

COMPLEX CARE COMMITTEE March 13, 2013

Attendance: Sheila Amdur, Karyl Lee Hall, Claudio Gualtieri, Molly Rees Gavin, Jill Benson, Julie Gelgauda, Quincy Abbot, Tracy Wodatch, Deb Polun, Pam Meliso, Margaret Murphy, Sheldon Toubman, Ellen Andrews, Rivka Weiser, Kate McEvoy, Neysa Guerino, Steven Moore

CMS intent is to fund 15 planning grant states--\$95 million pool, funding each state from \$1 to \$15 million with some potential for going over \$95 million pool. CMS is requiring supplemental applications around issues specified in the document shared with CCC. Submission date is April 1. COMMITTEE WILL HAVE FULL DRAFT BEFORE THE MEETING. State can apply for 100% of costs in year 1, and 50% of costs in year 2; not clear about year 3. ANTICIPATED NOTICE OF AWARD IS MAY 15. MOU: expected performance measures (some required, some DSS generated). Washington MOU only guide and will be resent.

Materials for CCC March 22 will outline RFP timetable, potentially implementation targeted to 1/1/2014. Committee members will receive a full draft by Tuesday, March 19, and members can make comments before March 22 meeting.

Draft response to CMS questions reviewed:

- Qualified providers for supplemental services: Claudio Gualtieri asked what those qualifications are. DSS will allow some latitude about how these services will be provided.
- Sheila suggested that Leads in HNs be asked to be specific about supplemental services and how they will be applicable to the range of people with chronic illnesses, including serious mental illnesses as well as those with intellectual disabilities. DSS will outline their preferences for certain services related to evidence based practices. Model 1 does build in some chronic disease self-education, and CHN will be looking at tailoring their current interventions to people who are dually eligible.
- Ellen stressed the need for evaluation. Kate indicated evaluation based on person centeredness, consumer satisfaction, cost and health outcomes, and focus on efficacy of supplemental services in terms of relating to future state plan amendment for these services. Sheldon stressed the difficulty of evaluating what factors impact outcomes.
- Financial payments: Originally proposed funneling through Lead. Now will make payments through MMIS—APMII to any direct Lead Care Management agency, by-passing the Administrative Lead and BH partner.
 - All Lead Care Managers must be trained with their staff including core curriculum about reaching underserved populations. Lead care managers does not supplant authority of waiver care manager.
 - Administrative Leads receive admin contract and also eligible to participate in performance payments. Advance payment of \$250,000 to develop infrastructure and on-going payment to Admin lead for monitoring outcomes. There will be contract standards for the duties Admin Leads will be performing, and payments could be reduced if standards not met.

- Claudio clarified that in Year 1 are solely based on quality standards. Benchmarks on quality measures requisite to value payments.
- Performance payments: DSS will solicit from HN Lead in application their methods for distributing performance payments based on requirements DSS has set. Mercer financial model will provide more information in draft application. Claudio asked how payment models will assist in changing provider behavior. Financial model will elucidate!
- DSS proposing to operate under various authorities for payments. Re PCMH, enhanced fee for service in current PCMH model will be done concurrently with dual eligible initiative under the same authority. DSS is looking more at episode based/bundled payments across Medicaid.
- CT has decided not to elect health home funding within the HN. BH Health Homes will be implemented at same time as duals initiative. For any client who has SPMI and is dually eligible, client will be designated based on whether they have relationship with BH Health Home provider or HN provider. Could have relationship with both, so rules of attribution will specify how client will be “passively” enrolled. Client education very important so they can understand if there are benefits to them in actively choosing one model; client can opt out, available on an on-going basis.
 - For Health Homes (which is state plan amendment), State will receive 90% federal funding for first 8 quarters of funding; then it will be based on state’s current Medicaid share requirement. Health Homes will receive PMPM payment. What is relative value of this to the APMII payment under HN? In other states that have elected Health Homes, and PMPM is all over the map. CT payment not yet determined under Health Homes. Ellen raised concerns about provider incentives to steer client based on payments they are receiving. Shared savings unknown under HN. Payment method will be disclosed to consumers.

