DHHS WAIVER ADVISORY COMMITTEE
MEETING MINUTES

Date: June 20, 2012 **Time**: 1:00 pm – 3:00 pm **Location**: McKimmon Center, Raleigh, NC

MEETING CALLED BY	William "Lee" Smith, Chairman
TYPE OF MEETING	DHHS Waiver Advisory Committee (DWAC)

ATTENDEES

COMMITTEE MEMBERS			STATE STAFF ATTENDEES		
NAME	**AFFILIATION**	**PRESENT**	**NAME**	**AFFILIATION**	**PRESENT**
Peggy Terhune	Monarch	☒	Ken Marsh	DMHDDSAS – LME Team	☒
Margaret Stargell	Coastal Horizons Center, Inc.	☒	Jim Jarrard	DMH/DD/SAS Asst. Dir.	☒
Jack Naftel, MD	NC Physicians Association	☒	Kathy Nichols	DMA Waiver Pgms Mgr	☐
Rosemary Weaver	State CFAC	☒	Kelly Crosbie	DMA Behavior Health Section Chief	☒
Carol Messina	State CFAC	☒			☐
Susan Monroe	Local CFAC	☒			
Marc Jacques	Local CFAC	☒			
Deby Dihoff	NAMI	☒			
Ellen Perry	IDD Advocate	☒			
Tony Sowards	SA Advocate	☒			
Cherene Allen-Caraco	Mecklenburg's Promise	☒			
Lois Cavanagh-Daley	NC CANSO	☐	**GUEST**		
Arthur C. Wilson	Transylvania Co.	☐	**NAME**	**AFFILIATION**	**PRESENT**
William Smith III	Wayne Co.	☒	Pam Shipman	PBH – LME-MCO	☒
Brian Ingraham	Smoky Mtn. LME	☒			☐
Ken Jones	Eastpointe LME	☒			☐
Mike Watson	Deputy Sec. for Health Srvcs	☐			☐
Tara Larson	DMA, Chief COO	☒			☐
Steve Jordan	DMHDDSAS Director	☒			☐
U. Nenna Lekwauwa	DMHDDSAS Medical Director	☐			☐

1. Agenda topic: Welcome and Approval of Minutes/Chair Housekeeping Items **Presenter(s):** Lee Smith

Discussion

- Reminder to board members to speak into microphones,
- Deby Dihoff chairing July DWAC meeting in Lee's absence
- A number of emails were submitted from board members – good comments and response from board and tracking process.
- Subcommittees continue to go over spreadsheets for posting, going to do more updating in next week and get comments back. Group represents many types of organizations. Discomfort expressed over inability to respond to public comments. Hope to develop mechanism to share with public by next month for responding to comments in appropriate manner and help get resolution, if it is appropriate for them to come to the DWAC to begin with.
- Minutes approved (some comments noted)
- Ellen – External Quality Review Organization begin ?? EQRO, external organization already started meeting with LMEs that go live in preparation for monitoring, doing quarterly technical assistance and updates to make sure ready for monitoring, annual performance measures, data flections. MCOs adherence to contract.
- As an advisory committee, who do we advise, any suggestions, do recommendations go to LOC or is it advisory committee to the state. Response: Advisory Committee responding back to the department. Ellen thinks some things should be sent to LOC. Response: Issue is something to talk to the committee about. How we respond as group, what do we do with information, do we communicate with LME/MCOs? Developing process. Who is doing crosswalk for performance measures – CMS, DMA, DMH, EQRO? Response: All those people. DMA/DMH responsible for set crosswalk and have them done. EQRO evaluates

	what we tell them to evaluate.
Conclusions	1) May Minutes approved. 2) April minutes corrected. The information requested on Peer Support from ECBH was answered by Leza Wainwright during meeting. Same questions presented to Don Herring, WHN during May meeting. Response also given though not reflected in minutes.

