SSI Dane County Managed Care Advisory Committee
Minutes
7/30/04

Attendence:

Peggy Michaelis, Dane Co. Redesign
Jim Maddox, MHCDC/Redesign/NAMI
Fran Genter, Dane Co. DHS
Marci Katz, MHCDC
Jenni Colligan, BMHSAS
Tom Lawless, TMG
Ginny Graves, TMG
Todd Costello, CLA
Jennifer Lowenberg, NAMI-WI
David LeCount, Dane Co. DHS
Bonnie Morely, CLA
William Greer, MHCDC
Tim Otis, MHCDC
Don Libby, APS
Heidi Herziger, DHFS/BHCSO
Michael Fox, DHFS/BMHCP
Mary Laughlin, DHFS/BMHCP
Angie Dombrowicki, DHFS/BMHCP
Peg Algar, DHFS/BMHCP

I. Review of the Minutes from Last Meeting

No comments were made on the minutes. They were accepted into the record and will be posted on the web page, along with other documents from our committee work. The web page address is: http://dhfs.wisconsin.gov/medicaid7/index.htm#medicaid

II. Review of Advisory Committee Issue Log

An Issue Log was created to track the issues that arise during our committee meetings. The log has a column for the issue, status of the issue and the date the issue was brought up. It was decided that issues outlined on the agenda for our initial meeting will also be included in the log and that it will be reorganized according to which workgroups the issues fall under.

III. Committee Workgroups

The Quality Assurance workgroup will be co-chaired by Dr. Urban and Dr. Joyce Allen. Peggy Michaelis and William Greer have indicated willingness to participate in the

group. If you are interested in participating in this or any other workgroup, contact Peg Algar at: 608-267-9555.

Question:
CLA staff asked if 503-C3 certified agencies might become HMOs.

Response:
The only requirement to become an HMO is a license or waiver from OCI.

Michael introduced Heidi Herzinger as a new addition to the committee. Heidi works in Operations in the Division of Health Care Financing (DHCF) and is an excellent resource on systems issues. She will be working closely with the EDS (the fiscal agent) on the system changes that need to occur to accommodate the new managed care program.

IV. Summary of the Senate Committee on Health, Children, Families, Aging and Long-term Care Meeting

This hearing was held on July 8, 2004, in response to a request from advocacy agencies to be able to testify regarding their opposition to the plan to expand managed care to the SSI population. Testimony was presented by a number of stakeholders. The projected fiscal impact of the program was discussed by the Legislative Audit Bureau. Many diverse groups were represented including CLA, iCARE, Managed Health, the Mental Health Council and advocacy groups. The Wisconsin Dental Association argued against having dental benefits included in the new program. Pros and Cons of managed care discussed include:

Pro
Services are more personalized under Managed Care and access to providers is be increased.

Con
Access to specialists may decrease.

An additional hearing will be held to follow up on how to deal with a loss in projected savings because of the decision to use a faster implementation timeline. Senator Roessler wants an update on the progress of the Milwaukee project and the savings issue. (The savings issue is related to "Incurred But Not Reported Claims". Because of the lag time between submission of claims and reimbursement, there will be an up-front loss of dollars for the project. In the beginning, capitation payments will be made for enrollees and at the same time, claims from previous months will be paid. Savings will occur only over time.)

Jennie Lowenberg asked that the Kitty Rhodes memo be forwarded to her. (See attachment.)

Comment
Consumers were notified at the last minute and were not aware of the hearing until it was almost too late to attend.
Response
Angie responded that hearings are usually announced a week ahead of time on the Legislative Web page. Everyone usually gets notified not more than a week ahead of the scheduled hearings because of the nature of the Legislative process.

Comment
One advocate who attended the hearing felt that consumers were not heard until the end and then they had little time to testify.

On a related topic, it was decided that a representative from the deaf community should be included on the Dane County SSI Managed Care Advisory Committee. Peg Algar will follow up on this issue.

