

The Department of Social Services wishes to respond to specific Legislative Program Review and Investigations Committee findings and recommendations included in the report entitled *Hospital Emergency Department Use and its Impact on the State Medicaid Budget*. The report offers 13 specific recommendations, paraphrased below, with evidence supporting each recommendation. After an overview of the Department's approach to Medicaid services, our responses will follow the order and format of the Committee report.

Overview

We believe that the seminal finding of the report is that:

Although the committee concluded that ED visits by Medicaid clients are not a major cost driver of the overall Medicaid budget, especially on a per-visit basis, the committee believes that strategies need to be developed to educate clients in myriad ways to reduce high rates of utilization. If clients were able to access community health care for preventative care, health outcomes would be improved and clients will not cycle in and out of the ED.

The Department of Social Services Division of Health Services is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. These include 1) use of an Administrative Services Organization (ASO) platform for Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services; 2) activities in support of improving access to preventative primary care; 3) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS); and 4) initiatives designed to "re-balance" spending on LTSS.

We concur with the Committee's conclusion that ED costs are not a major cost driver in the Medicaid budget, however as will be demonstrated below, the Department and its business partners are deploying a large variety of interventions and programs both to address overall ED utilization, by educating beneficiaries in the best use of their health services coverage including the ED, and most important, the truly significant cost drivers throughout our programs.

Administrative Services Organization (ASO) Platform

Recognizing opportunities to achieve better health outcomes and streamline administrative costs, Connecticut historically contracted with ASOs to manage its Medicaid behavioral health and dental services. On January 1, 2012, Connecticut expanded this effort by transitioning Medicaid medical services from a managed care infrastructure, that included three capitated health plans and a small Primary Care Case Management (PCCM) pilot, to a medical ASO. This extended state-of-the-art managed care services to the entire Medicaid and CHIP population. The medical and behavioral health (BH) ASOs (respectively, CHN-CT and Value Options) provide a broad range of services, including: member support, Intensive Care Management

(ICM), predictive modeling based on Medicaid data, statewide and provider specific performance measurement and profiling, utilization management, and member grievances and appeals. CHN-CT and Value Options coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a behavioral health unit staffed by credentialed individuals that is co-located with the medical ASO. The dental ASO (Benecare) has been an instrumental partner to the Department in providing a broad range of services, including member support, care coordination, dental care management, increasing provider participation, network management and improving access to care. Finally, effective in February 2013, Connecticut transitioned its Medicaid Non-Emergency Transportation (NEMT) services to a single ASO (Logisticare).

In support of its ICM activity, CHN-CT fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs (e.g. food and housing security), culturally attuned conversation scripts as well as chronic disease management scripts. Additionally, CHN-CT now has in place geographically grouped teams of nurse care managers. As noted above, an important feature of ICM is coordination with a co-located unit of Value Options (the behavioral health ASO). Care managers from CHNCT, DSS and Value Options meet twice weekly to review hospitalizations and planned admissions to identify the appropriate care manager to take responsibility for the member's care. In cases where neither the physical or behavioral diagnosis is primary, both the CHN and the Value Options care manager remain involved. At any given time, approximately 500 members are receiving ICM because they are diagnosed with a Serious and Persistent Mental Illness (SPMI) in addition to a physical diagnosis.

Access to Primary, Preventative Medical Care

Connecticut 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] Further, 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] The key elements of this approach are:

- **Person-Centered Medical Homes (PCMH).** The Department implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance

(NCQA). Practices on the “glide path” toward recognition receive technical assistance from CHN-CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures; practices on the glide path receive prorated enhanced fee for service payments based upon their progress on the glide path but are not eligible for quality payments at this time. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- **Electronic Health Records (EHR).** Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR support more person-centered care and reduce duplication of effort across providers. DSS is collaborating with UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September 2011 to January 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals. “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists.
- **Health Equity.** DSS and its partner CHN-CT are currently examining access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries. This project is focused on identifying disparities and equipping primary care practices with a toolkit outlining strategies to reduce these barriers. 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.

