

MEDICAL CARE ADVISORY COMMITTEE MEETING

Minutes of the January 19, 2012 Meeting

IN ATTENDANCE

- PRESENT: Kristine Fawson, Barbara Munoz for Lincoln Nehring, E. David Ward, LaVal B. Jensen, Michelle McOmer, Warren Walker, Russ Elbel, Tina Persels, Mauricio Agramont, Kumar Shah, Kevin Burt, Mark E. Ward, Pasu Pasupathi, Michael Hales
- EXCUSED: Gerald R. Petersen, Lincoln Nehring, LaPriel Clark
- ABSENT: Judi Hilman, Jason J. Horgesheimer, Rebecca Glather
- STAFF: John Curless, Jeff Nelson, Emma Chacon, Tonya Hales, Connie Higley, Dr. Joe Cramer, Tracy Luoma, Nate Checketts, Kolbi Young, Gayle Coombs
- VISITORS: Polina Konuchkova, Ray Baresn, Brian L. Currie, Tim Whalen, Zac Case, Barb Viskochil, Joyce Dolcourt, Janidei Emerson, Amy Bingham, Russ Frandsen, Sheila Walsh-McDonald, Kirsten Stewart

1. Welcome – Kris Fawson

Kris Fawson called the meeting to order at 1:32 p.m. She welcomed everyone to the meeting and then had everyone introduce themselves.

Approve Minutes for the November 17, 2011 MCAC Meeting **Approve Minutes for the November 17, 2011 Public Hearing**

Kris then asked if there were any changes to the minutes from the November 17th Medical Care Advisory Committee Meeting or the November 17th Public Hearing for HB211 (2011) – Community Service Medicaid Pilot Program Proposal or if they were approved. Russ Elbel made the motion to approve the minutes and Kumar Shah seconded the motion. Both sets of minutes were approved as written.

2. MCAC Business – Kris Fawson

Appreciation to Kumar Shah for Serving on the MCAC Since 2006

Kris then mentioned that this will be the last meeting that Kumar Shah will be attending. Michael Hales explained to everyone how much Kumar had done for the MCAC and told him how much we all appreciated his time on the MCAC and how much he had helped. Other people on the committee had comments to make about Kumar and how great he had been doing.

3. New rulemakings – Craig Devashrayee

Craig then went over the DMHF Rules Matrix 1-19-12.

Rule; (What It Does); Comments.	File	Effective
R382-10 Eligibility (CHIP); This amendment modifies the requirements for completing a periodic review of an individual's continued eligibility for medical assistance to comply with federal due process requirements. It also clarifies the requirements for a recipient to make timely reports of changes and to provide verification of changes. It further clarifies that the agency cannot end eligibility while it gives recipients time to respond to a request for verification and while it makes a redeterminations decision. In addition, this amendment clarifies the requirement to provide appropriate advance notice of an adverse action in accordance with due process requirements, changes the benefit effective date to the first day of the application month subject to certain limitations, updates citations, removes provisions that no longer apply, and makes other minor corrections.	9-28-11	12-1-11
R414-40-4 Service Coverage for Private Duty Nursing; This change clarifies that the number of PDN hours that a patient may receive depends on how the patient scores on the PDN Acuity Grid. It also removes language that no longer applies to service coverage for PDN patients.	9-29-11	12-1-11
R414-310 Medicaid Primary Care Network Demonstration Waiver; This amendment clarifies the process for reenrolling in the PCN program after each 12-month certification period. It also changes the benefit effective date to the first day of the application month and clarifies how changes during the certification period may affect eligibility. It further removes provisions that no longer apply and clarifies change reporting and proper notice requirements to comply with federal requirements on due process. It also updates and corrects certain references and citations in the rule text.	10-13-11	12-23-11
R414-320 Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver; This amendment updates due process requirements for completing a periodic review of eligibility for medical assistance, clarifies requirements for an UPP recipient to make timely reports of changes and to provide verification, clarifies that the agency cannot end eligibility during the verification process, and clarifies the requirement for the agency to provide advance notice of an adverse action. This amendment also changes the benefit effective date to the first day of the application month and clarifies how changes during the certification period may affect eligibility. It also updates citations in the rule text and removes provisions that no longer apply.	10-13-11	12-23-11
R414-305 Resources; This change clarifies provisions in the rule to make certain sections consistent. It also makes other minor corrections.	11-15-11	1-10-12
R414-308 Application, Eligibility Determinations and Improper Medical Assistance; This change includes provisions that treat certain actions by a recipient as an application for medical assistance when a recipient cannot complete a timely request for verification. It also clarifies the limitations for these circumstances and clarifies agency procedure for eligibility when a recipient reports a change. It also makes other technical changes to the rule text.	11-15-11	1-10-12
R414-14A Hospice Care; The purpose of this change is to implement by rule H.B. 230, which replaces outdated terms for persons with a disability. The other purpose is to implement new provisions for the concurrent care of Medicaid recipients who are under 21 years of age.	12-1-11	1-24-12
R414-61-2 Incorporation by Reference; The purpose of this amendment is to incorporate by reference changes to the Waiver for Individuals with Physical Disabilities, effective July 1, 2011. This amendment, therefore, clarifies extraordinary circumstances that must exist for parents or step-parents to act as paid providers of personal assistance services and amends the number of visits between participants and administrative case managers. In addition, this change allows the Department of health to explain quality improvement strategies in further detail that relate to participant direction of services, participant rights, participant safeguards, and systems improvements.	12-1-11	1-24-12
R414-510 Intermediate Care Facility for Individuals with Mental Retardation Transition Program (Five-Year Review); This rule is necessary because it sets forth client eligibility and program access requirements for Medicaid recipients who wish to transition into the Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions Home and Community-Based Services Waiver Program. It also implements service coverage under the waiver and reimbursement for providers of waiver services.	1-9-12	1-9-12

