

Case Management Services

Steering Committee

September 24, 2009

Minutes

Attendees:

See Attachment A for a listing of attendees.

Minutes	<p>Tara Larson, DMA's Chief Clinical Operating Officer, led the meeting.</p> <p>Tara reviewed the power point presentation which addresses the following:</p> <ul style="list-style-type: none">• Assumptions• Goals/Outcomes (handout)• Case and Care Management Definitions (handout)• Competencies (handout)• Short Term Goals• Proposed Model• Futures Plans <p>This information has been posted on the DMA website under Budget Initiatives.</p> <p>Legislative Oversight Committee met yesterday and discussed the proposed case management model. Secretary Lanier indicated that even though he knows that the Divisions must meet the budget targets, he does not want the case management system dismantled.</p> <p>The goals are what we want the system to look like 1/2/3 years from now. CCNC, Public Health and LMEs will be the hub of the public system.</p> <p>There is a workgroup currently working on details for coordination between CCNC and the LMEs. What the LMEs do currently fits into care management. The Department, DMA and DMH/DD/SA have gone on record that it supports a managed care waiver for MH/DD/SA.</p> <p>CCNC is to reach out and grow its local relationships and embrace them into the networks. It has been clear in these meetings that too many do not know about or understand CCNC's role.</p> <p>In order to accomplish the model, many things must happen such as:</p> <ul style="list-style-type: none">• Create a service definition that everyone can agree on and the linkages required between CCNC and other agencies. This requires CMS approval.• State plan amendments must be done on all areas of case management.• Outcomes must be defined at the provider and system level.• Contracts must be developed to pay on outcomes achieved.• Risk indicators developed indicating when generic versus specialty case management is needed as well as how to standardize based on recipient need and not provider finances.• Technical amendments must be submitted on all three waiver programs to make them more consistent.• Business processes and roles of various agencies defined to create an integrated
----------------	--

	<p>health care delivery system at the local level. Also to ensure that the state is serving a management role and not operating as a case manager.</p> <ul style="list-style-type: none"> • Data sharing agreements developed and executed • Payment structure determined and implemented • Develop implementation strategy and time line. Everyone has indicated that the time line is too tight and the infrastructure to do this is not in place. This will be a multi-year process. It will require a phase in process. • Training system wide <p>Short Term Goals</p> <ul style="list-style-type: none"> • Recommend putting hard limits on units into the system. Looking at the current median number of units per program and determining what amount to decrease. • Case management is required in all 3 waiver programs so why do we require prior approval for this? Looking at eliminating this. • Allow direct billing for waiver supplies. Allow direct enrollment of these providers. • Consolidate and reduce forms. • Consider a rate reduction further down the road as reach common definitions, reduce administrative responsibilities, and reach agreement on competencies. Cannot justify different rates if all case managers have the same responsibilities. • Eliminate duplication- putting an edit in the system to only allow one case manager to bill per month. <p>This is the vision for the short term and the future. The committee members were asked to provide comments which would be recorded and considered in developing plans for implementing. Members were asked to discuss this with their constituents and provide any additional comments to DMA by October 5.</p> <p>See Attachment B for the comments received at the meeting.</p>
Assignments	<ul style="list-style-type: none"> ▪ Take the information from today's meeting back to constituents and provide any questions/concerns/suggestions/issues to DMA by October 5.
Next Meeting	<p>October 13, 2009 (TENTATIVE) 2:00-5:00 Room 297 Kirby</p> <p>Call in number: 218.339.2699 Pass code 994881</p>