V. Summary of Risk Adjustment Meeting

Tom Lawless gave a brief summary of the Risk Adjustment Meeting that occurred last week. The technical aspects of rate setting were discussed. The CDPS was discussed. Also, quality performance measures were discussed.

Committee Comments:

- Collette did a good job of tying everything together and gave a good overview of mental health issues and rate setting.

- Michael stated that everything he heard about at the Risk Adjustment Meeting are issues we have been talking about for a long time at the State. For example, pay-for-performance is not a new idea. Financial incentives have been considered for the Medicaid HMOs. Predictive modeling has also been discussed**. The main concept that was emphasized at the meeting is that lots of tools exist to address risk adjustment, but no matter what method is used, good implementation is the key to making it work.**

- Collette's presentation was good, why haven't we better integrated MH and AODA before? What will change with the new SSI managed care projects? We need uniformity in the areas of: entry, service, outcomes, and practices. System change is good, but needs to be coordinated. We need to get the word out and define the process.

- There are many ways to do this. Statistics can be manipulated, so there is a need to be on top of whatever methodology is used. Liked Collette's presentation and comments on integrating substance abuse with mental health services.

- The idea is to try to get as accurate rate setting as possible. The quality of data that is used determines the accuracy of the rates. Additional questions to be addressed include: What services should be used to achieve outcomes? And How do we avoid creating more "silos" instead of a seamless system?

- Michael stated that we could get the rates "right" and still have the program fail. Conversely, rates can be technically bad, but if program management is good the program can be bottom-line effective. Multiple programs having differing bottom lines can draw attention to bad rates. There is also a "top line" related to growth in the program through new products, services and eligibles.

- Need to build the structure of the service system around outcomes, not have it driven by the fiscal bottom line. Sound clinical practice is key to good outcomes.

- Need to talk about program design, not just focus on money. Money just facilitates the program. We need to look at what works on focus on system integration and outcomes. We have a parallel system in the 51 system. We start out with a sum certain bottom line and whether things will get done is not always contingent on the money.

VI. Subcommittee Update

The QA/QI workgroup will be co-chaired by Dr. Urban and Joyce Allen. Peggy Michaelis and Bill Greer have offered to be on this workgroup. Dr. Ron Diamond will be contacted about participating on the committee also. Contact Peg Algar if you are interested in participating in this or any other workgroup at: 608-267-9555.

Dr. Urban states that her role will be to provide oversight to see that quality management focuses on uniform core competencies for all three pilots. Also, outcomes pertinent to individual projects and EQRO requirements should be addressed.

Comments:

- We need to make sure that we utilize any pertinent instruments that have already been used for the MH/AODA Redesign project. In particular, we should utilize the ROSA tool to measure quality of life outcomes.

- A question that needs to be answered is: How will the Mental Health Systems Transformation Grant be used in conjunction with sub-committee goals?

A crosswalk will be done on what has already been done for the MH/AODA Redesign and Family Care etc. We need to ensure that implementation moves along.

VII. Discussion on Participating Population

Michael gave an overview of the Analysis on Participating Populations in the SSI Dane County Managed Care Program. The paper addresses the following questions:

- Who should the program serve?
- Who is the program prepared to serve? And
- How will the target population be identified, given the limitations of existing data?

A major problem with identifying the population is that Medicaid data is based on medical status codes that change over a time period, and Medicare status that also changes for a subset of people during the period. Also, a subset of people change age groups during the same period. Even when these factors are broadly described (e.g., Medical Status Code 21 versus Other enrollable Medical status codes; MA only versus Dual Eligible; Age Groups), the changes make it difficult to construct queries, especially the links between tables in ACCESS, to avoid having duplicate counts for an individual.

For the Dane County initiative, this is especially complicated, as the relevant population is not as defined as for the Milwaukee County programs since the data cannot preemptively exclude the Waiver and MAPP persons.