Integration of Medical and Behavioral Health Care

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have complex health profiles. A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient’s medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions. The key elements of this approach are:

- **Demonstration to Integrate Care for Medicare-Medicaid Enrollees.** Connecticut has submitted an application for implementation funding under

the federal Demonstration to Integrate Care for Dually Eligible Individuals. This is a managed fee-for-service model. The Connecticut proposal seeks to integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote practice transformation, and create pathways for information sharing through key strategies including: 1) data integration and state of the art information technology and analytics; 2) Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease; 3) expanded access for Medicare and Medicaid Eligibles (MMEs) to Person Centered Medical Home (PCMH) primary care; and 4) a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value. The MME initiative will create new, multi-disciplinary provider arrangements called “Health Neighborhoods” through which providers will be linked through care coordination contracts and electronic means.

- **Health Homes for Individuals with SPMI.** Further, this unit is working with the Department of Mental Health and Addiction Services to implement health homes for individuals who are diagnosed with an identified Serious and Persistent Mental Illness (SPMI), have high expenditures, and are served by a Local Mental Health Authority (LMHA). As conceptualized, this model is anticipated to make PMPM payments to LMHAs that will permit them to incorporate APRNs within their existing models of behavioral health support.
- **Behavioral Health Screening for Children.** Finally, DHS is currently modeling a proposal to providing an annual behavioral health screen for children ages 1 through 17 years, as part of an EPSDT evaluation.

Rebalancing of Long-Term Services & Supports

Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut’s Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In 2011 54% of long-term care clients received care in the community, but only 40% of spending supported home and community-based care. Further, only 7% of the Medicaid population receives long-term services and supports (LTSS) but 61% (\$2.863 billion) of the SFY’12 Medicaid expenditures (\$4.714 billion) were made on the behalf of these beneficiaries. Key elements of this approach are:

- **Strategic Plan to Rebalance Long-Term Services and Supports.** In January 2013, the Governor, the Office of Policy and Management and the Commissioner of the Department of Social Services released an updated copy of the State’s Strategic Plan to Rebalance Long-Term Services and Supports. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive long-

term services and supports (LTSS). Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Payments Program (BIPP) activities; 3) nursing home diversification; and 4) launch of a new web-based hub called “My Place”. The strategic plan identifies ‘hot spots’ for development of services, including medical services, since it projects demand attributed to the aging population at a town level.

- **Money Follows the Person.** The Money Follows the Person (MFP) initiative has led efforts toward systems change in long-term services and supports. In addition to its work in having transitioned over 1,700 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and substance abuse intervention, peer support, informal care giver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions. An additional key aspect of the demonstration is the development of improved LTSS quality management systems. In 2012, the Governor publicly committed to a significant expansion in the target for individuals transitioned, to a total of 5,000 individuals.
- **State Balancing Incentive Payments Program.** Further, MFP also led efforts to submit an application to CMS under the State Balancing Incentive Payments Program (BIPP). Connecticut received confirmation in Fall, 2012 of a \$72.8M award. Key aspects of the award include:
 - The development of a pre-screen and a common comprehensive assessment for all persons entering the LTSS system, regardless of entry point. It is anticipated that medical offices, various State agencies administering waivers, and the ASOs will all utilize the same tool so that the people served by the State’s systems won’t be continually asked the same question unless there is a status change. The anticipated result is a more efficient system where information is shared and unnecessary duplication is eliminated.
 - The development of conflict free case management across the system.
 - The development of a ‘no-wrong door’ system for access to LTSS. Phase one of the State’s ‘no wrong door’ launched on June 27, 2013. The web based platform was branded “My Place CT” and aims to coordinate seamlessly with both ConneCT and the health insurance

exchange over the next two years. Additional information about My Place CT is detailed below.

- The development of new LTSS aimed to:
 - address gaps that prevent people from moving to or remaining in the community;
 - streamline the existing LTSS delivery system; and
 - build sufficient supply of services to address the projected demand.

- **Nursing Home Diversification.** Another important feature of rebalancing is use of a Request for Proposal (RFP) process and an associated \$40 million in grant and bond funds through SFY 2015 to seek proposals from nursing facilities that are interested in diversifying their scope to include home and community-based services. Undergirding this effort is town-level projections of need for LTSS and associated workforce, and a requirement that applicant nursing facilities work collaboratively with the town in which they are located to tailor services to local need.

