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Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration – DRAFT – 4/01/13

Statement of Values:

The State of Connecticut has a strong policy preference for person-centeredness in all care coordination activities. For the purpose of the Demonstration, person-centeredness is defined as an approach that:

- provides the Medicare/Medicaid Eligible individual (MME) with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;
- supports the MME, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and
- reflects care coordination under the direction of and in partnership with the MME and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Further, the State of Connecticut is committed to remedying barriers that have historically been and are currently being faced by MMEs, including barriers related to ethnicity, disability, culture, and values concerning health care that depart from the “norm”. Non-exclusive examples of these include the following:

- MMEs with physical disabilities and Serious and Persistent Mental Illness (SPMI) report being treated differently on the basis of these disabilities and/or stigma associated with these disabilities.
- Individuals with intellectual disabilities report that providers do not always take their complaints or reports of symptoms seriously.
- Homeless individuals face unique barriers in accessing primary preventative care, managing chronic conditions and receiving support with recovery from acute events.

Further, the State of Connecticut is committed to addressing the needs of individuals who may face barriers of access relating to communication (e.g. language of origin other than English, lack of reliable means of contact, housing impermanency), cognitive impairment (e.g. Alzheimer’s or other dementia, Acquired Brain Injury), lack of transportation, and/or functional limitation.

Health Neighborhoods (HNs) must commit to the principles of and indicate the means by which they will promote and evaluate the applied practice of person-centeredness. Further, HNs must illustrate the strategies that they will employ to address the types of barriers identified above.

Definitions:

- **Assessment:** For purposes of the Demonstration, an Assessment is a comprehensive, multi-dimensional assessment of domains including functional capacity, physical and cognitive status, formal and informal supports, and environment, which is used to prepare a Plan of Care.

is led by the MME and his/her LCM, and is composed of all relevant provider members of the HN, as well as any involved Information & Assistance Affiliates and Social Services Affiliates.

- **Plan of Care (POC):** For purposes of the Demonstration, a Plan of Care is defined as a document that is completed by a Lead Care Manager in partnership with an MME and his/her chosen representatives, which articulates the MME's goals, provides an inventory of the services that are being received by the MME, identifies the members of the MME's care coordination team, and includes action steps (e.g. toward improving communication and collaboration among MME and members of the care coordination team, effectively managing chronic disease, and preventing unnecessary hospitalization and/or nursing home placement).
- **Lead Care Manager (LCM):** An LCM is responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services. A Lead Care Manager must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration specific training.
- **Lead Care Management Agency (LCMA):** A LCMA is a Medicaid enrolled provider member of a Health Neighborhood that employs staff that meet requirements to serve as LCMs.

Capacity:

Each HN must demonstrate capacity to serve MMEs along a continuum of care coordination needs from minimal to intensive. Specifically:

- Each HN must enter into care coordination agreements with LCMA's that employ staff who meet the requisite qualifications to act as Lead Care Manager (LCM), and must proffer a list of such LCMA's in its response to the RFP. To act as an LCM, an individual must be a licensed clinician (e.g. APRN, RN, PA, LCSW, LMFT or LPC) and must following upon launch of the Demonstration, agree to complete Demonstration-specific core competency training in care coordination.
- HN's must ensure that the ratio of LCM's to MME's to whom they are providing care coordination does not exceed 1:80. HN's have the authority to substitute a more limited ratio based on the acuity and care coordination needs of a given LCM's caseload of MME's.
- HN's must ensure that LCMA's ave an identified and substantiated means of telephone coverage for after hours and weekend contacts.
- Each HN must enter into standard care coordination agreements provided by the State of Connecticut with all member providers that detail terms including, but not limited to:
 1. means of communication between MME's, LCM's, primary care, specialists and other providers;
 2. means of consultation among MME's, LCM's and members of MME's' multi-disciplinary care teams;
 3. role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).
- For purposes of the Demonstration, it is the preference of the State of Connecticut that HN's ensure that care coordination by LCM's is provided on a conflict-free basis. The State recognizes

by Local Mental Health Authorities (LMHA), and MMEs served by Money Follows the Person (MFP). The State of Connecticut will then transmit lists of cross-matched individuals to Xerox, which will use this information to tailor the above described enrollment materials to identify each cross-matched individual as assigned on a preliminary basis to his or her waiver care manager, LMHA care manager or MFP transition coordinator (provided that the entity has capacity to serve as an LCM). In advance of sending these MMEs enrollment materials, Xerox will provide lists of these cross-matched MMEs, as relevant, to their waiver care manager, LMHA care manager or MFP transition coordinator. Xerox will then send enrollment materials to each cross-matched MME, and each cross-matched MME's waiver care manager, LMHA care manager or MFP transition coordinator will follow up on mailed enrollment materials with telephone and/or in-person contacts to review the materials with the MME.

Required components of this review include identifying that 1) the MME may either remain enrolled in the HN or opt out of participation, in which case reverting to participation in Model 1 (Enhanced ASO); and 2) the MME may either remain affiliated, as relevant, with his or her waiver care manager, LMHA care manager or MFP transition coordinator as his or her LCM, or instead select any other entity from the list of qualified LCMA that is provided in the enrollment materials. The waiver care manager, LMHA care manager or MFP transition coordinator will then support the MME and his/her representatives in making these decisions, and returning to Xerox 1) the opt-out form, if the MME does not wish to participate in the Demonstration; and/or 2) the identification of LCM form, which must either indicate that the MME wishes to remain affiliated with his/her waiver or LMHA care manager or identify the qualified LCMA that the MME wishes to have serve that role. If the MME declines to complete the identification of LCM form, the waiver care manager, LMHA care manager or MFP transition coordinator shall be considered to be the MME's LCM unless and until the MME identifies a preference for an alternative qualified LCMA.

