

Medical Care Advisory Committee

Minutes of Meeting March 20, 2014

Committee Members Present: Lincoln Nehring, Russ Elbel, Michael Hales, Mark Ward, Donna Singer, Kevin Burt, Mauricio Agramont, Steven Mickelson, Danny Harris

Substitutes: Pete Ziegler for Warren Walker, RyLee Curtis for Matthew Slonaker, Joyce Dolcourt for Tina Persels, Kris Fawson for Debra Mair

Committee Members Excused: Jackie Rendo, Jason Horgesheimer, Greg Myers, Andrew Riggle, Mark Brasher

Committee Members Absent: LaVal Jensen, Michelle McOmber

UDOH Staff: Tracy Luoma, John Curless, Jeff Nelson, Rick Platt, Janica Gines, Emma Chacon, Craig Devashrayee, Shandi Adamson, Nate Checketts, Kevin Bagley, Josip Ambrenac, Summer Perkins

Introduction and Welcome

Minutes

A quorum was not present, so the committee took no action on the minutes.

New Committee Members

If you have anyone you'd like to nominate, we need to fill the position representing the business community. We will have additional vacancies in the coming months.

New Rulemakings

Craig Devashrayee presented the new rulemakings.

Joyce asked whether the renewals for UPP and PCN were only through December. Michael answered that they are. He explained that a Medicaid-funded plan could replace PCN and UPP in the near future. Mark asked whether the 100% FPL limit for PCN took effect in January. Michael said that technically it did, but we are still working with clients to transition to the exchange. Emma said that we had the HPRs make outbound calls to PCN recipients over 100% FPL. PCN will qualify as minimum essential coverage for the purpose of allowing recipients to enroll in a marketplace plan if their PCN coverage terminates. This would be considered a qualifying life event. The committee and audience did not know what the time limit was to enroll in commercial coverage after losing other coverage.

Budget Update

Rick Platt presented the enrollment report.

Lincoln asked out of the changes to the child populations on the report, how many could be attributed to the CHIP to Medicaid transitions. Michael responded that it was very unlikely to be 1 to 1, but much of the increase was likely for this reason.

Mark Ward asked if the Department will be tracking impact directly related to the ACA and added it would be helpful to see the baseline enrollment versus the enrollment due to the ACA. Rick responded that this was not a detail being captured. Michael added that the Department will look at the consensus number to try and gauge the increase, but many policy adjustments would have an unknown effect as new applicants are not being evaluated with both new and old policy. An example was provided of a child ages 6-18 who previously required an asset test but no longer does – eligibility workers would not request asset information as this would not be required, but could have disqualified the child previously.

Joyce asked whether there is still an asset test for disability. Michael answered that there is.

Michael said that we'll have 10-15K kids on standalone CHIP. If there's a strong voice to put families all on commercial plans together, we can take that account in our future rules. Currently, families don't have an incentive for CHIP families to move kids onto commercial coverage. It may be more cost effective for parents to purchase single/double coverage instead of a family plan and allow their children to remain on CHIP.

Rick mentioned that there's still a backlog of Medicaid applications. Kevin said that it's not such a backlog that we'll see a dramatic spike in enrollment.

CHIP Transition Update

Emma Chacon reported on the CHIP transition. When we pulled the initial list of kids who appeared that they would transition, there were about 20,600 children. We notified families and held a special open enrollment. CHIP families were very proactive. Most kids along the Wasatch Front stayed with their equivalent plan. Those outside the Wasatch Front typically went on to Fee-For-Service, or kept their previous plan if one was available in their area. Approximately 17,900 children are now off the CHIP program. We identified about 1,100 kids that we expected to transition had increased household income and stayed on CHIP. We haven't checked every family, but Select Health and Molina are providing us with lists of families that were enrolled in CHIP but now don't appear to be enrolled in CHIP or Medicaid. The plans took extra steps to make sure children did not fall through the cracks. The PMHPs worked hard to ensure the kids had continuity of care. We will continue to monitor enrollment to ensure that everyone who is eligible for coverage has it. If anyone is aware of a family that didn't transition appropriately, please e-mail Emma at echacon@utah.gov or call DWS.

