

MEDICAL CARE ADVISORY COMMITTEE

Minutes of the October 18, 2012 Meeting

IN ATTENDANCE

- PRESENT:** Lincoln Nehring, Russ Elbel, Kevin Burt, LaVal B. Jensen, Tina Persels, Andrew Riggle, Mark E. Ward, Michael Hales
- EXCUSED:** Warren V. Walker, LaPriel Clark, Greg Myers, Pasu Pasupathi, Debra Mair, Michelle McOmber,
- ABSENT:** Mauricio Agramont, Rebecca Glathar, Judi Hilman, Jason J. Horgesheimer, E. David Ward
- STAFF:** John Curless, Jeff Nelson, Tonya Hales, Gail Rapp, Sheila Walsh-McDonald, Nate Checketts, Keely Cofrin Allen, Josip Ambrenac, Gayle Coombs
- VISITORS:** Scott Larson, Joyce Dolcourt, Kris Fawson, Mindy Peterson, Allison Mathis, Amy Bingham, Russell Frandsen

1. Welcome – Lincoln Nehring

Chairman Nehring called the meeting to order at 1:35 p.m. and welcomed everyone.

Appointment of Debra Mair to the MCAC

Chairman Nehring said that Debra Mair was unable to attend today’s meeting.

Approve Minutes of September 20, 2012 Meeting

Chairman Nehring then asked if there were any questions about the minutes from the last meeting. Russ Elbel made the motion to approve the minutes and LaVal Jensen seconded the motion. The minutes were approved by everyone.

2. New Rulemakings – Craig Devashrayee

Craig then went over the DMHF Rules Matrix 10-18-12.

Rule; (What It Does); Comments.	File	Effective
R414-303 Coverage Groups; This amendment clarifies titles for sections in the text, defines the age limit for Aged Medicaid, and updates certain federal citations. It also removes criteria for HCBS waivers to place in Rule R414-307.	7-2-12	10-1-12
R414-307 Eligibility for Home and Community-Based Services Waivers; The purpose of this change is to incorporate eligibility criteria for all Home and Community-Based Services (HCBS) waivers and to implement eligibility provisions for the new Medicaid Autism Waiver program in accordance with House Bill 272, 2012 General Session. This change, therefore, implements eligibility for the new Medicaid Autism HCBS Waiver, incorporates eligibility criteria for other HCBS waivers, changes the age limit for eligibility under the New Choices Waiver, and makes corrections to match other waiver implementation plans.	7-2-12	10-1-12
R414-509 Medicaid Autism Waiver Open Enrollment Process; The purpose of this rule is to set forth the open enrollment process for the Medicaid autism waiver program, which was created in accordance with House Bill 272 in the 2012 General Session of the Legislature. It also clarifies conditions for open enrollment and specifies open enrollment procedures.	7-2-12	10-1-12
R414-308-3 Application and Signature; This amendment changes the application date for applications submitted through the online	7-31-12	10-1-12

