

## MEDICAL CARE ADVISORY COMMITTEE MEETING

Minutes of the July 18, 2013 Meeting

### IN ATTENDANCE

- PRESENT: Lincoln Nehring, Warren V. Walker, Matthew Slonaker, Tina Persels (on phone), Andrew Riggle, E. David Ward (on phone), Debra Mair, Michael Hales, Dr. Jensen (on behalf of Dr. Horgesheimer), Christine Evans (on behalf of Tina Persels), Jackie Rendo (on behalf of Rebecca Glathar)
- EXCUSED: Russ Elbel, Mauricio Agramont, Mark Brasher, Jason Horgesheimer, Greg Myers, Rebecca Glathar
- ABSENT: Kevin Burt, LaPriel Clark, LaVal Jensen, Michelle McOmber
- STAFF: Kolbi Young, John Curless, Craig Devashrayee, Rick Platt, Emma Chacon, Tonya Hales, Sheila Walsh-McDonald, Nate Checketts, Gail Rapp, Josip Ambrenac
- VISITORS: Bill Cosgrove, Roberto Penraza, Mark Ward, Nalani Namauu, Todd Wood, John Borer, Beau Calvin, Robin Muck (on phone)

#### 1. Welcome – Lincoln Nehring

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

#### 2. Public Hearing Discussion & Voting Instructions - MCAC Members

Chairman Nehring stated that the MCAC would be voting on the budget recommendations following the June public hearing. Michael re-capped the 6 items that were discussed in June and asked if any members of the committee had questions or items that needed additional discussion.

Dr. Cosgrove asked if administrative cost-savings were considered with the 12-month continuous eligibility. Providers may receive a benefit where they would not have to check on a member's eligibility each month. Michael stated this was not included in the estimates.

Tina asked how the transition program funding worked with the change from facility based care to a Medicaid waiver. Michael stated that each of the waivers individually needed to demonstrate cost utilization on aggregate less than the expense of receiving facility-based care. These estimated 16 new individuals would be added to that calculation.

No further questions or discussion took place at which point the members in attendance completed their ballots to add to those who voted prior to the meeting.

