GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DISTRICT OF COLUMBIA MEDICAL CARE ADVISORY COMMITTEE (MCAC)

Meeting Minutes
Wednesday, June 24, 2015
1:30 pm to 3:00 pm

Attendance

Katherine Barnes, Trusted Health Plan
Yvonne Fonge, Trusted Health Plan
Denise Calhoun, Trusted Health Plan
Michelle Mitchell, Trusted Health Plan
Cherylle King, Trusted Health Plan
Theresa Bittle, MedStar Family Choice
Stephanie T., HSCSN
Karen Dale, ACDC
Carla Lester, ACDC
James Christian, ACDC
Corinne Jones, Iona
Sarah Guerrieri, Children's National
Judith Levy, DC Coalition on Long Term Care
Cleveland Woodson, DHCF
Angela Wright, Trusted Health Plan
Debra Height, Trusted Health Plan
Tarita Basante, Trusted Health Plan
Ernestine Johnson, Trusted Health Plan
Margartia Jackson, MD, Trusted Health Plan
Judith Hinton, Trusted Health Plan
Wes Rivers, DC Fiscal Policy Institute
Hyesook Chung, DC Action for Children
Carmelita White, DHCF
Claudia Schlosberg, DHCF
Juliette Prioleau Michael, RCM of Washington
Cyd Campbell, MedStar Family Choice
Thomas Duncan, Trusted Health Plan
Felecia Stovall, DHCF
Lisa Truitt, DHCF
Kimberly Waller, Childrens Law Center
Zema Sanchez Fuentes, TPM Law
Colleen Sonosky, DHCF
Cavella Bishop, DHCF
Tallulah Anderson, MedStar Family Choice
Deniz Soyer, DHCF
Makenzie McIntosh, DHCF
Kivon Allen, DHCF
Saniya Suni, DCBHA
Shannon Hall, DCBHA
Keith Maccannon, AmeriHealth
Anita Lewis, DHCF
Janice Llanos-Velazquez, DHCF
Gwen Bell, DHCF
Suraj Navaratne, DHCF
Heather McCabe, DHCF
Patricia Quinn, DCPCA
Justin Palmer, DCHA
Jessica Foster, Health Management Associates
Dena Hasan, DHCF
Pearl Keng, DHCF
Yolanda Williams, DHCF
Constance Yancy, DHCF
Derdire Coleman, DHCF

Participation via Conference Call:
Veronica Sharpe, DCHCA
Shana Bartley, DC Action for Children
Alan Watson, THRASYS
Trina Dutta, DHCF
Douglas Garland
Barbara Bazron, DBH

I. Welcome, Introductions, and Approval of Minutes

Wes Rivers, MCAC Chair, called the meeting to order at 1:35 p.m. There were fourteen (14) MCAC members present. Mr. Rivers called for a motion to approve the minutes of the April 8, 2015, Medical Care Advisory Committee Meeting (MCAC). The motion was seconded and unanimously approved.

II. Presentation by Managed Care Organizations (MCOs) on Care Coordination *(The MCO's PowerPoint presentation may be found on DHCF's website at www.dhcf.dc.gov)*

Trusted Health Plan – *Ernestine Johnson, Director of UM*

Ms. Ernestine Johnson reported that Trusted's Case Management Program design is based on the Case Management Society of America's (CMSA) Standards of Practice for Case Management (2010), and that they use nationally recognized evidence-based clinical practice guidelines.

She stated that according to CMSA guidelines, case management is a collaborative process based on assessment, planning, facilitation, care evaluation, coordination, and advocacy.