- **My Place.** Finally, the plan emphasizes the need to enable consumers, caregivers and providers to access timely and accurate information with which to make decisions, means of connecting with services (both health-related and social services), and a clearinghouse through which formal and informal caregivers can find opportunities to provide assistance. In support of this, the state launched the “My Place” web site (<http://www.myplacect.org/>) in late June, 2013. Initially the site will start by focusing on workforce development - helping people who are entering or re-entering the workforce to understand what types of caregiving jobs are available, to list positions and to provide contacts. At later stages it will grow and evolve, and will encompass a partnership with Infoline 2-1-1. This effort will be promoted by an extensive campaign of billboards and radio ads. My Place CT envisions kiosks at various community entry points include medical offices, libraries, pharmacies, etc. providing access to people at community locations that they already visit frequently. My Place CT will be supported by community access points where people will not only have access to web based pre-screens and information but also one to one assistance. It is anticipated that RFPs for this service will be announced by the Department within the next 6 months. In the final phase of My Place CT, the web based system will support electronic referrals to both formal LTSS and to local community services and supports. It is anticipated that this support will be especially helpful to hospital discharge planners and others seeking streamlined, automated coordination assistance.

Committee recommendations and specific Department responses:

- 1. The Department should develop brochures, to be made available to clients at federally qualified health centers and primary care offices, about alternatives available to the emergency department if a client does not need immediate attention.**

The Department's medical, behavioral health and dental administrative service organizations (ASOs) have such brochures for HUSKY members that include steps members can take to seek alternative services for non-life threatening medical conditions. For example, the medical ASO developed written brochures and collateral to let members know that they have options for less serious ailments other than an ED. The materials developed include:

- Urgent Care Brochure (attached in English and Spanish)

The distribution strategy is as follows:

- Direct mailing monthly to all members with three or more visit to an Emergency Room within a 6 month period of time - March 2014.
- Posting on husky health member website - March 2014.
- Hand delivery to members by ICM team during Face to Face visits – March 2014



NHBTriFold-V6-ENGLISH.pdf

- Nurse Helpline Postcard and Magnet



Nurse-Postcard-V16.pdf



Nurse-Postcard-Magnet-V16.pdf

The distribution strategy is as follows:

- Direct mailing monthly in the Welcome Packet to all new members (postcard and magnet are in English/Spanish)-Began February 2014.
- Direct mailing monthly to all members with three or more visit to an Emergency Room within a 6 month period of time – Beginning March 2014.
- Direct mailing by ICM staff to all postpartum members enrolled in the ICM program – Beginning March 2014.
- Posting on husky health member website – Completed
- Hand delivery to members by ICM team during Face to Face visits – Beginning March 2014

- Nurse Helpline Posters



Nurse-Poster-V3-EN
GLISH.pdf

(Attached in English and Spanish)

The distribution strategy is as follows:

- Hand delivery to PCMH, GP, FQHC and large practices as part of the onsite visit by the Regional Network Managers, Community Practice Transformation Specialist and the Provider Relation staff – Began February 2014

Unfortunately, this intervention, used previously in Connecticut and currently across the nation by many Medicaid managed care organizations, has limited impact on ED usage because there are multiple reasons why Medicaid recipients use EDs. Some, listed in the report, include:

- a lack of accessible urgent care facilities that accept Medicaid;
- a limited number of PCPs in general, especially those who accept Medicaid patients and who offer extended hours/weekend hours,
- the greater prevalence of behavioral health and substance abuse conditions among Medicaid recipients,
- a growing use of EDs by those seeking narcotics, and
- incidents of public inebriation, with the inebriated person brought to the ED via ambulance.

Notably, lack of access to primary care, after-hours access and growing misuse of prescription narcotics are not unique to Medicaid but increasingly challenge those covered by all commercial and public health plans. This helps explain the high rate of ED use among the entire population.

Research demonstrates that the main reason Medicaid recipients access EDs for care more frequently than the commercially insured, is that they suffer with more chronic illnesses and disabilities than the general population, and therefore *should* use emergency services more often. Additionally, Medicaid recipients' social circumstances further limit their ability to viably access services in the community. In particular, Medicaid recipients more often work in low paying jobs where time off for a medical appointment might result in the loss of that job.

