**Delaware Health and Social Services**  
**Medical Care Advisory Committee (MCAC)**  
**June 8, 2011 Meeting Minutes**

**Date:** June 8, 2011  
**Place:** Kearns Center, Easter Seals  
**Time:** 9:00 a.m. – 11:00 a.m.  
**Presiding:** Richard Cherrin

**Members Present:** William Adami, Donna Barton, Judy Chaconas (via phone), Penny Chelucci, Richard Cherrin, Leonard Nitowski, M.D., Ann Phillips, Julia Pillsbury, D.O., Olga Ramirez, Paula Roy, Lisa Schieffert, Michelle Dennis (for Yrene Waldron via phone)  
**Guests:** Melanie Benning (CMS), Nancy Rapport (CMS)  
**Members Absent:** Kris Bennett, Susan Ebner, Herman Ellis, Brandi Niezgoda  
**Staff Present:** Anthony Brazen III, D.O., Cindy Denemark, Crystal English, Becki Gallagher, Steve Groff, Dave Michalik, Glyne Williams, Lisa Zimmerman  
**Staff Excused:** Rosanne Mahaney, Fury Fecondo, Shiela Nutter, Kay Wasno

<table>
<thead>
<tr>
<th>TOPIC FOR DISCUSSION</th>
<th>DISCUSSION / ISSUE</th>
<th>ACTIONS</th>
<th>FOLLOW UP RESPONSIBILITY</th>
</tr>
</thead>
</table>
| **Call to Order:**  
Julia Pillsbury, D.O. | • The Medical Care Advisory Committee (MCAC) meeting was called to order by Julia Pillsbury, D.O. at 9:09 a.m. |         |                         |
| **Approval of Minutes:**  
Julia Pillsbury, D.O. | • Julia asked for a motion to accept the minutes of the March 2011 meeting. Motion was made, seconded and carried. |         |                         |
| **Old Business:**  
Medicaid Cost Containment  
Steve Groff, Deputy Director | • Steve reminded everyone that DMMA was tasked with identifying five million dollars in Medicaid cost containment strategies. Proposals included limits on non-urgent visits to the ER, reducing physician, lab and x-ray rates, and co-pays for some services. Additional revenue was projected at the last DEFAC meeting and these proposals were not approved by the Joint Finance Committee (JFC). However, they did agree that non-urgent use of the ER is a problem and suggested the creation of a task force to examine ways this issue could be addressed.  
  o **Question:** Is there going to be a committee to study the Medicaid reductions?  
  o **Answer:** There will be a committee formed to study at the very least non-urgent use of the ER.  
• Much discussion evolved around possible alternatives to ER usage by the Committee ranging from urgent care facilities, care coordination, etc. The Committee wishes to have representation on the Task Force.  
• The additional revenue has also raised questions about the ability to offer some provider rate increases. Most providers have been frozen since 2009; we have some groups of providers, primarily home and community- | New Task Force to be established by Epilogue. The Committee wishes to have representation on the Task Force. |
**Managed LTC Update**  
*Lisa Zimmerman*

- Lisa handed out an updated Power Point presentation for 3rd edition of the Diamond State Health Plan Plus and went over it.
- DMMA received a letter from the Nursing Facility Association regarding the DSHP Plus proposal. They raised concerns about the planning process, implementation timeline, and stakeholder involvement. The Department has responded to the letter and feels that these concerns have already been addressed. Steve reiterated the importance of stakeholder involvement, collaboration between all involved parties, and our continued plans for public input going forward.
- **Question:** Will you refresh us on QMB and SLMB?  
  - **Answer:** QMB is Qualified Medicare Beneficiary and SLMB is a program through QMB. Those are clients who the state pays their Medicare premium and health insurance deductibles and for SLMB’s, we pay their Medicare premium.
- **Question:** How will people know if they are a dual eligible?  
  - **Answer:** A client with full Medicaid and Medicare coverage.

**Medicaid Cost Containment (Cont’d)**  
*Steve Groff, Deputy Director*

- based service waiver providers that have not seen rate increases in 8 years. Due to our reimbursement methodologies *some of our providers such as hospitals and nursing facilities have scheduled increases in the state plan that would give them inflationary increases and/or re-base them periodically. Other providers have negotiated rates that may only change when there is an action taken to fund an increase. The JFC approved a proposal to extend a 2% increase these community providers.* The Nursing Facility Association is also concerned that they have not seen an increase, although for a shorter period of time, and have asked the JFC to consider a rate increase for their members.
- As we move forward, whatever happens in terms of increases for any provider group at this point will go forth into the following years. We will be facing this in the 2013 budget. We are looking at a door opener for that budget year in excess of one hundred million dollars. We will be coming back to the table at that time and looking at ways we can lessen that burden and contain costs. This is only the beginning of the discussion; not the end.

