



Council on Medical Assistance Program Oversight

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Co-Chairs: Sen. Toni Harp & Sen. Edith Prague

Meeting Summary
Friday February 10, 2012
9:30 AM in LOB Room 1E

Attendance:

Senator Toni Harp Co Chair, Rep. Toni Walker, Rep. Catherine Abercrombie, Rep. Michelle Cook, Rep. Vicki Nardello, Steve Mackinnon ACS, Carol Trapp ACS, Dr. Mark Schaefer DSS, Richard Spencer DSS, Robert Zavoski M.D. DSS, Tracy P. Wodatch, Margaret Morelli, Jennifer Hutchinson DMHAS, Sylvia Kelly CHNCT, Debra Gould, H. Andrew Selinger M.D., Jeffery Walter, Amy Gagliardi, Beth Cheney, APRN, Anne Foley OPM, Cliff O' Callahan M.D., Shelia Amdur, Debra Polun Commission on Aging, Ellen Andrews, Victoria Veltri OHA, Rev. Bonita Grubbs, Roderick L. Bremby Commissioner, DSS, Rep for Renee Coleman-Mitchell DPH, Debbie Poerio SBHC, Katherine Yacovone Southwest CHC, Inc, Mary Alice Lee CT Voices for Children, Christine Bianchi (Via Conference-Call)

The Council on Medical Assistance Program Oversight meeting convenes at 9:30 AM in LOB Room 1E

Department of Social Services



Microsoft PowerPoint
Presentation

DSS- Presentation on Modernization- ConneCT

Commissioner Bremby speaks about the importance of modernization and the beginning on incorporating ConneCT within DSS. Discussion of DSS Modernization Overview included Key Technology Infrastructure Initiatives:

- Main Client Service/ Employee Facing Systems

- Medicaid Management Information System
- Eligibility Management System (EMS) Replacement
- Reuse of Core EMS Components
 - Eligibility Module

The current challenge DSS is facing includes:

- 43% increase in average monthly Medicaid and SNAP cases over the last 5 years (500K)
- >35% reduction in eligibility staff workers over the last 10 years (+/- 300)
- 879,000 phone calls per month
- 3.7M pieces of paper per month

The challenges include Access, Timeliness, Accuracy, and Inefficiency. The ConneCT partnership is underway with DAS, DSS, Deloitte, and First Data. Their visions and objectives need to achieve better client access. There are concerns about the accuracy they need to perform. States importance of things they can do now to improve their customer service. Program will save costs while increase access and worker enhancements. There was discussion about current out of date phone systems. Most clients will have better access to services. The three components include web services, telephony, and document management and workflow. There was discussion of an enhanced client and worker experience. ConneCT will be delivered incrementally in three deployments. In Deployment 1 includes the reduction of call volume and improvement of customer service. In Deployment 2 there is modernization the DSS worker experience. In Deployment 3 there are opening electronic submission channels.

There is discussion about the timeline and the long awaited benefits the state will endure.

Council Discussion

- Concerns were raised about privacy.
- IVF needs to tell clients what they need to bring when they come to a meeting.
- Spanish will be an option.

DSS - Mercer MME Dual Presentation



Microsoft PowerPoint
Presentation

Dr. Mark Schaefer discusses the Complex Care MME Dual presentation. There was discussion on the share savings Medicare and Medicaid individuals. The Dual presentation will offer individuals who are part of the proposed demonstration to capitalize on the ASO organization. Across the various organizations 80,000 to 100, 000 million dollar investments to better serve all Medicaid recipients. Infrastructure serves to serve a better care experience for the Medicaid recipient. There was a Dual Models Review.

ASO/ Health Neighborhood

ASO Services and Supports Today

There was discussion about potential value-added ASO Demonstration Services for MME's.

- Value Added Services for Medicaid – Integrated Data Base, running advanced data analytics, Intensive Care Management to promote Medicare and Medicaid

coordination and integration across the health care continuum. Demonstration would want to like to provide care management for dual eligible's for eligible's.

- Other consultative services (Pharmacists, Disease educators, nutritionist (if CMS permits).
- Outreach and engagement services. At a longer term council wants accountability and resources to provide.

Shared Savings- CMS/ State

- There was discussion about the Global Shared Savings 50/50 Shared savings planned. 50/50 even shared savings. Looking for the exactly the same arrangement the state has now. Expect to get the exact same services for Medicaid client for the Dual eligible population.
- State would be rewarded for making investments for ASO services to service delivery reforms to improve care experience, better quality. The savings would accrue from the shared savings for the better quality of service.
- Comments made about the program are a pilot. This will save money for better service. In line for nursing homes and saving money. If the state is getting back money for shared savings, how will they money get back to shared providers. Question is raised how you would measure the performance of the providers.
- Question- Is there a plan to work with the legislature, if the savings that are captured for the Medicaid budget and not the general fund for the legislature.
- 80,000- 100,000 million dollar investment for the improvement of the dual eligible population. The default assignment will do to the same from Medicare as it does now.

