Comment Received After the 9/24/09 Case Management Steering Committee Meeting

Mecklenburg County Public Health

1. Our final budget numbers for 2010 are due today to Carolinas Healthcare System and the books close Friday. We received the new reimbursement rates for case management except for CAP C and DA. We originally planned for a 20% decrease but see that it is more like a 50%-60% decrease. Should we plan for 50% rate decrease for CAPS as well?
2. We are meeting with our local CCNC program October 9th and want to begin discussions about collaboration and partnership, but we are not sure what we should be asking or talking to them about. Can you provide any guidance for us please?
3. Will the CSC and MCC addendums and requirement be revised with the new case management model as we will not be able to meet the same requirements/paperwork with less reimbursement?
4. Is the plan encouraging CSC and CDSA programs to consolidate?
5. We are ready and willing to begin restructuring, but need some guidance and direction. I feel like there are little clues here and there, but nothing concrete.
6. How will our non Medicaid case management grants for CSC and MCC be impacted if any?
7. How will our post partum home visits and rates be impacted?

We have over 800 maternal child health and over 750 CAP and HIV clients per month in case management, so we really want to make a smooth transition with all of this. We also have over 50 case managers that could potentially be impacted, so it is important that we have a plan in place. Any assistance or guidance you can give us would be greatly appreciated. Take care.

Craven County Health Department

I have reviewed the September 24th presentation of the Case Management Steering Committee on the DMA website. I understand questions/concerns/suggestions/issues regarding this plan and implementation can be provided to DMA by October 5th.

Where does Maternity Care Coordination and Child Service Coordination fit in the plan? What is the time frame for implementation? It is also hard to understand all the acronyms used in the presentation. I am concerned that Case Management in Local Health Departments is being "punished" for the "sins" of mental health reform. I feel the plan is being reactive not proactive for the citizens of North Carolina in this time of economic hardship. I feel case management in Local Health Departments (MCC & CSC) provides a much needed service to the clients and works closely with the clients and the community to help the clients/families reach their goals and obtain needed services which impact their medical health and development. In this time of economic hardship, I feel the services will be needed to a greater degree than ever. Psychosocial/ behavioral needs/concerns of our citizens go hand in hand with medical needs. MCC & CSC Social Workers work with clients around these needs as they impact their health care needs. I feel if these services are eliminated, our citizens will face a greater health care crisis than currently.

Watauga County Project on Aging

We've been trying to understand the PowerPoint presentation from the 9/24 meeting and really cannot decipher what it means. Can you please explain the draft chart to us, and if you can't, could you please forward this to someone who can? At this point, I really need to know, in plain terms, what this means for our agency and case managers, and how this is supposed to

work. We can't make comments at this point, because we don't understand exactly what has been proposed.

DMHDDSAS Stakeholder Feedback on Case Management (CM) Model

The primary concern is that the model presented does not seem to reflect much of the stakeholder feedback provided to the CM Steering Committee. In addition, the problems we face are severe, immediate and relate to implementation rather than service definition. There were five (5) overarching themes listed below in no specific order.

- Individuals losing CSS. Will they be eligible for CM? If so, who will provide it and how will consumers access those providers? There will be continued need in a reduced capacity environment.
- It has been stated that there will be limits on the number of units. Limits and caseload numbers must be clinically sound. What will these parameters be?
- Administrative efficiencies need to receive top priority. If the administrative burdens are not removed immediately, the system is at risk of collapse, especially in light of the recent and impending reductions.
- The group would like to see greater clarification between the roles and implementation of Care Management and Case Management within the CM system design. This is necessary to decrease the possibility of duplication of functions. Several bullets under care management functions appear to be services to individuals rather than system activities.
- There is concern about the capacity of the system to handle the changes. The number of providers will decrease and the assumption that there is provider capacity to compensate. The marginal communities are already underserved. Comprehensive service providers will not fill the gap.

Other Comments

- Need to ensure that there is no duplication of CM through coordination among agencies.
- Need to clearly differentiate between the care management of CCNC and the care coordination of the LME.
- Be careful not to underfund this critical service.
- Create a protocol for the monitoring of the quality of service provision for those individuals opt out of CM.
- Outcome measures (tools, leveling, e.g.) need to be developed or obtained from agencies currently engaged in the provision of CM services, for instance cost avoidance data. NCTOPPS value was diminished when some of the questions were removed. The training plan needs to be detailed and realistic, possibly internet based.
- Be mindful of potential litigation and claims of unfair practice.
- Allow direct billing for DD CM.

Other Questions

- What is the CM provided through CCNC?
- Who will provide CM? Will TCM continue to be provided in the manner that it is currently? Will there be stand alone CM agencies or will only comprehensive service providers be able to provide CM?
- What are the eligibility requirements for an individual to receive CM? How is that person identified? Is an individual who receives no enhanced services eligible?
- Where is quality in this discussion?
- How does an agency become authorized, endorsed or enrolled to provide CM?
- What will the authorization process look like?
- Can CM be used as a safety net in that case managers maintain stable individuals on their caseload, so that individual knows who to call when a need arises?
- How will the person's "center of care" be determined and the coordination of switching between providers occur? For instance, thought needs to be given to the person having an active authorization whose needs change during an active authorization period.
- What part does the electronic medical record play in this?

The Arc of North Carolina 10/1/09

Suggestions for Paperwork and Process Reductions

With pending reductions in rates and units of TCM service per person, The Arc of NC suggests the following corresponding reductions in regulatory issues:

Top 5 –

1. Revise and reduce the current PCP format. Create a simplified treatment plan format with 2 required pages of "vital information" that triggers services in the system, and an added, shortened, and flexible component that supports true person-centered planning.

2. Monthly F2F – eliminate the monthly face-to-face requirement for CAP recipients. Require face-to-face visits every quarter.

3. Daily progress notes – change requirement to a monthly summary.

4. Reduce training requirements – CPR and First Aid, stop requiring Case Managers to have annual Alternatives to Restrictive Intervention training. Case Managers are rarely alone with folks receiving supports, and that will be more so with massive reductions in service. This is an old facility-based requirement that is not justified in TCM.

5. Endorse and enroll TCM providers for direct billing to EDS NOW!

Create quarterly limits on units, instead of monthly cap, with no prior authorization, or at most an annual authorization or limit in EDS.

Allow APs to provide and bill for TCM services, under supervision of a QP.

Risk Assessment – eliminate the requirement for Risk Assessment tool to be used for CAP recipients.

SIS – hold off on further implementation of the SIS. Case Managers are expected, but not required, to attend this meeting and to contribute information to the process. This is not a billable function since they are not conducting the assessment. In addition, the information they receive back is not meaningful, and there is no direction on how to read or interpret the report they receive.

Omit requirement that LME has to approve guardian as provider of CAP services.

Stop requiring annual Target Pop forms. For people with developmental disabilities, an initial Target Pop determination and form is sufficient. LMEs vary in their requirements around Target Pop forms.
LME reviews – postpone all LME reviews for the remainder of this FY and consolidate all review formats for future implementation of no more than one LME review every 2 years for each provider.

Have LMEs determine DD eligibility as a part of their STR process. Case Managers do not have time to do this now, and much of the work required is not billable because the person does not yet have an eligibility determination (with proof from an evaluation) or Medicaid eligibility.

Enforce the expectation (and instruction from the CAP manual) that direct support providers must write the interventions (task analysis) portion of the person's plan. This must be completed a month or more before the plan expires to give the Case Manager sufficient time to get it to VO and approved before the implementation date.

End or suspend requirement for providers to conduct peer reviews of service records.

Reduce other paperwork and reporting requirements – needs study, and standardize to ensure all LMEs are requiring the same and not more than state requirements.

Release CAP slots for Tier I and IV immediately!

Increase push for rapid development of Tier II and III CAP services, and include the true Support Brokerage concept as a service. This could assist people in getting connected to their community, and replace some of what they will lose in limiting case management services.

Questions:

As people move in and out of Medicaid eligibility, while not eligible for Medicaid, and if no IPRS funded TCM is available for them, what will happen to them?

The Arc of NC **9/29/09**

Exceptions for 9 units/month limit on TCM services

The Arc of NC proposes an establishment of the following exceptions to any monthly cap or limit on TCM services.

Automatic approval for increased units:

1. Beginning CAP services for new recipient
2. Increased units in the CNR month for CAP recipients
3. Death of a family member who is caregiver
4. Deinstitutionalization or discharge from hospital

Approval by VO for increased units:

5. Addressing crises or emergencies
    - Use of emergency CAP slot to prevent institutionalization or hospitalization
    - Preventing homelessness
    - DSS involvement in abuse, neglect or exploitation
    - Supporting someone with legal issues, i.e. on probation
    - Supporting someone through a psychiatric crisis

Chatham County Public Health Department

10-02-09 DMA Case Management Steering Committee Questions:

1. The Case Management model depicted on page 14 of the presentation lists the following areas under Local Public Health: High Risk OB, Quality Assurance, Outcome Metrics, CSHN, and EI. In our current system, EI is operated regionally and the staff are State Employees…to depict them under the Local Public Health seems to imply a change to this system.
    a. Would the CDSA's continue to operate regionally or would they be integrated into local Health Departments?
    b. Would the staff, the Early Intervention Service Coordinators (EISC), be integrated into the local Health Departments as local (County) staff rather than State staff?
    c. Would the current pay structure then be changed for EISC as they are integrated from the State pay schedule to County pay schedule?

   d. Would the current EISC staff be transitioned from being State Employees to County employees or would they have to re-apply for their “same” positions due to the transition?
   e. If the two entities, CDSA and local Public Health are kept as separate systems, how will transition planning be integrated into the model?
2. How will the criteria for service determination be made for High Risk OB and CSHN? What factors will be considered for eligibility criteria? Who will decide the eligibility criteria? Will Maternal Outreach Worker services be included in the continuum of care?
3. Where does transition planning fit into the model?
4. Is there some way to assess every Medicaid client to determine need for services? Can assessment be part of the determination of eligibility for Medicaid process (aside from financial eligibility) to facilitate entry into needed Medicaid case management services?
5. Would the data sharing process be a system currently in use by CCNC or another OR does the data sharing process/system need to be developed? What is the timeframe for integration of the data sharing process/development?
6. Will Health Check be under Local CCNC Networks and no longer a part of the Local PH Departments?
7. Will the High Risk OB be provided only to those individuals who meet a specific stringent criteria and provided by staff in an “enhanced” MCC Provider role and likewise CSHN be provided only to those individuals who meet a specific stringent criteria and provided by staff in an “enhanced” CSC Provider role?
8. Will the timeline for implementation include allowances for transitioning of current recipients whose current eligibility criteria may not be as stringent as the eligibility criteria to be developed for High Risk OB and CSHN?
9. Will the eligibility criteria High Risk OB and CSHN include non-medical criteria such as multiple psychosocial risk factors (poverty, lack of social support, lack of stable housing, and/or maternal age <15 years)?
10. If a Time Line for implementation is developed please include the initiation date and targeted completion date for each item.

