

**MEDICAL CARE ADVISORY COMMITTEE MEETING**

Minutes of the March 21, 2013 Meeting

**IN ATTENDANCE**

- PRESENT:** Lincoln Nehring, Russ Elbel, Mauricio Agramont, Matthew Slonaker, Michelle McOmber, Greg Myers, Pasu Pasupathi, Andrew Riggle, Mark Brasher, Michael Hales
- EXCUSED:** Warren V. Walker, Kevin Burt, LaPriel Clark, LaVal B. Jensen, E. David Ward
- ABSENT:** Rebecca Glathar, Jason J. Horgesheimer, Tina Persels, Debra Mair
- STAFF:** Michelle Smith, John Curless, David Lewis, Emma Chacon, Sheila Walsh-McDonald, Dr. Steve Steed, Rick Platt, Josip Ambrenac, Gayle Coombs
- VISITORS:** W. E. Cosgrove, MD, Joyce Dolcourt, Mark Ward, Doug Springmeyer, Kris Fawson, Kelly Peterson

**1. Welcome – Lincoln Nehring**

Chairman Nehring called the meeting to order at 1:30 p.m. and welcomed everyone.

**Approve Minutes of January 17<sup>th</sup>, 2013 Meeting**

Chairman Nehring then asked for a motion in regard to approving the minutes from the last meeting. Russ Elbel made the motion to approve the minutes and Pasu Pasupathi seconded the motion. The minutes were approved as written.

**2. New Rulemakings – Craig Devashrayee**

Craig then went over the DMHF Rules Matrix 3-21-13.

<b>Rule; (What It Does); Comments.</b>	<b>File</b>	<b>Effective</b>
<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 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 (Updates to January 1, 2013).	<b>12-28-12</b>	<b>3-1-13</b>
<b>R414-301 Medicaid General Provisions (Five-Year Review);</b> This rule should be continued because it defines terms	<b>1-23-13</b>	<b>1-23-13</b>

necessary for eligibility purposes. This rule also discusses the authority of the Department to contract with the Department of Human Services and the Department of Workforce Services.		
<b>R414-302 Eligibility Requirements (Five-Year Review);</b> This rule is necessary because it outlines eligibility requirements for Medicaid clients to receive Medicaid services.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-303 Coverage Groups (Five-Year Review);</b> The Department should continue this rule because it establishes requirements for certain groups who qualify for Medicaid coverage and allows these groups to receive Medicaid services.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-304 Income and Budgeting (Five-Year Review);</b> The Department should continue this rule because it establishes income-based eligibility requirements for Medicaid applicants who want to become eligible for certain Medicaid programs.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-305 Resources (Five-Year Review);</b> The Department should continue this rule because it establishes resource standards to determine eligibility for categorically and medically needy Medicaid recipients.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-306 Program Benefits and Date of Eligibility (Five-Year Review);</b> The Department should continue this rule because it establishes criteria for program benefits available to Medicaid recipients and the dates of eligibility for these services.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-308 Application, Eligibility Determinations and Improper Medical Assistance (Five-Year Review);</b> The Department should continue this rule because it informs Medicaid recipients of requirements for medical assistance applications, eligibility decisions, and improper medical assistance.	<b>1-23-13</b>	<b>1-23-13</b>
<b>R414-303 Coverage Groups;</b> The purpose of this change is to extend Medicaid coverage for Transitional Medical Assistance (TMA) and the Qualifying Individual (QI) program in accordance with the American Taxpayer Relief Act of 2012, Pub. L. No. 112 240.	<b>2-13-13</b>	<b>4-8-13</b>
<b>R414-6 Reduction in Certain Targeted Case Management Services (Five-Year Review);</b> The Department should continue this rule because it defines TCM services for Medicaid recipients and specifies TCM services that are not available.	<b>3-8-13</b>	<b>3-8-13</b>
<b>R414-29 Client Review/Education and Restriction Policy (Change in Proposed Rule);</b> The purpose of this change is to clarify restriction policy and the restriction review process for the Medicaid program, based on internal review within the Department.	<b>3-15-13</b>	<b>5-8-13</b>

Pasu Pasupathi had a question in regard to rule R414-29 in regard to the restriction policy and Michael Hales explained that we were just changing some of the language related to how we initiate putting them on the program. Emma Chacon also stated that information was added on emergency criteria as well.