### 3. New Rulemakings – Craig Devashrayee

Rule; (What It Does); Comments.	File	Effective
<b>R414-70 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices;</b> The purpose of this change is to remove all references to the Medical Supplies List, which is replaced by the Coverage and Reimbursement Code Look-up Tool, and is not an attachment to the Medical Supplies Provider Manual.	4-17-13	7-1-13
<b>R414-1-30 Governing Hierarchy;</b> This change is necessary to comply with House Bill (H.B.) 106, 2013 General Session, which requires the Office of Inspector General of Medicaid Services (OIG) to identify conflicts between the Medicaid State Plan, Department administrative rules, Medicaid provider manuals, and Medicaid information bulletins (MIBs), and to recommend that the Department reconcile inconsistencies.	4-29-13	7-1-13
<b>R414-509 Medicaid Autism Waiver Open Enrollment Process;</b> The purpose of this change is to clarify legislative intent to implement the Medicaid Autism Waiver under H.B. 272, 2012 General Session. This amendment clarifies that children who are two years of age through six years of age are eligible to receive Medicaid services under the Autism Waiver if they meet other eligibility requirements. This change, therefore, extends eligibility for the waiver through six years of age. This amendment also makes other clarifications.	4-29-13	6-28-13
<b>R414-51 Dental, Orthodontia (Five-Year Review);</b> The Department will continue this rule because it sets forth eligibility and access requirements for the Orthodontia Program, and specifies service coverage and reimbursement methodology.	4-30-13	4-30-13
<b>R414-401-3 Assessment;</b> The purpose of this change is to calculate the per patient day assessment for both nursing facilities and intermediate care facilities for persons with intellectual disabilities (ICFs/ID).	5-1-13	7-1-13
<b>R414-506 Hospital Provider Assessments;</b> The purpose of this change is to implement the Hospital Provider Assessment Act in accordance with S.B. 166S02 of the 2013 General Session of the Utah Legislature and to update the rule to allow new providers.	5-1-13	7-1-13
<b>R414-11 Podiatry Services;</b> This amendment broadens client access to podiatric services through a provision that allows podiatrists to perform services within their scope of license to all categorically and medically needy recipients. It also makes other clarifications and refers to the Podiatric Services Provider Manual for descriptions of all non-covered services, covered services and service limitations.	5-1-13	7-1-13
<b>R414-52 Optometry Services; (Five-Year Review);</b> The Department will continue this rule because it sets forth eligibility requirements, service coverage, and reimbursement methodology for providers and recipients of optometry services.	5-1-13	5-1-13
<b>R414-53 Eyeglasses Services (Five-Year Review);</b> The Department will continue this rule because it sets forth eligibility requirements, service coverage, and reimbursement for providers and recipients of eyeglasses services.	5-3-13	5-3-13
<b>R380-250 HIPAA Privacy Rule Implementation (Five-Year Review);</b> The Department will continue this rule because it sets forth the responsibility of covered programs to safeguard health information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will also continue this rule to allow individuals under HIPAA to access their PHI, request to amend their PHI, and to request an accounting of disclosures.	5-6-13	5-6-13
<b>R382-1 CHIP Benefits and Administration (Five-Year Review);</b> The Department will continue this rule because it describes benefits, limitations, enrollment, reimbursement, cost sharing, and the fair hearings process for providers and enrollees within the Children's Health Insurance Program.	5-8-13	5-8-13
<b>R382-10 CHIP Eligibility (Five-Year Review);</b> The Department will continue this rule because it sets forth eligibility requirements for children to receive CHIP coverage.	5-9-13	5-9-13

<p><b>R414-14A-26 Payment for Nursing Facility, ICF/ID, and Freestanding Inpatient Hospice Unit Room and Board;</b> This change is necessary to comply with the mandate for concurrent care as found in the Patient Protection and Affordable Care Act. This change will promote the ability for children to receive true concurrent care rather than having to make a choice between hospice care and skilled care in a facility. This amendment, therefore, updates the Medicaid Hospice program to reflect the hospice room and board payment rate at 100% of the amount a child would have received in a skilled nursing facility or an intermediate care facility for persons with intellectual disabilities (ICF/ID).</p>	<p><b>5-22-13</b></p>	<p><b>7-22-13</b></p>
<p><b>R414-508 Requirements for Transfer of Bed Licenses (Five-Year Review);</b> The Department will continue this rule because it sets forth requirements for nursing facilities to transfer bed licenses, sets forth requirements for nursing facilities that receives bed licenses, and spells out provisions for license expiration and forfeiture. All of these requirements provide cost effective services for Medicaid recipients.</p>	<p><b>5-30-13</b></p>	<p><b>5-30-13</b></p>
<p><b>R380-250 HIPAA Privacy Rule Implementation;</b> The purpose of this change is to comply with S.B. 20 State Security Standards for Personal Information, which requires health care providers to provide notice to the patient or the patient’s personal representative that the health care provider either has, or may submit, personally identifiable information about the patient to the Medicaid eligibility database and to the Children’s Health Insurance Program (CHIP) eligibility database.</p>	<p><b>6-3-13</b></p>	<p><b>8-7-13</b></p>
<p><b>R414-51 Dental, Orthodontia;</b> This amendment clarifies access requirements, service coverage, limitations, and reimbursement for orthodontia services. It also makes other technical changes.</p>	<p><b>6-4-13</b></p>	<p><b>8-7-13</b></p>
<p><b>R414-1-5 Incorporations by Reference;</b> 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 Utah Medicaid Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Medical Supplies Utah Medicaid Provider Manual; Hospital Services Utah Medicaid Provider Manual with its attachments; Speech-Language Services Utah Medicaid Provider Manual; Audiology Services Utah Medicaid Provider Manual; Hospice Care Utah Medicaid Provider Manual; Long Term Care Services in Nursing Facilities Utah Medicaid Provider Manual; Personal Care Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals 65 or Older Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services Autism Waiver Utah Medicaid Provider Manual; Office of Inspector General Administrative Hearings Procedures Manual; Pharmacy Services Utah Medicaid Provider Manual; Coverage and Reimbursement Code Look-up Tool; Certified Nurse – Midwife Services Utah Medicaid Provider Manual; CHEC Services Utah Medicaid Provider Manual with its attachments; Chiropractic Medicine Utah Medicaid Provider Manual; Dental Services Utah Medicaid Provider Manual; General Attachments for the Utah Medicaid Provider Manual; Indian Health Utah Medicaid Provider Manual; Laboratory Services Utah Medicaid Provider Manual with its attachments; Medical Transportation Utah Medicaid Provider Manual; Mental Health Centers/ Prepaid Mental Health Plans Utah Medicaid Provider Manual; Non-Traditional Medicaid Health Plan Utah Medicaid Provider Manual with its attachments; Certified Family Nurse Practitioner and Pediatric Nurse Practitioner Utah Medicaid Provider Manual; Oral Maxillofacial Surgeon Services Utah Medicaid Provider Manual; Physical Therapy and Occupational Therapy Services Utah Medicaid Provider Manual; Physician Services and Anesthesiology Utah Medicaid Provider Manual with its attachments; Podiatric Services Utah Medicaid Provider Manual; Primary Care Network Utah Medicaid Provider Manual with its attachments; Psychology Services Utah Medicaid Provider Manual; Rehabilitative Mental Health and Substance Use Disorder Services Utah Medicaid Provider Manual; Rehabilitative Mental Health Services for Children Under</p>	<p><b>6-10-13</b></p>	<p><b>8-7-13</b></p>

