MEDICAL CARE ADVISORY COMMITTEE MEETING

Minutes of the January 17, 2013 Meeting

IN ATTENDANCE

PRESENT: Lincoln Nehring, Russ Elbel, Warren V. Walker, LaPriel Clark, Matthew Slonaker, Michelle McOmber (on phone), Tina Persels, Andrew Riggle (on phone), E. David Ward (on phone), Mark Brasher, Debra Mair, Michael Hales

EXCUSED: Kevin Burt, Pasu Pasupathi

ABSENT: Mauricio Agramont, Rebecca Glathar, Jason J. Horgesheimer, LaVal B. Jensen, Greg Myers

STAFF: Kolbi Young, Brian Beck, John Curless, Craig Devashrayee, Tracy Luoma, Emma Chacon, Tonya Hales, Sheila Walsh-McDonald, Aaron Eliason, Nate Checketts, Gail Rapp, Josip Ambrenac, Gayle Coombs, Andrew Ozmun

VISITORS: Kris Fawson, Bill Fawson, John Prince, Bill Cosgrove, Joyce Dolcourt, Tracy Altman, Mark Ward, Nalani Namauu, Emily Mitchell, Barb Viskochil, Chris Chytraus, Heather Sowby, Amy Bingham, Janida Emerson

1. Welcome – Lincoln Nehring

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

Approve Minutes of October 18, 2012 and December 20, 2012 Meetings

Chairman Nehring asked if everyone wanted to approve the minutes from the October 18, 2012 and December 20, 2012 meetings. Mark Brasher made the motion to approve the minutes and LaPriel Clark seconded the motion. The minutes were approved by everyone.

Introduction of Mark Brasher to the MCAC

Chairman Nehring then had Mark Brasher introduce himself to everyone. Mark will be representing the Department of Human Services on the MCAC.

2. New Rulemakings – Craig Devashrayee

Craig then went over the DMHF SPA Matrix 1-17-13.

Rule; (What It Does); Comments.	File	Effective
R410-14 Administrative Hearing Procedures; The purpose of this change is to clarify certain terms within the rule text and to clarify hearing procedures for the Division of Medicaid and Health Financing (DMHF), the Department of Human Services (DHS), the Department of Workforce Services (DWS), and for managed care providers.	**11-14-12**	**1-9-13**
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	**12-28-12**	**2-21-13**

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 Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual; Office of Inspector General Administrative Hearings Procedures Manual; Pharmacy Services Provider Manual; and Coverage and Reimbursement Code Look-up Tool.		
R414-27 Medicaid Certification of Nursing Care Facilities (Five-Year Review); The Department will continue this rule because it governs the certification of nursing care facilities to provide cost effective services for facility residents.	**1-9-13**	**1-9-13**

Kris Fawson had a question in regard to the term nursing facility and if it included Intermediate Care Facilities (ICF's) as well. Tonya Hales said the term nursing facility does also include ICF's in addition to Skilled Nursing Facilities.

3. **Budget Update** – Tracy Luoma

Tracy then gave the report on the budget. A handout was given to everyone entitled Utah Cases Served Report Number of Persons. Tracy said this report is on line. Tracy said the enrollment level for Medicaid in December was 255,436. Projected enrollment growth is currently 2.3%.

4. **HCBS Waiver Updates** – Tonya Hales

Tonya then gave the HCBS Waiver updates. A handout was given to everyone entitled Renewal of the Utah Home and Community Based Waiver for Technology Dependent/Medically Fragile Individuals. Tonya discussed the renewal of this waiver and said they are available on line for comment. She said they did make an amendment to one of the eligibility issues and in the document it shows the changes from the current waiver are as follows:

- **Updates to Eligibility Criteria**
  - In determining the needs allowance of Tech Dependent Waiver applicants, there will now be an earned income disregard, up to the substantial gainful activity level of earnings defined in Section 223(d)(4) of the Compilation of the Social Security Laws, when determining countable earned income.
- **Offering the Self-Administered Services (SAS) Delivery Model as an Available Option to Select Services**
  - Recipients and their families will now have more flexibility and choice as two existing services, In-Home Feeding Therapy and Family Support Services, will now be available as recipient/family directed services in addition to the traditional agency based option currently available.
- **Quality Improvement**
  - The State has enhanced the quality improvement strategies developing a Critical Incidents and Events Reporting Requirements Standard Operating Procedure to further safeguard waiver participants.

Tonya said they have to solicit public input when they update a new waiver or have a new waiver. She mentioned different ways they provide this information to groups to get their feedback on it. The information is

shared with the Utah Indian Health Advisory Board (UIHAB), the MCAC and posted on the Department of Health website for public comment.

