

## COMPLEX CARE COMMITTEE—MARCH 22, 2013

### MINUTES

Attendance: Shelia Amdur, Mag Morelli, Maureen McCarthy, Claudio Gualtieri, Quincy Abbot, Deb Migneault, Ellen Andrews, Jill Benson, Hillary Teed, Bo Smanik, Michael Taylor, Sheldon Toubman, Mathew Katz, Jennifer Hutchinson, Lori Szczygiel, Marie Smith, Siobhan Morgan, Marie Smith, Lakisha Hyatt, Bill Halsey, Rivka Wisner, Kate McEvoy, Tracy Wodatch(By Phone), Alicia Woodsby(By Phone)

Sheila reviewed the comment period on Duals application. Kate reviewed that each of the 15 states asked to submit supplemental information. Focus on implementation activities.

Attached to application will be:

1. Budget and Budget narrative (included in 20 page limit)
2. Section of Operating Plan re aspects of HNs, including composition, credentials, leads, BHP, etc. Kate asked if group had comments on: **Will institutional providers and/or stand-alone hospitals be allowed to be Leads?** Matt asked Kate to clarify to what the draft application is recommending. Original proposal: stand-alone hospitals and nursing homes not are allowed to be leads. The other alternative is to allow anyone to apply if they meet RFP requirements. Hospitals with affiliated physician practices could apply. Meg Morelli said a long term care provider that is developing a community approach should not be excluded. Matt moved that application eliminate “non-institutional provider” and focus on services that have to be provided. Meg Morelli seconded. Sheldon said that he is concerned that a nursing home whose business line promotes people in nursing homes is antithetical to the outcomes of this project. Ellen raised there are whole host of challenges related to this that should be explored in detail. There was an agreement that we would continue to work on this. Kate said this can be amended, and she suggested taking out exclusion if there is no consensus. Sheldon said that we could put a qualifier that this is not a resolved issue. Describe relationships with other state agencies. Sheila suggested that institutional providers who provide established community based network of community services may be considered as possible administrative leads. This can be coupled with existing language related to those with who are eligible. Bill Halsey suggested that if those who are providing the required services meet the standards, they could apply. This would exclude solely institutional providers. Motion passed with one vote.

**Consensus followed CT defining ADMIN lead based on services needed with preference to non-institutional providers.**

4. Work Plan will also be attached.
5. Definitions of all care management and levels of care management, including relationships to waiver providers/MFP.
6. Performance measures—Rivka Weiser said that CT looked at Washington State (also fee for service state), and used their measures, which will be obligatory. However, CT will secure an evaluator and work with CCC further on this, including consumer satisfaction and other measures group identified early in the process. Matt raised concern about state specific measures and not having duplication or developing an unwieldy group of measures. NQF report relevant to this population, e.g., measures that address person-centeredness across all subsets of duals population. Need evaluation requirements across settings of care also. Quincy

suggested looking at last quarterly report of MFP re quality of life measures for consumer. CT can elect how they choose to do this beyond the CMS minimum set.

7. LETTERS OF SUPPORT RE PARTICIPATION IN STAKEHOLDER PROCESS but not required.

Kate commented that they will further clarify BHP role definition. Interplay between LCM and other sources of care/case management support—Care management document describes this relationship. This does not change responsibility of waiver manager for LTSS and their budget. LCM and team will also interact with pharmacist who has completed special training related to medication management. AARP and Sheldon raised need for independent ombudsman. Only states with managed care has put into place grievance appeals process for Duals. Kate not quite sure how this will be done, and have to discuss with CMS how to marry this to Medicare appeals process. Sheldon believes there are limits to what we can do given Medicare appeals process. Sheldon said that the ombudsman can be separate from CMS. Kate clarified that they have to understand how other states have done this. Sheldon and Claudio clarified that this would be an independent function, and Kate agreed it would be independent. CCC will be able to comment on the development of this.

There will be a steering committee for the project and Kate agreed there will be consumers represented. Also expert stakeholders will be involved in developing performance measures.

BHP as a state agency: BHP state agency can apply to be BHP. Jennifer Hutchinson from DMHAS said any state agency that is a BHP would not participate in any payments of any kind under this application. State LMHAS can be LCMs. Kate also agreed that DMHAS can have no role in development of RFP or in choosing who will be leads or BHPs if they intend to apply in any HN to be the BHP. State run agency would have to compete like any other entity. Sheldon was concerned that DMHAS agency would not have the incentive to do the best job. Also the issue of enforceability of contracts with a state agency was raised. Sheila suggested that MOU be developed between the two agencies spelling out the requirements for any state agency participation that it be the same as any private entity. Matt also indicated that the Admin Lead must have the same ability to act in relationship to the state agency partner as it would with a private partner. Kate clarified that all demonstration funds will be spent on the demonstration. Bob Smanik said that this demonstration is requiring everyone to look how client needs should be met. Also said there is no presumption that LMHAS would be the LCMs or the BHP.

Language will be added regarding underutilization. Claudio raised concerns about operating call center on nights and weekends, and also adding evaluation criteria on disability type, and racial and ethnic disparities. Claudio noted that consumer could make changes re LCM on a monthly basis; Rivka said this has to be worked out with enrollment broker and specific standards will have to be worked out. Care coordination document expresses remedies to access barriers, and leads will have to address in RFP response how they will address those barriers. Focus will be also being on people who are homeless.

In evaluation, Sheldon raised issue of evaluating both Model 1 and Model 2. Also do supplemental services make sense to be part of Model 1. CT is unusual to be using ASO model and it will be evaluated.

Going forward CCC will see:

- MOU between departments
- Work group on requirements for Admin Lead: Ellen Andrews/Meg Morelli/Matt Katz/ Ellen Andrews/Sheila Amdur—will meet before next meeting.
- Further work on performance measurement

Conference call on Wed., March 27 at 8:30 a.m. to discuss redraft of the application.