

Medical Care Advisory Committee

Minutes of Meeting December 19, 2013

In Attendance

Committee Members Present: Lincoln Nehring, Mark Brasher, Michael Hales, Russ Elbel, Alan Pruhs (for LaVal Jensen), Mark Ward, Andrew Riggle, Steven Mickelson, Mauricio Agramont, Tina Persels

UDOH Staff Present: John Curless, Gail Rapp, Emma Chacon, Jeff Nelson, Rick Platt, Tracy Luoma, Nate Checketts, Craig Devashrayee, Janica Gines, Tonya Hales, Kim Michelson, Josip Ambrenac, Summer Perkins

Guests: Joyce Dolcourt, William Cosgrove, Beau Calvin, Rylee Curtis

Rulemakings

Craig Devashrayee presented the new rulemakings. There were no questions.

Budget Update/FY13 Review

Rick Platt presented the enrollment for November. There was a question last meeting about the decline in enrollments. It may be a sign that the economy may be improving, especially if child enrollment is decreasing as their parents are able to find employment with health insurance. We will continue to monitor the decline. It is in line with our projections. We have an economist who helps us. We expect there to be more children enrolling because of ACA in January and the changes in eligibility rules.

Consensus Forecast Process and Figures

Forecast Process

Rick Platt reported. His handout gave a web page where the final report will be available when it's finished near the beginning of the year.

Lincoln asked whether hospital and nursing assessments are included in Medicaid revenues. They are, and there are also seed payments, pharmacy rebates, and other things.

Alan asked whether provider types will be broken out in the final report—primary care, long-term care, etc. Michael replied that they are so divided. Michael pointed out that we will go over the final report at the January meeting. Lincoln asked how our expenditures compared to the budget. Rick replied that we were under budget, possibly because of increased revenues from MFCU and OIG. The surplus was about \$38M from FY13 that was carried.

State Budgeting Process

MCAC's recommended building blocks are combined with the department's, then prioritized and sent to the Governor's office.

Consensus is part of the building block process. We look for an agreement between the department and the legislative fiscal analyst in what should be prepared for. There's a group that comes together to work on that, but it prevents the need for a subcommittee meeting. The initial meeting was in November, and the numbers are revisited in January. There is \$13.1M in the FY15 budget for Medicaid caseload. There are several components in that building block. Specifically, there's a 2% increase for ACO rates in January and another 2% in January of 2015. Lincoln asked whether it includes any optional expansion. Rick replied that it does not. If we weren't increasing our payments to ACOs and doing the mandatory expansion, this would be a negative number due to a more favorable FMAP.

Lincoln asked whether there is any money in the account created by the ACO transition. Rick said that the calculation has been performed, but no money has been transferred.

Steven asked whether the recapture from OIG/MFCU were going up or down and whether the investigations were a clear deterrent. Michael replied that the deterrent effect isn't possible to gauge. Josip will send the OIG's report to the group. Recoupments in FY13 did go up, however the funds may be from many different years. The state also received several lump-sums from medical/pharmacy companies in settlements.

Russ asked whether the caseload would stay flat or decline. Michael said that is not the case. We still have general fund built in for increased caseload, but it is less than what we projected. We were expecting 40-50k people by June, but not all of them will come on right in January. We'll carry that base into FY15 and get more through the end of the 2014 calendar year. He predicted we will be just under 300K enrollees by June, not including CHIPicaid. We are tracking the transitioning kids in a separate budget because we get a higher match rate. We will likely be in the 315K-320K range, including the transitioning kids, in June.

CHIP to Medicaid Transition Update

Emma Chacon gave a report. We have a list from DWS that shows 20,593 children who will probably transition. This number is dynamic as always. There will be a letter to these kids' families saying that they have been identified to transition. It will go out between Christmas and New Year. It will let them know that they will not be moved until March, but that they are able to request a move sooner. It will be written at a reading level accessible to our clients and also translated into Spanish. We're giving everyone the choice of plans and holding a mini-open enrollment for these families. We've been working with PMHPs on continuity of care. PMHPs are engaging with some transitioning families already, even when they're not being reimbursed. Info will be going out in the December Interim MIB. We will share the letter going to families with the providers.

Russ asked whether families can transition before March. Emma replied that they can, and the letter will say so. Another state said that about 1,000 families of their 30,000 had contacted them to move to Medicaid ahead of the scheduled transition.