B. Discussion

Comments:

- Home and community-based waivers allow the money to follow the person in the community rather than be tied to an institution.

- Medical status codes can tell us whether the person is being served in the community. For example, in the iCARE program, a participant may be enrolled in a nursing home for 90 days and if they are still in the institution, their med. stat. code is changed to reflect that. MAPP is a buyin program for Medicaid, similar to BadgerCare, but for single persons with no kids. One has to have a documented disability to qualify and SSDI folks may also be enrolled.

- Some people enrolled in the SSI Waiver program are included under med. stat. code 21. Others have a specific waiver med. stat. code.

- Michael stated that the MEDS Directive attached to the paper reflects the specifications for data that will be used for rate setting. The directive links paid

claims to the eligibility file and pharmacy data. Med. stat. codes will be important for establishing eligibility for enrollment.

- It is not easy to sort out who has substance abuse issues as they are often co-morbid with other conditions. People may get their needs related to substance abuse met elsewhere.

- Often in the long term care population, substance abusers come into the system at a later date with a physical illness. How can we address the substance abuse issues? Perhaps screening should be done on a regular basis.

- This brings up the issue of undiagnosed conditions affecting the cost and not being figured into the rate structure. Could predictive modeling help control for this?

- Mike suggested that perhaps this is more of an implementation issue, than a rate setting issue. Also, it is better to do some predictive modeling even if it is not perfect in its parameters.--Better some than none.

- Tom asked that the specific waiver programs be identified in future data presentations.

Discussion on Who the Program Should Serve:

- The question of whether developmentally disabled persons should be included in the program came up.

- The program should provide primary and acute healthcare services and MH/AODA services. Would CLA retain the waiver services under a separate program or would they be integrated into the new program?

- CLA wants to integrate waiver people possibly at a future date, but this is not a long-term care model. Breaking waiver relationships down would be problematic. Including the waiver population is problematic at this time.

- Regarding the DD population, they have a whole set of different needs so we should probably not include this population until capacity issues are addressed.

Decisions on Population to be Served:

- No one under 18 will be served
- No one on a waiver will be served initially

- Possibly phase in the DD population at a later date.
- People in CSP should be served
- There was discussion about whether to include individuals over the age of 65, but no decision was made.

Comment
Gerry Born needs to be included in this discussion. Questions that came up include: How do we define the DD population? What provider system currently exists for this population? Degree of impairment is crucial in the decision and has service utilization implications. We need to separate out CIP and COP enrollees and try to find DD primary and secondary diagnoses.

Comment
Will PACT people be included?

Comment
Over time we should address people coming out of Badger Prairie (IMD) and back into the community. They would need primary health care, MH/AODA services and don't need 24-hour care. There would be a lag time in the change in their med. stat. code, so that would be an issue.

Decisions Made on Cohorts to Include in the Dane Co. SSI Managed Care Program

Adults over the age of 18 who are:

1. Physically Disabled
2. Severely and Persistently Mentally Ill and/or have a Substance abuse Disorder
3. Persons who age into the program (turn 65 during enrollment)

Decisions that Need to be Made About Including Additional Cohorts in the Program

Should the following cohorts be served:

1. *Persons on waiver programs at a future date*
2. *Developmentally Disabled persons at a future date*
3. *Persons aged 65 or older at a future date*

VIII. Next Meeting

The September 2nd meeting is cancelled. An all-day meeting will be held on September 24th in at the offices of TMG located in glass bank building on the square. The address is: 1 S. Pinckney Street. The meeting will be in the lower level conference center (no room number). The meeting will be held from 9:00-3:00, and lunch will be provided.

Topics to be discussed include:

- Predictive Modeling
- Informing Materials
- Enrollment Issues

Comments

TMG asked for a copy of the timelines used for informing materials for mandatory managed care programs. This information will be distributed before the next meeting.