Ms. Johnson's presentation on Trusted's Case Management & Care Coordination gave an overview of the following areas:

- ***Staffing*** – Trusted's staffing consist of three (3) teams. Each team consists of two (2) licensed cases managers (nurses), one (1) care coordinator, a social worker, a pharmacist, a behavioral health coordinator, and a number of people from the outreach center.
- ***Community Partners*** – Trusted has numerous community partners. *(List can be found on Trusted's PowerPoint presentation on DHCF's website at www.dhcf.dc.gov)*
- ***Cultural Competency*** – One of Trusted's major emphases with their population is cultural competency. Trusted believes that they need to meet the members where they are. They utilize interpreter and translation services to ensure that when they are communicating with members, that those members are being understood.
- ***Members in Case Management*** – January to April 2015. Active case management membership went from two hundred sixty four (264) in January, to six hundred fifty three (653) in April.
- ***Eligibility Criterion*** – Any member with a serious condition, a life threatening condition, a disability, a member who has difficulty navigating the system, members who have had three or more emergency room (ER) visits, these are all eligibility criterion.
- ***Identification of Members*** – Members are identified through a variety of sources. They are identified through internal referrals, self-referrals, providers, data collected from UM department, pharmacy, hospital discharges, lab, etc.
- ***Enrollment Process*** – Members are contacted by case managers for enrollment. They have the option to opt out.
- ***Case Management Tracking*** – Case management status for members is documented in Care Connect. The initial assessment is completed within thirty (30) days of being identified as eligible. There is the Referred member (new), In-Process member, and Fully Engaged member.

- ***Stratification Levels*** – There are three (3) stratification levels; low, medium, or high intensity. Low intensity is based on members with no significant barriers or compliance issues. Medium intensity is based on member with moderate complexity of needs and/or barrier to optimal care. High intensity is based on members with high intensity needs and significant barriers to care and/or compliance problems. Homelessness/housing status is taken into account. The stratification levels are based on at least one of six (6) categories; Medical Needs, Mental Health Needs, Provider and Access Issues, Psychosocial Issues, ER/Inpatient Utilization, and Education Needs.
- ***Trusted's Member Centric Complex Case Management Team Collaboration*** Trusted's Case Management Team *(Katherine Barnes, Tarita Basante, Debra Height-Williams, Angela Wright, Yvonne Fonge, and Denise Calhoun)* provided a presentation on how Trusted Health Plan brings member centric complex case management team collaboration to life *(a step-by-step overview of the process for complex cases).*

MedStar Family Choice (MFC) – *Cyd Campbell, MD, FAAP, Medical Director*

Dr. Cyd Campbell stated that MedStar Family Choice (MFC) has been in the District of Columbia for about two and a half (2½) years now, and in Maryland for about seventeen to eighteen (17-18) years. Dr. Campbell focused her presentation on MFC's program structure. They have Disease Management Programs and Complex Case Management (CCM). She discussed types of programs, which conditions MFC is addressing, staffing and resources, and a few examples of how MFC provides diabetes case management, disease management, and complex case management. Also, community resources, and population needs and 2015 initiatives.

Dr. Campbell's presentation on MedStar Family Choice's Case Management (CM) Program includes the following:

- ***Overview of Programs*** – Dr. Campbell stated that the case management program has two (2) major components; disease management programs, which has eight (8) conditions, and complex case management, which has different types of conditions. The disease management and complex management programs follow standards set by NCQA, DHCF Contract, Case Management Society of America, and Evidence-based bodies of knowledge (ADA, MedStar Clinical Practice Guidelines, NIH, CDC, etc.)
- ***Definition of Disease Management (NCQA)*** – Focuses on a multidisciplinary, continuum-based approach to health care delivery that proactively identified populations with, or at risk for, established medical conditions.
- ***Disease Management (DM) Programs*** – Adult Respiratory, Pediatric Asthma, Cardiovascular/Heart Failure/Hypertension, Diabetes, Early Intervention/Children with developmental and mental disability and delay, High Risk Pregnancy, HIV/AIDS, and Substance Abuse/Behavioral Health.
- ***Definition of Complex Case Management (NCQA)*** – Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
- ***Complex Case Management (CCM) Program*** – Dr. Campbell stated that they get to choose which conditions are included in their complex case management. For the MedStar population they chose to include in their criteria: transplants, catastrophic conditions, chronic

obstructive pulmonary disease (COPD), special needs populations (not covered in disease management program), multiple chronic illnesses with high utilization, and identified on high utilization reports.