The major challenge in diverting Medicaid recipients away from EDs is that it is difficult and cost prohibitive to duplicate the benefits EDs offer over other sources of care. EDs are the Walmart of health care; they provide one stop shopping without an appointment and are open when you need them. There is no need for a second or a third appointment for laboratory tests or imaging; everything is ready when you

need it. The Department and its ASOs assist Medicaid members to find viable alternatives to ED use, including but not limited to the PCMH program (which requires after-hours access), ICM, ongoing collaborative rounds that provide care coordination services for high risk users, and a growing number of out-stationed ASO staff in hospital settings.

One specific and timely intervention to improve access to primary care services should be highlighted, that is the ACA mandated increase in primary care rates to 100% of the Medicare fee. This increase in rates is federally supported for two years, ending December 31, 2014. In recognition of the important impact on access to care evidenced by this rate increase, Governor Malloy's budget address proposed extending the increase for the remainder of the biennium. We heartily endorse this investment.

Finally, the report suggests that because the Committee staff specifically asked the Department and its ASO to report on frequent users, we are unaware of the problem. This is a population for which the Department and the ASOs specifically target for collaborative ICM services.

2. The Department shall require its medical ASO to analyze and report on Medicaid clients' use of the emergency department on an annual basis, the report shall be provided to the Council on Medical Assistance Oversight.

The Department does utilize such reporting and is currently working on such a report, with minor differences, with the behavioral health ASO. In addition, DSS uses the annual medical ASO incentive payments to induce creative programming to further address inappropriate use of the ED, in particular development of a comprehensive pain management program that will include efforts targeting drug seeking visits to EDs.

3. The Department of Social Services shall require the administrative services organizations to conduct the mystery shopper survey of primary care providers and specialists, including whether the providers are accepting new patients, and wait times for appointments for new and existing clients to measure ease of access, as required in the administrative service organization contracts.

DSS currently is using the mystery shopper methodology to verify access to mental health outpatient services as well as for surveys of a variety of indicators of access to health and quality of care. In addition, the medical ASO is currently developing the annual mystery shopper survey with DSS to be conducted in Q3 2014.

4. Once a person is determined eligible for Medicaid and the ASO is notified of the eligibility, the ASO should contact the member to provide information

about primary care providers in their geographic area accepting Medicaid clients. Further, the ASO should inform the client of the advantages of the PCMH – like extended hours, urgent care, and same-day appointments – and offer to work with the client to make that primary care connection.

Contacting newly eligible members and educating them about their new benefits is the medical ASO's routine practice. This includes informing members of the availability and benefits of after-hours and urgent care when needed through their PCMH. The ASO facilitates continuing care for new members with their PCP if they already have a CMAP enrolled PCP, and assisting them in contacting a PCMH if they don't already have one.

The text of the report makes some incorrect assertions about the attribution methodology that should be clarified. First, the report suggests that the rate of attribution is low overall, especially for adults, due to poor access to primary care services. Attribution is a retrospective review of provider claims to identify a member's choice of a primary care provider (PCP). Once the PCP is identified, member's clinical and claims data is then made available to that PCP to better provide the member's care. Many members have other insurance coverage which pays PCP claims, or are institutionalized in nursing homes, group homes, etc. and therefore Medicaid does not receive claims to use to attribute the member. Others receive services only from specialists caring for a severe chronic illness, such as cancer; others choose not to seek primary care. For all of these reasons, member attribution will never reach 100%.

The report also highlights a decline in the attribution rate between the second and third quarters of 2013. This decrease was due to a one time adjustment of the attribution methodology after we discovered a small likelihood that confidential health information might be attributed to the incorrect clinician using the original methodology. Furthermore, compared to other states' medical home programs, that we attribute 67% of our recipients is an accomplishment of which we are very proud.

In addition, the report states that "Under the ACA, PCMHs receive enhanced payments..." Enhanced payments are made to PCMHs under policy adopted by the Department.

5. Once a Medicaid client has been attributed to a primary care provider, that provider's name and contact information should be printed on the Connect (Medicaid) card issued (or reissued at redetermination) to the client.

One of the reasons that the Department adopted attribution under the ASO model is that it recognizes patterns of access to care used by recipients. It is a retrospective assignment of recipient health information to clinicians who the recipient has chosen by seeking their care, which then enables that clinician to best provide that care. In other words, the recipient "votes with their feet" and their clinical data

follows them. Assignment, the old managed care methodology that used member cards, hoped that recipient's feet would take them where the plan assigned them, unfortunately more often than not they didn't.

