

COMPLEX CARE COMMITTEE—DEC. 21, 2012

The meeting opened with a moment of silence for those who were struck down in Newtown, their families and the community. Sheila also acknowledged concern about the cuts to basic services and supports for people with intellectual disabilities, and how the integration of health care across the care spectrum will be undermined when those basic supports and rehabilitation programs are cut.

Siobhan Morgan, Deputy Commissioner of DDS, presented overview of DDS population. 62% of 16,000 served live with families or their own homes with supports. Others are in group settings of various kinds. More people receive day services than residential supports. 20% are dually eligible for Medicare and Medicaid. Many others could be on Medicare and not Medicaid--# not known. Over 9,000 are on Medicaid, and remainder would be Medicare and/or private insurance. Challenges for integrating health care are: multiple surrogates, accessibility, and person centered care. Individuals also make decisions on their own.

Historically, it is hard to find medical providers who will work with individuals with intellectual disabilities, complicated by Medicaid rates. So health care disparities exist when even basic preventive exams are not done. Need to educate health care professionals about working with individuals with intellectual disabilities. Learn how to engage the individual, not just their surrogates.

Recommendations:

- Learning collaboratives to educate providers. Ellen noted that we need to also integrate cross disability education and assure that practitioners participate in this.
- Care coordination: Health care coordinator is a waiver service, a nurse, who works with individual. On DDS website there is a list of qualified health care coordinators, which is available under Individual Family and Support waiver. Kate McEvoy clarified that waivers, both for elders, intellectual disabilities, and others, outline care management in different ways. Will Duals initiative augment waiver payment or will it be considered duplicative of what is already being paid?
- Assure that preventative healthcare takes place, e.g., mammograms, colonoscopies, PAP smears, etc. based on the same schedule that anyone else would get such screenings.

Rivka Weiser reviewed the diagram of the Health Neighborhood Design. DSS is evaluating feedback about who can be a Lead Agency. Molly Gavin asked about ASOs' role. CHN has predictive modeling, data re formation of health neighborhoods, quality management, etc. Karyl Lee Hall said grievance procedure needs to be specifically referenced in implementation plan. **Sheila asked whether a state agency can be a BHPA. Kate indicated this is a particular**

issue that still needs to be resolved, along with how applicants can bring forward non-standard ways of managing and forming HNs. Agreed that we would show this on each agenda as unresolved issues. We will ask Committee members to raise formally issues they feel are still pending and what their concerns are. Also should anyone be excluded from leadership of the HN? Role of BHPA not fully outlined either. Sheldon commented that he believes there should only be one contractor with the state. Sheila indicated that Steering Committee of CCC would meet in early January to discuss what major issues are outstanding that need resolution and how that should take place. Kate indicated she really wanted the CCC to generate its concerns directly.

Operational plan outlines HN provider composition.; Neurologists, pulmonologists, Gyn, orthopedics among others recommended by Medical Society. Kate indicated that DSS will be distributing cluster information re where duals reside and receive information. Sheldon asked about why some services like DME and rehab services, such as PT, OT, are not listed as required. Kate agreed about adding rehabilitation services to the required services. Kate clarified individual retains individual choice of providers, but providers outside the Health Neighborhood can be chosen.

Quincy Abbott said many individuals self-direct and choose PCAs. Kate said PCAs not included as required since they are individually contracted; should they be included. Will be explicitly included under care coordination model. Lori Syzciel indicated that to make the required list of providers much larger, the more difficult it is to form a HN. Ellen Andrews suggested nutritionists, but they are mandatory under supplementary services. Ellen indicated that DME provide a service, but should not be part of shared savings. Sheldon asked if all the groups listed would receive shared savings. They do participate, but Kate said the model has to take into account degree of contribution to successful health outcomes for the individual.

Outstanding issue is whether Lead Care Manager that is a state agency can receive APMII payment.

Hillary Teed asked if BHPA could also be a care coordination LCM. Kate did not think two roles would be mutually exclusive. Aging and Disability Resource Center recognizes certain entities that offer certain services under grants to people across the age spectrum. ACA has given states additional revenue to promote more long term care in the community rather than institutions, \$73 million grant to develop universal assessment tool across H&CBS; conflict free care management which is not behavioral health model; no wrong door for people seeking assistance to their options. This might require certain kinds of staffing and services for existing set of ADRCs and a broader group. Kate said she will provide Council with background information.

Deb Polun asked about membership in HN. Every member or affiliate signs agreement re roles and responsibilities and how they participate in Care Coordination. Care Coordination Affiliates only would participate in shared savings. Any provider with appropriate credentials can do LCM and get payment. Smaller group is required Care Coordination Affiliate. Sheila noted that Care Coordination providers might potentially include addiction providers who have developed models for care coordination across the health care spectrum, even if they have no official “lead” role.

Kate reviewed supplemental services and also highlighted that chronic disease education and management must be relevant to all people served. Performance benchmarks will be developed related to these services; will be more related to health outcomes.

Credentials for providers—includes both for profit and state agencies. Anyone receiving shared savings must be a Medicaid provider.

Mary Ann Cyr indicated many specialists are Medicare but not Medicaid providers. Kate indicated that specialists would have to be enrolled in Medicaid.

Next meeting Friday, January 25 at 12:30.

Submitted by

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