Action Items	**Person(s) Responsible**	**Deadline**

2. Agenda topic: Presentation/Updates **Presenter(s):** Kelly Crosbie

Discussion

- Care Coordination and Community Guide – Review of Policy & Rules related to Care Coordination/Community Guide by policy
  - Multiple federal authorities for providing TCM/CC/CG
  - Different fee for service (many programs use Targeted Case Management. TCM is a service provided by providers, TCM not covered under 1915 (b)(c) waiver. Providers do additional services which are not billable. Four billable functions under Targeted Case Management.
    - Assessment – everything individual needs, paid and unpaid supports
    - Planning to meet these needs
    - Linkage/Referral to those services
    - Monitoring to see if the services in the plan are effective
      - TCM services could be paid for using State dollars. However, paying with State dollars would take away from others with limited array of services to give to those who have larger array due to Medicaid waiver.
  - TCM often coupled with Rehabilitative Services so TCM not needed all the time.
  - Coordinating Care for individuals who need care coordination.
  - Care Coordination – Administrative function within the LME-MCOs.
  - Targeted Care Coordination can be intensive.
  - TCM could have been chosen over care coordination it was a policy decision to combine with administrative functions.
  - In some services the provider may write the plan. In other services we have care coordination. There are certain populations that don't need Care Coordination.
  - LME/MCOs – get per member/per month funding for everyone (who is Medicaid eligible) regardless of needs.
  - Everyone who receives Medicaid will be entitled to receive care coordination if they need it.
  - MCOs can subcontract all or part of care coordination, whatever fits them as a business and the consumers they serve. MCOs are responsible to report how they are going to coordinate care. An MCO can change their mind. Responsible for seeing that care required is being accomplished and correctly. Smoky did public process looking at that option. It can be done.
    - MCOs are making individual decisions. They are responsible for providing information to DMA. As part of monitoring process we find out how they provide this process. They do not have to report, just tell how they are going to do it. Not sure if that information is available.
    - Smoky website provides information on the process used that resulted in their decision.
    - Decision varies across MCOs. Each vendor makes their own business decision and develops its own process for meeting requirements.
  - Federal requirements of care coordination are:
    - MCOs assess the individual to identify ongoing condition that requires course of treatment or care monitoring. Assessments must be done by qualified individuals in their field. MCO responsible to look at individual and assess. Person may have additional needs (OT, dental, etc.). Medicaid only allowed to pay what state plan allows. Individuals could have access to other unpaid services (such as Music Therapy).
    - MCOs must produce treatment plan. Individuals may already have one, if not, must create one.