CAP/DA Case Manager

I am writing in regard to the recent, ongoing discussions about **case management services**. I must say that even after reading minutes, comments and the power point presentation presented on 9/24/09, I am not sure exactly what the Steering Committee's proposal is. I understand that changes need to be made and in certain programs more uniformity; however, I feel as though the individuals making the new proposals have not actually listened to those who have actually been doing the job of case management.

Our agency is a small part of a large hospital system and changes have been made to the system's processes over the last 5 years as new hospitals have been added. When processes in administrative tasks and billing for our office were changed to new processes that pleased the new administration, it was found that the process that had been in place for numerous years worked best for our agency. Sending billing and administrative tasks to other departments outside of our agency did not work very well and mass confusion ensued. None of those making the new decisions knew how the CAP agency worked, but after thousands of dollars were spent to have an outside agency come in and audit processes, the new administration soon learned that those of us that had been here for many years did know more about what they were trying to change than they did. Changes still were made, but most processes were put back to how they were being done prior to all the changes that were made. When all involved worked and talked through it, the best possible plan was made. I would hope that the steering committee would slow down and hear all concerns from all parties that are involved before trying to hurdle the mass changes through for approval.

Since I graduated from college, I have done nothing but case management. I have worked as a case manager with individuals with HIV/AIDS as well as worked with the Families First program at DHS in TN. I have been a case manager for CAP/DA since 2003. I feel that it would be to the detriment of any client that currently receives case management services for those services to be limited.

I would like to make a few comments on the short term goals listed in the minutes of the steering committee. As we have to say to our clients when as a case manager when we see a service is not needed but asked for by a client, each service given/offered is given on a case by case basis. In saying that, I would comment on putting a cap amount on case management services; different clients need different amounts of case management. I have clients who will be under the amount of units allotted in their cost summary in their individualized POC for CAP services and some who will exceed, depending on how their health has been and if they have a continued needs review scheduled. I may not have to revise anything or contact other agencies on their behalf, but I may have to spend hours trying to get them assistance for fuel, electricity, new housing, etc. I live in rural Avery County and there are not many options for our clients to turn to, so they turn to us for help. Without their case manager advocating for them, the client is not being the center of care. Many family members may be present in the lives of these individuals, but they do not offer the assistance or know how to communicate with agencies that may offer assistance or for other reasons the family members once they have asked for help may be turned down and the client has to look to someone for help. That help is their CAP case manager. Many of my clients have stated they feel like a burden to their families and choose not to speak up to them for needed items or about issues with their health; they turn to me as their case manager to do this for them. If case management is limited, I feel many CAP clients will be underserved. When the letter from DSS was sent out to recipients about all the upcoming changes and my clients asked what it meant for their case management services and I said I wasn't for sure, but that the State may change how often I can come out and see you or they may change the agency that visits you, my clients have not been happy. They like to see a familiar friendly face visiting them that they know truly cares about their well being. It gives them a peace of mind that they have someone to turn to that will help them. There should not be cap on units in the system nor should case management be eliminated.

I do not feel that allowing direct billing for DME companies will save any money. If CAP is to remain a budget oriented program, this option would not be saving money. DME companies have had cuts in reimbursement from both Medicare and Medicaid and when they are allowed to direct bill, I for see an increase in the amounts billed for incontinent products and nutritional beverages. Currently we try to assist out clients in trying to find the lowest possible price for these products and many times it is NOT through a DME company, it is through a pharmacy.

Each program is unique and different in many ways, as they target different populations. To consolidate forms to be the same for all programs does not seem to be making things easier on those using the forms and working for the program, it seems easier for those at the State level so that they will not be confused. Each program has different agencies that the forms go to and they go for different reasons. Do not produce more confusion just to make things easier for the State.

I agree on eliminating duplication of services, however putting an edit in the system so that only one agency can bill seems extreme. I feel that the data sharing system proposed to identify individuals who are currently receiving case management services, if put in place, would eliminate the need for this edit. When our agency goes into a home we try to list all agencies that we know of, that could possibly be offering services to the client so as to coordinate and to NOT duplicate case management services and then allow the client to decide which program would offer them the best benefit. Seeing as a data sharing system would be expensive, if electronic, and if it is not put into place, and if an edit is in the system, there should be some kind of an override for those that offered case management that was not a duplication of service. The duplication that we have found in our county has been Access Care RNs who have come in after CAP has been in place for a while. Case managers were not aware of this service until an in-service recently performed by Access Care.

I would like to see from the case management services steering committee a more concise proposal sent to all agencies who will be involved in the changes. And if agencies currently offering case management will be put out of use, I would hope that those making the decisions would not be push approval of this proposal through without giving appropriate notice so that there are not hundreds of case managers left unemployed.

Having a goal oriented pay schedule would not be appropriate for all programs. I work with nursing home level of care clients, there goal for most days is just to wake up, get out of bed and hope to not be in pain all day. There are not many goals you can make for these individuals, as most will not get better. I feel as though our agency certainly is not provider finance oriented. Of course all companies look to make money; however, I feel since we are funded by Medicaid we have tried to be good stewards of Medicaid money and do not offer unneeded services. Looking at reports on the average amount spent on CAP clients, Avery County was below the average. I myself have turned in In-Home Aides to the nursing registry that I have found to be fraudulent on their time sheets and documentation sheets. NOTHING has been done to these individuals. And unless something is done, they will go to another county or to a PCS company and may do the same thing to other clients. To help the budget, when allegations are made, the State should be sending the appropriate personnel to investigate and to take appropriate action on the provider agencies being fraudulent.

I hope that comments are taken to the committee and that all comments received are TRULY looked at and taken into consideration when making your final decisions.

Comments from the CCNC Executive Directors

Re: Case management consolidation plan

1. CCNC success has been achieved through the strength of our partnerships. Our networks value the collaboration and relationship that they have at the local level with their partners. We are certainly willing to step forward and work with our existing and new partners and to share the tools we have to assist them in achieving their success and deliverables for DMA.
2. Providing support to our local partners will place additional demand on our networks already stretched resources, so additional resources will be needed. We cannot allow this activity to distract us from focusing on achieving legislatively mandated cost savings, which are key to preventing additional cuts to the Medicaid budget in the upcoming fiscal year.
3. Please provide DMA's definition for Quality Assurance, Outcome Metrics and Quality Metrics.

Sloop CAP/Avery Home Care Services

To Whom It May Concern:

I have been a registered nurse in North Carolina for the last 15 years. It became apparent from the beginning that there is a need for health care reform. There are many young people who refuse to work or attempt to better themselves so they can reap the benefits of free services for the indigent, i.e. Medicaid, food stamps, WIC.

That being said, I have worked in the home care field for the last 5 years, and have had the privilege of working with CAP and PCS. The clientele that we serve are typically disabled and elderly. The majority of these people are not going to understand the proposed changes in their care and providers. It isn't possible to see a client one time and determine his/her need for services. Many of the CAP and PCS recipients are proud people and will want to put a brave face on for a stranger. Then again, there are those that will exaggerate their circumstances to get services. The diagnoses on paper do not always reflect the need of the individual. Case management is a vital part of CAP services and needs to remain where it already exists. The role of the case manager is creating a Plan of Care tailored to the individual client's needs, assessing the safety and family support, in addition to procuring supplies, and managing the case.

Before making a final decision on changes to home care, please revisit the overall picture. The disabled and elderly need our assistance, don't penalize them. It isn't a black and white situation, but has many considerations and consequences to many. Look again at Medicaid and who is receiving the services. I believe you'll find better suited areas to make alterations.

Sloop CAP – Avery County

To Whom It May Concern,

In regards to the ongoing discussion on the Budget Initiative website, I have several concerns about the direction that the **Case Management** portion is headed.

1. It appears that the State Budget is the primary goal. This is understandable but providing a service to the sick and needy of NC appears to be of no consequence to those that are making the decisions. What is the benefit of restructuring Case Management if it does not provide a service that is truly client/patient centered?
2. Full disclosure has not been practiced. Most of the minutes from the Steering Committee meetings have been posted one week after the meeting occurred. This has (intentionally?) given case managers no time to respond. The name of the organization that each attendee represents has also not been disclosed. There could very well be

people in attendance that have an agenda of their own. These individuals could benefit from the changes being proposed.

3. Duplication in CM services appears to occur primarily in the areas of Health Check Coordinator, Child Services Coordinator and Early Intervention. It would be more effective to focus on the above mentioned services than to re-organize the entire structure of Medicaid Case Management.
4. My personal experience with CCNC has been limited. I was unable to see any apparent benefit to the individual clients by having them involved. I assume that CCNC was able to provide the State with statistical information.

I have worked as a Hospital Social Worker and as a Case Manager for the CAP/DA program in Avery County for the past 19 years. While working in the hospital, I relied on the CAP/DA Case Manager to assist with making sure the patient received adequate care and follow up when he/she was discharged. Re-admits were less likely with those patients who had a local Case Manager to follow up and make sure DME was delivered, IHA services began, and Home Health RN,PT,OT,ST were started in a timely manner.

While working as a CAP/DA Case Manager, I feel that it is my duty to be the “gate keeper” of this program. By denying clients that do not meet the criteria, we have saved the state money. I have also reported fraud, both individual and fraud from PCS companies that has resulted in money being paid back to the State.
In conclusion, it is my continued wish to assist the State of North Carolina in providing individualized, centered care for those with need.

