



Council on Medical Assistance Program Oversight

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www.cga.ct.gov/ph/medicaid

Sen. Toni Harp Sen. Terry Gerratana Summary for November 9, 2012 at 9:30 AM in LOB Room 1E

Attendance: Rep. Michelle Cook, Senator Terry Gerratana, Rep. Susan Johnson, Jeff Walter, Deb Migneault, Debra Gould, Mark Keenan, Jesse White-Frese, Vicki Veltri, Sheila B. Amdur, Alex Geertsma, Kathy Yacavone, Mary Alice Lee, Debbie Poerio, Rev. Bonita Grubbs, Carol Trapp, Steve Mackinnon, Amy Gagliardi, Renee-Coleman-Mitchell, Fredericka Wolman, Sylvia Kelly, Jennifer Hutchinson, Mag Morelli, Deb Hoyt, Dawn Lambert, Daniel Buckson, Rene-Coleman Mitchell, Kristin Dowty, Erica Garcia, Robert Zavoiski, Kate McEvoy

Rep. Michelle Cook began the meeting at 9:30 AM In LOB Room 1E.

There were introduction of the committee members.

Mary Alice Lee from CT Voices for Children presented on a study done on the *Loss of Coverage for Pregnant Women and New Mothers Husky B*. Mary Alice Lee stressed the importance of coverage continuity in Health Care.



Microsoft PowerPoint
97-2003 Presentation

Overview

- HUSKY eligibility during and after pregnancy. Notices and procedures for renewal. Findings based on analyses of HUSKY A enrollment data. Recommendations for HUSKY Program. Implications for coordinating coverage with Health Insurance Exchange beginning October 2013

Importance of Care Before and Between Pregnancies

- Health insurance is key to access to care
- Important interventions include:
 - Family planning counseling and care
 - Nutritional counseling and supplementation
 - Diagnosis and treatment of chronic conditions and infections
 - Oral health care
 - Treatment of substance abuse, smoking
 - Diagnosis and treatment of maternal depression

HUSKY Eligibility: Pregnancy

Pregnant women with family income <250% FPL (pregnant woman counts as 2)

OR

Pregnant parents of children in the HUSKY Program, with family income <185% FPL

OR

- **Pregnant adolescents** in the HUSKY Program, with family income <185% FPL

- **HUSKY Eligibility: New Mothers**

- **Family or child coverage**, with annual renewal (not tied to pregnancy)

OR

- **Pregnancy coverage** until 60 days postpartum, with transition to family or child coverage if:
 - Family income is less than 185% FPL
 - Mother provides information on non-custodial parent, if applicable
- **HUSKY Eligibility: Immigrant Women**
- **Legal permanent residents** in low income families are eligible for coverage during pregnancy, even if in the US less than 5 years
- **Undocumented immigrants** are not eligible during or after pregnancy (only for coverage of labor and delivery)
- In 2008-10 (study period), **adult parents** who were recent legal permanent residents were eligible for state-funded HUSKY coverage
- **End of Pregnancy Coverage**
- Hospital notifies DSS Central Office of baby's birth
- DSS Central Office notifies DSS case worker in the district office
- Case worker manually switches mother to postpartum coverage group, a process that triggers mailing of notices
- Coverage ends at 60 days postpartum
- **Reasons New Mothers May Lose Coverage After the Birth**
- Over-income?, Moved out of state? Obtained other coverage? Failed to complete renewal? Failed to meet child support requirements? Confused by notice(s) and renewal process?
- **Notice Sent to Women at End of Pregnancy Coverage**

“Your Medical assistance will be discontinued on [date]. We are taking action for the following reason(s):

YOU DIDN'T PROVE YOU ARE PREGNANT, OR HAVEN'T BEEN PREGNANT LONG ENOUGH, OR YOU FAILED TO VERIFY YOUR DUE DATE.
 Policy Reference: 2520.05, 8520.40, 8540.15.”

Source: Excerpt from notice obtained by Connecticut Voices from the Connecticut Department of Social Services.