<p>Authority of Department of Human Services, Division of Child &amp; Family Services or Division of Juvenile Justice Services Utah Medicaid Provider Manual; Rural Health Clinic Services Utah Medicaid Provider Manual with its attachments; School-Based Skills Development Services Utah Medicaid Provider Manual; Section I: General Information of the Utah Medicaid Provider Manual; Services for Pregnant Women Utah Medicaid Provider Manual; Substance Abuse Treatment Services &amp; Targeted Case Management Services for Substance Abuse Utah Medicaid Provider Manual; Targeted Case Management for CHEC Medicaid Eligible Children Utah Medicaid Provider Manual; Targeted Case Management for the Chronically Mentally Ill Utah Medicaid Provider Manual; Targeted Case Management for Early Childhood (Ages 0-4) Utah Medicaid Provider Manual; and Vision Care Services Utah Medicaid Provider Manual (Updates to July 1, 2013).</p>		
<p><b>R414-55 Medicaid Policy for Hospital Emergency Department Copayment Procedures (Five-Year Review);</b>  The Department will continue this rule because it defines emergency services to help Medicaid recipients and Medicaid providers to understand cost sharing responsibilities for non-emergency services. The Department will also continue this rule because it refers recipients and providers to copayment policy found in the Medicaid State Plan and in administrative rule.</p>	<p><b>6-28-13</b></p>	<p><b>6-28-13</b></p>

There were no questions regarding any of the rule changes.

4. Budget Update – Rick Platt

Rick provided an overview of some of the changes in Medicaid population numbers during FY13. In June, a total of 259,206 people were served, a decrease of 840 from May. By sub-group those over 65 had an increase of 512 in June, 618 for the fiscal year; Individuals with disabilities had an increase of 161 in June, 1,547 for the fiscal year; Children decreased 909 in June, but an increase for the fiscal year of 4,306; Pregnant Women had an increase of 38 in June, but a fiscal year decrease of 69; and Adults had a June decrease of 642, but a fiscal year increase of 231. Overall enrollment was at about 2.5% which was very close to projected.