Case Management Services

9/24/2009 Attendees

Richard	Anderson	Cheryl	Kegg
Peggy	Balak	Donna	Marple
Beverly	Bell	Suzanne	Merrill
Sam	Bowman	Lisa	Moore
Karen	Boyette	Peter	Morris
Jennifer	Brest	George	O'Daniel
Lois	Broun	Janice	Patterson
Rose	Burnette	Lisa	Perry
Melanie	Bush	Teresa	Piezzo
Christina	Carter	Debbie	Pittard
Jennifer	Childress	Connie	Renz
Jane	Clay	Michelle	Ricci
Janet	Clayton	Dave	Richard
Jennifer	Cockerham	Starleen	Robbins
Chris	Collins	John	Rouse
Terry	Cook	Lisa	Sammons
Yvonne	Copeland	Julia	Simmons
Vivian	Cowan	Julia	Sinclair
Kelly	Crosbie	Cheri	Singleton
Susan	Davis	Amy	Smiley
Ila	Davis	Andy	Smith
Jim	Dervin	Kim	Smith
Rebecca	Dobbelstein	Laurie	Stickney
Bert	Fisher	Angela	Suggs
Patti	Forest	Chris	Szwagiel
Thomas	George	Rebecca	Troutman
Catherine	Goldsmith	Martina	Tunat
Craigan	Gray	Fred	Waddle
Sue	Guptill	Leza	Wainwright
Phillip	Hardin	Jeannie	Walker
Gayle	Harris	Nancy	Warren
Jane	Harris	Vickie	White
Bob	Hedrick	Adeline	Williams
Gina	Hill	Dennis	Williams
Angela	Holcomb	Amanda	Williams
Ivy	Hosged	Laura	Williard
Michael	Howard	Buck	Wilson
Jim	Jarrard	Leonard	Wood
Rachael	Jerzak	Will	Woodell
Susan	Johnson	Dorothea	Wyant
		Donald	Yousey
		Eric	Zechman
		Dan	Zorn

**Committee Member Comments on Proposed Model
September 24 Steering Committee Meeting**

1. Long term vision of CCNC and LMEs needs to be clearly defined to show how they are not redundant.
2. Constituents do not like the word 'behavioral' health. It is a bad word for what we do. Serious concerns and major objections about managed care and think it is the opposite of person centered. In the Piedmont experiment, case management not allowed outside of LME unit. If that is what this is, will vigorously oppose this. People who control the dollars or authorizations shouldn't control the case management. Need to waive the current caseload requirements
3. Taken a hard look at the model and sees case management default back to the LMEs and that's problematic. Concerned with LME care and case management. Managed care with DD does not serve consumers best.
4. Need more information on how and when the short term goals will be rolled out so local level can do planning.
5. Don't appreciate the state staff talking to local staff and indicating that they may be losing their jobs.
6. Hi risk OB has specific definition and only a few local health departments do this now. This model proposes a change in what they are doing now.
7. Would like data sharing on all Medicaid recipients and not just Carolina Access. Make sure CCNC operations are standardized across the State on what can and cannot do and what should be doing.
8. Make sure you define administrative functions versus the four functions that can be billed fee for service. What will be the billing and contractual relationships between DMA, LME and providers?
9. Struggle with charts direct link to CCNC and LME on the side with link for providers and CAP MRDD. Why don't we do single PMPM and let it go that way? Address CMS' cost model between private and public.
10. Some programs have guidelines and outcomes for implementation. Who will do service linkages? CCNC, local provider? Under three waivers are eligibility stuff that have to be met to qualify and certain administrative duties have to do as part of administering program and not billable. If continue to be a lead agency in waiver may be things administratively that an agency has to do and how will it be compensated?
11. A non recipient no wrong door clearly needs case management. How will they access and benefit from case management if they don't have Medicaid? Is this case management or an administrative function of an agency as part of no wrong door policy?
12. How do we deal with people who opt out and mandatory versus optional.
13. If truly integrated, than everyone of sister agencies would have electronic medical record along with all providers. What will be the communication method? MMIS and internal systems difficult to communicate with each other. What will be the inter operability of medical record and communication and coordination method with each other?
14. When waivers are re written does requirement for case management remain in the waiver or go away?
15. How do we allow for exceptions if people need more units than the limits will allow to support person centered?
16. What are the criteria for specialty versus standard case management?
17. Is it meant that even FFS would have to go through CCNC for authorization and approval process before it can bill? Will there be PA in areas that may not have PA now?
18. What's the bottom line on time lines? Is there a way to implement more slowly or parts? What's on and off the table?
19. There needs to be more specificity about some of the information presented at meeting today so agencies can evaluate it.
20. There needs to be more information about the relationship and accountability between DMA and CCNC as

we move forward.

21. If there were a quick enrollment without endorsement for DME suppliers, we could begin saving money.
22. How do we ensure that providers and consumers understand that the system is changing? How do we get the vision and operational steps to them so they get the whole message?
23. If we reduce hours, obviously there will be a reduction in staff. There needs to be transition time for the short term goals. Direct billing in DD to DMA on case management would be a huge efficiency for providers so they don't have to go through LMEs. How do we do authorizations and what is the role of non waiver folks as we deal with eliminating duplication?
24. The medical home is an integral part of this process. Concern that clear direction needs to be given at the primary care, physician level so that they are brought into this process. There needs to be communication to the PCP of their roles and responsibilities.

The following themes were heard in the above comments from committee member:

- Communication
- Time lines
- More specificity