



**Rhode Island Medicaid Medical Advisory Committee (MCAC)  
Meeting Notes  
March 9, 2011  
Hazard Building, 7:00 AM**

**MCAC Committee Attending:** Mark Braun MD, Stephen Chabot, MD, Catherine Cummings, MD, Pat Flanagan, MD, Dave Feeney, Jerry Fingerut, MD, Mary Hohenhaus MD, Mack Johnston, MD, Richard Wagner, MD

**MCAC Chair & Ex Officio Members Attending:** Elena Nicolella, Ray Maxim, MD

**State Staff Attending:** Deborah Florio, Bill McQuade, Ralph Racca

**Members of the Public Attending:** Suzanne Chiarito, Stefan Gravenstein, Alan Post DC, Jody Rich, Susan Roberts

**Support Staff:** Marty Dellapenna

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**Meeting Began:** 7:05 AM

**Attendee Introductions**

**Updates from Last Meeting**

**Alternative Treatments in Pain Management**

Dr. Maxim indicated that it is the State's intent to pursue an approach to offering alternative treatment for pain management to at least some segment of the Medicaid population. A budget initiative that identified some modest savings has been approved, so the Department is actively working on developing a new model to be implemented on April 1, 2012.

**Screening, Basic Intervention and Referral to Treatment SBIRT**

Dr. Maxim reviewed the accomplishments of the cross-agency team that has been working together to implement SBIRT as a pilot at Connect Care Choice (CCC) practices Highlights are:

- Received Category I waiver change approval from CMS
- Developed the SBIRT screening tool
- Developed SBIRT expedited referral network for CCC members.
- Loaded and priced codes in MMIS
- 17 CCC sites have been trained to date.

The barriers to SBIRT discussed at trainings are primarily administrative and logistical (e.g. use of paper forms, SBIRT screen only worked for certain patients in a practice and cost of developing a template in each individual practice's EMR).

Next steps for SBIRT: Should be able to implement with two practices effective April 1, 2011

Potentially incorporate SBIRT into MCO contracts

Other SBIRT comments: SBIRT has been validated on youth, so MCAC advised DHS to ensure that there are adequate reinforcements for young people. Also, monitoring the program is vitally important, especially if SBIRT is to be spread to a wider segment of the Medicaid population. It was suggested that in an ED-type setting, the no-show rate for follow-up appointments could be reduced if an escort could be used to bring the patient to the evaluation. This process makes the evaluation immediate and increases the level of importance.

### **Health Insurance Exchange**

Elena N. reported that the Lt Governor's Executive Committee of Health Rhode Island Council is the entity out in front of the exchange in RI. The Exchange is significant for Medicaid under the Affordable Care Act (ACA).

Three major activities were reviewed:

1. Groundwork is being laid for what the exchange will look like. A five member executive committee will make most of the decisions about benefits and services.
2. DHS must determine a new eligibility system that combines both a clinical determination and an income-based determination. The income based-determination for children and families will be standardized using documents from the Dept. of Homeland Security and the IRS. This adds a level of complexity but the technology will take the information-gathering burden off families.
3. DHS is re-procuring its claims processing system and customer service will be a focus as enhancements to the new system are considered. Business processes are being considered and the Executive Office of Health and Human Services (EOHHS) agencies are a part of this process.

### **DHS Grants Update**

Elena N. outlined *the Money Follows the Person Grant*, which has a community-based LTC focus that assists states in acquiring community-based alternatives as opposed to a nursing home. The process has really rallied DEA and DHS to take a deliberate stand on community-based care. The budget has some dramatic cuts in nursing home rates.

### **New England Comparative Effectiveness Public Advisory Council (CEPAC) - Bill McQuade**

Presentation Highlights: The agency for Healthcare Research and Quality Grants (AHRQ) awarded the Institute for Clinical and Economic Review (ICER) with funding for three years beginning in October 2010.

Goal: Improve the process whereby medical evidence is considered and applied to payer policy decisions and clinical practice across New England.

A council is being formed that will enhance the dissemination of evidence-based guidelines and diffusion into the payment and practice patterns of the healthcare delivery system. The council will have 10-15 members with at least two from each of the New England states. Council participants must meet certain criteria. AHRQ review are good assessments of clinical effectiveness but have not been directly compared to a specific alternative treatment with concomitant cost-effectiveness measures. Medicaid has an interest in the selection of topics, the dissemination of results and the implementation of policy recommendations.

The MCAC made the following recommendations for the newly formed council:

1. Autism-related diagnosis and treatment
2. ADD, ADHD treatment and management

3. Consider comparative treatment for pain management

It is the state's intention to become more clinically-driven when making policy decisions. DHS will consider surveying MCAC members to get feedback on ways in which the Department can make policy decisions that are more clinically-based.

**Agenda Items for Next Meeting:**

1. Program updates
2. CEPAC Update
3. Health Homes

**Meeting Adjourned:** 8:05 AM

**Next Meeting:** Wednesday, June 8, 2011 (7:00 AM – 8:00 AM)