Craig said the final rule will be updated and changed to use more appropriate terms. Sheila Walsh-McDonald had a question about R414-308 – Application, Eligibility Determinations and Improper Medical Assistance. Jeff Nelson said this was in regard to addressing due process. This is client protection.

Russ Elbel had a question about the private duty nursing. He asked if this change matches up with what is currently in the Medicaid provider manual. John Curless answered his question and said what has changed in the rule also changed in the manual.

4. Budget Update – Tracy Luoma

A copy of the Utah Cases Served Report Number of Persons was passed out to everyone. Tracy said we are continuing to see a growth in Medicaid. On the report it shows that as of the end of December 2011, the number of People over Age 65 went up by 37, the number of People with Disabilities went up by 3, the number of Children went up by 394, the number of Pregnant Women went down by 56, and the number of Adults went up by 412.

SFY 2011 Annual Report

Tracy then went over some of the highlights from the 2011 Utah Annual report of Medicaid and CHIP. On pages 5 it shows the State Fiscal Year 2011 Division Highlights, on page 9 it shows the Division of Medicaid and Health Financing Total Revenue Sources SFY 2011, on page 13 it shows the Medicaid Enrollment and Percent of Medicaid Eligibles by Category of Assistance, on page 19 it shows Medicaid Services, including Hospital Care and Managed Care Organizations, and on page 29 it shows the Consolidated Funds SFY 2011. At the end of the report on page 40 it shows the annual Children's Health Insurance Program Finance report.

5. Update: Mental Health Services, Salt Lake County – Tim Whalen

Tim said they have made some significant changes on how they do mental health in Salt Lake County. He passed out a document entitled Total State and County General Funds. Tim thanked Karen Ford and Gail Rapp for all their help with making these changes. He said they have put out an RFP in regard to providing mental health services. Valley Mental Health is one of the providers. Mental health has been basically one provider, Valley Mental Health. Tim went over the different pages in the document he passed out. He went over some of the things on the chart showing the funding for mental health. He said to please contact them if anyone has any questions in regard to these figures. Tim then introduced the other members of his group that were at the meeting with him.

Tim said that this year Optum Health received the award for this rather than Valley Mental Health. They won on the score of providing quality clinical services. Optum Health took this over on July 1, 2011. Tim said there are some inefficiencies to this model. He explained what some of them are. The Medicaid dollars go directly to Salt Lake County now, not Valley Mental health. They then pass the Medicaid dollars to Optum Health. Salt Lake County sits down with Optum Health quarterly to see how they are doing with the measures they have been given. The incentive is for Optum Health to provide as many services as they can to their Medicaid clients. Valley Mental Health currently represents 80% of their network. Valley Mental Health has a contract with Optum Health and they are pre-paid on this. There are no barriers for client services. Tim explained what is done with any of the unused monies.

Russ had some questions for Tim on this in regard to Valley Mental Health being prepaid on this. Tim said there are no pre-authorizations required for most of the services. Tim mentioned different goals that they have. He said he would hate to see them carve back in. Tim explained different programs they are in the process of implementing. He mentioned the crisis teams they have to help with this. He said they have a Medicaid program and a non-Medicaid program. Their non-Medicaid program is very small.

Tim answered a question from Russ in what you do if you get a call and it is not one of their covered services. Tim said right now they don't have a covered service where they can do an in-home visit. Tim will make sure everyone gets his contact information. Tina Persels asked what you do when you contact Optum Health and they say they can't help them. She asked at that point, what does the client do? Tim said to contact him and he will follow-up on it. Tim mentioned that a lot of the people that they serve are mentally ill.