Russ then asked if he might be able to speak about what Select Health has observed. Approximately 11,700 were anticipated to move and identified in the DOH file give to SelectHealth (approximately 4,000 to rural areas, and 7,700 to urban areas). Of the 7,700 CHIP enrollees that were to move, 61%

moved to Medicaid, 12% remained in CHIP and 1% now have a commercial insurance product. Of the remaining ~25%, or about 1,900 children, a sample was taken through access now with 74% no longer eligible for either Medicaid or CHIP and 11% still saying CHIP, but there was no designation of which plan was selected. Many kids appear to have lost coverage and aren't enrolled in any program. Emma said that we continue to research these cases and we are looking at SelectHealth's report. Lincoln asked if there were any other issues possible contributing to the problem – DWS issues? DoH policy issues? Family issues? Emma mentioned that there were some concerns with eRep programming and the ACA changes, which both she and Kevin agreed had been remedied for the most part. Many families who don't have immediate medical needs don't follow through with their review or don't pay premiums. As we research the cases, we'll know more. If a family needs to access services and finds that they can't, we can get them taken care of right away.

Lincoln suggested that kids not be denied access to CHIP because of enrollment in an indemnity plan. That doesn't appear to be the case. Emma said that we are aware of the issue and would welcome specifics. CHIP Advisory Council will be on the 8th of April.

Utah Eligibility Interface Update

Kevin Burt provided an update on the state interface with the Federal Health Insurance Marketplace. The latest from the Marketplace is that they are now able to use the application info that DWS is sending them on individuals DWS has determined to be ineligible for Medicaid. This information is then being used to determine if the individual/family may qualify for a tax credit. This has not been confirmed, but that is the report that has been received.

A work-around for this process is also rumored to be available. During the application on the Federal exchange, a question about "have you been recently denied Medicaid/CHIP by your state?" appears. Should the applicant indicate they have, it allows them to continue for tax credit assessment.

DWS has pulled in every application up to January 20 and most of the applications up to February 23. We do not know what the application volume will be for March, as the last month of open enrollment. We don't know what the exceptions are for Open Enrollment or whether an individual who applies for Medicaid and is not denied until after April 1.

Lincoln asked whether DWS is hearing issues with CHIP families getting tax credits through the FFM. Kevin said that the recent changes should have cleared any of those issues up.

From October 2013 to February 23rd, 24,600 applications have come in from the FFM. About 45,000 people were represented in those applications. That's about one month's worth of applications for DWS. 100% of the applicants through January and most of the applicants through February have been reviewed. Members of the public may mistake this information to mean there would be 45,000 new Medicaid recipients, however there is much more occurring. Families may have had household members on CHIP/Medicaid, but adults were seeking coverage. For 22% of applications, the family already had an open case with DWS. There are also a number of duplicate applications (6%).

The FFM also continues to assess adults eligible with less than 100% FPL, and they're not. Only about 40% of the applications we receive are potentially eligible. Utah is currently at a 3.9% unemployment rate. DWS is seeing significant drops in enrollment for all programs. January was the first increase in persons served for DWS in quite some time. Lincoln asked whether Kevin expects the process to work better in November for the next Open Enrollment. Kevin says that he does, because the FFM appears to be complete – provided information on the Federal side does not change.

Russ asked if there was additional information that could be supplied on the 24,000 apps. Kevin responded that about 13% did not have an SSN associated to them, making them incredibly difficult to track/associate with existing cases. 6% were duplicates, 22% already open, 21% were quick denials. Quick denials meaning that the information provided clearly disqualified them from Medicaid, possibly as they would be part of the optional expansion population. The remaining 40% requires additional analysis.

We also don't know how many of the people who applied through the FFM actually wanted to apply for Medicaid. A significant number of those will not follow through. People who go to the FFM don't go there to apply for Medicaid. Russ asked when we will be able to have good numbers. Kevin responded that it would be about May.