Healthcare Task Force/Medicaid Expansion Update

Nate Checketts gave a report. Over the last few months there has been a fair amount of discussion of Medicaid expansion options using managed care organizations. Rep. Dunnigan presented a new option of expanding solely in the form of premium assistance.

Three options are on the table.

1. Mandatory expansion only. (Would create a coverage gap for adults not Medicaid eligible, but income too low to qualify for premium assistance).
2. Premium assistance + Benchmark Benefits up to 100% FPL
3. Premium assistance + Benchmark Benefits up to 138% FPL

The state will get a 70% match rate instead of 90% if we stop at 100% FPL. Rep. Dunnigan had assumed in his presentation that we would get 90%.

These programs would require an 1115 waiver. If the legislature approves a bill by the end of the session, we are looking at providing benefits by January 2015.

Andrew asked what the Medicaid Benchmark would be. Nate responded that there have been several terms used, and they are not necessarily synonymous. Benchmark currently means the Medicaid plan the state is operating. The state would also have the option of offering an Essential Benefit Plan or an Alternative Benefit Plan. Comparable private insurance plans offering cost-sharing typically are viewed only in terms of service coverage. Implementing that level of coverage would not allow the state to pass the cost-sharing component to Medicaid recipients.

Lincoln asked when the options might get a little more detailed. Nate said that on the legislative side, this will be the level of detail they stay at. More details in the legislature make for more complicated implementation. Most legislators aren't able to understand these three options yet.

Using premium assistance to do this expansion would cost approximately the same as a full expansion, we think. The estimate includes a blanket amount for administrative costs. Administration may be more or less complex with the premium assistance than with expansion.

Alan asked what the stakeholder comment process would look like. Michael said that any 1115 waiver has a significant public input process. Any expansion scenario that isn't just an expansion of current benefits would require an 1115 waiver. Each one of the options has its own set of difficulties. This premium subsidy will require some pretty creative work. Nate added that the timeframe for our last waiver was about 18 months, and we're trying to implement this one in 9 ½. This is a very aggressive timeline. There has to be a waiver creation and submission and CMS approval built into our timeline. We may end up having to go back to the legislature if CMS's approval is too different from what's approved in statute. We understand that people expect to be covered immediately after the legislature makes a decision, but that isn't feasible.

Lincoln pointed out that premium assistance gives up some discretion from the DOH to the Department of Insurance. This may have implications for vulnerable individuals.

Dr. Cosgrove asked how quickly we could implement a full expansion. Michael replied that we could probably implement that much more quickly, but a specific timeline is difficult to gauge. We would need to add coverage groups and change contracts with ACOs.

It was pointed out that the benefits might be slightly less from a commercial plan.

Russ asked how a wraparound benefit would work. Michael replied that we would need to figure that out. In general, whatever the plan doesn't cover that Medicaid is obligated to cover, we would. Michael pointed out that "medically frail" individuals have to be covered under Medicaid, not premium subsidies.

Director's Report

Governor's Budget

We discussed the governor's budget already. To summarize, we are giving back \$48.1 million of general fund. \$38.5 million are carry-forward funds from last year. \$5M was for the mandatory expansion being lower than projected, \$4M was a give back in CHIP, but only a \$500k reduction ongoing. (Part of the return was a cost-settlement). Nothing else was funded outside of consensus projections. Full expansion, dental benefits were not included as the priorities from the MCAC public hearing. We have \$1M recommended by the governor for MMIS. Of the \$15.5M we need to finish the project, about \$6M have been funded, this appropriation would bring the total to \$7M. Expenditures on the program are anticipated to exponentially increase as progress is made on the project. We can draw on program expenditures to fund our cash flow needs and then go back to the legislature for supplemental money.

MMIS Replacement

About a year and a half ago, we implemented a new pharmacy POS system. That is now in operation. We will be moving into some new releases in 2014. In April, we will make an online portal available to providers to look up eligibility. Should this system work successfully, we can transition to plastic Medicaid cards in lieu of the current paper cards issued monthly. This will be a fairly big transition and education effort. We have a governance committee for MMIS, and one of the things that was helpful was representatives from the pharmacist community sitting in on those meetings. We will invite representatives from provider and advocacy groups as ex officio members of the governance committee. We want there to be adequate time for providers to make any necessary changes. We will be bringing on an outreach worker to educate providers and consumers. If MCAC committee members are interested in these meetings, they may contact Josip. Michael will be extending invitations to the nursing home and hospital communities as well. Jason Stewart, the MMIS project director, will be visiting these meetings in the next few months and will likely speak with the MCAC as well. We want the portal to be up a few months prior to plastic Medicaid cards so the providers can make necessary changes in processes and we can work any bugs out. The plastic cards will be distributed to newly

eligible individuals or replaced upon request. The frequency of when new cards will be sent will be determined by their durability.