Andrew Riggle asked what was driving the increase in the number for individuals with disabilities. Rick stated that was not known, but that segment was growing at roughly 5%. Chairman Nehring asked how close the Department was to fiscal projections. Michael stated that growth of the Medicaid population was very close to projected, but costs were quite a bit lower than anticipated.

5. Medicaid Autism Waiver Amendment – Tonya Hales

Tonya Hales then spoke regarding proposed changes to the Autism Waiver. Department staff have been holding meetings with providers which include the operating agency at DSPD, support coordinators, providers and department staff. Many changes have been recommended, a few are looking to be incorporated into an amendment to be submitted in the upcoming weeks.

One change is to have a new classification of individual added to those who can supply consultation service under the waiver. Currently, only BCBA's, licensed Psychologists and BCBA interns (those pursuing a BCBA and under direct supervision of a BCBA) are able to provide the service. BCBA's are Master's prepared individuals. Providers stated there is another group of workers that is similar to the intern classification called BCaBA's. These are Board Certified Assistant Behavior Analysts who

are Bachelor's prepared but have completed 1000 hours and are also under direct supervision of a BCBA. The Department is looking to add this classification of individual to provide consultation services. This will help extend capacity of service providers.

Also, the supervision component of interns which currently requires at least 1 hour per week is to be changed to a ratio of the numbers provided, along with a monthly component. There are currently many individuals who may be working at locations such as Pingree who are willing to supply a small number of hours but current supervision requirements are prohibitive.

The unit length of consultation service is also to be changed from the current hourly unit to a quarter hour unit to more accurately reflect utilization.

Tonya added that discussing these items with the MCAC was a requirement in order to file the amendment to solicit feedback or address concerns prior to the implementation of the changes.

A question was asked regarding the future of the program and what outcome data might be available. Tonya responded that as part of HB272 a Legislative report is required that will be delivered to the Health and Human Services Interim Sub-Committee this fall. This report is currently in construction and will include information on the 250+ children receiving services. It will also discuss any concerns about the program implementation such as rural access issues. One challenge the Department is currently facing is acquiring workers in the Vernal/Price areas. When regional economies are performing well it can be challenging to find qualified providers. The existing provider network has made an outstanding effort to reach families throughout the state and expand their services to accommodate so many children so quickly.

Warren then asked questions on how progress was being determined. Tonya responded that industry accepted standardized assessment tools were looked at during the program development. A baseline assessment is completed and then a reassessment at 6-month intervals by the BCBA/psychologist. Chairman Nehring then asked if any kind of consumer satisfaction survey was being completed. Tonya replied that another assessment tool, called the Vineland II, was being completed by parents at the same intervals to capture progress they see in their children.

#### 6. Dental Accountable Care Discussion – Lincoln Nehring

Chairman Nehring then reintroduced a topic from the June MCAC that needed additional discussion, but without a quorum, the committee could not take any action at this time. This discussion was in regard to the changes to Medicaid dental in the Wasatch front under an Accountable Care model.

Dr. Jensen, who was sitting in on behalf of Dr. Horgesheimer who introduced this topic in June provided an update on what has been occurring. He introduced himself as the current Treasurer for the State Academy of Pediatric Dentistry and wanted to discuss concerns about access issues and transfers to the ACO model. He mentioned that there have been meetings between providers, the