Joyce Dolcourt then asked for more of an explanation in regard to R414-303. Craig responded that this was a reinstatement of transitional medical assistance and QI (Qualified Insured) programs which were set to end December 31, 2012 but were reinstated and funded through the end of the year. Russ asked if they had to go through the rule making process and Craig said yes. Michael also added that continuing these programs past the date would have meant using 100% state funding. Dr. Cosgrove asked if there is any ability to access the State's rainy day fund to grant coverage for an extra 30 days after the funding deadline. Michael said there is no way we can do that now. He said any money not linked to the Legislative guideline would require Legislative appropriation. Greg Myers asked if this was something that could be accomplished through the interim session with the Legislature. Michael said he felt this would be a good avenue to start discussing at one of the interim meetings, at the very least to alert the Legislature to this issue and its impact on Medicaid recipients.

### 3. **Budget Update** – Tracy Luoma

Tracy then went over the 2012 Utah Annual Report of Medicaid and CHIP. She said page 5 goes over the Division Highlights for SFY 2012 and page 7 goes over Medicaid Finance. Page 13 gives information on Medicaid Enrollment, page 19 discusses different Medicaid Services and page 41 is in regard to CHIP.

Tracy then gave the report on the budget. A handout was given to everyone entitled Utah Cases Served Report Number of Persons. Tracy said we are still on track for what we have been predicting for the year. The enrollment level for Medicaid in February was 259,786.

Some discussion occurred about the observed spike in enrollment numbers in January of 2013, however many factors may have attributed to the increase. Michael mentioned a potential reason may have been the re-enrollment of individuals previously dis-enrolled from the transitional and QI programs. Application dates and processing dates may have fallen into different months causing some data volatility.

Tracy then introduced Rick Platt who is the new Director of the Bureau of Financial Services.

**4. PCP/VFC Provider Enrollment Update – John Curless**

John said they have posted a spreadsheet on the attestations they have received. He went over some of the things they found on this spreadsheet in regard to the attestations. At this time, 1,864 physicians were enrolled without any noticeable spikes in progress week to week. They have had a few instances where non-physicians were applying as well as approximately 85 cases where a self-attestation was not completed; it was another individual applying on behalf of the physician. The State Plan amendment was just submitted to CMS, allowing a maximum of 90 days for a response, but the State has requested it be expedited (Submission was made on 3/20/13). Emma Chacon has been the lead on the Managed Health Care part of this with CMS. The on-line spreadsheet will be updated weekly.

Dr. Cosgrove asked a question in regard to the vaccination fees and how they have increased. John said it is based on the lower of in regard to the fees. He said they will still be paying the maximum \$14.52 for Medicaid. Providers should continue billing their usual and customary charges; the enhanced payment will help cover the difference in the \$14.52 rate and the provider charge, up to a maximum of \$20.72. Russ asked where this is on line. John said you go to the link below <http://health.utah.gov/Medicaid>, then click on fee schedule, and then click on physician enhancement.

**5. Quality Measures Update – Emma Chacon**

Emma said they are going to begin their meetings at regular times. She said their first meeting will be April 3<sup>rd</sup> from 1:00 to 4:00 p.m. and they plan on meeting every couple of weeks through May. She said after this process, they will have some language they can take back to draft the July 1 contracts. The plans will then have 6 months to work on preparing for the implementation. The State Quality Committee has been meeting to review existing measures and evaluating standards. Their goal is to come up with performance standards that everyone will agree with to create meaningful oversight and help improve/maintain patient outcomes. Michelle McOmber asked if there were any physicians on this committee. Emma said not at this stage, the work thus far has been internal to the Health Department, but that participation from the public and stakeholders will be greatly encouraged. A new website is being created to store agendas, minutes and meeting information.

**6. MCAC Representation on Quality Measures Project – Lincoln Nehring**

Chairman Nehring mentioned that a sub-group of MCAC members to be on this committee could be very valuable. Michelle McOmber, Matthew Slonaker, Chairman Nehring and Russ will participate on this committee. Kelly Peterson also stated she would like to participate.

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

**PCG Medicaid Expansion Report**

Michael said the PCG is the Public Consultant Group. They are working to gather data on the cost/savings to Medicaid expansion. He said they want to get all of this information and make sure it is accurate. Some specific areas being looked at currently are the impact expansion would have on the County jail and State corrections systems as well as the Mental Health system. These are areas where the State may be able to save significant funds if the expansion was adopted.

Pasu asked who is responsible for the report. Michael stated it is the Department of Health, but a deadline or time frame for the completion has not been established. All relevant factors to the discussion are being collected.