- **Purpose of This Study** To describe coverage continuity for pregnant women and new mothers, To investigate the association between Medicaid coverage group and loss of coverage in the postpartum period
- **Methods** Identified mothers who gave birth in 2009 while in HUSKY A, based on linked birth-HUSKY A enrollment records, compiled enrollment data longitudinally for the nine months before and nine months after the birth (19-month period), Determined which women were enrolled for continuous periods before and after the births
- **Affect of Coverage Group?**
- Grouped mothers by coverage group at the time of the birth:
 - **Family coverage** (pregnant parents, adolescents)
 - **Child coverage** (pregnant adolescents)
 - **Pregnancy-related coverage**
- Checked for continuous enrollment in any coverage group in the 19-month period
- Adjusted for maternal age, race/ethnicity, primary language, education, residence
 - **Results: Coverage Before the Birth**
- **Results: Coverage After the Birth**
- **Results: Risk of Losing Coverage**-New mothers in pregnancy-related coverage groups were **five times** more likely than those in family groups to lose coverage

- On average, new mothers in pregnancy-related coverage groups had **1 to 2 fewer months** coverage than those in family or child groups
- **Results: Risk Varied by Where the Mother Lived**
- Mothers living in towns served by DSS offices in **Bridgeport, Danbury and Hartford** were at greater risk for losing coverage
- Availability of community-based application assistance or care management may also affect risk of losing coverage
- **Postpartum Coverage in Other States. Loss of Coverage Postpartum- See Chart.**
- **Conclusions- Some mothers are at risk for losing HUSKY coverage after giving birth**
- **Risk varies by Medicaid coverage group and where mothers live**
- **Recommendations for DSS-Revise notices and procedures** to simplify coverage transitions in the postpartum period. **Do not issue automatic discontinuances** without a review of eligibility in other coverage groups. **Ensure that mothers receive information** about Medicaid family planning limited benefits, Charter Oak, and health insurance exchange products if they are over-income for parent coverage
- **Recommendations for Community-Based Support-** Anticipate the need for coverage renewal after the birth. Encourage community-based social services, maternity care providers, and pediatricians to assist new mothers who are at risk for gaps or loss of coverage following pregnancy
- **Implications for Health Reform- Goal:** Creation of an integrated, coordinated eligibility management system that ensures seamless transitions between Medicaid, CHIP and health insurance exchange products. **Plan for transitions:** Personal and family circumstances will lead to coverage transitions for many Medicaid recipients, including new mothers.
- **Acknowledgements-** This work was conducted with state funding under a contract between the Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices for Children. Data management was performed by Amanda Learned of MAXIMUS, Inc. Data analysis was conducted by Sarah Esty of Connecticut Voices. Additional funding was provided by the Connecticut Health Foundation. This report does not express the views of the Department of Social Services or the State of Connecticut. The views and opinions expressed are those of the authors.
- **For more information:**
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Discussion MAPOC Discussion on Women's Health

- **Recommendations for DSS-Revise notices and procedures** to simplify coverage transitions in the postpartum period. **Do not issue automatic discontinuances** without a review of eligibility in other coverage groups. **Ensure that mothers receive information** about Medicaid family planning limited benefits, Charter Oak, and health insurance exchange products if they are over-income for parent coverage.
- **185-250%** how many of those above the poverty level will lose coverage. Important to know if women initiate a renewal process or initiates it and doesn't complete it.
- Other Treatments that mothers need to know Dental and Diabetes Care.
- **Recommendations for Community-Based Support-** Anticipate the need for coverage renewal after the birth. Encourage community-based social services, maternity care providers, and pediatricians to assist new mothers who are at risk for gaps or loss of coverage following pregnancy.
- Will reach out to Community Based organizations, American Academy of Pediatrics and FQHCs.
- The Chairs thanked Mary Alice for the presentation and opened it up to discussion.