two plans and state staff to discuss problems and come up with solutions. One of the biggest concerns from dentists was that while this change has been known about for several months that providers were not given materials/manuals/rules policies until just recently from the insurance companies. This information was critical for them to negotiate with the plans. The manuals were just received on Monday and providers have such limited time to prevent any issues if the plans were to go into effect on September 1<sup>st</sup>. Dr. Jensen continued to say he was very appreciative of the recent collaboration with the plans and thinks there is certainly common ground but would like to request more time so that the dental provider network has more time to prepare. An additional 30-day extension is being requested and although they understand the issue with postponements, the provider community feels as if they finally have the details they need. Emma commented that a 90-day transition period is part of the contract and would require the plans to pay any dentist during this period. She continued to say that the system changes need to take place and progress needs to move forward. Further delays may not be possible. Provider lists have been requested frequently, they will now be supplied weekly. Mailings to clients are also continuing directing them to the website/contact numbers of the plans and HPR's with the state to find out if their providers are still available, or the begin moving their records and appointments to a new provider. The 90-day transition window seems it would be sufficient to accomplish this.

Emma continued to say that one of the plans is modeling their enrollment and operating procedures to a system that was very close to the state's administration of the program while the other plan has chosen a different method. The Department is committed to working to ensure continuity of care is maintained. As new providers enroll, it is the Department's intention to help facilitate any change that may be needed for a family to keep their preferred dentist. Chairman Nehring then asked if the list of dentists show the difference between specialists and general dentists. Emma confirmed that this information is being posted. Chairman Nehring asked what communication families have received so far. Emma responded that letters are being created to send out to all affected individuals and letting them know what steps they need to take. The Department strongly encourages anyone with questions to contact the plan's customer service lines, but is really advocating for them to call the HPR's.

Chairman Nehring asked how a client can find out which dentist is on what plan. Emma stated this information can be obtained from the plans, either through their website or by calling the plans or by contacting the HPR's. The benefit of contacting the HPR's is that they can assist a family from start to end in this process. A question was asked on if mailed correspondence includes a full provider list as well. Emma stated it does not as it would contain far too much information and would be out of date fairly quickly. The information is very basic, kept to contact information and letting them know a choice is required, or a plan will be assigned. The material is kept to a 6<sup>th</sup> grade reading level.

Dr. Jensen expressed appreciation for the work being done but wanted to reiterate that providers have only had the information from the plans for 2-3 days and would like more time to evaluate. A significant amount of administrative work will need to be done providers if they choose to

participate or not. Michael commented that the end of August is not a deadline and that provider enrollment can occur well after that and mentioned that October will be an incredibly busy time for the Department with many of the ACA changes taking place. It was re-stated that the plans are required to pay any dentist during the 90-day transition period, but if an agreement can be reached with the plan before that that would work as well. Dr. Jensen stated that the 90 days isn't the biggest concern providers are facing, however it is appreciated. The confusion to clients is a much larger consideration. Many providers may not have made a decision and a large number of pediatric dentists have reservations.

A question was asked on if dentists were allowed to help clients select a plan. Emma confirmed it is ok for providers to let clients know which plan they participate with and share their preferences. They can also provide information to clients on how to contact the HPR's to request a plan change. Changes would then be reflected on the individual's Medicaid card in future months.

Chairman Nehring then brought attention to a letter supplied by Dr. Cosgrove. Dr. Cosgrove wanted to state that the medical pediatric community is in strong support of pediatric dentists and is concerned with how the slices of pie in Medicaid funding keep getting smaller and smaller in addition to the overall issue of the size of the pie and ensuring adequate funding is being received.

#### 7. Dental Coverage for Elderly/Nursing Facility Groups – Warren Walker

Warren started by sharing a slogan: "life happens in the kitchen". This is a concern that elder residents share. It is understood that there is not currently enough funding available for all medical need in society but that we need to advocate for areas that are underrepresented. An area of concern is for dental care for those who may be admitting to nursing facilities for short-term rehab stays or for more long term placements. About 60-70% of current admits have moderate to severe oral concerns.

Skilled nursing facilities are highly regulated, both by the federal and state governments. Surveys and investigations are conducted frequently. The surveys have very specific questions about dental care: Does the facility have a dentist? Their name? Do they perform services timely? Oral screen performed? Pain mouth/pain chewing? Dentures fitting ok? Nutritional level ok? If a facility is found deficient in any of these areas, a citation may be issued.

