

# MaineCare Managed Care Specialized Service Committee (SSC) Meeting Minutes

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September 13, 2010, State House Taxation Room 127

**More detailed information can be found at:**

[http://maine.gov/dhhs/oms/mgd\\_care/mgd\\_care\\_index.html](http://maine.gov/dhhs/oms/mgd_care/mgd_care_index.html)

## **SSC Attendees**

Betsy Sawyer Manter (EIM/Senior Plus), Anna Cyr (ME Parent Federation), Pam Marshall (Long Term Care Ombudsman Program), Betsy Grass (Alpha One Now), Helen Bailey (Disability Rights Center), Kathryn Pears (Maine Chapter; Alzheimer's Association), Leo Delicata (Legal Services for the Elderly), Leticia Huttman (DHHS, Office of Adult Mental Health Services), Nancy Cronin (ME Developmental Disabilities Council), Rose Strout (Homeless Voices for Justice/ MaineCare Member), Christine Holler (MaineCare Member), Diane Geyer (City of Portland, Maine Healthcare Homeless)

## **Public Attendees**

Merrill Friedman (Amerigroup), Romaine Turyn (DHHS, Office of Elder Services), Judiann Smith (Spurwink), Jim McGregor (ME Merchants Association), Kate Knox (Bernstein Shur), Shara Garland (Certified Interpreting), Carol DeStefano (Certified Interpreting)

## **Project Staff**

Stefanie Nadeau (DHHS, MaineCare Services), Sarah Stewart (DHHS, MaineCare Services), Shannon Martin (DHHS, MaineCare Services), Paul Saucier (USM Muskie School), Nadine Edris (USM Muskie School), Julie Fralich (USM Muskie School), Marianne Ringel (USM Muskie School), Eileen Griffin (USM Muskie School), Linda Kinney (USM Muskie School)

## **Updates**

- SSC meeting notes from July 26,2010- reviewed and approved
- DMC meeting summary from September 2, 2010
- MeHAF grant
  - Muskie School will provide a written report about the four member listening sessions that are underway
- There is an RFP open (through MeHaf) to help fund programs to support ACO organizations in Maine.

- For rural Maine providers to help them develop the capacity to act as ACOs and interact with managed care

## Overview

The Special Services Committee (SSC) meeting included an overview of Managed Care 101 including the background information and federal rules:

- Medicaid Managed Care Basics PowerPoint Presentation
  - Risk-based contracting
  - Managed Care compared to existing MaineCare approaches
  - What would / wouldn't change for MaineCare members
  - CMS requirements for states participating in Managed Care
    - Choice of plan
    - Quality Management Program, EQRO, and grievance process
    - Services offered to members
    - Actuarial sound capitation payments
- Federal Rules for Medicaid Managed Care
  - Two ways to gain federal approval
    - State plan amendment (changing the states contract with CMS)
    - Waiver request (asking for an exception from federal rules)- standard Managed Care Waiver or demonstration waivers
  - Members who are excluded from mandatory managed care enrollment and require a waiver
    - Duals (dually eligible for Medicaid and Medicare)
    - American Indians
    - Children with special needs- children who could be in an institution (Katie Beckett), Foster care/adoption assistance, Blind/disabled (SSI), and children getting services for special needs from Maine CDC

\*There may be more children with special needs in other groups that require special protection if in managed care
  - Choice of provider is usually two but can be only one in rural areas
  - Services can be enhanced but not decreased with Managed care

## Presentation to the Design Management Committee by Kathy Penkert

- PowerPoint given to committee members to read and consider
- Children in the child welfare system and children with behavioral health needs in Medicaid managed care

## Populations and Services

- Proposed phases of enrollment by eligibility group
- Mandatory/voluntary/excluded enrollment proposals
- Eligibility groups that are mandatory/voluntary/excluded in PCCM as a reference point
- Required authority for mandatory inclusion
- Potential overlap with specialized services populations
- Total expenditure by managed care eligibility groups data
- Committee members' goals and concerns

## Committee flow and organization

*(Key: SSC = Specialized Services Committee, SAC = Stakeholder Advisory Committee, MSC = Member Standing Committee, DMC = Design Management Committee, EMT = Executive Management Committee)*

- Committee flow chart
- MSC and SSC representatives will present discussion points/recommendations to the SAC
  - Two MSC members have been elected to join the SAC
  - SSC will need to select a member to present recommendations to the SAC
- A SAC representative will present discussion points/recommendations to the DMC
- DMC will make recommendations to the DHHS EMT and bring discussion back to the SAC
- EMT will make final decisions
- Agenda items for the SAC, SSC, MSC, and DMC will be the same to start but discussions should go in different directions and the expectations of what we hope to get out of the meetings will be different
- Information and recommendations will flow back and forth between committees and workgroups
- All SAC and SSC meetings are open to the public
  - SSC members should also talk with co-workers that may be on the SAC to represent their concerns/issues

