application. She also sees some conflict between the sophistication of what is being asked, but are these the groups with the community based experience that are being sought.

Sherry Ostrout raised the issue of whether for-profits could apply.

Submitted by,

Sheila B. Amdur