Access to Healthcare for Children with Disabilities

Jennifer Adams introduced herself as a member of the Legislative Coalition for People with Disabilities (LCPD). A handout was provided that was a compilation of data from DSPD's annual reports.

The Katie Beckett Waiver is for families of children with significant disabilities who may or may not have commercial insurance. The cost of care for children on private insurance is still enormous. It may send the family into bankruptcy or cause parents to quit their employment in order to qualify for Medicaid. The options for some children's care are very limited. In order to get off the DSPD's wait list, kids need to be in crisis. At age 18, most of these children will become eligible for disability and Social Security.

Katie Beckett waivers can also allow for cost sharing. This provides an opportunity to continue caring for the child at home and continuing to work. The child would need to meet SSI criteria for disability and institutional level of care. A cost-neutrality demonstration is also required with CMS.

Russ asked whether the child's care was covered if he or she were a ward of the state. Michael confirmed that when a child was in DCFS custody that the state is required to pay for all required medical expenses. Rep. Redd asked about Katie Beckett waivers during this legislative session. The state general fund need would be about \$20M. It's a heavy lift, but the benefit to the families is clear, and the families still participate in the cost of care. It becomes a very difficult discussion for the legislature. Funding for the waiting list typically doesn't help many families as their children are not reliant on life-assisting devices and many do not have intellectual impairments. It is a group currently being missed by the Medicaid state plan as well as the existing waivers.

Emily Wagner: Daughter is almost 5 years old and has been on the DSPD waiting list for 4 years. The family pays \$20-30K per year on top of medical insurance and is \$70K in debt. The waiting list for DSPD disqualifies many families who also don't qualify for Medicaid. Families that don't qualify for Travis C. and whose kids don't have behavioral problems rank lower on the list. Even if the family declares bankruptcy, the medical bills won't go away. A Katie Beckett waiver would allow the child to qualify on his or her own income instead of on the family's. The family is willing to contribute and buy in, but cannot continue to go into debt. Primary Children's threatens collections constantly.

Michael added that many of the expenses are not covered by traditional insurance, like diapers and formula for older children. There is some relief in terms of lifetime limits from the ACA. Respite care is also a great need.

Russ asked what the biggest cost driver is. Emily replied that copays, out of network providers, therapy, equipment, etc. add up. Many of these children are accessing healthcare more than once a week. The volume of services is hard to keep up with. Even after out of pocket limits, there are many costs that are not covered at all. Out of pocket limits also do not apply to copayments. Medicaid spend-down is even too high sometimes to be cost effective.

Lincoln reminded the committee that June is the public hearing and July is when MCAC makes recommendations for building blocks. He said the committee would discuss the Katie Beckett waiver then.

Joyce asked whether the Katie Beckett waiver would have to have a waiting list. Michael replied that it would be a State Plan Amendment, which has the benefit of enrolling everyone in services who needs them. The downside is that the financial burden is high. Raising the visibility of the issue is a good opportunity. Many people are under the impression that most of the unmet needs were addressed by ACA, and lots of policymakers fall into that misconception. Most higher-income families are largely invisible and they assume that everyone with disabilities get coverage under Medicaid. Michael said that we need to articulate the long-term consequences of failing to support families. Gina Pola-Money pointed out that keeping a child at home results in a \$50,000 cost savings versus keeping the child in a facility. Mark Ward asked whether there is a budget neutrality requirement. Tonya and Michael clarified that the cost effectiveness test would be at home vs. in a facility. CMS would monitor on an ongoing basis to make sure we're paying less to keep them at home than in a facility, then that would be the upper payment limit. Russ asked whether cost sharing could be on a sliding scale. Michael replied that higher income families contribute more in absolute dollars.

Minutes, Revisited

Since a quorum had been assembled, Mark Ward moved to approve the minutes. The motion was seconded and passed.

Director's Report

Legislative Recap

HB 88 allowed the Autism Waiver to continue permanently. We will have open enrollments to put kids into services. Kids would be eligible from age 2 until they turn 7.

