

Delaware Health and Social Services
 Commission on Medicaid Cost / Health Care Containment
 September 14, 2011 Meeting Minutes

<p>Date: September 14, 2011</p> <p>Place: Easter Seals/Kearns Ctr. New Castle, DE</p> <p>Time: 9:00 a.m. – 11:00 a.m.</p> <p>Presiding: Richard Cherrin, Chair</p>	<p>Members Present: William Adami, Kris Bennett, Penny Chelucci, Richard Cherrin, Evelyn Nestlerode (for Lori Christiansen), Calvin Freedman, Jim Lafferty, Dr. Leonard Nitowski, Ann Phillips, Olga Ramirez, Kimberly Reinagel, Lori Ann Rhoads, Paula Roy, Lisa Schieffert, Yrene Waldron</p> <p>Guests: Donald Langer, Robert White, Brendan Peppard, Jaime Conrod</p> <p>Members Absent: : Judith Chaconas, Senator Catherine Cloutier, Susan Ebner, Herman Ellis, Wendy Gainor, Senator Harris McDowell, Representative John Mitchell, Brandi Niezgodna, Dr. Julia Pillsbury, Representative Dennis Williams</p> <p>Staff Present: Steve Groff, Rosanne Mahaney, Sheila Nutter, Greg Roane, Glyne Williams, Lisa Zimmerman</p>		
TOPIC FOR DISCUSSION	DISCUSSION / ISSUE	ACTIONS	FOLLOW UP RESPONSIBILITY
<p><i>Call to Order:</i> Chairman Richard Cherrin</p>	<p>Chairman Cherrin called the meeting to order at 9:04 a.m. and welcomed everyone.</p>		
<p><i>Approval of Minutes:</i> Chairman Richard Cherrin</p>	<p>Chairman Cherrin asked if everyone had reviewed the minutes from the 8/31/11 meeting and called for any alterations or additions. Ms. Schieffert reflected that under the presentation by Dr. Lee on pages 4 and 5 of the previous month's meeting, DHIN offered specific examples concerning cost savings, (providing 3 examples) and that an evaluation would be forthcoming and felt it important to include that information in the minutes. With that addition being made, Chairman Cherrin called for a motion to accept the minutes. Ms. Waldron motioned to accept the minutes as corrected. Ms. Roy seconded the motion. Motion carried.</p>	<p>Revise 8/31/11 minutes</p>	<p>Rebecca Gallagher</p>
<p><i>Medicaid MCO's:</i> Donald Langer (United Healthcare) Rob White (DPCI)</p>	<p>Mr. Langer walked the Commission through a presentation (attach #1) and extended an invitation for all to view table presentation and feel free to ask any questions of his associates in attendance.</p> <p><i>Question: Do you have any idea of what percentage of your members admitted to acute care facilities come through ER?</i> <i>Answer: The average varies by state, but I would estimate between 30 – 50%.</i> <i>Question: Do we know who is sitting on the Utilization Study Group looking at ER usage?</i> <i>Answer: Megan Brennan from OMB is facilitating that Group meetings. The</i></p>		