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Sloop CAP – Avery County
I am convinced that the consolidation of all Medicaid case management services will do more harm than good and is not in the best interest of those we serve. More thought needs to be put into place, when discussing consolidating **all age groups** into one entity for case management. I have been following all of the meeting minutes that have taken place to date and more thought as to what the **cost** of consolidating all case management services would income.

My experience and expertise is with CAP for disabled adults (CAP/DA). I have been with CAP/DA for twenty years- 8 years as a case manager and 12 years as a Director of the program. CAP case managers operate on a monthly budget limit, and work hard to keep all the services a disabled adult needs within the set cost limits. CAP case managers work very diligently to find the best price for all purchased items.

Avery County has an excellent record on their diligence and frugality. Please refer to the N.C. Medicaid paid claims data for further information on what I am stating. We are a rural county, with 16.7% of our population less than 100% poverty. Fifteen percent of our population is Medicaid eligible. CAP/DA program statistics for Avery County for June 2008 is as follows:

Recipients: 135	Avg cost per recipient for Avery Co.	**$1,255**
	Avg cost per recipient for the State	**$2,333**

I do not see any duplication with the CAP/DA in case management. To change our areas of case management will only cost the State more in the long run, for the following reasons:
1) To give case management to an entity such as CCNC, will be giving the case management to a group that can not meet the needs of the client in a timely manner. The relationship between the case manager and the client is very important. It takes time to know what the needs are and can not be done in a short visit every quarter. There is a lot of background information that is known when you live and work in your own rural area that a centralized hub entity can not accomplish, and know the resources that we have contacts with. We know locally how to get a need met: often with a cut to a price or a group that will meet the need for free as a civil service.

2) When you are working with people who have a need or a change in a service, this has to be done in a timely manner. When a client is discharged from the hospital and needs a bedside commode or diapers, this need has to be met immediately. You probably think this need can be met with a discharge planner, but the CAP case manager knows what the budget will allow. You can not just these items.

Please pay attention to the threats you have listed when you consolidate all case management into one. The threats expose what the costs will be to Medicaid. Just to mention a few you have listed: 1) Loss of local control or attempts to regionalize case management ultimately ends up confusing clients and breaks down communication and resources that have been built up within county systems 2) Waiting time will increase for services 3) Increase in fraud 4) Quality of care may be decreased if case management is not personalized 5) Lead agencies will go out of business 6) Loss of gatekeeper monitoring and 7) Greater number of institutionalizations.

The list goes on but just the few I named above will increase the cost Medicaid spends on the recipient.

How much will it cost to put into place what is being proposed?? I haven't seen any figures that show a savings in your proposal to consolidate all age groups into one area of case management. How much was spent on the MUST uniformed screening program that was never put into place??

I can't speak for the other case management / care management programs that Medicaid reimburses but I can speak for CAP/DA. The proposal is dismantling a

program that has been very beneficial in keeping people at home and out of an institution. Avery County has an excellent track record in keeping client expenses at a minimum for the number of people we serve. Our citizens that need this assistance will suffer with the proposal plan to give all the case management to CCNC. I am requesting that you speak to CAP/DA representatives, look at the costs and the threats to this program, before it is dismantled. It will cost Medicaid more in the long run with the proposed plan. Presently, CAP/DA is on a freeze to limit the number of clients participating on this program. The reimbursement for case management services was decreased $3.00 on the hour, at a time when everything else has increased. We are at risk at losing the whole program.

I will be eager to speak with anyone who has any questions on the CAP/DA program case management and how the program operates.

Sloop CAP – Avery County
I am a CAP/DA and CAP/C Case Manager for Avery and Watauga Counties in North Carolina.

On behalf of the approximately 140 clients we have on our CAP/DA program and the 3 we have on CAP/C I would like to give my reasons for why the proposed budget reduction and restructuring of Medicaid Case Management Services is not a good plan. I feel there would be an increase in spending and fraud and a decrease in person-centered care.

A definition of case management that I read mentioned "Case management should be individualized, person-centered, empowering, comprehensive, strengths-based, and outcomes-focused." I believe whole-heartedly in this definition and don't see how this can be obtained, especially regarding individualized and person-centered, if the proposed changes to case management were in effect. At this time, CAP Case Managers are able to focus, many on an every day basis, on our clients. I have 29 clients at this time and feel that it would be nearly impossible and very overwhelming for someone to have more cases than that including other clients who receive services from other NC Medicaid programs. Each NC Medicaid program has a different goal along with different rules and regulations.

At this time, case managers focus on the individual needs of their clients. No In-Home Aide task sheet or plan of care is the same. CAP case managers are also responsible for closely monitoring the budgets of all of our clients to make sure they are within the monthly budget limit. If the proposed changes to case management were in effect then these could go over limit because Medicaid billing claims and client budgets could not be monitored as closely.

Our CAP Agency is in a small rural community. We are aware of past situations with clients where there have been health and safety issues. We are also aware of the history and backgrounds of in-home aides where fraudulent acts have occurred. Within the past year I have reported 2 different cases of fraud to the nursing registry. There could be an increase in fraud with the proposed plan because our cases would not get the personal attention they receive with us now.

I feel that our agency and case managers have been good stewards of Medicaid's money and that in the end Medicaid would lose money instead of saving it.

GRS Resource Coordination, Inc.

Q: Referring to the Case Management flow chart in the 9/24/09 power point presentation;

"CAP MR DD Including CM" appears in a box under LME's. Does this infer that DD Targeted Case Management for individuals with CAP MR/DD will be provided by the LME's or will private TCM providers still exist?

Q: Referring to the Case Management flow chart in the 9/24/09 power point presentation again;

Where does the case management for individuals with developmental disabilities with Medicaid, that are not recipients of CAP MR/DD, come from? These individuals do not appear to be mentioned on this chart.

Q: Will targeted case management providers still be required to obtain national accreditation within one year of CMS approval of the service definition?

Concern: As a small, private non-profit targeted case management provider, having suffered the rate reduction in January 2009 from $22.50 per 15 minute unit to $18.75 per 15 minute unit, in addition to Value Options limiting TCM services to 5 hours maximum per month (although many full completion of a person centered plan and all required elements can take up to more than 8 hours in a month), and now or first of at least 2 additional rate reductions since the 09-10 budget was passed, we have already ended the 08-09 fiscal year in debt. If national accreditation is required, the cost of accreditation alone may force providers to close.

Concern: By separating a person's medical issues and allowing these issues to be managed by CCNC, and at the same time allowing a case manager to "manage" all other issues and not have any responsibility for the medical side of the person seems to defeat the purpose of person centeredness, serving the person as a whole and considering everything that the person is made up of. A person's medical issues have a direct impact on all other aspects of their life.

Q: What does "no wrong door" for timely and uncomplicated access to care mean?

Q: What does "uncomplicated access to care" mean? Access to care *is* complicated because the current system is overrun with waitlists and prioritization tools. There are NO services to link an individual with DD to if they do not have CAP MR/DD.

Q: What happens to the "fire wall" implemented in 2006?

Q: Can struggling Targeted Case Management providers merge with a larger agency that provides other services than TCM (both serving individuals in common)in order to survive?

Q: Why is it standard practice for Mental Health and Substance Abuse providers to bundle all of a person's services, including their case management under one "roof", yet an individual with developmental disabilities is forced to have a separate case management provider which causes continuity of care issues?

Q: Who will provide Case Management and who will provide Care Management?

Q: Is there a requirement that a case manager has to be a licensed professional to provide case management?

Q: When will prior authorization, through Value Options, for Targeted Case Management services end?

Catawba County DSS

Thanks for representing us. Our only comment is that we do understand that there will be a limit on CAP/DA case management, likely based on a statewide average. This could work well with the exception of initial assessments, continued need reviews (CNR's) and change in status assessments. Currently these assessment activities are listed separately on the client's plan of care from the ongoing case management, but are all billed with the same code. Activities during the assessment month could possibly be over the new capped amount of case management if the assessment activities are included in the case management cap. Our recommendation is to separate these two activities for billing purposes or to look at the average for the entire year as opposed to a monthly average or capped amount.

Rockingham County DSS

After trying to do an analysis of the information that was provided on DMA's website concerning the proposed changes to case management, I am preparing a summary of our concerns and relevant points in this email. Please forward to the appropriate persons. Thanks!

1. Though I am not opposed to having a care managment program such as CCNC, there has not been very much discussion on how this model will look and operate, particularly with the type of case management services that Dept.'s of Social Services provide. As you are aware, many times we are working with persons no one else wants to provide services to, either because of where they live, the types of problems or issues these persons may have or because we are such a rural community, other providers just won't provide the services.

2. As I was reviewing all of the information available on the web site, it became apparent to me there was a huge concern again, about how this will impact mental health services, such as rate cuts, administration and paper work issues. As I reviewed the documentation on the Summary of Case Management and Related Services posted document, it became apparent in FY 08-09, when combining all mental health services and comparing to all other types of case management services offered, more than 5x's the number of units and dollars were spent providing these services, even when these providers were being **monitored** by their LME and outcome measures were mandated to be in place. Though those dollars were greatly reduced in the first part of 2009, they still totaled much more than ALL OTHER programs combined. It feels as if the state is punishing all other responsible providers in other arenas for a system that has responded poorly to mental health implementation.

3. I would like to congratulate the Division of Aging and Adult Services and Division of Social Services for including a document on DMA's web site that shows the ACTUAL COST of providing At-risk CM services to children and adults. Now, take those numbers and compare that to how much it cost for an adult to be placed in an adult care or family care home versus providing at-risk cm for that same adult to remain in their home, which is much more person centered. Similarly, compare the cost of a child/family receiving at-risk case management services versus that same child having to be placed in foster care and what it will cost the community (financial and emotional) for that child to be in foster care 6 months. Our plan for children is to remain in the community with their families; at-risk case management accomplishes this for a very minimal cost. So, before you begin making major changes to the at-risk case management program, consider the overall financial cost savings, the person center approach that it honors and how adults and children can remain in their community.