- Vicki Veltri commented about by 2014 the state will be required having a process that is integrated. Comments: Pregnancy related benefit is critical and because in the private market there isn't maternity related coverage. We need to make sure people are not falling off of Medicaid that doesn't need to fall off. DSS should be assisting these and enrollment assistance, if there is other coverage groups available. There should be enrollment assistance. This is a very serious issue. Office of Health Care Advocate has dealt with these issues before. The level of assistance was not provided but just given the notice.
- Alex Geerstma commented about not covering the parent effects the utilization of services on behalf of the child. Lack of appropriate utilization of services. He asked Mary Alice- Where CT lies on the Kaiser Scale for the percentage for women automatically eligible.
- Mary Alice responded with the eligibility bars lies in close relation to Illinois. There was a referral to Slide 21 with the Loss of Coverage post- partum- The rate is 1.3 of women lost coverage in the post-partum visit. Our eligibility bars look similar to Illinois in comparison to pregnancy. CT will fall around 1/3 of women loss of coverage in the postpartum visit.
- Alex questioned if it is continuous data. Alex also commented about budget pressure placed on eligibility levels to put less people coverage. People are at a loss for health care and continuing eligibility is important. Alex Commented about how when DSS is pressed to decreased eligibility levels for fiscal pressures, it is important in consider when discussing continuity of coverage.
- Mary Alice discussed the changes o of coverage and eligibility in CT from 100%- 150%. Poverty level with the goal of covering parents and children in the state. It is important for the State of CT to maintain the coverage for entire families in very low income groups below 185% of poverty level.
- Katherine Yacavone commented the access service disconnect. Comments made about how WIC and Medicaid are delinked. There is a large portion in different programs that are already eligible. There needs to be enrollment people in both programs and connect the systems. There isn't an assigned person at the WIC sites for the eligibility workers, it is a great way to make sure mothers and children are covered under Medicaid.
- Rene-Coleman Mitchell commented about the DPH and Relation with DSS. They are working hard to getting a liaison between WIC and Medicaid Client. Working to get the one MOU to get that started about a year ago.
- Debra Gould asked about the immigrant status and Medicaid coverage. Commented about how to teach about medical opportunities available.
- Mary Alice Lee commented about how those undocumented will not be eligible for coverage. Comments made about rules about legal residents and coverage with children and adults. There needs to be notices developed very clear in the notices that they speak. There needs to be a robust community network in understanding what benefits they are eligible for.
- Jeff Walter commented about notices and if the notices are have regulations in the notices.
- Kate McEvoy recognized the importance of having continuation of coverage in the health needs. Everyone in the department is aware of the problems and need more information. One of the issues identified is the language in the notices. It is a challenge because there is a notice of action concerning about loss of benefits or changing of benefits. It is important to have language that is understood by the beneficiary. The task of changing the letters is difficult because of the changing systems. Addressing those who may lose coverage there needs to be a navigator process in relation to community based systems. They did recognize as important issue for those who do not have coverage.
- Rev. Bonita Grubbs discussed the notices and navigator references. It is important to be clear and user friendly language because it is critical to the access of coverage.
- Mary Alice Lee commented about how they weren't able to determine which form they are sent out to families. The short 4 Page form is sent to families with children with prefilled form. Some families are receiving the 8 page form. Would like to receive further information about the process.

DSS Presentation- Impacts of the Affordable Care Act in Connecticut

Kate McEvoy began introducing the initiatives DSS has taken to set the background of the Medicaid in the State. She considers the department and CT very fortunate to have the support for the importance of initiatives and anticipating many opportunities for health care reform and many obligations along with it. Where are we known and where are we going.



Microsoft PowerPoint
97-2003 Presentation

Presentation

- Medical Assistance Program Oversight Council
November 9, 2012
- **Connecticut Medicaid and Health Care Reform:**
 - **Where are we now?**
 - **Where are we going?**
- Where are we now?- A snapshot of the program, Transition to medical Administrative Services Organization (ASO), Projects related to primary preventative care, Projects related to integration of care, Rebalancing
- **A Snapshot of the Program: Participation**
- Overall, Medicaid currently serves over **575,000** beneficiaries (**20%** of the state population)
275,000 children (one out of every four kids in Connecticut and Medicaid covers one out of every four births)
 - **148,000** parents
 - **65,000** older adults and people with disabilities who are eligible for both Medicare and Medicaid- Dually Eligible
 - **45,000** older adults and people with disabilities who are eligible only for Medicaid
 - **83,827** low-income adults ages 19-64. This number went past initial projections.
 - Comments made about the adults 64 and older, some are still on Medicaid maybe because of immigration status.
- A Snapshot of the Program: Costs in Context
- Connecticut has: the **fourth highest level of health care expenditures** at \$8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska, the ninth highest level of Medicare costs at \$11,086 per enrollee, **the highest level of Medicaid costs at \$9,577 per enrollee**[Kaiser State Health Facts, 2009 data]
- A Snapshot of the Program: Costs in Context- Among populations in need, the cost profile for Connecticut individuals who are dually eligible for Medicare and Medicaid is of particular concern, with per capita costs exceeding the national average by 55%
- **A Snapshot of the Program: Reimbursement-** Based on 2008 data, Kaiser State Health Facts indicate that Connecticut's overall Medicaid-to-Medicare fee index in 2008 was 0.99. This is strongly influenced by favorable rates for obstetrics
 - Comments made about building the reimbursement rate in relation to the dually eligible population. Comments made about prenatal care and obstetric care and how there still is a disparity. Comments requested to clarification on the comparison.
 - The chart displays where we are on the reimbursement compared to Medicare rate. They are looking comparative across states in coverage categories, designed to be a snap shot and the aspect to this discussion. DSS is aware of other states that have higher rates.