6. HCBS Waiver Amendments – Tonya Hales

Tonya told everyone how they have changed the name of their bureau from the Bureau of Long Term Care to the Bureau of Authorization and Community Based Services to better reflect what they do. Tonya said they are in the process of making amendments to three of their waivers. They have six Home and

Community Based Waivers in all. They also use the Utah Indian Health Advisory Board (UIHAB) on this and meet with them to discuss these. Tonya went over the three documents that were given to everyone on the three amendments they are working on now. The three amendments they are working on are as follows:

- Amendment to the Utah Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions
- Amendment of the Utah Technology Dependent/Medically Fragile Individuals Waiver
- Amendment of the New Choices Waiver

The primary change they are making to the Utah Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions is that they have a respite service available for these services. Tonya said that the State's use of the terms Mental Retardation and ICF/MR was changed to Intellectual Disability and ICF/ID. Glen Larsen is the waiver liaison for the first and second waivers. His contact information is included at the bottom of the handout. Tonya went over each one of the waivers. Tonya said at the end of each year they have to send a report to CMS on their expenditures for the waivers.

Their next waiver is the Utah Technology Dependent/Medically Fragile Individuals Waiver. Again, they are making changes in the terminology there.

Tonya then went over the third waiver and said that Jason Stewart is the contact person for the third waiver. Tonya said that on all the waivers, the individual must meet nursing home quality of care. Tonya went over the different changes on each one of the waivers. She said assisted living is one of the services that are used very much in the waivers. Personal care is also available in the New Choices Waiver.

Kumar asked if funding is an issue with this. Michael said we will be monitoring all this as we go along. Tonya said she feels we are meeting the goal in regard to the New Choices Waiver. People are staying in the program until they have improved and then can move on.

7. Director's Report – Michael Hales

Date Changes for Medicaid Pharmacy Point-of-Sale System

Michael said due to hearing concern from many pharmacists and extended flexibility from CMS, the date has been postponed to the weekend of President's Day.

1115 Waiver Request Update (SB 180)

Michael explained some things about the waiver. He said that CMS has told us what they will or will not approve in regard to the waiver. CMS is approving a lot of the payment reform components and the move from a more traditional managed care where you provide an all inclusive rate for the billable events that have been provided to still allow us to move to paying for the quality of care and measuring the quality outcomes and having the rates still be held constant while we make those payments and not necessarily have to show the same utilization of services. However, they did deny some of the provisions

that we thought were key components of our Accountable Care Organizations (ACO) piece. The things they will approve or not approve and that we are directed by statute to do are listed below:

1. Restructure the program's provider payment provisions

- a. Using risk adjusted capitated payments for all of its ACO contracts. Using this payment approach the State will eliminate the incentive for providers to deliver care based on reimbursable or billable services. – **CMS approval**
- b. Retaining the current level of payments and not penalizing ACO for innovation and a willingness to venture into this new reform proposal. – **CMS approval**
- c. Preserving supplemental funding to maintain current funding levels for ACOs. – **CMS approval**
- d. Maintaining or improving the quality of care through an enhanced focus on quality of care measures and standards. The Department of Health will pay for quality rather than billable events. – **CMS approval**
- e. Providing a premium subsidy option for Medicaid clients which would allow them to purchase insurance through the exchange. After the Department made concessions to the original proposal, CMS rejected it. **CMS disapproval**
- f. Integrating non-behavioral pharmacy benefits into the ACO scope of service to better align the incentive of prescribers with the goals of the State. **CMS approval**

2. Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds

In order to ensure that the growth in Medicaid expenditures would be compatible with the overall growth in General Funds, the Department proposed employing a plan based on a benefit prioritization program, as used in Oregon's Medicaid program. After the Department made concessions to the original proposal (having it apply only to adult populations and not children), CMS still rejected it. – **CMS disapproval**

3. Restructure the program's cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status

An important aspect for enhancing physical well-being and reducing service utilization is patient accountability for personal health status. This includes compliance with recommended treatment. Increasing patient compliance results in better outcomes, lower costs and long term stabilization of chronic conditions. This waiver proposal would have allowed an ACO to offer some incentives and copayment modifications that would have helped increase patient compliance, and in other cases helped promote enhanced client responsibility. Further, the introduction of incentives and the modification of archaic copayment regulations would have improved ACO plan competition through product differentiation. – **CMS disapproval**

Michael mentioned the different things that CMS said would be an option and other things they said would not be an option. Michael said the Oregon plan has been approved for about 15 years. He said

they refuse to approve this for Utah but continue to approve it for Oregon. Michael said it does kind of get to the heart of the matter and how much CMS is willing to help the State with this. This administration is not even willing to consider the same type of 1115 waiver as they had before. Michael said it does either point to a political or philosophical intervention with this. CMS is not willing to pay \$14.00 out of \$20.00 for an incentive for people to get the care they need so they will have better health. Michael said he has a follow-up call on this tomorrow morning with Cindy Mann from CMS. Michael explained what the things they are not approving impact. He said one of the questions we have is whether you should even look at this as an ACO organization but just look at it as a State of Utah Managed Health Care (MHC) organization.