Andrew asked about the MCAC budget priorities and the discussion of possibly including funding for the transition program as part of the overall Medicaid budget instead of as a building block. Michael responded that ensuring opportunities exist for individuals residing in facility-based care being able to access community resources is an issue that the department is very sensitive to, and that its likely funding can be found in the overall caseload and utilization budget.

Healthcare.gov

Healthcare.gov is still fraught with challenges. We started sending applications to the exchange two days before the last MCAC meeting. Two weeks later, they let us know that they were unable to do anything with these applications. They said they would reach out to applicants to ask them to apply through healthcare.gov. We have been asking folks to apply with the exchange directly if they call for status. We're having DWS and DTS work through the system to receive the information feed from the exchange. We are an assessment state, which means that the application has to come to the state to have eligibility determined. There have been enough problems with healthcare.gov that we feel comfortable with that decision. We think we could be ready by about mid-January to process applications from the exchange. In the meantime, we are getting a "flat file" with the client's demographics and stated income. We are working with DWS to go through the backlog. We are looking for the highest quality applications first (applications with social security numbers, programs that are easier to determine like pregnant women and children). The cutoff for signing up and paying your initial premium is December 23 for benefits in January. That may be challenged. From the clients' standpoint, we have a lot of challenging situations of being caught in a loop of denials. From a Medicaid coverage standpoint, we should emphasize that we do retroactive coverage. We can pay expenses incurred in January even if their eligibility determination is delayed. Alan pointed out that some adults in the expansion population are getting referred to Medicaid. Nate said that CMS will look at applications if you have application IDs.

PCN

We will have a letter authorizing PCN through 2014 by Christmas. PCN will cover people up to 100% FPL. Some individuals over 100% FPL who have eligibility into 2014 may stay on through March. The enrollment fee will be going away. The cost sharing will be identical to Medicaid. We will be able to maintain the limited enrollment and limited benefit. This will give the state the opportunity to work out an expansion. Steven asked whether there would be a wraparound to cover the EHBs. Michael replied that PCN would be an anomaly in that it would not cover all of the 10 essentials.

Discussion with Tech Waiver Families

We had a follow up meeting with a handful of families. We've also had a meeting with Healthy U and with Harmony Home Health. We talked through a number of issues. We have a follow up meeting with Healthy U this afternoon. We have a number of children enrolled in ACOs who are technology dependent and receive private-duty nursing. Harmony Home Health has been the provider and has been contracted with Healthy U. Healthy U had notified Harmony that their contract would be terminated.

We have contemplated whether it's still appropriate to have tech dependent kids on ACOs or whether we should move them back to fee-for-service. Michael will report back at the next MCAC meeting.

Tina asked how we can keep this from happening with other ACOs, and how families can complain, and how the acuity grid can be applied fairly. Michael replied that we need to get to a quality measure that accounts for this. This population is such a small percentage of the ACO that our usual quality measures don't assess them adequately. If we keep them in the ACO environment, we will need to apply specific quality measures. We are trying to assess whether this problem is specific to Healthy U and Harmony of whether it's a larger problem. Contractually, even in addition to quality measures, we can add contract language ensuring staff treat Medicaid recipients with dignity and respect. Individuals with concerns can contact the Constituent Services representative, Randa Pickle, at 801-538-6417. She creates a report of constituent issues every month. Her e-mail is randapickle@utah.gov if clients would rather e-mail. We are getting closer to a final resolution. The acuity grid is more of a DOH issue in making sure we give clear guidance to ACOs. It has been administered by DOH in the past, but it's being interpreted differently in the ACOs. We will issue policy guidelines early in 2014. Michael apologized for not returning a few calls from MCAC members, but promised to keep everyone posted. Tina asked how quickly a contract extension could be turned around. We will try to get the question turned around by Friday. Michael thanked Tina for facilitating the process of working through the issues. Tina pointed out that families do not know the relationships between ACOs and Medicaid.

Minutes

The committee approved the minutes.

Adjourn

With no further business to consider, the meeting adjourned at 3:28.