- Vicki Veltri commented about how it is what Medicare pays and what Medicaid pays overall. It does not represent the utilization of service.
- Dr. Zavoski commented about the importance of having this chart in the presentation. Affordable Care Act will increase the rates up to Medicare rates so they will be equal nationally. It helps for context for later in the presentation.
- **Transition to Medical Administrative Services Organization (ASO)**
- Transition to Medical ASO: Member Services
- Centralization of member services with CHN-CT has enabled streamlined support with:
 - Referral to primary care physicians- Very successful rate of referring people to PCPS. It helps with connectivity with providers.
 - Referral to specialists- especially those who need to get to a specialist that has a wait time.
 - Assistance with prior authorization requirements and coverage questions
- Transition to Medical ASO: Provider Services
- Centralization of provider services with CHN-CT has improved support with:
 - Prior authorization requirements
 - Provider engagement was an important point and ease of access.
 - Coverage questions
 - Referrals- Provider care referrals.
- Transition to Medical ASO: Predictive Modeling/Intensive Care Management
 - All Medicaid beneficiaries have access to Intensive Care Management and provider a no-wrong-door approach. Emphasizes Care center-ness and prioritize what is important to that individual. Anticipating needs of all different individuals. Husky B and Charter Oak includes the coverage groups.
 - Predictive modeling tools and other referral means (e.g. self-report, provider referrals) enable CHN-CT to identify those beneficiaries most in need of care management support.
 - Through Intensive Care Management (ICM), CHN-CT nurse care managers use a specially developed care coordination tool to work with beneficiaries to set goals and address needs
- Transition to Medical ASO: Administrative
 - DSS' contract with CHN-CT includes a performance withhold that will be paid based on a range of measures related to health outcomes as well as beneficiary and provider satisfaction with CHN-CT
 - CHN-CT is at an advanced stage of preparing a series of reports that will illustrate performance.
 - Data is an important element of the transition and will report back ongoing.
 - DSS is in process of completing the rate "melds" that was required in transition from Medicaid MCOs.
 - DSS is at advanced stage of melding those transition rates.
 - Sylvia Kelly commented about how they are working as a team to meet requirements as a team. The transitioning the number of members into one and thanked the staff. There was no gap in care plan in the time frame. Members were able to have no gap and providers were able to keep in the network.
- **Projects Related to Primary Preventative Care**
 - The themes to tie into the health care initiatives.
 - Person-centered medical home (PCMH)
 - Electronic Health Records (EHR)
 - Rewards to Quit
 - Health Disparities Grant- Disparities related to Race and Ethnicity.
- Projects Related to Primary Preventative Care
 - Why are we focusing here?