myCase application process so the date of application is the date in which the applicant submits the online application to the Department of Workforce Services.		
R414-310 Medicaid Primary Care Network Demonstration Waiver; This amendment adds insurance that an employer offers through Utah Health Exchange as a form of creditable health insurance. It also adds, clarifies, and deletes certain definitions, clarifies effective dates, and makes other minor corrections.	7-31-12	10-1-12
R414-320 Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver; This amendment adds insurance that an employer offers through Utah Health Exchange as a form of creditable health insurance. It also adds, clarifies, and deletes certain definitions, clarifies effective dates, and clarifies reenrollment and benefits in Utah's Premium Partnership for Health Insurance (UPP) program. It further removes the requirement for children to apply for UPP only during an open enrollment period and makes other minor corrections.	7-31-12	10-1-12
R414-320-10 Income Provisions; This amendment increases the income limit from 150% of the federal poverty level to 200% of the federal poverty level to qualify for UPP assistance.	7-31-12	10-1-12
R414-70 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Five-Year Review); This rule is necessary because it specifies criteria for Medicaid recipients who are eligible to receive medical supplies, DME, and prosthetic devices as either optional services, mandatory services, or services provided in long-term care facilities.	9-27-12	9-27-12
R410-14 Administrative Hearing Procedures (Five-Year Review); This rule is necessary because it establishes a fair hearing process for Medicaid recipients and CHIP recipients who disagree with any decision made by a state agency or MCO that is based on payment of a claim, service coverage, or client eligibility. It is also necessary because it establishes administrative hearing procedures for the Division of Medicaid and Health Financing, the Department of Workforce Services, the Department of Human Services, and managed care organizations that carry out the fair hearing process.	9-27-12	9-27-12
R414-1-5 Incorporations by Reference; Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services (CMS). The purpose of this change, therefore, is to incorporate the most current Medicaid State Plan by reference and to implement by rule both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Utah Medicaid Provider Manual, Medical Supplies Manual and List; Hospital Services provider Manual; Speech-Language Services Provider Manual; Audiology Services Provider Manual; Hospice Care Provider Manual; Long Term Care Services in Nursing Facilities Provider Manual; Personal Care Provider Manual; Utah Home and Community-Based Waiver Services for individuals 65 or Older Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual; Utah Home and Community-Based Services for Technology Dependent, Medically Fragile Individuals Provider Manual; the Office of Inspector General Administrative Hearings Procedures Manual; and the Pharmacy Services Provider Manual (Updates to October 1, 2012).	9-27-12	11-21-12
R414-301 Medicaid General Provisions; This amendment removes the list of different categories of Medicaid coverage groups and refers to these categories more generally. It also adds and updates definitions and certain provisions throughout the rule text.	9-27-12	11-21-12
R414-2B Inpatient Hospital Intensive Physical Rehabilitation Services (Five-Year Review); This rule is necessary because it establishes program access, prior authorization and restrictions for inpatient hospital intensive physical rehabilitation services.	10-2-12	10-2-12
R414-29 Client Review/Education and Restriction Policy (Five-Year Review); The Department should continue this rule because it implements a restriction program for Medicaid recipients who over utilize Medicaid services. The continuation of this rule, therefore, will allow the Department to provide cost effective and medically necessary services to all Medicaid recipients.	10-5-12	10-5-12

Craig explained that some of the changes were just renewals and nothing had been changed.

3. **Budget Update** – Tracy Luoma

Tracy said the enrollment level remains about the same and that numbers had stabilized at approximately 253,000 individuals on Medicaid. She said the structured imbalance of the Medicaid budget was pretty much taken care of this year and enrollment projections have moderated. Michael said in the previous consensus process leading up to this session we were looking more in the 7 - 8% growth, but in the first few months of Fiscal Year 2013 and the last 4-5 months of FY2012 growth rates were around 3%. Discussions about the projected growth rates and the impact of the Affordable Care Act and additional woodwork effects will lead to a lot of uncertainty in Medicaid growth. (eg. Individuals who believe they are eligible for an insurance subsidy may in fact be eligible for Medicaid coverage). Additional funding may be requested for these unknowns when the 2014 Medicaid budget is developed. Additional information on these items will be coming out the middle of December.

Chairman Nehring asked Kevin Burt if the slower growth in Medicaid has affected the DWS budget. Kevin said they are still in a structural deficit and are getting deeper into it. DWS will have the same budgetary challenge as Health given the unknown impact of the ACA.

The total enrollment for September was 253,052. On the report it shows that the number of People over age 65 went up by 199, the number of People with Disabilities went down by 7, the number of Children went down by 83, the number of Pregnant Women went down by 84, and the number of Adults went down by 161.

4. CHIP Marketing Materials and Results of CHIP/Medicaid Surveys – Julie Ewing and Keely Cofrin Allen

Julie passed out a document to everyone entitled Application, Renewal and Closure Surveys for the CHIP and Medicaid Programs. The graphs in the document were discussed as well as other notable items.

Keely Cofrin Allen, who co-authored the report, led an additional discussion. For certain responses, a 'miscellaneous/other' category was used. Respondents were able to input their responses, but that detail was not captured in the report at this time. Andrew Riggle asked if Keely could give an overview of why some people had difficulty applying for Medicaid. (Survey response was that 60-70% found applying for Medicaid to be a fairly easy process; however details on the 30% who had difficulty were not in the report.) Keely said she could re-look at the information to see if any comments were added. Information about the demographics of the individuals who had the most difficulty applying was also mentioned by Tina Persels as something that would have value. Russ Elbel asked if there was a similar graph like the one on page 19 (program closure data) for people on Medicaid as this data was exclusive to CHIP enrollees. Medicaid information is not currently available but could be discussed for future surveys. Kevin Burt stated that DWS is able to capture closure reasons for Medicaid and CHIP. Keely said she would be happy to provide everyone with a copy of the actual survey.