        - Allow instant access to specialists
        - Use continuous quality improvement process.
    - Care Coordination follows TCM but broader, more flexible. Allows for targeted care for individuals who require it that didn't get it before.
    - For years community upset their involvement in planning process only required a signature. Now hearing "actively involved".
    - Care Coordination responsibilities include:
        - Education about all available MH/SA/DD services and supports
        - Education about all types of Medicaid-funded services
        - Linkage to needed psychological, behavioral, education, and physical evaluation.
        - Assist with development of Individual Service Plan (ISP) or Person Centered Plan (PCP)
        - Monitor ISP, PCP and health and safety of the recipient
        - Coordinate Medicaid eligibility and benefits
        - Coordinate care with each enrollee's PCP/CCNC physician/HealthHome.
    - Chart review of treatment plans on file, ensure treatment plan contains quality input. These issues in contract with MCOs.
    - Planning and linkage are assigned to Care Coordinators.
    - Care Coordination – Population Management
        - 24/7 crisis triage & assessment
        - Coordination and monitoring of hospital and institutional admissions and discharges
        - Follow activities to enrollees who do not appear for scheduled appointments. And Enrollees for whom a crisis service has been provided as the first service (ED, FBC).
    - Care Coordination bigger then TCM.
    - Are care coordinators required to show up rather than provider? If provider has made agreement with LME/MCO to provide after hours care, that is what is expected. MCOs responsibility is to monitor provider. Provider expected to reach out to follow individuals, MCO to monitor and ensure it is done.
    - Inquired how does consumer know what exists and whether they are eligible? Response: the LME is the local source for individual.
    - MCOs get paid for care coordination – PMPM or additional funds
    - Numerous questions raised regarding how we set fees for Care Coordination. Suggestion made to present at future meeting on how we set capitation payments.
    - Some of what we look at has nothing to do with how we get capitation.
    - Money built into the PMPM – MCOs take the amounts out of those funds for additional services.
    - Care Coordinator serves as gatekeeper - can be weak link, are there measures to ensure things being done.
        - Care coordination only part, there are others involved. Ways to make sure, as a whole, care being provided
        - Request for follow up surveys on results, feedback and balanced perspectives.
    - Brian offered Smoky's experience. MCOs learning from each other. MCO experience to be shared at future meeting.
- For folks that qualify as high risk individuals (at this moment in time) in IDD Innovations waiver we are required to make sure someone coordinates their care. They can be eligible for innovations with no waiver slot.
        - Anyone with IDD in a facility – DOJ, Juvenile Justice, etc. that may need services.
        - Children that we know are probably at risk of out of home placements get special attention up front.
        - Adults with persistent Mental illness, someone who has never been linked to service, target and assist, stabilize into our networks.
        - Substance dependence (substance dependence diagnosis) – have corresponding services and special extra coordination of care.
        - Opioid dependence, individuals with co-occurring diagnoses. System of care philosophy.
    - Does this include someone moving from out of state? Everyone. Refer to LME/MCO.

	○ IDD care coordination - if on innovations waiver, required to have IDD care coordination. Do same things as in care coordination but on innovations more is prescribed and required. ○ Care Coordinator to coordinate with recipients with special health needs, IDD, children with MH – at risk, Adults with MH. ○ Required to have annual meeting or if significant changes. ○ Independent Care Coordination Case Managers – Is someone who works for MCO going to stand up to MCO to get something done. ○ Comparison made to guardianship perspective. From contracting standpoint, Care Coordinator who works for Corporate Body as opposed to MCO has same issue, employed independently pay is going to independent or MCO employee. ○ Nowhere in TCM or Care Coordination does Medicaid pay for Medicaid providers to advocate against Medicaid. ○ Due process across Medicaid requires that whoever creates plan, write down what the recipient wants whether you agree with it or not. UM's duty is to authorize what is medically necessary. Also role of care coordinator to explains services and what's written into the service. ○ Community Guide is a service independent of MCO, supportive and assistant. Help individual self-direct, guide into community for services and supports needed. Guide through planning process. Includes finding physician visits, grocery store, attend groups regularly, etc. ○ "Medically necessary". Medicaid service definitions defined in Medicaid policy (service definitions). Expect MCOs to look at those to make good decisions with input from physicians, provider advisory boards. Some flexibility sometimes. Utilization used guidelines to make decisions. Recipients have opportunities to appeal. Administrative law judge has final decision. ○ Requested future presentation on How much Community Guide services are used and length of time used. Peer Support another services that can be used. Individual can access Community Guide or Peer Support the same as they have done in the past. ○ How does a person find a Community Guide? ○ Community Guide is a B-3 waiver service with specific budgeted amount and cannot exceed that amount. Have to provide it. Community Guide, Peer Support, and Respite, are services we look at and if we find they are effective we can allocate additional money for it.
Conclusions	Board members can refer to Smoky's website for various data/results.