- Adults do not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 receiving recommended care. [Commonwealth Fund, 2009]
- Indicators we want to improve upon.
- **Projects Related to Primary Preventative Care**
 - A report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009]
 - **After Hours Care.** Access to care is still an issue still between work hours. How we work to reduce barriers to access is important.
- **Person Centered Medical Home (PCMH) Defined**
- Dr. Robert Zavoski discussed the definition of PCMH. Patient is taken out of the definition and level the playing field with person. DSS is moving forward to make sure members have access to PCMH in the coming years.
 - *A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care. NCQA*
- **DSS PCMH Initiative: Overview-** implemented January 1, 2012, an investment of financial and technical resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA)
- **Team going into the practices getting them into the PCMH. CHN are very experiences and also using financial incentives.**
- **DSS PCMH Initiative: Financial Model-** financial assistance to NCQA-recognized practices includes advance payments, enhanced fee-for-service payments and retrospective payments for meeting benchmarks on quality measures
- **DSS PCMH Initiative: Key Features-** key features of transformation include helping practices to:
 - enhance their medical care coordination functions
 - Increase capacity for non-face-to-face and after hours support for patients
 - work towards meaningful use of interoperable electronic health records
- Erica Garcia commented about the efforts of CHN. The work has been collective. She reviewed the PCMH Statuses.
 - DSS PCMH Initiative: Participation
 - Approved PCMH Practices = 14
 - Total # of PCMH Sites = 109
 - Total # of PCMH Providers = 411
 - According to past claim history, these 109 PCMH sites served over 100,000 Medicaid members.
- **DSS PCMH Initiative: Practice Types-** See Chart. Glide path 28 in process or in review with 392 providers. These providers are moving towards NCQA recognition.
 - DSS PCMH Initiative: First Steps Toward Multi-Payer Approach
 - PCMH is a meaningful example of efforts in support of a multi-payer approach
 - DSS PCMH uses the same core measures of success and similar payment strategies to those being used by the Office of the State Comptroller State Employee Health Plan PCMH

- This helps providers engage with private payers. This helps them get them to PCMH standards that helps them with Private Payers.
- Commissioner Bremby and Dr. Schaefer deserve credit for being instrumental for going to these approaches.
- **Electronic Health Record (EHR)**
 - another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR
 - DSS is also collaborating with UConn Health Center to administer the Medicaid EHR Incentive Program and to improve outreach and education to providers
 - Collaboration with UConn Health Center. Exciting capability practice.
 - incentive payments disbursed to date (September, 2011 to October, 2012):
 - \$17,056,679 to 780 eligible professionals
 - “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, dentists
 - \$15,780,928.04 to 22 eligible hospitals
- **Rewards to Quit (R2Q)**
 - five-year federal grant of up to \$10 million
 - tobacco cessation program
 - Partnership with DPH and build upon Quit-Line Efforts. This will be included with FQHC practices. DMHAS will a partner in the effort as well.
 - smokers and their providers will engage in counseling and training sessions, peer coaching and other smoking-cessation techniques
 - participants will receive financial incentives for achieving various milestones toward quitting
 - Exciting to test that type of intervention with the resources available.
 - Comments made about how the Quit Line is fully staffed.
- **Health Disparities**
 - Through generous funding from the Connecticut Health Foundation, DSS and its partner CHN-CT have the opportunity to examine access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries.
 - Pat Baker has been a leader with these issues and work towards learning tools.
 - This project is focusing on identifying disparities and equipping primary care practices with tools and strategies to reduce these barriers
 - Dr. Zavoski, Erica Garcia and Steven Colangio.
 - DSS is also continuing to partner with the Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations through the development of policy and programming designed to eliminate disparities
 - Comments made about the OMH efforts with data and information.
 - Develop a tool kit that is tailored to address disparities among those measures.

Comments and Discussion

- Sheila commented about discussing the reimbursement issue of how to expand health staff. The issue needs to be addressed.
- Alex commented about how importance about the infrastructure of the Affordable Care Act.
- Katherine Yacavone commented about having a streamline process for providers that have multiple sites.
- Jeff Walter questioned about the Glidepath. PCMH Practices, and how many will be served.
- Amy Gagliardi questioned how the Quit-Line will be prepared for all the expected calls.
- DPH is working out the agreement to additional population for those calls. They are working this out with DSS at this time.

- DSS allows Medicaid program to fund the quit line.
- Katherine Yacavone questioned if the relationship between the programs and DMHAS. One of the difficulties of the practice path, it is done by site. One of the suggestions is to look at different potential paths for accreditation.
- DMHAS needs to come back with an answer.