ID cards are issued by the medical ASO within 15 days of enrollment; however, the member's primary care provider (PCP) information is specifically not included on the card. Were this information on the card, multiple cards would need to be issued to the member as they change PCPs at considerable expense yielding minimal benefit. Furthermore, including a primary care provider's name on the card is often a barrier to care because many other providers refuse to see members not assigned to them for fear of not being paid. Although the Department has never limited payments this way, many commercial plans do so this fear still persists.

6. Statutorily adopt a 12-month continuous eligibility provision for children during the 2014 legislative session. Further, DSS shall immediately seek an amendment to its 1115 waiver from the Centers for Medicare and Medicaid Services to implement 12-month continuous eligibility for all adult Medicaid recipients.

The Department is assessing the fiscal impact of continuous eligibility, however, Connecticut does not have an 1115 waiver and we are unaware of any effort to seek one. Furthermore, the Department sought to amend coverage for the Low Income Adult (LIA) coverage group through an 1115, but the waiver was denied by CMS.

7. By January 1, 2015 DSS engage in a demonstration project as authorized in P.A. 12-109 and that at least one demonstration project reimburse for specialist services delivered by a telemedicine or telehealth model.

The Department and the University of Connecticut Health Center established a partnership in late 2013 to collectively conduct research and program review benefitting the Medicaid Program. The partnership's first project is an evaluation of the impact, cost-effectiveness, and most importantly, patient safety of the pilot program mentioned in the report, as well as a review of other such programs nationwide. The Department hopes to broaden the scope and reach of the telehealth pilot in the first half of 2014.

8. The Department monitors its administrative services organizations' reporting requirements to ensure all contractually obligated reports, including the Emergency Department Provider Analysis Report by ValueOptions, are issued as required.

It remains the Department's intent to continue to closely monitor all reports.

9. The Department of Mental Health and Addiction Services, in conjunction with DSS financial staff and the Office of Policy and Management, ensure that

expenditures for all intensive case management services eligible for Medicaid reimbursement be submitted to the Centers for Medicare and Medicaid Services.

We believe that all eligible expenditures are duly submitted for federal financial participation; however DSS will again confer with DMHAS about this matter.

10. DSS and DMHAS should contractually require that the intensive case management teams of CHN-CT, ValueOptions and ABH: identify hospital EDs for the program based on the number of frequent users; and engage ED staff of the relevant hospitals in helping to identify Medicaid clients who would benefit from this community care intensive case management.

DSS and DMHAS should contractually require that at least one staff member from the regional intensive case management teams be co- located at hospital EDs participating in the program, at hours when frequent users visit the most and when ED use is highest.

11. These ICM staff should:

- **work with ED doctors to develop a care management plan (and accompanying release of information) for clients who agree to participate;**
- **be knowledgeable about the community services and providers in the area;**
- **serve as liaisons between the hospital ED staff and the community providers identified in the client's care plan; and**
- **meet weekly with providers to monitor clients' progress.**

DSS and the medical and behavioral ASOs conduct Hospital Watchlist- case rounds meeting twice weekly. The rounds include clinical staff of all sorts from all three organizations to identify members with multiple physical and behavioral health conditions. One group specifically targeted is those members who show a high pattern of visits to the ED related to alcohol and substance abuse conditions. Members may be seeking narcotics; which makes it challenging to manage their care. They demonstrate an elusive pattern of behavior and create barriers to providing continuity of care; hence all Intensive Care Management teams (CHNCT, CTBHP and ABH) are working collectively to address each identified member's situation and need for support.

Medical ASO ICM Care Managers also participate weekly on-site at specific hospitals willing to accept them (Waterbury and Midstate) to address inappropriate ED use. We hope to establish ongoing participation at Middlesex Hospital as well and have participated onsite at Yale, St. Francis and Bridgeport in roundtable meetings identifying actionable steps to address the frequent ED user. ICM also established a direct referral process for providers and hospital social work staff to reach ICM for

not only discussion and referral of high ED users; but also for members with frequent readmissions.