- ***Staffing*** – MedStar has licensed professionals in nursing, social work, and behavioral health that do provide their case management, disease management and complex case management programs. The staff include ten (10) registered nurses, two (2) social workers, one (1) licensed professional counselor plus one (1) peer support work, two (2) case management assistants, one (1) registered nurse supervisor, and one (1) registered nurse director.
- ***Supplemental Staff (Outreach, Care Coordination and Education)*** – MedStar also has wellness and preventative care coordinators, external outreach workers, and community relations associates. The wellness and preventative care coordinators contact health risk assessments on new members, and provide outreach wellness programs. The external outreach workers (bilingual staff) assist in locating members for HRS, wellness programs and CM program by phone and in person in the community. Community relations associates educate community on benefits, wellness, chronic conditions, CM programs. They also partner with outreach and CM staff in planning and staffing events.
- ***Standard CM Processes for DM and CCM*** – Identification, engagement, assessment, stratification, interventions, and treatment plan. Member remains in program until goals are met or contact is lost.
- ***Identifying Members*** – Referrals (self, provider, agencies, or hospitals), health risk assessment, claims and encounter data, pharmacy and lab data, UM and CM data/processes, ER review process, new member orientation, community events, disease monitor (disease specific reports from McKesson system), and Electronic Health Records (EHRs) *{when applicable}.*

Dr. Campbell reviewed the CM assessment process, DM: Diabetes types of interventions, and DM Diabetes stratification levels (High Risk – Level 3, Medium Risk – Level 2, and Low Risk – Level 1).

She also presented the DM: Diabetes enrollment, participation and outcomes for 2014. Enrollment and refusals were four hundred forty six (446) Diabetes DM Cases initiated, and sixty eight (68) refusals. The measure success-HEDIS was also presented, along with the key outreach events, community relations programs screening and education, cultural initiatives and partnerships, and annual needs assessment and initiatives *(see MedStar PowerPoint on www.dhcf.dc.gov for additional details).*

AmeriHealth Caritas District of Columbia – *Karen Dale, Market President*

Karen Dale introduced three (3) members of her team – Carla Lester (Integrated Health Management), James Christian (Operations), and Keith Maccanaan (Marketing & Outreach). Ms. Dale stated that she would be anchoring on AmeriHealth's members. She expressed that she was glad that AmeriHealth was the last MCO to present to the MCAC, because now she does not have to repeat some of the same subject matter that has already been covered by the other MCOs. Ms. Dale said that she would be discussing where AmeriHealth is with coordinating care for their members, and she will provide a close view of how that is done, and what makes the difference and what doesn't.

AmeriHealth uses a servant leadership model. In terms of the members that they serve, their lives are very complexed. What they are focused on doing is coordinating care in terms of the care management, but more importantly, customizing their approach. AmeriHealth follows the

contract, and they have the required complex disease care management categories and those things. However, when you talk to a member, it's not about the disease that they have. There may be all kinds of other things going on that are affecting them. If you really want to engage them, you have to deal with those things first.

Ms. Dale stated that they acknowledge that where their members are involves their cultural heritage. AmeriHealth focuses intently on ensuring that the diversity of their staff is there. The language line is available, but to the extent possible, they try to have care managers and other staff that speak the language. The language line is there for a last resort. She also spoke a little more detailed about the patient-centered approach which addresses the patient's preferences, concerns, lifestyle, culture, beliefs and readiness.

There was extensive discussion regarding member engagement and empowerment, value added provider and community partnerships, true integrated care management, integrated healthcare management, stratification approach, integrated healthcare maintenance organizational chart, Asthma Focus-Pediatric, care management activity reporting: current state, and 2014 outcomes. *(For more details, please see AmeriHealth's PowerPoint on DHCF's website at www.dhcf.dc.gov).*

Q&A's regarding MCO Presentations

- Stephanie Taylor (HSCSN) asked whether or not care managers who provide interpretation services go through any type of language proficiency for medical terminology program or certification, or are they just bilingual care managers? Karen Dale (AmeriHealth) answered that for the most part, they are bilingual care managers. However, they do have a program for interpretation services. She stated that she was not sure that they all go through the program, but she would follow-up with Ms. Taylor. Carla Lester (AmeriHealth) stated that the care managers who are bilingual working with Spanish speaking members, no they are not going through that class. For anyone who provides translation services internally for different departments will go through the certification training. Judith Hinton (Trusted Health Plan) stated that they use the language line, as stated during their presentation.

