

COMPLEX CARE COMMITTEE JANUARY 25, 2013

Sheila noted that each agenda will list unresolved issues about which we do not have consensus. This should include contractual requirements and responsibilities for state run services that are part of the Health Neighborhood.

CMS had questions about demonstrations growing larger than originally anticipated and also issues in managed care states. CMS issued new clarification to states that received original grants, indicating that the 15 states will be asked to submit supplemental applications that detail more of their proposal. CT will submit a supplemental 20 page application by April 1. States will be eligible for awards up to \$15 million/state for a total of \$95 million for the states. DSS will share in draft form with CCC for comment. Karyl Lee Hall said she wants to be sure consumer rights are adequately addressed. Link to CMS requirements will be shared. CMS has to accept our model, and will negotiate an MOU based on their requirements. CMS has yet to send formal comment on CT's application.

H&CBS waiver providers, CHN, Value Options, CCCI and So Central Aging, DDS, and DMHAS have talked through multidisciplinary, multi-department aspects of care management. Rifka Weiser went through outline of Integrated Care Demonstration Operations Plan based on that discussion and the original application. Enrollment issues will be discussed at a future meeting.

- Data analysis re risk level and potential adjusted PMPM payment. Matt Katz asked who will make determination of risk based on what data. Medicare and Medicaid data will be used in predictive modeling for initial risk assessment—can be adjusted based on reality of client's situation. **Still to be determined exactly how this will be done, but will expand on CHN who is already performing this function—will be in financial modeling.**
- Enrollment on opt out basis. Once in HN, then care coordination for all care through Lead Care Manager.
- Clients will be asked to choose an agency for LCM. LCM will be responsible for identifying specific client responsibility. If already working with waiver provider, would initially be assigned to that waiver provider, but could choose another entity.
- If person doesn't choose LCM, then HNs might be asked how they would propose to assign LCMs with preference to those already providing services.
- LCM designated staff person be a single point of contact for all aspects of care. Licensed providers as LCM but in a team based approach. Should institutional provider be able to be an LCM? An LCM must be a licensed medical provider, and LCM must be a credentialed and licensed individual. Matt Katz raised the cost of this and if clinical expertise is needed. Molly Gavin indicated that these individuals must be knowledgeable clinically and be able to communicate with physicians, hospitals, etc. Lori Szygiel said someone must be able to understand and monitor health and changes in symptoms. Matt is suggesting that a more specific description of the LCM qualifications re clinical expertise be defined, and Physician's Assistant should be

included. Molly Gavin indicated that this demonstration is more intensively involved with clients' care than any other home care model. Work force issue may be faced.

- Standardized comprehensive assessment of needs instrument—should person who does assessment also be care manager? (Standardized assessment tool MUST address homelessness or those at risk of homeless.) CT under 50% in terms of its long term cost spending in the community-national goal is to be over 50%. This assessment tool will also be used in all waiver programs. (Any behavioral health expertise in developing assessment?)
- Care assessment reviews were specified.
- Care coordinator to member ratio—1 to 70 to 80 for least risk; 1 to 50-60 for moderate risk; 1 to 30-40 for intensive risk.
- Document outreach to client, some of which could be performed by “extender.” How do we assure capacity and capability of LCMs to reach people who are homeless and outside of traditional provider involvement? Also racial, ethnic, cultural and language capabilities—needs to be explicitly addressed. Alicia Woodsby reported that the Behavioral Health Partnership Health Home Committee has talked about this and said that there has been discussion of non-traditional providers who provide care and support to people who are homeless, need housing stability and linkage with services. Would this service fit as a supplemental benefit? Should LCMs contract for these specialized “extenders?” Tracy Wodatch said payment models make it difficult to define homebound for someone who is homeless! Some agencies are placing nurses in homeless shelters at specific times to build trust and have people go to them instead of ER.
- Alicia pointed out that if we do not build housing stability and placement into this, individuals will not be able to manage their health care.
- Sheila indicated BHP Health Home Committee needs to make a specific recommendation.
- Kate asked what incidence of homeless individuals are dually eligible and may help inform whether this should be targeted intervention or a full scale supplemental service.
- Molly noted that under MFP there is housing coordinator position which might inform this.
- Lori pointed out that LCM needs to weaver together and broker services specific to individual.

Bob Smanek from Day Kimball said not to be too prescriptive and realize rural nature of areas like northeastern CT in terms of work force. Be careful not to define our future from our past—some changes like patient centered medical homes are rapidly advancing and recognize where particular areas of the state are in their care coordination development.

CHN will develop provider portal for providers/care managers to access client services and treatment in multi settings to assure collaborative, coordinated care.

Jill Benson asked if intensive care management is a subset of LCM. In application it was conceived as higher level of care management but as part of LCM responsibility.

February: Beneficiary protection/DMHAS-DSS will come back their agreement.

March: Financial Model—David Parella lead consultant for Mercer and will also help develop supplemental application

Kate said we will continue to work on details of implementation after April. For unresolved questions, looking for CCC to provide comment. For state affiliated entities, DSS has to make joint position with DMHAS and come back in February. Also should there be any entities that can be excluded from being lead agency.

NOTE: NEW DATES FOR MEETINGS—

MARCH 8

MARCH

Submitted by,

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