Tina had a question in regard to this and the incentives. She mentioned the co-pay that is made when the client goes to see their doctor. Russ asked if the Managed Health Care organizations should stop using incentives for their customers. Michael explained a lot of the things that are really frustrating him in regard to this. David Ward had a question in regard to training everyone in regard to appropriations law and Medicaid expenditures. Michael said he would look into this. Michael said he has a lot of questions in regard to three of the denials CMS made.

Michael then answered some questions from Russ in regard to the time line from this point forward. Michael said we will plan to amend the 1915B waiver. He also mentioned the history of managed care. Molina is already a capitated plan, but the other plans would have to move forward with this. Michael said we want to make sure that we are all on the same page. He will try to get a better sense of how long it will take for CMS to approve this. He said it should be approved well before July 1, 2012. Michael said he hopes this will be approved by the middle of May. He said he thinks we can start moving forward with the list of assumptions with what might be allowed at this point.

Michael then discussed premium subsidies. He explained what CMS wanted us to do with this. Michael said we would like the families to have the chance to choose. CMS said the families are too vulnerable to be able to make these decisions.

Governor's Budget

Michael said he wanted to report on the Governor's budget proposal as it relates to Medicaid. He wanted to talk about some of the building blocks we are asking for. They are asking for \$44,300,000 of general funds to keep the status quo in place for covering the existing eligibles who are on in 2011 and to cover the new ones coming on in 2012. The \$44,300,000 supplemental has basically moved into 2013. \$57,000,000 of on-going funds and \$11,000,000 of one-time funds will be put into the 2013 budget. These are estimates right now and the Governor's Office is working on them now. Michael said this is the new process they are working on. The supplemental amount is much larger this year. Michael said in future years we would not need a supplemental for this or get funded. The \$68,000,000 is 2013, 2012, and part of 2011 all rolled together.

Michael mentioned moving from more of a fee-for-service payment model into a capitated payment model. He said there is a one-time request in 2013 to essentially cover the payment of claims that would be dates of service in 2012 that the payments don't get made until 2013. Michael said there is a timing issue of about 60 days on a lot of those claims. He said they have requested about \$8,000,000 of general funds that would be a one-time appropriation in 2013. This is in regard to the ACO's. Michael said if anyone has any suggestions in regard to what to call the new ACO to let him know.

Michael said there is also a proposal that Representative Dunnigan passed out of the Legislature last year to convert the Medicaid fee-for-service dental program that still covers pregnant women and children to a managed care program. He said that is out for an RFP right now. If we end up awarding contracts, they would have similar transitional expenditures from the current fee-for-service claims payment system into the new managed care model. Michael mentioned some different things they are requesting funding for.

Upcoming Legislative Session

Michael said the Legislative sessions will begin next week. He said they have 14 meetings with the Legislative Committee. They are giving the prioritized list on February 14th to the Executive Appropriations Committee. Michael said we will be going through all our building blocks next Wednesday at the Legislature. Representative Bill Wright is now the House Chair on the committee. Representative Blast will still be the Vice-Chair and Senator Christensen will be the Chair for the Senate in the House and Representative Holly Richardson has resigned and won't be on our committee and Senator Liliquest has also resigned and won't be on our committee.

8. Other Business – MCAC Members

Kris asked if there were any other comments. Kolbi Young asked if they were planning on canceling the February MCAC meeting. Everyone seemed to agree that the February meeting will be canceled and the next MCAC meeting will be in March.

Michael said he would be willing to give an update meeting on February 16th if everyone decides they want to. This will be an informal meeting at the Capitol. Kris will reserve the room at the Capitol and then send the information to Kolbi and she will distribute it to everyone. It was again mentioned that this will just be an informal meeting.

There was no other business, so Kris adjourned the meeting at 3:35 p.m.

**THE NEXT SCHEDULED MCAC MEETING WILL BE ON THURSDAY, MARCH 15, 2012
CANNON HEALTH BUILDING, ROOM 125, FROM 1:30 – 3:30 P.M.**