Warren continued by stating that caring for the elderly requires much more intervention than just home health, physical therapy, or skilled nursing services alone. Many common ailments have links to poor oral health. Heart and liver disease as well as many other medical issues can be found through oral exams.

A research campaign was started with the U of U aiming to document that preventative dental care can improve overall health and emotional care of patients. The group looked at were from the ages of 45 to 90. A hypothesis was developed to see if dental care could improve many common medical

issues such as weight loss, high rates of infections, pain management, etc. The project has not been completed at this time, but preliminary findings indicate a strong correlation between dental care and positive health outcomes such as decreases in medication needs and declines in behavioral issues.

The state should consider/reconsider where dollars are spent. There may be a substantial cost savings/offset that is not currently being considered. Obtaining dental services can be costly. Getting patients to dentist, finding dentists, especially if there are any mental health concerns is very challenging. Facilities are currently bearing this cost to prevent issues during site surveys. Many admits require significant dental work, often exceeding the \$1200-1500 initial need that Medicaid children have. An investment in preventative care may lead to better quality of life, health outcomes and could help prevent nursing home admits in the first place.

Medicare does not pay for most preventative services and long-term Medicaid patients are typically only able to keep \$45 per month of income for their personal needs. The remainder of their income is paid as their contribution to care. This amount can be reduced if the individual has an insurance policy, but the question is how to get this insurance and providers to supply care. Unpaid medical bills can also be supplied to eligibility workers at DWS to reduce the contribution to care payments to help acknowledge these expenses as well. Michael added that Medicaid currently pays for around 60% of long-term care clients statewide. He also asked if this issue extends to private pay and Medicare clients and if the nursing facilities also assist these clients. Warren added that the cost for these individuals is often incurred by the facility as well.

Michael continued to say that the use of unpaid bills/acknowledge insurance premiums may be something that case managers and facilities are not aware of. This is reliant upon a Medicaid client having income. Those without income, or receiving SSI would not have a contribution to care requirement.

Warren concluded by state that an expansion of adult dental coverage would greatly aid to address these health concerns.

#### 8. PCP/VFC Enhanced Rate Update – John Curless

John started by saying that Fee For Service payments have been made for the first and second quarters of 2013. For the first quarter, the enhanced reimbursement was for claims that were received and paid in the quarter and that occurred on or after January 1, 2013. It is likely that many which occurred in the first quarter were not processed immediately and some will fall into quarter two. \$388,000 was paid out in Q1; \$1,071,000 in Q2. More providers have now become eligible as well which could be a factor.

Quarter one of managed care has been paid as well, approximately \$1.5 million. Quarter two has not been paid yet, hopefully in the next couple weeks.

Not too many more attestations have been received, although many duplicate submissions and re-attestations have.

Dr. Cosgrove commented that he thinks this is a strategy to develop a larger provider network and the reason for physicians enrolling to become Medicaid providers should be captured. John confirmed that motive is not captured at this time. Michael mentioned that by looking at the overall new physician enrollment versus the new physicians eligible for the enhancement could provide some information on this. Historical and current enrollment trends may help as well. Dr. Cosgrove then asked if there may be any benefit to survey providers. Michael mentioned that the Department could look for anything objective that could be observed from the existing data and added that managed care payments are being published by physician. John stated this was occurring for FFS too. Michael commented that this is being done so that physicians know what their reimbursement should be after it is passed through by the ACO. John added that the amount may be slightly different as the enhancement would be the amount needed to reach Medicare levels.

9. 3<sup>rd</sup> Party Medicaid Information – Matt Slonaker

Chairman Nehring stated that this agenda item will be postponed for a future MCAC meeting.