4. My concern with the changes occurring in case management is that there has been no thought in the ballooning aging population. DAAS has not had any significant increases to SSBG dollars in years, yet, we have an increasing aging population who are entering our system more regularly and with higher concentrations. Adult Service units at Dept.'s of Social Services are having more difficulty meeting this demand. At-Risk CM billing helps alleviate some of those costs and provides needed assistance, however, if the model moves to restricted units, safety and well being of our at-risk aged and disabled populations will be put in jeopardy. Before making changes to case management services, please ensure you have appropriate funding authorizations for our other at-risk populations, other than those who are currently in the mental health system.

5. Recently, our agency has been experiencing an influx of serving consumers with mental health and mild developmental disabilities due to providers in our community not wanting to serve individuals, mainly due to representative payee issues. The providers are willing to bill the Medicaid, but they are not willing to provide any direct service. So instead, they request a public representative payee, which in many communities is the Dept. of social services, and then want social workers at DSS to provide all the direct case management responsibilities. Our program is set up where we will not bill Medicaid if another provider is billing case management services, but these same providers will not arrange, link, re-assess or monitor the consumer's progress. There should be some type of oversight for these types of situations.

6. There are serious concerns about the wording the power point presentation concerning LME's being allowed to have at-risk case management. Does this mean they will be allowed to bill at-risk case management? If so, this is against the directive of why LMEs were developed. LMEs provide oversight and management of mental health, substance abuse and developmental disabilities services. LMEs shouldn't be providing direct services and receiving payment for those services.

7. There is concern about whether there will be a need for pre-authorizations for at-risk case management? I don't really see a need, due to the fact that at-risk cm was one of the lower utilizers of Medicaid units billed. Furthermore, if you read the at-risk cm requirements, the person has to meet certain requirements to be admitted into the program. Has the state reviewed the agencies who provide at-risk case management and see how they scored on their audits? Now compare those to other case management programs.

Advocate for individual living with disabilities!

The Division of Medical Assistance is contemplating changes in a critical (the only for many children) services for individuals, most often children, with developmental disabilities, autism and traumatic brain injury. You all claim to be a champion for children. If you are you will not allow the Division for Medical Assistance to reduce the amount of Targeted Case Management each individual gets per month to 2.25 hours from the current 5 hours per month.

1. This is the only service many get.
2. This is a critical service for the best utilization of state and Medicaid dollars in that the Targeted Case Manager coordinates services preventing duplication of services and making the most out of taxpayer dollars.
3. The Targeted Case Manager is the state's eyes to ensure that the services being paid for with taxpayer dollars for individuals with developmental disabilities, autism, and traumatic brain injury are being provided and are of good quality.
4. The Targeted Case Manager is the last and only voice of advocacy, to stand up for, and help the individuals living with these disabilities stand up for, themselves.
5. While there were serious misuses in mental health services (community support) those misuses were avoided in services to individuals living with developmental disabilities, autism,

and traumatic brain injury because of the watchful eye of Targeted Case Management.
6. The change that needs to be made to Targeted Case Management is not a reduction in hours or rate but instead rules which prohibit some of the Targeted Case Management companies in North Carolina from doing Targeted Case Management when they, or their subsidaries or partner companies, provide the direct services that they are suppose to be monitoring. If an agency or company is going to do Targeted Case Management they should only be allowed to do Targeted Case Management and no other service.
Thank you for stopping this before North Carolina's most vulnerable children and adults suffer even more from the lack of concern, compassion, and foresight of those who are contemplating these changes. This is one service that is well worth the minimal
$ 351.20 you currently pay per month for such a critical services. Compared to your costs for other services Targeted Case Management is a bargain!

Co-chair, Child Fatality Task Force

I am writing on behalf of the Child Fatality Task Force, a legislative study commission charged with studying the causes of child deaths in NC and making recommendations to prevent future deaths. The Task Force has placed a special emphasis on the reduction of infant mortality.

The Task Force has noted that evaluations of Maternity Care Coordination have shown that this service helps to reduce infant mortality, while also saving money in infant intensive care. In our prior studies of this service, we have found little or no duplication of services. We therefore believe that Maternity Care Coordination is a truly efficient and effective way to reduce infant mortality.

We realize that the General Assembly has required serious reductions in the broad service category of case management, and empathize with the challenges that you face in this regard. However, we are very concerned that we have received inconsistent messages regarding the intentions of DHHS in implementing the required budget reductions.

During the legislative session, the Secretary was quite explicit to us that case management services under the purview of the Division of Public Health would not be affected by the proposed legislative actions. (To this day, legislators also tell us that it was not their intent to affect DPH case management services.) At its September 14 meeting, Task Force members expressed concern that it appeared that Maternity Care Coordination and Child Services Coordination would indeed be affected. The Task Force wrote to the Secretary to express its concerns in this regard. The Secretary responded that the required budget reductions were so deep that DPH would have to be affected, but that the DPH case management budget reductions would be held to 19.4%. (He also put this same message in writing to local health directors and to Sen John Snow.)

Given the tenor of the times, the Task Force reluctantly agreed that the 19.4% reduction was appropriate, as long as there were opportunities for DPH and CCNC to establish demonstration projects to seek more efficient and effective ways of providing these critical services. We were disappointed that the Case Management Steering Committee notes of its September 24 meeting made no mention of the 19.4% reduction, nor is it clear where Maternity Care Coordination falls within the chart in the notes.

We were then surprised and dismayed to see that the DMA October Bulletin announces approximately 40% budget reductions in DPH case management services. A reduction of this magnitude places all DPH case management services in jeopardy, which will likely lead to compromises in the health of children with special needs and the birth outcomes of low-income pregnant women.

We are desperately hoping that there has been a misunderstanding. Would you please confer with the Secretary to produce a DHHS position statement on this important issue.

NC Providers Council

Page Number	Bullet number	Question/Concern/Comment
2	1,2,3	I don't think you can assume consensus of goals/outcomes/KSAs across all stakeholders. There may (or may not) be a consensus in the committee, but a broad- based consensus has not been developed.
3	2	Until CM is available to MH clients, there will be "no right door." Access to care will be very complicated and not timely.
6	1	The maze seems to be largely in the minds of the state. In cases where there are 2 case managers—and I haven't seen evidence of much—it is because the specialized expertise of both is needed. (AIDS and DD, for instance, or maternal and child health for a high risk pregnancy of a young girl with DD, or where DSS has custody and a child has MH or DD.)
6	2	I haven't seen a list of the duplication of functions. There is not a consensus that such exists.
8	2	Curious as to what type of payment structure you have in mind. Certainly there is a need for a rate structure that supports a great deal of extra training and the willingness to pay for relevant educational accomplishments as well as demonstrated competencies.
11		What KSAs have been developed? What handout are you referring to?
12	1	Goal is to limit units, but there is no indication of how you will consider the impact on outcomes and determine units for a particular consumer. What will be the basis for this determination? What guidelines will you give those authorizing the services?
12	2	Yes!, especially consolidating and reducing forms
12	3	It is hard to see how one set of qualifications and one rate fits all. Also relevant: How you can determine market rate for specialized expertise and apply that across the board. As a purely hypothetical example, suppose there is a huge demand for people with expertise in developmental disabilities, but because of lower prevalence less for AIDS. Those with expertise in DD will continue to leave the field if they cannot earn market rate. Although the state controls much of the market place, it does not control it all.
13	1	You will also need to have a means of notification of agencies receiving authorization that the consumer has chosen another agency to begin services. The consumer may not know to notify as they may see services separately. You also must make all authorizations effective the 1st of the month. To allow adequate closure and transition, communication of the assigned agency for the next month must occur at least 10 days before the end of the month. This, of course, restrict freedom of movement and freedom of choice.

13	2&3	Which PA are you referring to? That abbreviation stands for many things in the different systems you are considering. Also, you might be referring tom the PCP as it is know in MH/DD—and if the PCP remains that might make sense for coordination of physical and mental health, but you might be referring to the Primary Care Provider, where you want more to coordinate with CCNC.
14		Differentiation between Care Coordination and Case Management is murky. You have Case Management with CCNC, but also with providers of MH and DD services (where it needs to be).However, those same individuals should have a medical home and would receive case management with CCNC? There are similar conflicts with other CM services listed. Managed Care Capitated Rate for the LMEs: Have you analyzed the lessons from Carolina Alternatives? A wholesale change to a PBH (Piedmont) system would be a disaster. If you like their results, think of the length of time they spent planning and the problems at start-up. Since there are no DMA $$ in At Risk CM, how can you ensure there complete integration, especially in light of differing legal obligations?
15	1	The future is developing the definition, but there are individuals needing MH case management now. Who will do it without CS? You really are leaving a group of people out there who won't know how to navigate the systems. People are not going to show up for therapy just in case the therapist might give them a referral to somewhere else. Think of the people who might need med management, housing, help in advocating for appropriate school services; where would they start? They wouldn't know. If STR is going to do this (as they probably should), then they need a LOT more training and more skilled people. Perhaps the state should review the referral forms sent by CrossRoads, for instance—and lots more. NO information, no screening, sent to inappropriate places, etc..
15	2	History shows a long time for approval—and lots of states, lots of SPAs are lined up.
15	3	Different outcome metrics imply different services, different qualifications for providers, and different rates.
15	4	Different risk factors imply different services, different qualifications for providers, and different rates.
15	5	Different time tables will apply for SPAs and waiver revisions. How will you coordinate in the interim?
16	1	Let providers develop their own business processes—that's one of their areas of expertise, not the state's which has a different set of rules. Monitor for outcomes ***closely*** so that you don't repeat the mistakes of CS (some of which are continuing to made as far as monitoring and holding agencies accountable are concerned.)
16	5	In the meantime, you have to find a way to provide CM to MH consumers to avoid chaos in the system.