Julie then discussed the distinction between marketing and outreach where marketing is the promotion of a health plan while outreach is the promotion of a program. Under 42 CFR 438-104 it allows the plans to conduct outreach activities. However, all plans used by a managed plan for marketing have to be approved by the Health Department. The CHIP Advisory Council did agree to act as the body to approve/deny outreach materials and public events, but the MCAC did not. Select Health and Molina came together and said they would like to do a joint plan. The CHIP Advisory Council approved some of them for the purpose of doing outreach and so did the State. Julie said the joint campaign has been going on for several months now, but they have not seen much of an increase in CHIP enrollees. Chairman Nehring asked if the Department has had any concerns in regard to any of the marketing and outreach efforts thus far that the plans had been doing in regard to CHIP. Michael said they have not allowed marketing but have allowed outreach. He said we have had a pretty manageable program in regard to outreach.

Julie said that the first couple of ideas that were presented to the CHIP Advisory Council were not approved at first. The CHIP Advisory Council had a sub-committee to review these materials. The materials that are out there now can be used and were approved by the CHIP Advisory Council. There were a lot of comments and questions in regard to this. Amy Bingham from Molina had some comments on this and how it has affected them. Enrollment numbers remain somewhat stagnant, but where the strategy is relatively new, it is difficult to gauge if additional time is necessary to evaluate its success. Russ said in general this has been beneficial for Select Health. Chairman Nehring began a discussion on if this approach could be taken for Medicaid.

Russ asked for the distinction between marketing and outreach. Julie said they do marketing for promoting each individual health plan and the Medicaid product, where outreach is more promoting Medicaid. CHIP's aim is outreach. There were a lot of different comments made in regard to this. Kevin from DWS said if a person

comes in to apply for CHIP and they are eligible for Medicaid, they are ineligible for CHIP; therefore, by promoting CHIP, increased enrollment may have been absorbed by Medicaid. In answer to a question from Russ, Julie explained some of their initial frustrations in regard to all of this. Tina asked at what point when you apply for CHIP or Medicaid do you choose your provider. Michael said when they are determined eligible for Medicaid they are sent the information so they can set up an interview or an opportunity to choose the plans. Michael said some people don't pursue that and then we have to make a choice on their behalf given whatever medical information we have available about their previous enrollment history. Once they are determined eligible and they live along the Wasatch front, we make them make a choice. This is all part of the education process that we do have in place. The client is able to see what all the plans have to offer.

Chairman Nehring asked if we wanted to make a recommendation to the Department on what we think they should do with this since we have a quorum. Andrew said he is all in favor of outreach. He did ask if the Legislature had approved this and have there been conversations with them. Michael said we have not yet. Chairman Nehring said in terms of process, the Department would have to change the contracts and then the MCAC would have to agree to review the materials. Chairman Nehring made the motion that we recommend to the Department that we explore allowing the plans to do an outreach program with a MCAC review of their materials, like something modeled after the CHIP marketing plan. LaVal Jensen seconded the motion. Everyone agreed so the motion carried.

5. ACO Follow-Up Discussion - Gail Rapp

Quality Measures Grant

Quality Measures Development Plan

Gail then discussed the quality grant and the time frames. This is officially called the Adult Medicaid Quality Grant to Fund Measuring and Improving the Quality of Care in Medicaid. The award for this grant will be made on October 31st, 2012. The intent of this grant is to hire four FTEs. Gail explained the intent of the grant. This is a two-year grant with \$1,000,000 a year. Michael said this will help us build the infrastructure for the ACO's and develop quality improvement strategies. This grant targets the adult population. Andrew asked if this grant is restricted strictly to adults, and Gail said yes, it is. Gail explained what the four positions would be and explained what these people will be doing. They will have a Project Analyst, Data Analyst, Programmer, and a Quality Improvement Specialist. Michael said this is a two-year grant and will not be continued after that, but it will allow for the building of the infrastructure in how we gather the information, finding what we want to measure. It will then allow the Department to work with the Accountable Care Organizations and other providers to define what we are going to be looking at and set that in place so it can continue after the two-year grant ends. The framework may then be leveraged to extend to child populations.