All waiver care managers met to determine how to develop common functional assessment tool which will be used across all waivers and in HN demonstrations. Can “populate” information for HN through existing current waiver data. Sheila clarified that current LMHAs do not have care managers, but have case managers. Karyl Lee asked what consumer’s rights are related to care plan if they don’t agree with it. Kate indicated that will follow waiver process. Julie indicated that with person centered planning this rarely happens. Consumer can formulate appeal/grievance. Consumer rights process must be delineated with clear information about how to file a grievance. Sheldon Toubman said that person should be given this information at the time care is denied, or client disagrees. This is process that will be followed.

Levels of Care Coordination: Need more detailed descriptions of extenders who can reach underserved people within Lead care management role. Lead Care Management must be Medicaid enrolled entity and could delegate information and assistance on their own staff as an extender. Social service affiliates of HN can specifically describe homeless providers. DSS did not assume that Lead Care Manager could subcontract. Jill suggested that HN decide if they wanted to subcontract and be clear about this.

- Claudio asked if payment is tailored to assessed need of client, then should categories be more specific? Kate indicated that any suggestions would be welcomed. Rivka indicated methodology would have to be clear in terms of how risk adjustment is secured, based on claims. Quincy said that DSS should be cautious on not promoting an incentive to have more claims! APMII still under consideration.
- Ellen asked does Lead Admin agency have responsibility for building team partners? DSS will have standard curriculum to be applied across all HNs re providers becoming part of HNs.
- Long term care Services Providers are nursing facilities/home health/adult day care/waiver providers.

PCMH: CHN says 71,000 active dually eligible individuals, and 12,994 are attributed to PCMHs. 96 approved PCMH sites currently. NCQA Levels II or III standards followed by PCMHs.

Claudio recommending that “No Wrong Door” language be added. Quincy asked if people in DD Group Homes would be carved out since they are already receiving health care coordination. Sheila suggested that populations not be carved out because of “value added” of HN. Kate clarified that open enrollment is to define who will be in HN, but person can opt out at any time.

Re undecided issues:

- Hospital as Lead Admin agency—Discussion ensued re whether stand alone hospitals should be Lead agencies ; would thi stifle participation given that hospitals must support their own market share. Ellen indicated there could be protections in contracting to assure broader participation. Kate said that we are not “time bound” related to who can be leads; application to CMS will not focus on this detail.
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State agencies as BH partners: Deb Polun raised the following recommendation:

"If a state agency is a BH partner in the Health Neighborhood, their contractual requirements will be the same as any private entity. The state agency as the BHP will subcontract for care management to build community capacity and will not directly provide care management as required in the Health Neighborhood MME initiative. The state agency will not receive either PMPM financial payments nor will it share in any 'shared savings' since the intent of the initiative is achieve better health outcomes, consumer satisfaction and lower costs by building community capacity to provide more effective health care to people who are dually eligible for Medicare and Medicaid."

- Kate indicated that DSS support costs of waivers in other state agencies. DSS agrees that state run LMHAs can serve as BH partners and must follow same standards. DSS said they will pay state run but will not make duplicative payments. DSS and DMHAS position is that all state contractors should be treated the same regardless of whether they are a state agency. So DSS will pay another state agency and funds may not be reinvested into the community.

Molly raised that risk management issues are not the same for state agencies who can't be sued. Ellen asked if person chooses Lead Care manager at state agency, will that person receive same level of services as at a private non-profit? Kate agreed to provide language spelling out their agreement with DMHAS.

- Deb Polun asked how DMHAS will use any funds they are getting. State agency as BHP does not have to be decided before April 1. May need separate meeting to resolve this issue.

Steering committee will have conference call before next meeting.

Submitted by,

Sheila B. Amdur