



Council on Medical Assistance Program Oversight
Complex Care Committee
(Previously ABD Committee)

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Chairs

Rep. Susan Johnson & Sheila Amdur

COMPLEX CARE COMMITTEE—May 24, 2013 Summary

Attendance: Sheila Amdur, Maureen McCarthy, Claudio Gualtieri, Bob Smanik, Molly Rees Gavin, Quincy Abbot, Ellen Andrews, Margaret Murphy, Deb Polun, Sheldon Toubman, Mathew Katz, Jennifer Hutchinson, Liz Collins, Marie Smith, Mary Ann Cyr, Siobhan Morgan, Bill Halsey, Rivka Weiser, Kate McEvoy

The Committee thanked Rivka Weiser, who will be moving to Washington, D. C., for her work on the Duals application and her contributions to the CCC and the state.

Kate McEvoy presented review regarding implementation funding from CMS. States have been frustrated about the drawn out review process, lack of clarity of performance standards, and shared savings model. Benchmark timetable is contingent upon execution of CMS (CMMI) MOU. CCC should look at previously circulated MOU between CMMI and Washington State. Originally CMMI was supposed to provide 3 years of declining implementation, now it is a 2 year funding grant.

Matt reported that six applicants have withdrawn and nine states have delayed implementation, Massachusetts indefinitely. CMMI had pushed 1/1/2014 implementation date, but with delay that is not possible. CT not planning to withdraw. Ellen asked are there other pieces that could be implemented by January 1. Kate indicated that PCMH participation has increased dramatically; intensive care management under CHN also ramping up. These are areas that can be amplified, as well as access to primary care. Tobacco cessation program is first ever incentive program in Medicaid that has been implemented. Targeted ICM for duals under ASO does not have funding source.

Sheldon asked about how many of the 20 states that are left in the duals program are fee for service—Kate indicated there were 6. Kate indicated that the Oregon design has features that may be helpful for us. Sheldon also raised the issue re why use PCMH authority rather than

waiver, and to lay out factors for which decision. Kate indicated that time is the issue in responding to this request, not the willingness to do it. CMS will have to comment on this also.

Sheila said that the complexity of moving forward on this should allow data to be available now and the financing model should have more clarity. Kate said the RFP will outline all this, but have to wait on MOU. Sheila suggested speeding up on cluster data so that providers can start considering where they might concentrate and what the marketplace will be. Revised cluster analysis will not be available until June. Some modeling on types of practitioners and travel costs need to be included in APMII. General shared savings guidance has been issued and shared with CCC. Matt Katz suggested that more meetings be scheduled with providers with orientation. Bob Smanik asked about presenting to regional groups of providers and consumers about interplay with medical and behavioral health providers, and also on more detailed data. He suggested that this would be a conceptual presentation. Kate indicated that this was a useful suggestion. Claudio suggested outreach to thought leaders in the community who represent consumers. Kate asked whether CCC could host Forums. Executive Committee of Council meet to make recommendations about potential forums or regional meetings. Kate will share draft materials to be shared for comment.

Kate is working with internal group on grievance and appeals for consideration of small work group. Sheldon Toubman and Margaret Murphy will be added to small work group.

Care Coordination standards: Rivka Weiser reviewed the current draft document. Matt Katz asked about the assessment which doesn't talk about health and well-being of client. Under "care coordination", not clear what "care" means. There is discussion of chronic disease self-management, but not obligation for disease management overall. "Values" need to be more specific. Also need to define what "effective" management is. In more detailed aspects of care management, this is clear. Marie Smith asked re planning of care in team based model—how will members of team have access to data? Kate indicated that care coordination documents will outline shared responsibility, accountability, and how data will be shared so there is measurable accountability. DSS is reviewing some electronic DIRECT protocols that can be helpful to providers, and will send link on this. Kate asked how prescriptive they should be or look at what comes in on RFP process and look for innovation. Marie said that providers may not have that degree of information, and that more information needed on state's HIE "vision." Caregivers and consumers also need input on this.

Liz Collins said there may be natural clusters of providers around the state who will come together. She believes that the document should set framework for this to happen. Ellen raised that there must be verification that care plan has actually happened in terms of what is outlined, and that MME participated (and or declined). Quincy raised his continuing concern that care coordination will be through medical lens only, rather than focusing on supports and

services to help someone live their life including medical needs. On bottom of pg. 3, the emphasis on preference for “conflict free” care coordination contradicts other federal funding requirements the state has received; this was the rebalancing initiative to shift from institutional to community based (over 50%). Kate noted that there are different existing models related to care coordination that would be difficult to implement, particularly in behavioral health, in terms of “conflict free.” Quincy also raised the minimum frequency of 6 months and whether it would happen and is it always needed.

Sheila asked if consumer picks existing care manager who doesn't meet qualifications will they be able to use that individual. Molly said that we expect those individuals to bridge the medical world, and Molly indicated that the less credentialed, the more they will meet resistance. Kate wanted to review this with DMHAS and DDS. Sheila noted it's quite important not to disrupt the person's care. Jennifer Hutchinson from DMHAS added the complexity that there will be individuals who are eligible for both Health Homes and Health Neighborhoods, so “attribution” to which model will have to be clarified. Kate also indicated that the HN assessment will build on long term care assessment now under development. Siobhan Morgan clarified that many people who live at home do not get waiver services, and that the care management under APMII payment will be paid to each care manager, but will also wrap around other waiver payments, primarily WISE. Jennifer Hutchinson that DMHAS does not pay for care coordination now. Kate said that the reference to LMHA affiliates will be removed.

Rivka reviewed the revised Key milestones and contingencies. Matt asked re JEN data integration and timetable—they are waiting for CMS to provide data. Sheila suggested staging outreach to providers before release of RFP so potential partners and affiliates can begin to organize, with which Rivka agreed. Mary Ann Cyr asked if there is any known date for CMS to provide complete Medicare 2011 file. CHN is using 2012 crossover data now. To have provider portal ready, CHN would need data ready by September 1 for January 1 start date. Mary Ann is referring to data that would be used for actual care management, and it needs to be historical as well as current. Rivka said she believes monthly data will be available. Matt asked when RFP is put out, what will potential applicants have access to in terms of evaluating clusters and needs of population. Kate clarified that DSS wants to release detail behind cluster analysis. They would welcome input on what data would be needed for people contemplating response to RFP. Not clear when data will be released.

Deb Polun thanked the Department in terms of clarity in the documents presented. Deb asked if there are any risks in Connecticut's application not being approved. Kate does not think this will happen. Sheldon asked if RFP pushed forward, will January still be the implementation date, given what else will be happening on January 1. Kate said focus is on improving experience for beneficiaries, but CMMI is still pushing January 1. Molly indicated that

attribution for ACOs has been very difficult, and that in the HN, there are complications re overlapping initiatives, and whether there will be 5,000 people who can be found and are eligible. Kate agreed this will be a challenge!

Next meeting: Friday, June 28 at 9:30 a.m.

Submitted by,

Sheila B. Amdur