16	6	Please include providers in developing the transition plan—and do so in a meaningful way, which means from the beginning.
16	7	Again, give the topics and outcomes and let the providers take care of the training. Monitor ***closely*** to see that it is being done and done well.
1	#2 All bullets Assumption s 2 2 2 4 & #5	I am concerned that the model isn't reflective of stakeholder feedback? In fact it suggests that the Committee "reached consensus." I was there for most of the meetings, and sensed little agreement on much of anything. There continues to be many questions and few answers. We don't know enough about anything to agree on too much? I am concerned that the model isn't reflective of stakeholder feedback? In fact it suggests that the Committee "reached consensus." I was there for most of the meetings, and sensed little agreement on much of anything. There continues to be many questions and few answers. We don't know enough about anything to agree on too much?
	3 1	The model appears to be in conflict with "recipient-centered service"? In fact it suggests movement from agency to agency, depending on the most prevalent disability. • What happened to "one C. Mgr. providing the 4 federal functions"? Who determines which agency serves? • How do we move an individual from one agency to another? • How do we manage authorizations between agencies?
2	1 2 #2 #2 & #3 Goals & Outcomes	We have never identified, systemically, what case management is supposed to achieve. There may be basic "care management" outcomes that we hope to achieve, i.e. number of service recipients entering CM, and number of recipients exiting the system, etc…, but "Case Management" outcomes will be as individual as the recipients themselves. I absolutely support the idea of professional standards for C. Mgrs. We will need a deliberate, competency-based training curriculum that is based on the Case Management Competencies. We should apply "lessons learned" to this issue.
3	#1 #2 Goals & Outcomes	While I support an interoperable medical record, we need to ensure that its development does not result in additional financial burdens for the providers. Many Providers and LMEs have invested significant dollars in electronic systems that don't interface well. It will be difficult to convince us to scrap those expensive systems in lieu of another…

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<tr><td>3</td><td>2
2
Goals & Outcomes</td><td>When determining what payment structure is most appropriate we have to ensure that the service is adequately funded. The fact that Case Management was rich (while provided by the Area Programs) should not now give us reason to reduce it to an unsustainable level. Again, the reduction of administrative burdens is critical to the survival of CM, and should be addressed before any rate reduction and/or capitation of rates occurs.</td></tr>
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<tr><td>4</td><td>#3
All Bullets
Short Term Goals</td><td>Our challenges are severe and immediate, and relate to implementation rather than the service definition itself.
Direct enrollment of CAP DME providers will take time.
Direct enrollment for CM provider agencies should be achieved before any rate reduction and/or unit capitation.
Any capitation of allowable units should be based on reasonable clinical assumptions; not simply a need to reduce volume across the system.
Can capitation be quarterly based as opposed to monthly; providing for exceptions when acuity and such requires additional service.</td></tr>
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Short Term Goals Cont.

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4</td><td>If we plan an edit to prevent two separate providers from billing for CM in the same month we will “handcuff” our ability to move a recipient to a more appropriate CM provider, per the most prevalent disability?

Coordination with CS workgroup should include the following:
Will individuals exiting CSS be eligible for CM?
If so, who will provide it and how will consumers access those providers? There will likely be continued need in an environment that has reduced capacity?
I am concerned about the capacity of the system to handle the changes. I fear the number of providers will decrease, and assumption that there will be provider capacity to compensate is dangerous. Many of our rural communities are already underserved, and I am afraid that our “Comprehensive” service providers will not be able to fill the gap.</td></tr>
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5	2 The Model	I am not sure why we need CCNC, VO, and the LME in the model? • There is significant administrative efficiency to be gained by utilizing only "one" Care Manager. • Why is MH/DD/SA viewed differently than the other DHHS Divisions? In the current "LME Box" CAP MRDD (including CM) is listed, as is Comprehensive MH Providers (including CM). • Where is CM for non-waiver DD? • If an agency is providing CM to individuals with DD (and no MH/SA services), does that agency have to meet "comprehensive" benchmarks to continue providing CM ?
2	4, 5	Question/Concern/Comment When standardizing forms, what considerations will be given to Waiver specifics?
3	2	With the no wrong door policy, who will be the point of contact? Will the "network" filter referrals where they need to go? Who will keep database information on referrals, types, needs for the state?
4	1	The goal is to decrease administrative processes where allowed- How will this be achieved with the implementation of the NC CCN referred to on pg 14? By implementing yet another go between the agencies and DMA wouldn't that increase wait times, paper work delays, and possible miss placement of critical forms needed in the initial and CNR process?
5	1-3	Will case managers have to take on cases from a variety of programs and not just the one they currently serve? For example, will a case manager have 2 CAP-C; 3Aids, 2 CAP-DA on their caseloads? How will training and performance criteria be maintained? Howe will specialization and programmatic mandates be addressed? How will mandatory assessment and follow up by specialized professionals such as RN's be maintained?
8	Bullet #1	Will audits be conducted by the CCNC Network, DMA, and Program integrity? When managing other funding sources how will Federal mandates be documented?
10	All bullets	Would this be through the appointment of the NC CCN and the CCNC referred to on page 14? Will the CCNC network be one agency or a collective? If it is a collection of agencies, will there be a limit as to how many can be represented? Who decides what agency is qualified to take on this role? What are the performance criterion used to choose? Will the NC CCN be in the role of oversight?
12	Bullet #3	When reducing the rate, will consideration be given to very specialized staff such as RN's? For example, CAP-C case management mandates assessment by a nurse and oversight with collaboration by a SW. Now, the rate is $61.00/hour. Most RN's make between $69.00-90.00. What consideration if any will be given to this given the going rate in the private sector for the same type of personnel?

14	Grid itself	Who is responsible for intake across programs? How will DMA and Federal guidelines be imposed by an agency or agencies not already authorized to provide the service? How will choice be factored in?
15	Bullet #5	How will waiver revisions be handled with CAP-MR when Waiver was just approved last year under various revisions before submission will little consensus within its own sub-committee? How are individual needs going to be met in system that still relies on labels/ diagnosis to place?
16	Bullet #1	When developing a business process and role, will consideration be given to continuing the business process once it is started? Rates have continually been reduced in some programs with the same if not more standards for service provision being mandated. Service from solid businesses can only work if there is money to help it flow. Rate reduction and service reduction has occurred in this field since 1995 and the needs did not change they only grew.

Comments:
The primary concern is that the model presented does not seem to reflect any of the stakeholder feedback provided to the CM Steering Committee. In addition, the problems we face are severe, immediate and relate to implementation rather than service definition. There were five (5) overarching themes listed below in no specific order.

· Individuals losing CSS. Will they be eligible for CM? If so, who will provide it and how will consumers access those providers? There will be continued need in a reduced capacity environment.
· It has been stated that there will be limits on the number of units. Limits and caseload numbers must be clinically sound. What will these parameters be?
· Administrative efficiencies need to re chive top priority. If the administrative burdens are not removed immediately, the system is at risk of collapse, especially in light of the recent and impending reductions.
· The group would like to see greater clarification between the roles and implementation of Care Management and Case Management within the CM system design. This is necessary to decrease the possibility of duplication of functions. Several bullets under care management functions appear to be services to individuals rather than system activities.
· There is concern about the capacity of the system to handle the changes. The number of providers will decrease and the assumption than t there is provider capacity to compensate. The marginal communities are already underserved. Comprehensive service providers will not fill the gap.

Other Comments

· Need to ensure that there is no duplication of CM through coordination among agencies.
· Need to clearly differentiate between the care management of CCNC and the care coordination of the LME.
· Be careful not to underfund this critical service.
· Create a protocol for the monitoring of the quality of service provision for those individuals opt out of CM.
· Outcome measures (tools, leveling, e.g.) need to be developed or obtained from agencies currently engaged in the provision of CM services, for instance cost avoidance data. NCTOPPS=2 0value was

diminished when some of the questions were removed. The training plan needs to be detailed and realistic, possibly internet based.

- Be mindful of potential litigation and claims of unfair practice.
- Allow direct billing for DD CM.

Other Questions

- What is the CM provided through CCNC?
- Who will provide CM? Will TCM continue to be provided in the manner that it is currently? Will there be stand alone CM agencies or will only comprehensive service providers be able to provide CM?
- What are the eligibility requirements for an individual to receive CM? How is that person identified? Is an individual dual who receives no enhanced services eligible?
- Where is quality in this discussion?
- How does an agency become authorized, endorsed or enrolled to provide CM?
- What will the authorization process look like?
- Can CM be used as a safety net in that case managers maintain stable individuals on their caseload, so that individual knows who to call when a need arises?
- How will the person's "center of care" be determined and the coordination of switching between providers occur? For instance, thought needs to be given to the person having an active authorization whose needs change during an active authorization period.
- What part does the electronic medical record play in this?

True Vision NC- QP

Thank you for the opportunity to respond to the letter, however this is a quick turnaround in response. The timeframe could have been a little longer than today's date.

1) Who is our representative in Mecklenburg county who is part of this decision making progress concerning Targeted CM?

2) Have the focus group considered or obtained data from other case management agencies about High risk individual (crisis)?

3) I do not feel that 2 hours 15 minutes will be suitable to meet all individuals needs. How was the 2 hours 15 minutes of case management decided upon? What data was utilized to come up with this average?

4) Once the 2 H 15 minutes have been utilized, how do we get this across to parents without them feeling neglected or becoming upset? What is the states plan on transitioning this process with families?

5) One way for the state to save money is to come up with software to recognize when an individual is receiving services (silo) elsewhere? Each customer's MID# can be accessed in the system to include services rendered or other settings individual has tried to utilized. When I first heard about SILO case management, this does not occur with us (targeted dd cm).

6)Have you considered coming up with one number of hours CAP individuals can receive. For example, 15 Hours/w for wchool age and 20 Hours for Adults. Enabling parents to work with their adult developmental disability has also put Medicaid in the Red. When I first entered Case Management, the CAP-MR/DD definition was to enable support and relieve stress from families. How is it relieving stress when they are being paid? Many NC tax payers are unaware of this, they know about community support issues, but we have some of the same issues in the CAP world. We do have some parents who are not being parents because our tax payers are taking care of their children?

7) How many DD targeted case managers was included in the focus group to capture what we do?

8) I was informed that equipment would have to be worked out between parent and vendor, you will not save money this way but enable vendor's to over charge as some do. I am not a new case manager, I always check items on the interent and question cost trying to be cost efficient.

9) If rates are going to continue to decline, case management needs to go back to the LME because agencies will not administratively be able to pay staff.

10) When the LME's had case management some of the same problems existed but know since the divesture, case managers are clearly blamed for everything.

11) When will case management agencies know when the actual changes will be addressed, and the families.