- In order to be served in the ASO population you need to stay within.
 - Would recipients have a choice?
- How would we know how much savings will be accrued if it's on the Medicare side?
- They would use that rate on how much we ought to spend in a year. Virtual capitalized system where there is no risk or actually change in cash.
- Are the FCAC's involved on the lower end of the system?
- Pull together a health team and figure out a plan to address. FQHC, The ASO becomes a tool.
- The advantage using ASO will provide better care statewide immediately. Move those resources. Building infrastructure. Share results of the investment. Accountability should rest locally and opportunity to invest shared savings.
- Comments are made about the incentives to providers in relation to the success of the program. Keep focus on the pilot.

Demonstration Population

- There has been a preference to include a no-wrong door system. All Medicaid eligible's at the level of the ASO. How this might play out at the ASO level. Similar to other Medicare organization incentives like ACO, CPCI, D-SNP. All of the organizations are not limited to any populations. Cannot participate in the other organizations.
- Group discussed how they are looking at an op-out and other enrollment provisions for MME's for data sharing.
- Attribution concept approach would be the most 'seamless, rather than an enrollment approach.

Health Neighborhoods

Dr. Mark Schaefer describes the members of the team would include core participants: PCP, Physician specialists, hospitals, home health agencies, behavioral health providers, LTSS providers, nursing facilities. They would have integrated person-centered care plan development. Support provided by ASO for key functions such as data analytics and predictive modeling to identify high risk/high complexity individuals. They would have all the data to monitor the data over time via Health Information Exchange.

- How do you create those collaboration tools?
- HITE-CT will implement secure messaging between providers which will greatly improve the exchange of health information in the coordination of care while also improving the security and privacy of patient information
- Communication governed by strong patient privacy and patient data control policies. This will reduce duplication. HITE will be able to distribute teams and will be able to create the ability to create their own health record that don't have HITE or home health record. Other key participants will be able to use in the neighborhood.
- May invite David Gilbert if this is a concept we want to integrate to become a part of the over-all contribution.
- Comments are made about compatibility between current electronic systems providers have. Health Information Exchange will be the connector between the other electronic health systems. Built in the plan for the exchange will be automated.

- Questions rose about who would be in charge of the health neighborhood or health team. Health Neighborhood is a team of providers who agree to coordinate care. If they health neighborhood include specialists behavioral, or individuals in the waivers.
- CCC needs to think about the person's experience coming in. Coordination of care for all the people with the complex needs.
- There are comments about talking about dental care in this coordination of integration of care and integration of data. There needs to be a combination of the social aspect of the coordination of care such as housing. It's a person-centered support plan.

Health Neighborhoods

- Local Accountability for care experience, quality and outcomes and cost
- ASO would measure performance on a broad range.
- Global Shared Savings

Spoke about key questions to be spoken about Health Neighborhood. Spoke about timeline and application deadline.

Discussion:

- There was discussion about the amount Medicare and Medicaid pays for that is covered by the savings.
- Request for web link on the presentations.
- Conversation of who is participating with shared savings, including Access agency.

PCMH UPDATE

- There will be a possible PCMH update in March.

- Sixteen 16 PCMH Applications received.
 - 129 Practice sites
 - 367 PCMH Providers out of the 608 total practice providers.
- Clinic vs Practices
 - 9 FQHC
 - 7 independents practices
- NCQA Certification Level
 - 86 practice sites applied for the PCMH Level 3
 - 43 Practice Sites eligible to pursue Glide Path
- 4 Practice sites approved for PCMH services
 - 1300 members being served
- 125 Practices sites under review
 - approximately 140,000 members
- There was discussion about Medical ASO support, community practice transformation specialists.
 - Community Practice Transformation Specialists
 - Use of a range of practice improvement approaches and methods to build the internal capacity of a practice.

Discussion:

- Questions were raised about the timeline.
- Discussion about unexpected interruptions.
- The majority of the applications will be PCMH certified.
- How many members will be served by these sites?

Next Meeting Items Discussion

- Run on a report on what members being served.
- Request for report in March, supports for ASO and patient centered medical homes, NCQA wasn't built for this population.
- How these populations are being served.
- Request on report on glidepath process and MLIA waiver and concept waiver.
- The impact on the Low income MLIA.

Meeting ended at 11:30 AM

Next Meeting March 09, 2012