- Hyesook Chung (DC Action for Children) had a question around coordination of the case management. She asked whether or not the MCOs are using multiple data sets? Is it computerized? Are the different data sets shared? Teresa Bittle (MedStar Family Choice) stated that they use multiple data sets to identify members. They have access to CRISP, and they have hospital records of their own physician practices. Everyone at MedStar Family Choice works out of the same program. Judith Hinton (Trusted Health Plan) stated that they use one system as well for everyone.

- Dr. Barbara Bazron (Department of Behavioral Health) asked if the MCOs could speak to the results of their care coordination activities. Have you seen a reduction in hospitalizations, or a reduction in the degree to which certain illnesses has not become acute as a result of the care coordination that you have provided. Karen Dale answered that Trusted has seen a difference in less gaps in care for those members that have been engaged in care management, and they have seen more adherence to their treatment plan. The person that is engaged in care management for diabetes, regardless of whether that's being done by the internal care managers, or healing our village, or Dr. Bland at Howard University Hospital, these members tend to take their medications on time, have controlled glucose readings, they will get their eye exams, and those types of things. AmeriHealth sees

that difference, and would like to see more of a difference. We see that there is a difference in closing gaps in care, and low acuity emergency room utilization. Part of the challenge sometimes is just being able to manage the data over time. Judith Hinton stated that Trusted Health Plan's results are similar. But the challenge is if you can reach the member, and get them actively engaged in their care. We do see a difference in compliance, and a decrease in emergency room utilization, and in hospitalization, and improved health. Ms. Dale also stated that there is difficulty on the behavioral health side getting consistent engagement, and the fact that between what services are provided by the MCO and what is provided by DBH, we don't yet have the best coordination in sharing of data. So this makes for some challenges in terms of really fully coordinating care. That's one of the things in our big work plan, but that would really help so that we can better coordinate and really make sure that we close up those gaps. There was additional extensive discussion regarding this issue.

- Xenia Sanchez-Fuentes asked each MCO how many care managers do they have serving children, and how many children are in case management in each of the organizations? Trusted answered that they have one case manager and seventy five (75) children in case management. They also have an outreach team that works with EPSD population. AmeriHealth stated that they have four (4) case managers for early intervention and children with special needs, and they have care coordinators that support that team. All other pediatric engagements could have anyone of the twenty plus care managers engaged depending on caseloads, severity, etc. Within their complex team they have four (4) care managers who have extensive pediatric experience. AmeriHealth did not have the information regarding the number of children in case management available, but will provide it to the MCAC following the meeting. MedStar Family Choice answered that they have two to three (2-3) care managers working with children, and their diabetes disease management care managers work with children and adults. They also have their wellness and preventative care coordinators who are reaching out to children. If they included all of these services, it could be thousands of children that are in case management.

III. Director's Report

Wes Rivers reported that he would be striking item number five (5) on the agenda, (Director's Report) to spend the last twenty (20) minutes on two items *(New Proposed Rules for Managed Care and Quality and the Impact on the DC Medicaid Program, and Update on Health Homes)*. Mr. Rivers requested that members submit any questions that they may have regarding the Director's Report to him, and he would refer them to the department for feedback.

IV. New Proposed Rules for Managed Care and Quality and the Impact on the DC Medicaid Program

Claudia Schlosberg, Senior Deputy Director/Medicaid Director for DHCF stated that CMS is in the process of promulgating new managed care rules for Medicaid MCOs. This was a major topic of discussion at the National Association of Medicaid Directors (NAMD). Many states have a host of concerns. DHCF's assessment is that they do not see them as having too much of an impact on their program.