12) How will first responder exist under the 2 hours 15 minutes for individuals.

13) Enable some parents who get paid for working with their adult invididuals to self-direct their services. They are already gettting paid.

14) Since the rumors have been dwelling, we have 2 parents who have provided a list of items(home mod, vehicle adapt, and aug com equipment) they want accomplished before the case management change? At first I thought, how in sensitive both parents are about the prospective change, then I thought if they are responsible for engaging with a vendor, it will never get done or at what cost to tax payers.

15) Has anyone considered doing developing an assessment tool to indicate an average for each participant in need of case management?

16) Case Manager's caseloads will double/triple with the change going into effect?

I do hope that my questions will be at least taken into consideration because I am truly concerned. Thank you in advance for your cooperation on this matter.

Watauga County Project on Aging

I am e-mailing in response to the information on the DMA website in regard to Medicaid Case Management Budget Initiatives, more specifically the power point presentation and the minutes from the meeting on 9/24/09. I am appalled at the manner in which this

has all been carried out. Under the guise of "transparency" information has been posted on the website from the meetings held, however I believe, by careful design, the information released only allowed the public to have what little information the "powers that be" want the public to have, which rendered the cryptic information we were given essentially useless. I believe this served two purposes, 1) to make it seem as if those involved were being transparent in this process and 2) so that the public, providers and consumers would be unable to make much noise about the process due to not understanding it.

My agency has been following this very closely and has made several attempts to gain a better understanding of this information, only to be told things such as, "the information is on the website", and "There has been a group, that includes individuals from Aging and CAP DA community, that has been working to develop the specific plan for case management." - which we obviously already knew. We only grew more frustrated at the fact that our CAP/DA consultant didn't have any more information than we did and her attempts at getting more information from her immediate supervisor seemed delayed or failed. I would also like to point out that minutes were not posted on the website in a timely manner. Information on the website indicated that the only people expected to attend or call into the steering committee meetings were those "representatives empowered to make decisions" and were chosen to be on the committee. The call in number was, for the first meeting, posted without a passcode, but later removed, and we were even told by our consultant that she had mistakenly given out that information. For the following meetings the number was posted after the meetings were held, without passcodes. Only after pressing DMA by contacting legislators were we told the meetings were open and was eventually given a wrong number for the last meeting. We did manage to get a correct number and called into the last meeting, missing the portion where Tara Larson reviewed "the plan". I heard a comment made that a better job needed to be done in getting specific info out to the public and I heard Tara Larson say in her closing statements that the common theme she was hearing from the comments were that there needed to be "communication, time lines, and more specificity". I feel this was only paying lip service to the needs of the community, we've received none of this. (Even for this meeting we were "assured" the number and passcode would be posted on the website prior to the meeting, it wasn't until afterward).

The feeling this process has given is that there is dirty, underhanded, stereotypical politics going on at DMA. As taxpayers and members of the professional community we deserve answers in a timely manner, we pay your salaries. Further more, I unfortunately believe that the meetings of the steering committee were only held for show. To make it appear that input was sought and considered, when in reality decisions were already made and work begun in that direction. I am also concerned that personal motives and how this might best benefit DMA and CCNC are driving this plan rather than the needs of the community. I am completely and utterly dissatisfied with the way in which the people involved have done their jobs.

In regard to an actual consolidation plan, I first must say I am not opposed to changes that could save the state and taxpayers money, as long as it is not detrimental to the clients we serve. I agree with Secretary Lanier Cansler, it appears the case management system is being dismantled. How about fixing the problems we have in each specific program, being firm with the rules already in place and stopping some of the leaks we have that Medicaid dollars are pouring out of? I specifically work in CAP/DA and know that policies aren't held up, i.e. there is no catch in the system for services billed without case manager approval and the current appeal process does not support case manager's decisions to terminate clients. (As well, we've been waiting on a new manual for approx. 4 years now, I'm guessing that it's out the window now.) Of what little I think I understand from the information being given, it's not designed to support our program and the needs of CAP/DA clients. In most cases, CAP clients are chronic and terminal and can be expected to remain on the program, and out of the nursing home hopefully, until their death. Expecting clients to be "case or care managed" off of the program once specific goals are met is unrealistic and won't work for this program. The goal of CAP/DA is to keep eligible clients out of the nursing home, it is a long-term care program. Otherwise, I must say, it is impossible to comment on changes I don't understand and when you're not allowed to ask questions that certainly hinders the process. Again, I believe this is all by design. We don't know if we oppose or support the plan or how to advocate for our clients. No one has told us what the plan is, how are we supposed to comment on it? I'm sure someone will say "it's all on the website...". No it's not, bits and cryptic pieces are on the website.

Aside from all this frustration, we want answers to 1) how or will current CAP/DA Lead Agencies play a role in this new plan and 2) when can we expect these changes to begin. We have clients and employees we are responsible for answering to (as your letter to our clients indicated we would). You are responsible for answering to us, and you have handled this very, very poorly.

Watauga County Project on Aging

Thoughts on Case Management changes:

- Feel that Steering Committee/DMA has not been transparent with local Case Management providers, as was their initial claim after receiving word of Medicaid Case Management reductions.
- Case managers have first hand knowledge on clients and how the impact of reductions in services or restructuring the case management system would affect them. Seems that decisions were made long before the Steering Committee was put into place, and that DMA does not have any intention of gaining insight from those currently serving clients.
- Most Case managers would agree that CAP and other programs could use some improvements, but why not let Program Integrity do their job of making sure that individual agencies are operating within guidelines, instead of making broad assumptions about Case Management as a whole?
- Can Case Managers now assume that we could be facing job loss at any time, and the method of letting us know will follow the same “transparency” pattern that has occurred so far?

- If CCNC takes over Case Management, will they have the staff capacity to support the ongoing monitoring that is crucial for CAP clients? If CAP clients are not seen on a regular basis, not only is their care put in jeopardy, but Medicaid fraud increases.
- Case Managers currently do not bill Medicaid for Administrative functions.
- Avoiding duplication of Case management service should be a simple process. Most Case Managers would not have a problem letting clients know that they can only have Case management from one provider, and asking client to make the choice as to which service they want Case management to be provided from.
- Limiting number of units that Case managers provide limits the ability for Case managers to make professional decisions as to what level of case management needs to be provided for a client in a month. If emergencies come up and a client requires increased Case management, case managers need to feel they can provide that without focusing on cost. Crisis case management is unusual, most months clients remain at a stable level for case management.
- Seems that the focus is not clients of the care they receive. By consolidating the service within one agency, you take away clients advocates and the ability for one person to establish rapport. which is the only way to get a true assessment on what a clients needs. Having regular home visits and client contact is the best way to meet client's needs in a cost effective manner.
- How are the Case managers going to be trained? Will the Case mangers/care managers all be nurses? If not, will there be a focus on training current case managers in order to become Case/Care managers for CCNC?

Ashe Services for Aging

To all concerned,

I am an employee of Ashe Services for Aging and I am making comments in regards to the proposed changes in case management for CAP/DA clients. I have been employed by Ashe Services for Aging since 1983 and have been the finance officer for 25 years. This agency was one of the first in the state to provide CAP/DA services and we have been told by CAP consultants, consumers, aging advocates and aging professionals in the state that we are one of the best CAP departments in the state. We are also a PCS care provider and an in home aide provider and were the first accredited in home aide provider in the state. Since then we have been accredited 4 times. As with every other state funded agency we are aware of the shortfall and the need for a mixture of tax increases and budget cuts to insure our state's financial stability and we realize it is up to all of us to do our part in this initiative but it shouldn't all be at the expense of one particular group such as our older population. CAP/DA is a viable and less expensive form of care than nursing home care and it provides better quality of life for its clients in most cases. As I understand it case management will soon be restructured in the CAP/DA program and the rates have also been reduced. I understand that all Medicaid rates have been reduced and this is necessary to meet budget restraints. I don't understand the thinking behind consolidating case management services for all programs. The greatest majority of CAP/DA clients are elderly and don't understand what kinds of care are available to them or in fact what kind of care they need to be able to maintain themselves safely. In many cases they have no one in their family who is readily accessible to take care of their everyday needs. This may be due to family living in other areas or no living family left. Some of these people in rural areas have never done anything but farm their whole lives and have no more than a high school education. Many of these older clients have dementia or Alzheimer's disease they can't tell you their name much less what they need to maintain their daily living. This type of client needs specialized guidance and management of their care as much or more so than any other group. From the information received from the steering committee for case management MH/DD/SA clients are to be excluded from this process. In most cases these clients have some one to advocate for their needs but a lot of our older folks are out there on their own with no one but their case manager to insure their health safety and

welfare. I can readily speak to this not only from my job experience but also from my personal experience. My mother was a public health nurse for 30 years and provided home health care for these same types of clients. When her time came she was lucky and I still lived in the area and was able to oversee her private pay care in her home. She would not have been able to do this for herself even with all of her prior knowledge and experience because she was a dementia patient. Please rethink this option for these CAP/DA clients because many of them have no one to help them who understand what they need but their case manager and their in home aide. Thank you for your time and consideration in my request.

Ashe Services for Aging

After reviewing the proposal by the Case Management Steering Committee, I would like to voice the following concerns. I have been the CAP/DA Program Manager for the past 11 years and I have experienced many changes in the CAP/DA program. But I can not believe that the state can possibly feel that all Case Management can be put under one model. We have many wonderful programs in our state and I am so glad that they are available to our consumers, but each program is so very different and each one targets a different population and need.

I fully understand the economical difficulties that we are now facing and the need to reduce costs in each program, but I think we are going in the wrong direction. The CAP/DA program deals with clients who are on a nursing home level of care. Many of these clients have chronic conditions and ongoing needs, which can only be met through diligent Case Management. From what I am reading from the Steering Committee Minutes, it appears that they plan to decrease costs by limiting what can be billed, decreasing home visits and increasing client caseloads. How can this possibly be patient centered?? If anything, this will greatly limit the Case Management that each will receive. Each of our clients rely on their Case Managers heavily as problems are continually occurring and many of them have very limited family support and many family members live out of the county or state. Just as Case Management is available to nursing home clients on a 24 hr basis, it should be continually available for our clients also.