While ICM does not presently have the resources to assign a regional Care Manager to be positioned onsite at each hospital to address inappropriate member utilization of the ED, we have established a process of flagging and referring members immediately to ICM. ICM when appropriate has made real time onsite visits to requested sites. Please note hospitals would need to be required to accept these resources.

DSS, with DMHAS and the behavioral ASO, is also enhancing existing protocols for frequent ED users. DSS, DMHAS, and ValueOptions will be identifying the top five EDs based on utilization and re-admission and will deploy a ValueOptions ICM staff to those EDs to impact unnecessary use of the ED and re-admission. Similarly, the medical ASO is endeavoring to co-locate workers on a more limited basis in high volume institutions. This effort would be facilitated by more active cooperation from many of the state's acute care hospitals.

Regrettably, there is an intervention not identified by the Committee's report that should be discussed. The report notes high incidence of ED visits by individuals covered by HUSKY C but says nothing more. A major cost driver among this coverage group is inappropriate ED use by nursing home residents. We request that the Committee amend its report to urge both the nursing home associations, and the hospital association, to partner with the ASOs on ICM and care transitions.

12. Emergency department physicians, should, as a first step follow ACEP guidelines, which includes checking the state's prescription drug monitoring program, prior to prescribing controlled prescription drugs to a patient in the ED.

The Department agrees, however, the Prescription Drug Monitoring Program is overseen by the Department of Consumer Protection/Drug Control and access to that system must be requested and obtained through DCP.

13. The CMS strategies bulletin should be circulated among the Program Integrity and Pharmacy Management staff of the Department of Social Services. In addition, the Office of Quality Assurance shall identify Medicaid clients who are outliers in the state's Prescription Drug Monitoring Program and refer these clients to the review team to determine whether these clients should be placed on the Medicaid prescription restriction program.

We appreciate the Committee's recommendation for drug treatment. DSS' Office of Quality Assurance is the only unit within DSS that is allowed access to the Prescription Drug Monitoring Program. Currently, the Office of Quality Assurance does alert staff within the Division of Health Services/Pharmacy Program of

potential outliers and individuals who should be considered for the pharmacy lock-in program. The pharmacy lock-in program is a functionality of the Retrospective Drug Utilization Review Program which is a requirement of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires state Medicaid programs to conduct a comprehensive drug utilization review program based on outcomes identified through the review of Medicaid paid claims data. The RetroDUR program collects and analyzes claims data against predetermined criteria to identify and correct aberrant prescribing practices, client misuse, and provider fraud. The RetroDUR program also has functionality to identify potential pharmacy restriction candidates and to specify a pharmacy and/or physician provider to assist in correcting client abuse or misuse.

Concurrent with RetroDUR and using the resulting data, the Department's DUR contractor also conducts a pharmacy restriction program. Through RetroDUR, the contractor identifies certain clients who demonstrate the potential to abuse or misuse of prescription drugs. These clients are offered the opportunity to change their behavior and demonstrate appropriate use of prescription drugs. If the clients continue inappropriate behavior, they are restricted to the use of a single pharmacy for a one-year period.

Statistical Errors

Lastly, per your request, the Department of Social Services wishes to respond to a few factual errors that we have found in the report:-

1. The Executive Summary Page 1, Paragraph 5 stated that "In comparison with overall ED use, the number of Medicaid visits to the ED has increased from 519,312 in 2010 to 589,260 in 2012."

Correction from DSS: - The correct Medicaid ED visits in 2012 were **605,506** instead of 589,260.

2. Page 18 of the Report, Figure I-11. Costs by HUSKY Program per Visit and per Client: CY12 shows that ED per visit for HUSKY B is the highest at \$431 when compared to all other HUSKY Program. Also all the figures showing in the graph for Per-Visit Cost among all HUSKY program are not correct.

Correction from DSS: - ED per visit cost in HUSKY B is not the highest, but rather the lowest among all other HUSKY program. This is due to the fact that the HUSKY B population is comprised of children.

Please see the table below showing the correct figure of ED per-visit cost for each HUSKY program:

HUSKY Program	Per-Visit Cost by ED PRI (Page 18 - Figure I -11)	Per-Visit Cost Correction by DSS
HUSKY A	\$271	\$307
HUSKY B	\$431	\$295
HUSKY C	\$378	\$460
HUSKY D	\$306	\$403