Tonya then mentioned a couple of amendments they have underway in regard to the Acquired Brain Injury Waiver as well as the Community Supports Waiver. This has to do with the income deductions waiver participants receive for the programs. These changes are being made in order to be more consistent throughout the individual waivers and are very minor adjustments.

An amendment is also in process for the Medicaid Autism Waiver. This had to do with increasing the rate of the direct service worker. They increased the rate for this from $21.52 per hour to $28.32 per hour. This change was made following a cost-survey and rate analysis and will ensure access to waiver services. The direct service worker hours will be decreased from an estimated 20 per week to 15 per week as feedback from providers and families was that it would be difficult to add additional services given other preschool and early intervention programs the child may be attending. One other change that they made was that they increased the consultation service. They increased that from 72 hours to 90 hours a year. Tonya said there are also options to give feedback on this waiver. It is available online as well.

5. **ACO Transition/Continuity of Care** – Emma Chacon

Emma then discussed the ACO transition. She mentioned that there had been some system issues in regard to this and they have been in communication with the plans on a daily basis. Meetings have also been held with representatives from the plans and the plans have been responsive with issues that have surfaced. Due to the transition, the Health Program Representatives have received phone calls to change plans as provider panel adjustments may have impacted clients. Home health and private duty nursing services have had emphasis placed on them due to the fragile populations who receive these services. At this time, the ACO's are paying for providers currently out of their network in order to help transition and ensure Medicaid recipients do not have an interruption in coverage. The transitional period can be up to 90 days or until the recipient can be moved to another provider.

Chairman Nehring asked if ACO's are currently operating within the 90 day window. Russ Elbel stated the current 90 days would run through March 31st, 2013, however, that time-frame has been extended to June 30, 2013 to assure smooth transitions occur. Additional outreach is being completed by Select Health to aid recipients impacted by the change.

Chairman Nehring then asked if sufficient information was being supplied to clients to help in their transition/selection of a new provider. Russ Elbel replied that information has been provided, but that all individuals covered by the plan are welcome to speak with their care manager for assistance if they require it.

6. **Update on PCP/VFC Rule Change/Enrolled Providers** – John Curless

John first explained that PCP stands for Primary Care Physician and VFC stands for Vaccines for Children. He said that providers who meet certain standards, who are family medicine, internal medicine, pediatric medicine or they have a sub –specialty recognized by the American Board of Medical Specialties, or the American Autoplastic Association, that such providers could qualify. The final rule was published on November 6th, 2012 with an update on December 14th. He said as of the day before, 1,446 providers have applied for this, and completed the self-attestation requirement. A change has been made with this requirement, in that if a provider were to complete a self-attestation during a quarter, they could be eligible for retroactive payments back to the start of that quarter. LaPriel asked if the Local Health Departments were also eligible for the enhanced payment. John

stated Federal clinics were not eligible but will look into this and provide clarification. LaPriel then asked if the Division had a contact person for questions on these issues. John stated Andrew Ozmun could be contacted with any concerns.

John said the providers have to self-attest or the State cannot pay them. There is a self-attestation form they give them to fill out. This form is also on line. They also need a copy of the certificate faxed to them and the form filled out to qualify for this.

John then discussed the managed care side of this. He said they are still saying there will be quarterly payments to the providers if they qualify. He mentioned three different models they can use in regard to this and the capitation rate. John said the Medicare rate is the floor on the payments but the payments can go above the Medicare rate. New dollars coming in are designed to bring Medicaid rates up to the Medicare rates. The providers are not required to pay the high rates until Medicaid has given them the money to do that.

The question was asked whether this would affect what can be charged to a patient and John said this would not affect Medicaid. The supplemental quarterly payment is what would bring the providers up to the Medicare rate. John said this will only last for two years.

Russ wanted some more clarification on how these supplemental payments would work for the plans in areas where the ACO's are served. More discussion is necessary in this area and John and Emma stated they would speak with the plans. John reiterated that at this time no payments can be made as the payment methodology has been submitted to CMS, but is awaiting approval. The earliest would probably be the first part of April. A question was asked if we could discuss the decision in being made to increase the administrative fee from $14.00 to $20.00. John said he is not aware of anything in regard to this. Michael mentioned the change impacted VFC and Medicaid clients only. The State's outlook for the FQHC is not available for this, even though they are a VFC provider. For the ACO's, the supplements will require a method to identify the physician providing the service and how the enhanced rate will reach them. Encounter data may be one possible solution.

Janida then had questions on the types of facilities that qualified for the payment and believes that there may have been an incorrect interpretation on policy. John and Michael agreed to continue the conversation outside of the MCAC to see if a resolution could be found on this issue.