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<p>Medicaid MCO's (Cont'd): Donald Langer (United Healthcare) Rob White (DPCI)</p>	<p><i>members include: Dr. Anthony Brazen, Medicaid Medical Director; Dr. Paul Kaplan, Medical Director BCBS; Dr. Charles Reese, DelACEP & Christiana Care, Dr. Kevin Bristowe, Beebe Medical Center Chief Medical Officer; Dr. Gary Siegelman, Bayhealth Sr VP Quality & Patient Safety; RN Sharon Anderson, Christiana Care; and Dr. Stephen Ogden, Medical Society of Delaware member.</i></p> <p>Ms. Waldron made a motion that the Utilization Study Group discussing non-urgent care visits to the emergency rooms provide the Commission with meeting minutes or a meeting summary and we will present the same to them so that we are all on the same page with our discussions. Ms. Ramirez seconded the motion. A vote was taken. The motion passed unanimously.</p> <p>Mr. Langer returned to his presentation after the vote.</p> <p><i>Question: Do you have any sense of whether a cash incentive is more effective with the Medicaid population vs. the general population?</i> <i>Answer: We've discovered is that even a small incentive that helps to meet their needs is a very effective incentive.</i></p> <p><i>Question: Are these incentives provided and paid for by Medicaid?</i> <i>Answer: There are strict federal guidelines regarding Medicaid member incentives. They must be tied to accessing preventive services and improving care.</i></p> <p>General discussion ensued concerning the effectiveness of incentives and cost savings as a result of incentives used. Dialogue turned to types of programs that impact behavior and how that is being utilized. Mr. Langer gave a brief explanation of the initiatives in place for encouraging healthy habits and methods to achieve those goals.</p> <p><i>Question: With incentive programs, how do you change people's thinking to make good decisions for the good of their health?</i> <i>Answer: The incentive captures their attention, which then gives you the opportunity to educate the member.</i></p>	<p>Ask the Utilization Study Group to provide a summary of their meetings.</p>	<p>Director Mahaney</p>
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<p>Medicaid MCO's (Cont'd): Donald Langer (United Healthcare) Rob White (DPCI)</p>	<p>A broad conversation revolving around using methods to urge people to make healthier decisions about their habits and choices took place. An issue of client/patient accountability was also discussed entailing legislating behaviors by placing taxes on unhealthy choices people make. Co-pays and deductibles were also discussed as possible options to cut costs. However, the general reflection was that co-pays and deductibles essentially would be cost shifting to the medical provider. Although options resulting in down-the-road cost savings should be considered, attention was drawn back to the next budget cycle and what immediate cost savings could be put in place.</p> <p>Mr. White presented five different cost savings ideas for the Commission to consider.</p> <ol style="list-style-type: none"> 1. Mr. White felt that offering preventive dental care for Medicaid adults would pay for itself. He noted that Medicaid had to cover all emergency room care involving dental issues and those dollars could be redirected to cover dental services. Director Mahaney stated that there is an issue with capacity in the community to provide dental services for adults. There has been a challenge just getting enough dentists to serve Medicaid and CHIP children. DMMA still finds children under CHIP and Medicaid that have difficulty accessing dental care because there are not enough dentists in Delaware. 2. Medicaid's plan to expand managed care to its long term care and dual eligible populations in 2012 will be a win-win-win situation. The patients and family members will find the increased community supportive services it provides very attractive. In addition, it eventually will save the State money by delaying and avoiding the need for more expensive institutional care. 3. There are cost savings to be gleaned for those who are eligible for both Medicare and Medicaid. The federal government is making new models available to better coordinate and integrate the care provided by these two public insurances. Such models would allow DPCI and United to better coordinate the care of these dual eligibles. <p><i>Question: Is this similar to the PACE program?</i> <i>Answer: Programs for All Inclusive Care for the Elderly (PACE) are generally</i></p>		
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<p>Medicaid MCO's (Cont'd): Donald Langer (United Healthcare) Rob White (DPCI)</p>	<p><i>very small in size. There are only about 20 thousand people nationally in PACE programs. Medicaid programs must submit a letter of intent to the federal government regarding implementing a Medicare-Medicaid integrated model by October 1st and develop the program by the end of 2012. Mr. Groff added that under the Affordable Care Act, CMS has created a new Center to obtain better integration between the Medicare and Medicaid programs. There are currently some disincentives for coordinating care because Medicare, as the primary payer, is incentivized to place people into facility-based care, which then becomes a Medicaid expenditure. The new Center is breaking down the existing walls, making data sharing available, and encouraging payment reform. DMMA will be exploring all those things. The Medicare/Medicaid capitation model involves a three way contract between Medicare, Medicaid and the MCOs. It could delay our new managed long term care program as it requires that all Medicaid services be folded into the MCO benefit package (we currently have pharmacy, PPEC and Dental carved out), and requires a competitive procurement process.</i></p> <p>4. Mr. White indicated that the State could see savings from folding pharmacy into the MCO benefit package. Placing pharmacy in DPCI and United's service package would provide the MCOs with the opportunity to be more engaged in the health care of their members. Mr. Groff added that the primary reason that DMMA chose to carve pharmacy out of the MCO benefit package was because, prior to the recent federal legislation, states were not eligible for the drug rebate if they were managing their pharmacy benefit through capitation. That has changed and now states are eligible for rebates even if the pharmacy benefit is rolled into the capitation payments, which makes a big difference.</p> <p>5. Lastly, Mr. White indicated the need to aggressively support the health home concept and to recognize care coordination starts with primary care. It is important to appropriately incentivize physicians to engage more closely in the case management of some of their members, to offer expanded hours, engage in team medicine, provide nursing</p>		
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<p>Medicaid MCO's (Cont'd): Donald Langer (United Healthcare) Rob White (DPCI)</p>	<p>supports and be more actively engaged in the collaboration of the patient care.</p> <p>Further discussion regarding end of life care evolved and the cost of said subject because of the lack of education regarding long term care supports, hospice care and advanced directives.</p> <p><i>Question: How can all of these things contain costs when it sounds like we'll be spending more in order to save money?</i> <i>Answer: Adult dental is going to be a very challenging recommendation to support because we will need extremely good data to add a service to save money. The services we already provide are in place either because they save costs in the long run by avoiding more costly treatment down the road or it's a service that the state would otherwise be required to provide with all state funds. Capacity is also an important issue to consider. Just because you offer a service, doesn't mean it's available and accessible.</i></p> <p>It was noted that Dentistry is a closed shop in Delaware. It was requested that Director Mahaney invite someone to present to the committee the barriers incurred when attempting to obtain a dentist license in Delaware.</p>	<p>Invite someone to address this issue to the next meeting.</p>	<p>Director Mahaney</p>
<p>Update on Medicaid Expenditure Date Rosanne Mahaney, Director, DMMA</p>	<p>Director Mahaney shared a handout (attach 2) on Medicaid Expenditures and presented an overview.</p> <p><i>Question: Have you had the opportunity to assess the impact of the DoJ Settlement agreement?</i> <i>Answer: We are working with the Division of Substance Abuse and Mental Health to try to maximize Medicaid reimbursement for the services they are mandated to provide so that we can pull down the federal match and reduce the cost to the state of that settlement.</i> <i>Question: Do these figures include DPC and can you break down the facility expenditures for DPC, Stockley, Mary Campbell Center, Exceptional Care for Children and separate out ER spending from hospital expenditures?</i> <i>Answer: Yes.</i></p>	<p>Provide new breakdowns to the next meeting.</p>	<p>Director Mahaney</p>