MMEs who are not affiliated with a waiver care manager, an LMHA care manager or MFP transition coordinator will receive educational materials and contacts from Xerox, identifying itself as the Department of Social Services. Xerox will follow the above required elements of contact and counseling, and will forward identification of LCM forms to all LCMA in the HN that are selected by MMEs to serve that role.

HNs must attest to observe the following standards, and are permitted to detail innovative means of building upon these minimum requirements, especially with respect to means of safeguarding MMEs' free and informed choice of participation in a HN and of LCM.

Assessment

An LCM must complete an Assessment for each MME who has chosen that LCM.

To complete a Demonstration Assessment, an LCM must 1) populate the standard Demonstration Assessment tool with any existing assessment results (e.g. results completed by a waiver care manager) that are not more than six months old; and either a) complete any missing elements of the Demonstration Assessment by interviewing the MME and his/her preferred representatives in person; or b) if the results of an existing assessment is more than six (6) months old or there has been an intervening life event (e.g. serious illness, hospitalization, bereavement), complete the entire standard Demonstration Assessment tool by interviewing the MME and his/her preferred representatives in person. If an MME's LCM is not also serving as his or her waiver care manager, LMHA care manager, or MFP transition coordinator, the LCM shall have authority to contact and to receive assessment results from the MME's waiver care manager, LMHA care manager or MFP transition coordinator.

revisions, the LCM must modify the Demonstration POC and share the revised copy with the MME and his/her representatives for signature indicating approval.

The LCM must then electronically post the MME's approved Demonstration POC to the CHN-CT secure portal.

At a minimum frequency of each six (6) months, and as often as is clinically indicated if the MME has experienced an intervening life event (e.g. serious illness, hospitalization, bereavement), the LCM must meet face-to-face with the MME and his/her representatives to determine whether any modifications or enhancements of the Demonstration POC are necessary and to determine whether the level of care coordination support that is being provided continues to be consistent with the MME's needs and preferences. If the MME's level of care coordination support requires adjustment; either to reduce the level of interaction due to improvement in health status or other indicators, or to increase the level of interaction due to such events as an illness or care transition; the LCM must document such change on the updated Demonstration POC. The LCM's type and incidence of support must be informed ongoing by the requirements for that new level of care coordination support.

HNs must attest to observe the following standards, and are permitted to detail innovative means of building upon these minimum requirements, especially with respect to strategies to support the applied practice of person-centeredness in development of POCs.

Care Coordination

Once the MME, his/her preferred representatives and his or her LCM have mutually developed a Demonstration POC, the LCM shall for purposes of the Demonstration act as the Single Point of Contact for purposes of communicating with MMEs and coordinating their services and supports. Each LCM shall for purposes of the Demonstration be guided in his/her level of care coordination support for each MME by the level of care coordination support identified with the MME and his/her representatives through the Demonstration Assessment.

The LCM shall utilize the secure messaging function available through the CHN-CT to communicate with members of the Care Team. Non-exclusive examples of the types of communications that the LCM is expected to make include 1) referrals to HN providers; 2) requests to start, modify, suspend or terminate medical, behavioral health, long-term services, supplemental services and/or social services; 3) information on changes in health status; 3) information on care transitions; and/or 4) need for collaborative problem-solving with the MME to address an emerging issue.

The LCM shall on behalf of the MME and his/her preferred representatives order any supplemental services that are indicated in the POC, and shall modify, suspend, or terminate such service at the request of the MME or where indicated by an event such as a change in health status or care transition.

The type and frequency of care coordination support that an LCM is providing to each MME must be informed by the level of care coordination support that the MME requires. The requirements listed below should be considered to be a minimum set on which the HN is permitted to build.

- **Level 1 Targeted Outreach:** Targeted Outreach is a brief, focused intervention that is provided on an as-needed or situational basis. Targeted Outreach can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g.

of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams; and c) role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

The LCM must document the types of Care Coordination that he/she is providing to the MME on the MME's Demonstration Plan of Care.

- **Level 3 Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization, and/or inappropriate nursing home placement. LCMs must observe the following standards in providing Care Coordination:
 1. LCMs, or qualified proxies, must respond to telephone or other contacts received from MMEs during business hours (8:30 a.m. – 5:00 p.m.) on business days (Monday through Friday) by the close of the business day on which they are received.
 2. LCMAs' after hours/weekend back-up system must ensure that telephone or other contacts received from MMEs after hours or on weekends are routed to their LCMs and that urgent matters are responded to on the day on which they are received, and non-urgent matters must be responded to by the close of the next business day following the contact.
 3. LCMs must coordinate contacts with the MME, his/her preferred representatives and members of the care team to identify immediate and near-term strategies in support of meeting the MME's needs. If the LCM is not also the MME's waiver care manager, LMHA care manager or MFP transition coordinator, that individual should be considered to be an essential member of the care team. The LCM must consult with the MME and his/her preferred representatives to determine the composition of the care team most relevant to the MME's needs.
 4. LCMs and members of the MME's care team must observe requirements of the Demonstration care coordination contracts in: a) means of communication between MMEs, LCMs, primary care, specialists and other providers; b) means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams; and c) role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

The LCM must document the types of Intensive Care Management that he/she is providing to the MME on the MME's Demonstration Plan of Care.