Comparison of Health Neighborhoods and Health Home Models

- New local multi-disciplinary of care. 5,000 dually eligible individuals. Model at PMPM and a range of supplemental services to implement smaller focused hubs. Under the health home option. Pay a PMPM for Care Coordination and range of supplemental services. Slide 44.
- Rebalancing- Money Follows the Person- How does the Affordable Care Act initiatives, doing it as well as possible.
- Dawn Lambert discussed how the Affordable Care Act initiatives connect to one another and how to connect them well.
 - Access to healthcare and Person Centered theme. Make people to be autonomous and then cause people to be dependent upon the health care system.
 - MFP- Money Follows the Person in coordination with DPH, DDS, Office of Policy and Management ,
- Other Initiatives- MFP, Nursing Home transformation/ workforce, My Place Campaigns, State Balancing Incentive Payments Program
- Why are we focused here?
 - 7%- children - 18-64 and elders. - 61% of Medicaid budget- 2.863 billion.
- Mercer projects by 2025 will double long term support services. Go from 40,000 to 88,000 users.
- This has an impact of provider rates and access in the providers in the community.
- **The Solution: 3 times as many people for a Medicaid dollar instead of long term care in the community.** People want that option. If they don't have access to medical care in the community that they do in institutional setting. Need to know where the medical providers
- Utilization is doubling- partnerships do get F-MAP back to the state, access barriers and transitions.
- All issues are important for all populations who are long term support and service users.
- Demonstration services- for those who move out of institutions. Track those people for a year acute care side and look at ER Usage.
 - Followed the strategic plan- 2025 what the demand is on the town level. What the impact projected to be in counties and workforce demand projection. In institutional demand and community based. They do have the projections for the workforce demand.
- In December they will be grants in nursing facilities for less demand for institutional care. They want to partner with the.
- My place campaign is about workforce development what will kick off in March. They will have access to information.
- State Balancing Incentive Payments (Under the Affordable Care Act) they have to have a common comprehensive assessment and conflict free case management. Hoping it is going to be integrated. ConneCT will be connected in a single entry point. Submitted proposal 31 September- 72 Million Dollars and a comprehensive assessment.

Questions and Discussion:

- Alex commented on how it is a mighty endeavor with different areas of expertise. Proposing individual meetings with people in each area. Comments made about continuing long-term care. These are component parts and not sure how they are EMR to put the parts together.

- Rep. Johnson thanked DSS for the presentation. She question about making transition from nursing facility to staying in the home, what types of transitional supports. Have adult day care? In order to have a true transition skilled nursing to assisted living or having some support.
- Dawn Lambert discussed how the Demonstration study gaps in the system and make recommendations in the system. Transitional gaps. She discussed Adult Family Home. She discussed modifying the home to providing assisted technology and increase independence for the person. DSS has People to find housing-that is accessible. Services include: apartment set up, substance abuse and alcohol and behavioral health issues. Some are eligible for some waivers. Some of the different things they are going to look at next year.
- Jeff Walter questioned if the Medicaid services are available for long term care transition into the community.
- Dawn Lambert commented about the member needs to be on Medicaid and Medicaid needs to pay the last day. She commented about the capacity issues, pver 450 people waiting for referral. There are more and people asking to transition to the community. There is a need to address those gaps. There is a need to improve and be more than 5 billion dollars.
- Rep. Cook thanked the department for the presentation. Rep Cook. Asked the department to review the rest of the presentation on hold for next meeting.
- Vicki Veltri asked if the presentation can be reviewed completely at the next meeting.
- Jeff Walter requested if everyone can look at the slides in review and then DSS review the presentation for next meeting. He suggests there is more dialogue.
- Mary Alice Lee suggested we hear about the Health Insurance Exchange information.
- Kate McEvoy commented about how Office Health Care Advocate will be working together on presenting. She commented about access, community access, examining the scope, the means which we provide service, the means enabling participating, and meaningfully payment strategies, and evaluation of results. Will welcome to engage next month in this discussion.
- Mag Morelli commented about how it is helpful to see the slides.
- Debra Gould requests an update for the computer system.
- Kate McEvoy can give an update when there are changes on the timeline.
- Rep. Cook stressed the important to go over the information and make sure the services are there for the people that need it the most.

Rep. Cook closes the meeting at 12:00 PM.

DSS will review and finish the presentation again at the December MAPOC meeting. Committee members are asked to review slides prior to the meeting to encourage discussion.

Next Meeting will be held on December 14, 2012 at 9:30 AM in LOB Room 1E