- Lisa handed out an updated Power Point presentation for 3rd edition of the Diamond State Health Plan Plus and went over it.
- DMMA received a letter from the Nursing Facility Association regarding the DSHP Plus proposal. They raised concerns about the planning process, implementation timeline, and stakeholder involvement. The Department has responded to the letter and feels that these concerns have already been addressed. Steve reiterated the importance of stakeholder involvement, collaboration between all involved parties, and our continued plans for public input going forward.
- **Question:** Will you refresh us on QMB and SLMB?  
  - **Answer:** QMB is Qualified Medicare Beneficiary and SLMB is a program through QMB. Those are clients who the state pays their Medicare premium and health insurance deductibles and for SLMB’s, we pay their Medicare premium.
- **Question:** How will people know if they are a dual eligible?  
  - **Answer:** A client with full Medicaid and Medicare coverage.
### Managed LTC Update (Cont’d)

**Lisa Zimmerman**

- and QMB is not a full Medicaid client. We will exclude clients who choose to enroll in PACE and clients who are in the hospital for 30 consecutive days program. Out of state clients will also not be enrolled.

- There is a mailbox set up for the program: [DHSS_DMMA_DSHP_Plus@state.de.us](mailto:DHSS_DMMA_DSHP_Plus@state.de.us)

- The website for the program is: [http://dhss.delaware.gov/gov/dhss/dmma/dshpplus.html](http://dhss.delaware.gov/gov/dhss/dmma/dshpplus.html)

**Question:** How many clients do you expect to be in the program and do you have any idea how many clients will be moved from an inpatient setting to a community setting?

**Answer:** Between 11 and 12 thousand clients at the time we start the program. DSAAPD is already starting to work with the hospitals and community agencies to get clients into community settings as much as possible. Also, with the Money Follows the Person (MFP) program, they have been able to transition 39 clients to the community. It’s a slow moving, careful process to make sure clients get the support they need. Recently, the MFP program received funds from the Affordable Care Act (ACA) that allow us to assess each individual in the state facilities to determine what capacity and what desire they might have to be returned to a community setting. We do not want to disrupt the care of the client.

**Question:** As you move clients from an institutional setting to the community setting, won’t that require a primary care giver on site?

**Answer:** With the MFP program, family support plays a large role. The client solicits friends and family that would be willing to support them in this transition. The MCO’s have a responsibility as case managers. They have a list of criteria to follow just like they do today.

- Some discussion evolved around managed care plans; the requirements, the cost, expectations and work groups who are working on these issues.
New Business:
Open Enrollment
Glyne Williams

- Results are not dissimilar from the last results. There is 50% fewer people requested change from the last enrollment period. This enrollment period we have 866 people requesting changes and there were 1600 last year same time. The general reasons for requesting change is they generally were not satisfied with their medical care but were not able to specify what medical care they were unhappy with. Secondly, their specialist of choice did not accept the plan they are currently in. Third reason is their PCP of choice does not accept current plan. Fourth reason is family linkage; clients switched plans so they would have the same plan as the rest of their family.

  - Question: Are you going to explore the 800 people who changed because of the specialists? What specialties were missing? I think mental health is one of the specialties.
  - Answer: In fact, you are correct. One of the challenges had much to do with pain management and mental health diagnoses.

HBE Activities
Steve Groff
Crystal English

- Steve began with reminding everyone that we’ve received a one million dollar planning grant to begin planning the implementation of the Health Benefit Exchange (HBE) effective January 2014. Crystal English was introduced as the project manager of the HBE program. Crystal has been working with a consulting firm we have engaged, Public Consulting Group (PCG) and a lot has taken place in the past two months.
- We have been focusing our efforts primarily on governances. We were able to come to an agreement on a recommended approach for governance of the exchange. We are looking at our information technology requirements and PCG is helping us to do an assessment of our current systems and what we will need in the way of changes to the new systems in order to meet all these requirements of the exchange and integrate eligibility terminations for the Medicaid and CHIP programs. Finally, we are heavily engaged in stakeholder input and holding a number of public forums and sessions. Crystal will give an update on that.
- One of the things PCG recommended was transitioning to a more public stakeholder process. Yesterday, a public forum was held at the
## Pharmacy Update

*Cindy Denemark*

- Doubletree Hotel in Wilmington and it focused on Health Benefit Exchanges in general. Someone from Secretary Landgraf’s office will participate. The actual presentation was given by one of the PCG consultants. The whole process will be topic focused. It is casual setting and is designed for the participants to walk away with a thorough understanding of the topic matter. We will have a session on Commercial carriers on the 16th of June, the Consumer Information forum is set for the 28th of June and the Medicaid and CHIP forum on the 29th of June. The calendar is posted on the DHSS website under Health Information Exchange as well as the Health Care Commission’s website. The mailbox is not up yet but will be for people to send in information, ask questions, etc. A summary will be brought forth at the September meeting.