Action Items	**Person(s) Responsible**	**Deadline**
□ Develop presentations for future meetings: ○ How capitation payments are set. ○ How much Community Guide services are used and length of time used	Assigned DWAC Staff	Future Meeting
□ Care Coordination results and feedback requested.	Assigned DWAC Staff	Future Meeting

3. Agenda topic: PBH – LME-MCO Expansion Area **Presenter(s): Pam Shipman**

Discussion	• Review of PBH expansion report ○ Presented map with view of counties served by PBH (including AC eff. 10/2/11, Five County eff. 1/1/12 and OPC eff. 4/1/12. ○ Combined general population 1,377,507, Medicaid population 212,718. • PBH has been MCO for 7 years • Utilization Strategy ○ Customized for each geographic area ○ Gradual changes in utilization patterns ○ Gradual reduction in costs as medical necessity enforced ○ Develop plans for each area acquired because the areas are different. ○ Worked on maintaining local presence while achieving financial efficiencies ○ Community operations center in place where LME was, left in local communities. Retained leadership from AC, Five County and OPC and clinical staff. ○ Provider relations, consumer affairs, quality staff, Medicare Coordinators (MH, IDD, SA) still available where it was.

- Some functions not available at local operation centers include: call centers, claims processing, finance, HR, Info Systems, and Specialty Operations Support. These are being done in Kannapolis. This took about half the duties away from the LMEs
- Acquired many more providers, evaluating need for those providers
- Provider Network Comparison – Five County – 480, AC – 403, OPC – 322, PBH - 277
- Initially met with Value Options to plan transition, data received on current authorizations. Providers not required to submit authorization during first 30 days for MH and SA. Paper authorizations issued for Innovations if provider not fully enrolled.
- Training: **AC:** 21 Provider training sessions, 10 meeting for General Public, 4 meetings for Consumers and Families. – total attendees: 1,192. **Five County**: 14 Provider Sessions, 6 General Community Meetings, 5 Consumers and Families, total attendees: 1,170; **OPC**: 17 Provider Trainings, 3 General Community Meetings, 8 Consumers and Families meetings – total attendees: 1,033.
- Information System Training/Support for Providers: 75 live on-line trainings and Recorded on-line training – Ongoing. Assistance from Provider Relations staff from Community Operations Centers. Assistance from PBH Helpdesk Claims Staff, Network Operations Staff and others.
- Over time PBH got better at provider contracting and trainings.
- Intensive Training for Care Coordinators – Basic Introductory Training, Community Guide vs. Care Coordination, ISP documentation/Service Monitoring, UM Criteria, Transition Plans, Medicaid Deductibles, Cardinal Innovations Waiver, General Waiver Training, Progress Notes in CI.
- Consumer & Family Members hired in each center for support. Advocacy, etc. even if they have a Care Coordinator
- #s served to date (AC, Five County & OPC) – 14,842.
- Community Relations in each County – Juvenile Justice, DSS, Children's Services
- CARDINAL INNOVATIONS HEALTHCARE SOLUTIONS – New name effective July 1, 2012. Local Operation Centers kept their original names
- Organize Governments – stay connected
- Community Oversight Boards consist of CFAC Chair, 3 members from each County, appointed by County Commissioner or designee, other consumer or family member Citizen or Stakeholder
- Governance Board consisting of 13 members – Resolution eff. 7/1/12
- Question regarding rules of Care Coordination – Are they cross-trained for dual diagnosis and if dual does the primary diagnosis determine services. Response: PBH requires licensed professional to determine, can transfer to back and forth if necessary.
- Request for definition of provider. Response: Agency provider – incorporated company, residential provider, CABHA
- Is PMPM covered by PBH across area? Response: no, each area has its own, will stay that way until see trends. Kept their own CFACs – process of forming regional group.
- Marc Jacques commended them for centralization efforts. Questioned Peer Support as direct service. Response: expressed concern on why Peer Support so slow to catch on – may be it needs more structure, need peer coaching structure since many don't know what to do. Possibly use web-based peer coaching model. Need to do more to get that going. Many who need it Medicaid, don't have it.
- Inquiry on what criteria to be used for limiting # providers. Response: PBH has too many child residential providers, want to do more home-based MST, Intensive In-Home to be developed over time.
- Has PBH hired anyone from providers? Response: Can't provide answer, have asked for that info. Not yet available.
- Cherene Allen-Caraco and Marc Jacques both offered to assist with Peer Support
- Request for information on Peer Support from Marc Jacques

- Update - Fact Sheets for MH, IDD, SA – Marc Jacques
  - Requested input from committee for developing goals, email to Marc at Jacques.1111@hotmail.com
  - Request for source documents used as references on Fact Sheets – Source documents are included, that column needs to be unhidden.