## Specific Recommendations to the SAC

- Children with special needs should be in phase II as they may be hard to identify
- If we could split up services (ex: behavioral health services from medical services) then children with special needs should be voluntary in phase I, if not they should be excluded
- Duals should not be included as they are potentially in a home-grown managed care system already and issues may arise
- Older adults should not be in phase I as more time is needed to segment the eligibility groups for enrollment

## Scheduled meetings

- SSC future meetings all held in the State House Taxation Room 127:
  - October 12, 2010 1-4 pm
  - November 15, 2010 1-4 pm
  - December 13, 2010 1-4 pm
- SAC future meetings all held in the State House HHS Room 209 :
  - September 17, 2010 1-4 pm
  - October 15, 2010 1-4 pm
  - November 19, 2010 1-4 pm
  - December 17, 2010 1-4 pm

These meetings will all be broadcast live through the internet at these times.

## Next Steps

- SSC will select a committee member to present recommendations and an update to the SAC
  - Nancy Cronin of the Maine Developmental Disabilities Council volunteered but is unable to attend the meeting this Friday, September 17<sup>th</sup>

## Committee Questions/Concerns/Key Discussion Points

- How will choices of providers be available?
- How will we ensure that deaf people with mental health needs are able to access the services they need (including interpreters) no matter where they reside in the state?
- How do we inform doctors that services such as interpreters need to be available?
- Will fewer services be offered to people with special needs?
- Will programs that are already underfunded remain underfunded when we transition to Managed Care?
- How will we calculate funding needed for MaineCare in subsequent years? How do we compare managed care financially to fee for service?
- Will members have a choice with specialists as well as primary care physicians?
- Can we have a managed care program as well as a medical home program?
- Would children that were considered to have no special needs be dis-enrolled from managed care if they receive a diagnosis later?
- What are other states doing with special populations of people?
- What protections will be in place for children with special needs?
- Should we start with the assumption that every service and population is in?
- Can someone be on a waiver program and be part of managed care?

- Can someone receive a waiver services and still have managed care for acute and preventative care?
- Anxiety that the EQRO will be contracted by MaineCare and could be a conflict of interest if the EQRO's interest is in making MaineCare happy, and not improving services to the child and family
- Can we see a programmatic diagram of the state plan or waiver option that demonstrates what can be excluded or must be excluded?
- Many people have no transportation and have to plan to get their medication. Why does Wal-Mart require people to wait 30 days before filling the prescription again and then the person is in jeopardy of running out of the medication?
- RAC/RATE codes do not accurately represent an eligibility population because they are often incorrectly coded or one code is used for many populations and one population can use many RAC/RATE codes.
- How do we plan for members that change RAC/RATE codes frequently?
- In order for managed care to be successful don't we need to have everyone included?
- What is the advantage of including duals in managed care when most of them are already included in a home-grown system of managed care?
- Older adults can include duals, individuals under home and community based waivers, in a residential setting, in the community, etc so we need to look at this group closer
- What is the advantage of enrolling people who require 24/7 home and community based care?
- Should individuals who cannot sign informed consent be included such as people with cognitive disabilities?
- How do we ensure continuity of care?
- Will there be a profit motive for the third party to build a communication system between providers? Or between providers and itself?
- Will the capitation rate be different depending on the population?
- Will statutorily defined benefit packages be withheld?
- Will case management services be cut?
- How is the capitation rate determined?
- Could you have an ASO and MCO at the same time?
- Can quality issues found in the first or second phase be included in the contract for the next phase?
- Do you expect the incoming Governor to make reductions?
- Should we do all the work for phase I and II together but not actually phase them in? Would this allow the system to better handle individuals that do not neatly fit into one eligibility group or another such as a disabled person that is receiving benefits under family related?
- Is it too ambitious to think that the RFP can be completed by April 2011?
- Will the potential bidders that must go through the Bureau of Insurance Licensing be able to do that by the April 2011 deadline even if the RFP is ready?
- What would happen to the provider network if the structure is completed in phase I?

- Concern about the RFP- we want the RFP to be complete as possible but it is very complicated and a lot to work out
- How do we get all the quality measures in place by April, when the RFP is due?
- How do we have public providers such as schools become network members like everyone else and have rates like everyone else?
- If we offer voluntary enrollment, what information will we provide to parents to help inform their decisions?
- Can split families (that may have a member with special needs and others without) opt in or out?
- What is the rationale for phase II and III when a number of people are on a waiver?
- Can we really provide quality services if we are talking about a cost neutral program and allowing the third party to make a profit while chipping away at reimbursement to providers?
- How do we guarantee that providers will give the information we want to analyze to the MCO/ACO?
- If people are forced out of the system and disappear as far as data is concerned, how will we look at that information when it is not true cost savings because the cost is somewhere else?
- Healthcare reform will allow us to get data on adult members regarding admission to IMDs but if it is 3 years off the perverse incentives may already be in place when we get the data.
- What happens to DUR (Drug Utilization Review) under the MCO? Does the MCO have to follow conditions of the DUR committee?