7. **MCAC Website (health.utah.gov/mcac)** – Josip Ambrenac

Josip then showed everyone the new MCAC website, which is health.utah.gov/mcac, and explained the different things about it to everyone. He said he is hoping this will be helpful in getting information and materials out to those interested. Meeting materials and information will be archived. He said that if anyone has any suggestions in regard to this web site to let him know.

Michael then discussed the annual report available on the Medicaid section of the Department of Health page.

8. **Director's Report** – Michael Hales

HAC Strategic Plan Advisory Group

Michael stated that a new advisory committee has been established to provide assistance to the department; it will be known as the HAC (Health Advisory Committee). Nate Checketts provided some additional details of the committee and the goals and strategies it will employ. Improving health outcomes and transforming Medicaid

are a few examples. Nate then asked if any of the MCAC members would like to participate as part of this group working on these goals. Should anyone be interested, they are welcome to contact him directly or Josip Ambrenac who can forward the request. Their next meeting is February 6th at 9:00 a.m. They will have a conference line for this. The HAC will be an on-going project and will likely become more of a 'living process' and seek to address problems or opportunities for improvement. Russ said it would be helpful to have something sent out to the MCAC members in regard to this and Nate said he would do that.

Michael then went over the strategic goals in regard to this. There are four goals. The first goal is healthiest people, then health and health reform, transform Medicaid, and a great organization. Michael said they will get everyone a little write-up in regard to this.

Upcoming Legislative Session

Michael said the tentative schedule on Appropriation Meetings is supposed to be posted tomorrow. This will be posted with various subjects that will be discussed at these meetings. They will be having public testimony at these meetings for the first 20 or 30 minutes of the meetings. Michael went over what the meeting schedules will be for this. He said they will probably have public hearings between 5:00 and 7:00 p.m. The first meeting will be on January 30th. Medicaid expansion will be discussed on February 1st. Michael encouraged everyone to go out to the Legislative web site, le.utah.gov, to see what the schedule is and it will show you what will be discussed on the different days.

Michael said there are a lot of new members on the Committee. He mentioned who will be the chair and vice-chair of this committee and who will be on the committee. Michael said we as members of the Department have tried to meet with as many members of the Appropriations Sub- Committee as we can.

Michael then discussed different legislation. He said there are a number of bills that have already been numbered out on the web site that people can go look at.

Michael said we are expecting to get the report back on Medicaid expansion by the end of January. The Appropriations Sub-Committee wants this presented.

National Medicaid Issues

Michael first mentioned the fiscal cliff and how it affects Medicaid. He mentioned the sequestration but said Medicaid is in a hold harmless in regard to this. Michael mentioned different things that could be affected if the sequestration does go through in answer to a question. Michael mentioned two populations on the Medicaid Program that are only authorized on a temporary basis. One is the qualified individuals who are a dually eligible population, Medicare and Medicaid beneficiaries, as well as the transitional Medical Assistance and Medicaid. Both of these programs ended up being extended to the end of 2013. Michael said we have now been working on re-opening these cases. He said he has recently been told that all the cases have been reopened. Approximately 14,000 cases were involved.

CMS has been issuing some new rules this week. He said one of the new rules is relating to the new eligibility expansion. Michael explained the application of the mental health clarity and addiction bench-mark materials. The Division has not had the opportunity to look at these items too in-depth and additional reading will be needed to find out the implications of this. There is likely to be some changes made with changing differential co-pays for some of the drugs. Starting in 2015, for the population under 150% of the poverty level, the co-pay

will be $4.00. For a non-preferred drug, they would allow us to charge $8.00. This is likely in response to previous requests and proposals by states to allow coverage for non-preferred drugs.

9. **Other Business** – MCAC Members

Michael then talked about the data loss that was announced yesterday. He explained that this happened as a result of a third-party contractor from Goold Health Systems (GHS) misplacing some personal information on approximately 6,100 Medicaid clients. Goold Health Systems processes Medicaid pharmacy transactions for the Utah Department of Health (UDOH). The information misplaced included their Medicaid ID, their age, and information on pharmacy claims, but no Social Security numbers or dates of birth. The contractor from Goold Health Systems lost a memory stick containing this information. The action taken by this worker was in violation of the contract which Medicaid has with Goold. The Division has been working to notify the individuals who may be impacted by this breach as well as the general public.

Russ asked if we knew what plans these people were in. Michael said he did not think we had looked at this yet. Emma said she had sent information to the plans in case they get any questions in regard to this. She said they have the same information on this as the Health Department staff do. Emma said that she asked Todd Neff to send this out to all the providers, etc.

Michael said we are taking measures to recover any costs associated with this incident. He said we are going to be working very closely with the company that did this in regard to penalties and fines.

Chairman Nehring suggested that we adjourn the meeting and Russ seconded his suggestion. The meeting was adjourned at 3:30 p.m.