Gail said there is a proposed time frame for our additional ACO quality outcome and performance measure development. A handout showing this time frame was handed out to everyone. The time frame would go from January of 2013 to January 1, 2014. On January 1, 2014, a new contract amendment will be in effect. ACOs will begin data collection for new measures and continue data collection for existing measures. Gail said that between March 18th and through the end of May 2013, the Department plans on having an open discussion with Stakeholders regarding the current measures and proposed measures to be included in the January 1, 2014 contract amendment for ACOs. Contract amendments will be finalized in July 2013 making this a very dynamic process. More ambitious measures may have to wait until they can be thoroughly developed.

Russ asked if there is staff identified already in regard to this. Gail said until we have the grant, we cannot hire new staff for this. Michael said our commitment is to measure quality and be rewarding and reimbursing for quality outcomes rather than billable events over the course of time. Chairman Nehring had some comments in regard to expanding what we do with this. Michael said if anyone has any additional thoughts in regard to this later, to let him know.

Russ asked what the plan was quality measure wise if we don't get the grant, and Gail said that Emma Chacon had already said they would continue with what Char Frail-McGeever and her people are doing now for CHIPRA, HIT, Meaningful Use, etc.

6. Director's Report – Michael Hales

Michael provided an update on the autism waiver. He said they will continue taking applications through the end of this month and that funding is available for approximately 250 individuals to participate in this program through fiscal years 2013 and 2014. As of 10/17/12, 320 applications for the program had been received. He said they have decided to disburse these positions across the state in geographical health districts. Within the twelve local health departments, waiver openings were allocated proportionately based on state population figures from the 2010 census. It is anticipated that approximately 400 applications will be received by the end of the month. He said it looks like we will be able to serve a much higher percentage of the applicants than we originally had thought we would be able to. In answer to a question from Kris Fawson, Michael said that if a child does age out of the program, which would be at the age of six, they will put a new person into that slot. Children ages two through six who have been diagnosed with an Autism Spectrum Disorder may be served by the program. Assessments to gather reporting data will be completed on a six month basis. Households with more than one child meeting program eligibility requirements could be served by the waiver. If one of the children in the household is selected, all children in the home will participate on the program. He said we will be enrolling people fairly soon. They will be looking at the ones who have applied in November.

Andrew asked how it had been going in regard to recruiting providers to help with this. Michael said that he felt this was going pretty well so far. DSPD and DOH are working on contingency plans in regard to this. Michael said Josip Ambrenac is the person overseeing this waiver.

Social Services Appropriations Sub-Committee Update

Michael said two weeks ago they had an all-day meeting with the Legislature. The majority of the morning meeting dealt with the Federal Health Care Reform overview that was presented by Legislative staff in terms of talking about the impact of the Affordable Care Act's passage, what that means, and what the options are for State lawmakers. A public hearing was held for approximately an hour and was a big focus of the discussion. Some of the statutory reports were reviewed and issues were identified in controlling Medicaid costs. Based on the information received, the State has the option of expanding current coverage to receive additional federal funding and could retract at any time without penalty.

Kris asked if there had been more significant discussion on block grants, etc. Michael stated that CMS has not been able to provide any additional guidance on this. Clarifying questions on how to interpret the 133% federal poverty guideline have not been answered at this time. It is unclear if the State may choose to expand, but to an amount lower than 133%. The Legislature requires explanation on this and many other details before it will make a decision causing any expansion efforts to be delayed.

Andrew had a question in regard to this and getting people enrolled in full Medicaid or would our option be to

enroll them in the benchmark plan. Michael said that the Medicaid expansion program would be guided by a benefits package that the exchange has chosen in what we could offer in the full package that Medicaid offers. This is also one of the questions requiring additional information in regards to the expansion.

Michael said that the asset test for children will be removed effective January 2014, so a lot of the children on CHIP will move over to the Medicaid program. Additional adjustments such as the Child Medicaid program for those ages six through eighteen will have a change in the income level used to determine eligibility (133% of the poverty limit versus 100%) and will cause children to move from CHIP to Medicaid. This possible movement may cause a conflict with existing policy depending on if the child has insurance and where the family's income level is.

Russ asked if Michael will have to make a report on this to the Legislature, and Michael said that he felt he would be doing this, possibly in the Executive Appropriations Committee.

7. Other Business - MCAC Members

There was no other business, so Russ made the motion to adjourn and everyone agreed. The meeting was adjourned at 3:10 p.m.