10. Movement of Children from CHIP to Medicaid – Emma Chacon

Emma started by talking about the changes with the ACA causing many current CHIP recipients to become Medicaid eligible due to the income limit/asset changes in policy. The Department initially believed that CMS would allow CHIP children to move to Medicaid as their renewals became due. The Department had been preparing to move children throughout 2014. Roughly 23,000 of the currently enrolled 35,000 children on CHIP would become Medicaid eligible. CMS has now clarified that all children should be moved accordingly on January 1, but will accept proposals from states to move all children in a 3-4 month period. These proposals need to be submitted and approved by CMS.

The Department plans to communicate this to families starting in September to make them aware and providing additional notice in December containing more information. As changes occur additional info would be provided as well. The Department's priority is to maintain continuity of care.

A large concern is the operational impact to DWS. Moving families throughout a 12-month period would have been greatly beneficial. Meetings have been set up to develop strategies, both to acknowledge the concerns of families and state staff. This plan will be submitted to CMS.

Chairman Nehring asked if this information is being given to providers. Emma confirmed this is being shared with the CHIP and Medicaid plans during monthly meetings and the change is understood.

Chairman Nehring followed up by asking if rural areas are offering less choice. Emma responded that this hasn't been looked at quite yet. Rural individuals have the option to go FFS, or can pick a Managed Care plan if one does exist in their area.

Dr. Cosgrove asked if there was a difference if providers will accept CHIP or Medicaid or both. Emma confirmed there were a handful of CHIP only providers that did exist. Their clients would need to select a new provider and hopefully the early communication efforts by the Department will aid in this. Dr. Cosgrove then asked if there were any HIPAA concerns with pediatric physicians pressuring other doctors in their field to enroll as Medicaid physicians. Michael stated this is likely not a HIPAA issue as provider lists by plan are available, however it may be a very sensitive topic.

#### 11. Director's Report – Michael Hales

Michael started by announcing some upcoming dates. The ACO workgroup on quality measures is scheduled for 7/29 from 1-3 p.m. for their quarterly meeting. The reduction of ER utilization in non-emergent situations is scheduled as the discussion topic. The Medicaid Expansion workgroup is scheduled for 8/1 at 1:30 p.m. The 5 sub-groups will be reporting back and this material will be presented in late September at the Governor's summit.

The Department received information from CMS that the PCN program has been extended. It would have otherwise terminated on 6/30. The waiver requires renewal every 3 years; however CMS only provided an extension through 11/15/13. CMS would like the state to continue to evaluate the options for Medicaid expansion. The Governor's summit is likely going to be a key activity in this discussion.

If the waiver were to end in mid-November, the state would have a 6-month transition period to move individuals off the program. Insurance tax credits may aid in this transition as they can be provided to individuals at 100% of the FPL. An option the state is considering is extending eligibility to 100% of FPL, then allowing the tax credits for those over 100%. Should the state not expand Medicaid eligibility, there is approximately \$4.5-5 million in general funds that could be used for an alternative plan. The state would lose the 70% FMAP match however which is currently around \$12 million. If Medicaid expansion does not take place, many decisions will need to be made. MCAC members are being asked to be prepared for these transitions and the discussions that may be needed. The Department will need assistance to discover possible transition issues. As an example, the state may choose to use the general funds to cover adults up to 25% of the FPL. A limited benefit program is likely not going to be optional moving forward. Efforts could be made to restore the previous UMAP program.

#### 12. Results of Voting – Michael Hales

Michael then went over the results of the MCAC voting on the budget items:

##### 1. Medicaid Adult Expansion

2. Adult Dental Coverage
3. 12-month continuous
4. 5-year bar elimination
5. Transition program
6. Circumcision coverage

Dr. Cosgrove asked if optional Medicaid expansion would also include adult dental coverage. Nate Checketts responded that the essential benefit package only requires coverage for children. Michael confirmed adult dental would still remain a separate decision.

The meeting was adjourned by Chairman Nehring at 3:25 p.m.