Conclusions			
Action Items		**Person(s) Responsible**	**Deadline**
• None			

4. Agenda topic: Public Comments **Presenter:**

Discussion	• Patricia Weigand & Casey Wiegand
	  ○ Case Management – not doing a lot of good to ask for Case Management. Daughter has many needs requires 24 hours of coverage. What needs to be added or taken away? Wants daughter to have productive life. Wants to keep Independent Case manager. Care Coordination by phone, Community Guides are a joke.
	• Christy Webb – Personal Support Specialist Care Giver since 1999
	  ○ Has seen Case Managers go above and beyond to assist families going thorough crisis. Concerned services being cut because needs not apparent at that particular time but needed at a later time and difficult or impossible to get services back. Requested crisis situations are considered before implementing.
	• Kathy Reiter – Parent, Case Manager
	  ○ Offer more information on twin boys she spoke of in May meeting. Boys transitioned from CAP to Innovations, at risk of institutionalization. Hours of service decreased from 16 to 7 hours, lost 1:1 support, expelled – no response, got individual services back. Cost rose $10,000 but lost 4 hours of service per brother. Parents provide residential support.
	  ○ Support Independent appeal process, independent second opinion not related to MCO.
	• Mary K. Short & Katie
	  ○ Presented 600 page notebook of Public Comments/Input regarding clinical policy, CAP to Innovations, Loss of Respite, etc. and nothing working. Questioned effectiveness of public input if nothing works. Emailed a request for best practice information and got no response, had to do a freedom of information request to get the information.
	• Crystal J. De La Cruz-Hopper and Isabel S. De La Cruz
	  ○ Community Guides a joke, parents have more information than Community Guides
	  ○ Recipients have no due process, continue to not be heard
	  ○ Requested opportunity to present at next meeting
	  ○ Recipients/families don't have opportunity to speak
	  ○ HB 1075, version 3 gives raises to staff
	  ○ Need for Care Coordinators, stressed damage done when services pulled
	  ○ Introduced her daughter, Isabel
	• Lisa Poteat
	  ○ Community Guide services – people expect to flaw, not being used. According to all numbers – 7% of folks who lost TCM referred for Community Guide Services. 1,200 lost, 120 referred to Community Guide Services Supplementing with Care Coordination – get what they need when TCM gone.
	  ○ Utilization Rate – need to get authorized and out there
	  ○ Who isn't getting DD, if don't get in transitions, 1/3 of people with IDD won't get.
	• Holly McNeill & Chandler – 29 years
	  ○ No parent involvement in making these decisions
	  ○ Have they looked at caseloads for Care Coordinators, response time in contacting, quality of services
	  ○ Request for more time for Public Comments presenters – Committee to Discuss
	• Dave Richards – The ARC of NC
	  ○ Suggestion to move comment period from end of agenda
	  ○ Care Coordination is technical stuff. One successful initiative is to have someone other than MCO
	  ○ Smart MCOs figure out how to make work what the people are asking for
	• Paul Peters
	  ○ Discussions on Case Managers, Date, Care Givers – Outsource the Care Coordination

Conclusions	○ Suggestion made to email committee members – Ken sent to some, not all. Marc questioned stopping services (Lee to get Appeal Process out to members)

Action Items	Person(s) Responsible	Deadline
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Meeting Adjourned
Next Meeting: Wednesday, July 24, 2012, 1:00 p.m. – 3:00 p.m.