Ashe Services for Aging has made every effort to make sure that we are only billing for necessary services and we frequently audit our records to make sure that we are in compliance with CAP policy. We keep our program very "person centered", as our goals on our Plans of Care would quickly prove.

I would like to see that those responsible for the different programs in the state, be responsible for also coming up with ways to make our program more economically efficient. I think that DMA should give specific deadlines/timelines, for making our programs more cost efficient, but also challenge those responsible for each program to assure that all counties in the state are billing appropriately and that they are keeping the program "person centered" and each program be responsible for Case Management training that is deemed necessary for that particular progam. In these difficult economical times and with the provider cuts that have already been issued by the state, how can providers possible be responsible for paying for the on-going training?? Each program is so different!! You can't fit us all into one kettle!!

I understand the need for QA and auditing of records and perhaps CCNC could do this for all programs, but that should be their main function. Allow those who have worked in these programs for many years and have valuable experience, do the job that they do best!!

Please reconsider the consolidation of all Case Management. Give us all the opportunity, with guidance and specific guidelines, to prove that we can be more cost effective and allow us to give the clients the Case Management that each are so in need of.

Thank you for considering these comments.

Ashe Services for Aging

Upon reviewing the case management steering committee plan, I would like to voice my concerns. I am currently a CAP/DA case manager, but I have also had experience as a case manager for children's services in a local mental health agency. I feel that each program needs to be examined separately. The needs of a CAP/DA client is very different from the needs of a CAP/MR, CAP/DD, CAP/C or a client

receiving mental health services. I feel that standardizing case management services across the board would only take us further away from client-centered care. I believe that my clients need specialized case management because of their varied and sometimes extensive health issues and other needs. My clients are mostly seniors, many of whom have varying degrees of family support. Most of my clients live alone, have limited to no family support or their family does not live locally and are only able to assist with their care on a sporadic basis. If my clients were in a SNF, they would receive case management services within that facility. There is no way that our clients, who are the same level of care, can be expected to make completely independent decisions about their care or handle important decisions when a crisis arises. Over 10% of the client's in my caseload have either Alzheimer's or dementia; these clients are incapable of managing their care. I also have CAP/DA clients who have developmental delays and mental health issues. Our clients need someone who is experienced in accessing appropriate resources for each different need. I also believe that successful client centered care can not be limited to a specific number of units per month. I feel the case managers in my particular agency try very hard to provide for their clients' needs as well as stay within the number of units allotted in each client's individual budget. If home visits were limited, I feel that our clients would suffer. The home visit is a very valuable tool for assessing continuing needs and identifying new needs. It is the perfect time to reassess their home environment and make suggestions for things that could improve their well-being. The home visit also allows case managers to monitor for signs of abuse and neglect by all caregivers, both agency or family. Our agency also performs quarterly Quality Assurance audits of each of our programs and billing to assess strengths or weaknesses of each program.

I believe that training for newly hired case managers is needed, but that off site training or clinical supervision would be very costly. Our agency currently provides required trainings to our staff throughout the year. My agency will suffer great monetary loses due to recent rate reductions as will many other agencies; this agency will not have the funds to provide the additional trainings that are being proposed. If other trainings could be provided via web or teleconference this would be more cost effective.

I believe it would be beneficial to examine each county program and to identify what's working and what needs revision at that level. Thank you for your thoughtful consideration.

Ashe Services for Aging

After receiving and reviewing the information that was presented and discussed at the Case Management Services Steering Committee meeting on September 24, 2009, I was compelled to write to you with some serious concerns about the proposed changes to Case Management Services.

I am a Registered Nurse/Case Manager with the CAP/DA Program at Ashe Services for Aging. I have held this position for the past 12 years. During this time, I have developed trusting relationships with my clients, and they often look to me to help them make difficult decisions, especially when there is a lack of family support for various reasons, which is a large majority of the time.

I am troubled by the Committee's proposal to try and fit in every form of Case Management under one model. I feel that this simply will not be effective, nor will it be person-centered. First of all, an elderly client who is on the CAP/DA program and a mental health client simply have different and very individualized needs. Also, any client who is approved for the CAP/DA program has had to meet Nursing Home Level of Care guidelines, which means we are dealing with very frail, and medically fragile clients who will need continuing Case Management. In nursing facilities there is always a Social Worker/Case Manager available to assist the client's with their needs. Should we do away with this simply because the client is at home? The answer is No. These client's are just as fragile as nursing home client's and need continual

Case Management to meet their ever-changing needs. The CAP/DA program has proven that we can serve these client's at home at a much more cost-efficient rate, so why change what IS working?

I feel that the CAP/DA program is coming under fire due to the abuse/overbilling of other Case Management agencies. Here at Ashe Services for Aging, we have made every effort to only bill what we actually do for our clients. We do frequent internal audits to insure that we are billing appropriately. The CAP/MR/DD programs are reimbursed at a much higher rate than we are and it has been that way for years. Why not lower rates for some of the other programs to help cut the cost of Case Management and take a look at each individual program and see what can be done to make each program more efficient without changing the entire Case Management system?

The needs of our client's simply cannot be met with one standard for Case Management. If the goal is to be "person-centered", then look at each program in each county and make amendments to each individual program that will put everyone in compliance state-wide. This way, we are staying person-centered and it seems as if it would be much more cost-effective because all of this additional training and the expense of such training would not be necessary. And, no matter how much training the system wants us to go through, it simply cannot compare to the years of experience we have in our fields and in the trusting relationships that we have built with our clients.

I appreciate your time in considering my concerns about this issue..

Watauga County Project on Aging

On June 25, 2009, we received a copy of a memo from Tara Larson with DMA that was sent to DPH, DMH/DD/SA, DSS, and Aging. The end of this memo stated that "Our goal is to be inclusive and transparent in this entire process." Unfortunately, I think that DMA has failed in meeting this goal. DMA's plan has been revealed (9/24/09 meeting), but has still not been explained. The information that has been posted to the website through this entire process has been confusing and not easily understood by those of us who did not attend or call into the meetings. It was also not made clear that we could call in or attend these meetings, and even our CAP/DA Consultant was not aware that we could.

I attended the meeting on July 8, 2009, and again, did not gain any understanding of the direction DMA was headed, or what specifically the problem was with case management services (besides duplication). I don't think agencies have been provided with enough information regarding where duplication is occurring. We are not aware of any duplication of case management for our CAP/DA clients in Watauga County. As I have said several times, I am not opposed to telling CAP/DA clients that they can only receive case management from one Medicaid funded service and that they have to decide which program/service they want to receive. We were also told at that meeting that DMA did have an idea as to what direction they were headed, but that it wasn't going to be shared at that meeting because we would "push them up against the wall". DMA wanted to wait until the steering committee meetings were held before they told us what they were planning. We were told at that meeting that questions would not be answered, but would be noted and answered at some point during this process. We were given a chance to comment, but without knowing what changes DMA was planning to make, it was difficult to comment.

I am still not able to comment on the consolidation plan, as I do not understand the plan (PowerPoint presented at the 9/24/09 meeting). I have attempted to gain more understanding so that I could comment by sending an e-mail to my CAP/DA Consultant (9/29/09), who forwarded the e-mail to her supervisor, Michael Howard, who then forwarded the e-mail to Debbie Pittard, at which point, I got no response.
At this point and before I can comment on the plan, I need the following questions answered: 1) Will CCNC be providing case management for CAP/DA clients?; 2) What will this plan mean for CAP/DA Lead Agencies who are currently providing case management services?; 3) What, if any, role will current CAP/DA Lead Agencies play in this plan?; 4) What are the timelines for implementation of this plan, more specifically, when current CAP/DA Lead Agencies will no longer be providing case management?; 5) Regarding the chart in the PowerPoint presentation, what does "data transfer", "clinical coordination", and "quality metrics" mean (specifics/examples)?
I would also like to comment on the perception that some programs that provide case management services are not transitioning clients off of their programs, but rather continuing to provide services indefinitely. I can only comment on this as it relates to the CAP/DA program. Since CAP/DA clients are by their very nature, chronically ill and require long term care, most are not able to be transitioned off of this program. CAP/DA clients typically do not get better and are on CAP/DA until they are placed in a facility or pass away.
I realize that DMA is not capable of answering every question that providers and consumers have as to how this plan will affect them. At this point, I'm sure that they cannot fully explain how all of this will work. However, I do feel that the questions I have posed can and should be answered at this point. DMA has sent letters to Medicaid recipients regarding changes to their case management services and have instructed them to direct their questions to their case managers, but have not provided agencies with enough information to answer their questions.

CAP/DA Agency
This is in regards to the **Case Management Steering Committee meeting on September 24, 2009.**

I am speaking from my experience as a **rural CAP/DA Case Manager** since 1997. My degree and training are in Social Work. Not only did I receive training in doing **assessments, writing and coordinating care plans, making individual and community referral/linkage and monitoring/evaluating** but this **is a daily intricate part of my job**. The Community Alternatives Program (CAP) already has training in place specific to this unique program**.**

I question why CCNC would take over these tasks when we already do it so well with no other case management duplication. It would appear to me to be a **waste of the State's money** to make so many changes to a very efficient program. I note from the chart that the Committee designed that there appears to be duplication in several of the Children's programs but I am not familiar with their mandates so I could not comment on how their programs would be affected by the changes.

CAP/DA Case Managers already save the State money by

- Assisting Disabled Adults to **remain in their homes** where the majority of us are the most content **at a fraction of the cost of Nursing Homes**

- **We do not bill for making referrals** (ex. We have been referring "non recipient no wrong door" folks to the appropriate agencies/services long before anyone thought of MUST
- **Decreasing healthcare dollars spent**. CAP/DA **CM are in the home** at least every 90 days which gives us the opportunity to develop a relationship based on trust.

  1.) This helps us to see **when what they are telling us does not fit with what we see**. "Managing care" does not work optimally over the phone or by mail. We can get them to go for care earlier rather than ending up in the hospital in worse condition spending multiple thousands of healthcare dollars

  2.) We have the **opportunity to see more readily potential for fraud**.(in the past I have had to address the situation of IHAs not being in the home when they said they were or doing tasks not allowed on CAP/DA)

  3.) We are the ones who send the participation notices to Providers so we are aware of what, how often and many of an item should be billed. Our monthly reviews have saved countless dollars over the years. **We are able to catch mistakes before they are billed.** (ex. Diabetic lancets and test strips were being automatically shipped every three month by some companies without contacting the client for continued need which at times created a great deal of waste-supplies go out of date).