Lincoln asked how this report will be released to the public. Michael stated that it had not been determined at this time.

### **Legislative Session Update**

Michael said in terms of caseload, there were two counter-active parts of this for Medicaid. Based on projections for the newly eligible population as of 1/1/14, costs are estimated at \$15 million, however the Department experienced approximately \$17 million in savings leading to a net 'give-back' of \$1.8 million. For the CHIP program, many children will become eligible for traditional Medicaid with the changes to eligibility policy and an anticipated \$2.3 million in general funds was appropriated. An observed plateau in current enrollment has led to an \$800,000 return in funding.

A 2013 fiscal year adjustment was made for \$40.9 million of one-time funding to be returned. This was due primarily to lower than anticipated growth rates as well as a decrease in per-member, per-month (PMPM) utilization. Additionally, funding was provided to extend credit monitoring services for an additional year to those impacted by the data breach. MMIS project funding continuance funding was not appropriated, but cash-flow flexibility will be allowed in FY14.

Michael said the consensus numbers in regard to case load were broken out. He said this year the Federal match rate went up a little bit. Michael said there was an allowance for a 2% increase in the ACO service rates. In addition, the ACO administrative rate was also asked to be increased and this was also funded with one-time money for FY 2014.

HB-106 – This bill passed. This was related to the Inspector General's Office. This was moved out of the Governor's Office into the Department of Administrative Services. They extended the term from a two year term to a four-year term.

HB-315 – Representative Dunnigan's bill passed on its own right. They are focusing on having the Inspector General educate providers. It establishes the hierarchy of information relayed to providers when conflicting information is found in Medicaid Information Bulletins, manuals, rules, etc.

HB-140 – Sponsored by Representative Barlow – Payment Reform Payment Project. This is voluntary on behalf of providers. The Department has to form a group in regard to this.

HB-141 – Medicaid Emergency Room and Primary Care Amendments. They want to have incentive in place for people to use the emergency room appropriately.

HB-292 – Premium Assistance under Medicaid and CHIP.

HB-315 – A lot of this got wrapped into HB-106.

HB-329 – Medicaid Vision Amendments. Michael said we do not cover eye glasses for all Medicaid clients, only pregnant women and children. Michael said the implementation would involve the Division having to be cost neutral and coordination of the Health Plans and FFS would be needed.

SB-20 – The focus is for DTS to have certain enhanced reviews of their security systems. Privacy practices in regard to this were mentioned and the patients being made aware of them.

SB-56 – Utah 211 Referral information Network

SB-156 – Hospital Assessment Amendments. This authorizes the hospital assessment until 2016.

SB-207 – Repeal on Health and Human Service reports. Some reports were taken out of the statutory amendments.

### **New Federal Rules**

Preventive services were discussed. CMS sent out a document showing what preventive services would qualify for an additional 1% FMAP increase. Michael mentioned a letter they received earlier this week from Cindy Mann. Some new items that were mentioned in the letter were discussed that CMS is planning on starting June of this year. In June of 2013, the State will have to submit an updated payment report to CMS on in-patient/out-patient and nursing home coverage. In June of 2014, the Department will have to add more items such as medical clinics, intermediate care facilities, and residential treatment facilities to the report.

New information from CMS on prescription drug coverage was also discussed. For families at 150% below the poverty level, the co-pay will be able to be raised from \$3.00 to \$4.00. For non-preferred drugs for families under 150% of the poverty level, they could go up to \$8.00. For emergency room non-required use they could go from \$6.00 to \$8.00. Final regulations from CMS are to be developed; the Department will keep everyone posted on this.

### **Data Security/Privacy Update**

Michael said the Department has created a data security and privacy office consisting of 3 staff members. These individuals will be working closely with DTS to ensure standards are being followed. The target date for full implementation is July 1<sup>st</sup>. This is a continued effort to reinforce the sensitivity to data security and privacy.

### **Impact of Sequestration**

Michael said Medicaid and CHIP are exempt from this. He said the Department of Health may be targeted in future cuts and the long-term future of several grants is unknown. Many federal agencies still do not fully understand the impact of the budget reductions and information from the grant agencies should be disseminated as it becomes available.

Michael said he will keep everyone involved in regard to this.

**8. Other Business – MCAC Members**

There was no other business, so Pasu made the motion to adjourn the meeting and Michelle seconded the motion. The meeting was adjourned at 3:05 p.m.