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<p>Health Homes <i>Glyne Williams</i> Health Homes (Cont'd) <i>Glyne Williams</i></p>	<p>Mr. Williams started by saying the Health Homes is an Affordable Care Act Option under Section 2703; which came into effect January of this year. It allows eligible populations to be moved into or be treated in a specific way in a doctor's office, clinic, etc. Eligible populations are defined as individuals having two chronic conditions or one chronic condition and at risk for another. Chronic conditions included are substance abuse, asthma, mental health, heart disease, obesity, and possibly HIV Aids.</p> <p>Service requirements include timely and high quality services, comprehensive care management, care coordination, health promotion and comprehensive transitional care with follow-up. Individual and family support fall into this realm. CMS provides states with a 90% match on the expenditures incurred in this program for eight quarters, however, there are strings attached. The types of teams included in this are medical specialists, pharmacists, dietitians, nurses, etc. Decisions are made by the health team concerning the care of each individual. Beverly Weigand is leading this initiative for DMMA. She has put together a work group and invites volunteers to join in the development of this program. Some further discussion about Health Homes ensued.</p>		
<p>Adjournment</p>	<p>Chairman Cherrin asked if there were any public comment. Being none, the meeting was adjourned at 11:00 a.m.</p> <p>Next meeting is Wednesday, October 19th at Easter Seals.</p>		

Respectfully submitted,

 Rebecca W. Gallagher, Recorder

 Date Approved

 Richard Cherrin, Chairman