- The Pharmacy and Therapy Committee met on May 5th. They focused on physical issues. The November meeting will focus on behavioral health.
- There were 60 drug categories expanded including oral contraceptives and HIV therapies.
- One of the new classes added was HIV and AIDS drugs. There are not many states that have this listed because it is controversial. We hope to stimulate the manufacturers to provide something with supplemental rebates to the states.
- A 90 day period for smoking cessation product criteria were modified to allow for multiple treatment failures in a given year.
- Changes were made to the allowable usage of narcotics such as Percocet and Oxycontin. The classification of narcotic analgesics is being made to allow for tracking of therapy duplication in this area. The changes will specifically alert the pharmacists when two or more agents have been prescribed such as Percocet and Vicodin.
- Delaware does not have a prescription monitoring program (PMP) in place. The MCAC was asked to draft a letter to the JFC using language that expresses support and documentation of the benefits of the PMP. A motion was made to draft such a letter, motion was seconded; motion Committee votes to send a letter to JFC regarding PMP.
was carried. As a follow up to this meeting it was discovered that the Secretary of State’s office is making good progress moving this project forward. Their office anticipates the program will be implemented by the end of the calendar year.

- For a number of years, DMMA has been working with the Delaware Assistive Technology Initiative, which now falls under the U of D’s Center of Disabilities Studies, to plan for and implement a durable medical equipment and assistive technology reutilization program. DATI’s name for the program is “Delaware Recycles and Reuses Assistive Technology”. The recycling program is scheduled to kickoff on July 1, 2011.

- Under the equipment recycling program, certain pieces of DME/AT will be targeted for recovery and refurbishing when the equipment is no longer needed by the client. The pieces of equipment which will be recycled under this program include: augmentative communication devices, bath benches, bi-paps, car seats, commodes, feeder seats, feeding pumps, gait trainers, hospital beds and hospital bed accessories, nebulizers, oxygen concentrators, patient lifts, quad canes, scooters, shower chairs, standers, strollers, walkers and wheelchairs and wheelchair accessories. DMMA has modified its DME policy to retain ownership of this equipment in preparation for the recycling program.

- As Medicaid purchases any of these DME/AT items, we will inform DATI about the acquisitions and DATI will supply a barcode label for use in tracking the equipment. Goodwill Industries has entered into an agreement with DATI to serve as the central repository for storing and refurbishing the equipment.

- To help drive access to the equipment inventory, DATI will create a web-based portal where DME vendors will be able to search for equipment that has been prescribed by the client’s doctor. When the equipment is available, the DME vendor will purchase the refurbished items from Goodwill and will in turn provide it to the client. The DME vendors will then bill Medicaid for the equipment. We expect to construct a reimbursement methodology that will serve as a strong
### DME: Collaboration with Center for Disabilities Studies (Cont’d)

*Dave Michalik*

<table>
<thead>
<tr>
<th></th>
<th>incentive for DME providers to participate in the recycling effort. However, when a refurbished item is not available from the Goodwill inventory, DME vendors will continue to provide new equipment. We expect the inventory to grow over time as more and more equipment is recovered for reuse. Also, while we believe refurbished equipment will be equivalent to newly purchased DME/AT, clients will have the option to decline the refurbished equipment and opt for a new item.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Initially, because this is a complex undertaking, we are going to limit the recycling effort to our fee-for-service population. Once all the challenges are worked out we will expand it to the managed care organizations.</td>
</tr>
<tr>
<td></td>
<td>- We expect to achieve certain outcomes through this initiative: First, to provide Medicaid clients with appropriate DME/AT; Second, to support an environmentally responsible approach to reusing equipment so that it doesn’t end up in landfills unnecessarily; Third, to achieve some long term cost containment results, and finally, to support the general population in Delaware who are not Medicaid clients but who may still need to acquire medically necessary DME and AT and will have access to that equipment through the Goodwill inventory.</td>
</tr>
<tr>
<td></td>
<td>o <em>Question:</em> Did you look to see if there was any incentive to clients to utilize this plan?</td>
</tr>
<tr>
<td></td>
<td>o <em>Answer:</em> We are hoping that education and promotion will help publicize the program. Equipment won’t be inferior.</td>
</tr>
</tbody>
</table>

### Miscellaneous

- An inquiry was made as to where the ICD10 program currently stood. Steve answered by saying that we are working toward full compliance for the 2013 deadline. Some states are implementing a crosswalk between ICD9 and ICD10. A decision was made to revisit this topic at the September meeting.

### Adjournment

- Meeting was adjourned at 11:02 a.m.
Respectfully submitted,

Rebecca Gallagher
Recorder

Date approved

Chairperson