Lisa Truitt, Director, Health Care Delivery Management Administration (HCDMA) at DHCF, stated that the proposed rules are around Part 438, which is specifically managed care. The document is over two hundred plus pages, so the department hasn't had an opportunity to go through each and every component of it to give a full assessment review. DHCF's Office of the General Counsel is

assisting HCDMA in the review of the rules. Ms. Truitt stated that she would speak about a few of the changes. There are some changes around appeals and grievances. CMS is looking to have a streamline process through the market place and managed care. There are some recommendations to make some changes to the language that is in the regulations. For the most part, the department will be looking to see what those specific changes will be. These are some of the pieces that DHCF will be reviewing. Requirements are being made around rate development and actuarial soundness. States may have some flexibility in the medical loss ratio percentage. The District's medical loss ratio – the health plans cannot go below eighty five percent (85%). States are being allowed to establish a higher percentage if they choose to do so.

Ms. Truitt provided additional extensive information regarding the new proposed changes to managed care. She also stated that the department has a lot more to review before she could speak on them.

V. Update on Health Homes

Dena Hasan, Project Manager, Health Homes, reported that the Health Homes SPA was submitted to CMS on Thursday, June 18, 2015. CMS is anticipating a ninety-day (90) turnaround. The department has been in close communication with CMS throughout this process getting their feedback on the program development, rate methodology, etc. The Health Homes Program focuses on those with severe mental illness in the District. Individuals eligible for the program will be enrolled through Medicaid claims data. About 20,000 plus individuals will be eligible for the program. Key to the District's Health Home Program is that the District will use an opt-in process for enrollment. This program will need to coordinate with the MCOs.

Ms. Hasan also discussed the Health Home population. She stated that they stratified them by a high and low acuity. The PMP rate that the District is looking to use for the high acuity group is around $400+, and the low acuity group is around $300+.

The Health Homes Program staff will be meeting with the appropriate groups to ensure that what is being proposed makes sense, and to get their feedback on the Health Homes Program operations.

VI. Senior Deputy Director/Medicaid Director's Announcements

Claudia Schlosberg stated that DHCF has been moving forward on a lot of reforms in Long Term Care. She announced that the Adult Day Health Program was approved. DHCF is moving forward toward a July 1st implementation, with a July 31st repeal of the old day treatment rule. There are Six (6) providers in the pipeline who are going through provider readiness at this point. There are site visits that are kicking off on July 25th. There are approximately 168 current beneficiaries receiving day treatment who are teed up for assessments and are going through the eligibility process.

Ms. Schlosberg reported that with the changes in Federal law, DHCF is making changes again to case management and home health agencies. There continues to be on-going law enforcement activities. DHCF is actively recruiting new home health agencies by reaching out to those that currently have CONs, licenses, as well as serving Medicare but are not in the Medicaid space. DHCF will be reaching out to them to see if they can start serving Medicaid beneficiaries. DHCF is also actively recruiting new case management agencies. She asked if anyone knows of any organizations that may be interested, and would not be conflicted because they are also providing waiver services to please contact her, or Ms. Trina Dutta.

She also reported that the ACA had a primary rate increase that ended December 31, 2014. DHCF extended it through the end of fiscal year 2015. DHCF is now working on a SPA that they hope to get to Council before they recess that would extend that increase, for certain primary care services for certain beneficiaries permanently. DHCF is extending that payment to psychiatrists, as well as OB/GYNs and advanced practice nurses.

Finally, Ms. Schlosberg stated that DHCF has a number of key vacancies. DHCF is actively recruiting to fill those vacancies. Those vacancies are for a medical director, program integrity director, long term care director, and a policy director. If you are interested, or know someone else who would be interested, please notify Ms. Schlosberg. She stated that she would like to get those positions filled by qualified, compassionate individuals.

Dr. Barbara Bazron stated that the former CEO of St. Elizabeth has stepped down, and the chief medical officer has stepped down to take another position in another state.

VII. Adjournment

The meeting was adjourned at 3:03 pm

Approval of Minutes:

Wes Rivers, MCAC Chair

July 22, 2015
Date