I do agree with the 9/24/09 Minutes that "It has been clear in these meetings that too many **do not** know about or **understand CCNC's role**". This is based on my one experience with CCNC. They contacted a client of mine who had no idea who they were. They asked my client a lot of questions saying they were from Medicaid. My client was anxious about the experience and asked me to follow up. I did and **I learned that CCNC provided no benefit of any type (ie. Hands on or educational) to my client but was paying Medicaid money monthly to the client's physician for giving them her name.** This is what the CCNC told me when I questioned the purpose of her call and how it would benefit my client. **If you want to save Medicaid money, this may be an area to look into.**

I know from my experience that CAP provided at the local level serves the client/consumer best.

Recommendations

- Continue to operate CAP/DA with their Case Managers in place (they are already doing what the committee has set out as Goals and Outcomes).

- **If** the Steering **Committee chooses** to have "CCNC, Public Health and LMEs as the hub of the public system" I strongly encourage you to include Social Workers in the employment mix of these agencies.

- If you choose to limit the number of hours monthly for CM then I would suggest you have one code for normal routine CM and another code for CNR (yearly reviews) and crisis issues.

- Keep the waiver supplies billing (as indicated above it can prevent fraud and save the State money).

Sloop CAP – Avery County

Upon review of the recent minutes from the Case Management Steering Committee, many concerns have arisen. As a case manager, I feel strongly that the system should NOT be dismantled. I as a case manager am an integral part of the overall functioning of the program. I feel as though I am a good steward for the Medicaid dollars that are being used to provide care to these clients. I watch every dollar and monitor for correctness and fraudulent activity.

I feel that as a case manager, I am already trained to provide the highest standard of service delivery and do not require any additional training that would only cost the system more monies. I feel it would be nowhere near as effective to have someone from Raleigh trying to establish a relationship with these clients while at the same time being familiar with and knowing of all the known resources, as well as the unknown ones, here in this county. The clients here will not be as open to a new outsider that they do not know anything about. It takes a lot to establish rapport and relationships with these clients; it also takes time to build their trust.

I feel as though the costs have been considerably reduced through the most recent rate reductions. These reductions were very significant and will most certainly add up in the end.

Regardless, the proposed plan and restructuring of the case management system needs to be much more clearly defined and presented to us. It is very frustrating to watch these things happening before our eyes. Please consider how vital the case manager role is upon reviewing of current processes and procedures.

Ashe Services for Aging

In response to the proposal by the Case Management Steering Committee, I would like to submit the following comments. I have reviewed the minutes and handouts posted on the DMA website, and I understand the need to reduce costs within Medicaid programs at this very difficult time in our state. However, I feel that the duplication of services and/or overuse within Case Management can be more effectively resolved within each individual program. I have been a CAP/DA Case Manager in Ashe County for over six years. Throughout this time, our agency has been very responsible with our Case Management billing. We work diligently to only bill for appropriate case management tasks and frequently audit our charts to review for any overuse.

The CAP/DA program, as well as other Medicaid funded programs, works hard to remain person-centered. However, there is no true way to consolidate Case Management and remain person-centered. The CAP/DA program focuses on the care of nursing home level patients. Because the CAP/DA program is an alternative to nursing home placement, the clients served by this program require continuous monitoring due to chronic health issues. If a patient were served within a nursing home, they would have continuous access to nurses, social workers and case managers. The current proposal by DMA/CCNC appears to limit home visits and reduce case management services to the clients served. This would not be appropriate for our CAP/DA clients. As a CAP/DA Case Manager, I attempt to visit my clients on a monthly basis. Because

of the chronic medical conditions and frailty of many of our patients, monthly visits are necessary to monitor for health changes, equipment needs and to establish a working relationship with the patient and family. Frequent home visits also allow an opportunity to evaluate the home environment and monitor for abuse or neglect. Many of our patients have limited family support, which results in more dependence on Case Managers.

The notes provided on the DMA website discuss increasing training and education requirements of Case Managers. I feel that appropriate training would be very beneficial, however at a time that providers have already faced rate reductions, who will be responsible for paying for trainings? I agree that continuous training is needed to promote the highest quality of services, but each waiver program has specialized care needs that need to be addressed. The CAP/DA program would benefit from additional trainings on special care clients, such as those afflicted with Alzheimer's disease, but this would not necessarily be an appropriate training for CAP/MR-DD Case Managers. It is important to expand the knowledge of Case Managers, but I feel this will be more effectively and efficiently done by targeting each individual program. Another goal listed by the Steering Committee is to "implement client specific outcomes which address all identified needs." The CAP/DA program addresses specific client needs in the Plan of Care, which is updated at least annually and as needed. The proposal also suggests allowing DME providers to bill for waiver supplies directly. This is a wonderful thought, however most DME providers will bill at the Medicaid allowable rate. Our county negotiates with providers and receives many waiver items, such as Ensure and Boost, at reduced rates. This helps to save money and provide our clients with additional, needed services.

The state of North Carolina is facing a serious budget deficit, and I understand the necessity of reducing costs. However, I am also aware of the numerous programs that were initiated but never developed, such as "MUST." I imagine a tremendous amount of State dollars were spent on these ideas. The CAP/DA program is already facing rate reductions, and providers are struggling to keep their doors open. I feel that the most appropriate way to reduce Case Management expenditures is to review the billing within each program and within each county to assess any abuse or overuse. The consolidation of Case Management will only result in a reduction in person-centered care because one model for case management care for the mentally ill, mentally handicapped, chronically ill and elderly cannot effectively work. Please consider these concerns as you move forward with your proposal. I have only the best interest of my clients at heart. I feel that the implementation of these changes will be confusing and frustrating to my clients. I also worry that Case Managers will have larger case loads, which would result in less time for each client. The CAP/DA program is a wonderful program that helps to maintain clients at home, at a much cheaper cost than institutionalization. However, consistent Case Management is needed to provide the care and services required by this special population. Thank you for your time and consideration.

Ashe Services for Aging

Here are my questions and concerns regarding changes in the future under Budget Initiatives.

Information given was too vague to trully understand at this time. Big Picture is to save money & cut duplication.
Case Management Services need to have more specificity for all programs in order to understand coordination, billing, etc.
Do all programs now come under the umbrella of CCNC Networks. Does this mean 1 big database system for all programs?

What does direct billing for waiver supplies entail & will all local providers need to enroll as a provider with CCNC?
In Ashe County, our local providers give us a good discount currently for CAP/DA & provide quality service to our clients.
CM's in Ashe County have a wealth of experience and knowledge of CAP/DA and do a wonderful job in serving clients currently.
If hours, services, and CM is cut the CAP/DA program is no longer "Person Centered" for our clients. Some of our client's depend
on us for daily decision making and life support as they don't have family members locally.
Ashe County currently has around 185 clients and 6 Social Workers for the CAP/DA Program. We are reimbursed less than
other counties and efficiently manage billing for all our clients.
Case Management Competencies are very detailed and will require extensive training for current staff. Who will pay for trainings,
certifications, re-certifications etc?
Will agencies currently providing services need to bid in the future to be able to do CM?
Contracts will need to be developed for outcomes? Need specificity on outcomes & how to meet them. Goals, Metrics specified.
What is the timeline for all changes above & when do policies, procedures, regulations, definitions, meetings, trainings occur?
This appears to be such a big undertaking. Anytime programs, services, agencies, etc. try to make something universal "one
size fits all" concept, it's usually doomed for failure.

Pathways LME

I am writing to you on behalf of CFAC for Pathway's LME as the current chair. We have received a copy of the DMA's long-term vision of integrated healthcare delivery. In our examination of this proposal, we have a number of questions concerning this idea for our now troubled system of care. It would help us to understand better how this is going to work and what benefit it will be to consumers, providers, and the state of NC.

We are very excited to hear that the state is addressing the need to provide a better system of care through case management, and there seems to be prospects for positive outcomes for the consumers we presently have in care. It is and has been our goal as CFAC representatives to make sure every effort is made for everyone involved to be successful and meet the challenges they face.

In a CFAC sub-committee meeting we reviewed the PowerPoint presentation from your email to our LME. We have several questions we would like to address with you for further clarification, so that we as an advisory committee, can educate ourselves and other consumers prior to yet another abrupt change in the system of care.

- How will consumers impact the decisions that are being made here?
- Who exactly will be in charge of the workings within this proposed idea?
- How will this concept affect consumer choice?
- Who will be in charge of checking the out-comes and determine if needs and progress is met?
- How will you make sure that "case managers" are trained appropriately to receive the knowledge they need to be successful in their efforts to support their clients?
- Who will provide the training, and how will the continuation of trainings be monitored, and by whom?

- How will this new system save our system money? It appears to us that a third party being involved would only increase the amount of money spent. Please elaborate to us how this is incorrect if indeed it is.
- How will this new system save time and give fast, adequate services, without delays in retrieving information that is sometimes needed quickly?
- It would help us understand this proposal also if we had definitions of the acronyms listed on this presentation.
- It is also our feeling that measurable progress should be based on consumer's ability and the professional support they receive. How will this plan ensure this for them?
- What responsibilities has CCNC had in the past that makes them capable to be successful in their role with this? What is their track record? How will their staff be trained to recognize our consumer's issues enough to make good rational and beneficial decisions for consumers in care?
- Exactly who will employ the "case managers" that do and have dealt with consumers to this point? Would the local LME, or CCNC? What effects do you perceive if consumer's yet again must experience "change" in the system of care?
- May we as a CFAC ask for future "meeting minutes" from future discussions from the group looking at this proposal?
- And last but not least, how could someone from our Consumer Family Advisory Council become a part of this workgroup? Would you be interested in the recommendations that a council such as ours could give?

Again, we are very excited if something can be done to improve quality of care for consumers here in our area and across the state. We would love to share the perspective of individuals that this idea will eventually affect. Thank you for your time and consideration to us.