Rep. Menlove also sponsored HB 92, Utah Telehealth and Education Network: Medicaid would build some infrastructure to better use telehealth services. There may be a pilot program for kids with special healthcare needs who live away from the Wasatch Front. The money is a general appropriation to provide Medicaid services through telehealth. CMS has recently said that services can be delivered through telehealth and billed through Medicaid; historically, they have been restrictive about what services can be billed through telehealth. We will build our pilot on populations where telehealth is likely to be successful.

HB 401 sponsored by Rep. Dunnigan: The Health System Reform Task Force will study Medicaid expansion options, "Access Utah".

SB 14 sponsored by Sen. Weiler: Medicaid will move forward with a state plan amendment where payouts from long-term care insurance will be exempt from asset limits so the individual can qualify for long-term care with Medicaid. Eligibility effectiveness will be retroactive to July 1.

SB 29: Allows ACOs to get information on the restriction population through DOPL's Controlled Substance Database.

SB 57: Sen. Shiozawa's bill that mandates autism coverage for certain plans starting January 2016. We will be working on coordinating benefits on our Medicaid autism program. The bill is believed to have a sunset date, approximately 2019. This bill may impact the autism waiver due to possible primary insurance coverage needing to be billed.

Dr. Cosgrove asked whether the autism program will still be based on a lottery. Michael replied that it will be a random selection process.

SB 121: Tobacco settlement fund for CHIP population who are now on Medicaid can be used for Medicaid.

SB 251: Partial Medicaid Expansion: Passed the Senate but not the House. CMS announced that South Dakota had submitted a similar request and was denied. We have been told that we need to cover the entire expansion group in order to get the full match amount.

SB 261: Sen. Valentine sponsored a bill reversing Rep. Kennedy's legislation on ED use. Passed in the senate, bill did not move in the house.

\$43.5M was taken out of our budget as a negative supplemental. The consensus estimate of \$13.1M was not funded. We have no new money for the new fiscal year. Much of that was related to increased enrollment from ACA that didn't materialize. This was the sub-committee's #1 priority, but nothing was

received from Executive Appropriations. We may go into the next session with a supplemental request. There was a \$3.5M request for the ACOs to get their scheduled 2% increase in January. The plan was to keep the growth sustainable. We were able to get intent language in HB 3, line 719, that it was the intent of the legislature for the department to move forward with the 2% increase. Depending on what happens with caseload growth, we may have to go for a supplemental. We could fund the increase for ACOs with the change in the federal match rate.

Joyce Dolcourt asked what this might mean for the transition program to move individuals from facility-based living arrangements to the community. Michael responded that this may mean the program is put on hold until the Department can evaluate if funding might be used. If so, it will likely be much more limited than the approximate 16 individuals transferred each year.

We got \$2M for the MMIS replacement project and \$1.5 as a contingent amount. DWS will have to generate savings in order for us to get that. The full \$3.5 would get us through the fiscal year and would give us \$9.5M of the \$15.5M the project needs.

\$2M appropriation to increase nursing home rates. There was a raise in the assessment for Intermediate Care Facilities. \$2.7M in dental rates. Michael said "about" 10-15% increase in the dental reimbursement rates. There were slightly over \$2M pf general fund for a cost increase due to ACA taxes. In June, we will need to discuss which of these one-time monies are our priorities. \$3.7M for substance abuse and mental health was transferred from HHS back to DOH. This will allow for caseload increases for inpatient psych, since more people are coming in.

Medicaid Expansion

House proposed essentially the current PCN with a richer benefit, or not, based on funding available. Senate proposed partial expansion to 100% FPL. Governor's plan was premium assistance to 133% FPL. The Governor has been directed to study the matter. We have been directed to negotiate with CMS to see what they're willing to approve, and that's what Michael has been doing.

Nurse Practitioner Coverage

We will move forward with allowing NPs to bill Medicaid directly. The State Plan Amendment will take effect, probably retroactively, on April 1. We are working to get NPs 100% of what we pay physicians. We couldn't justify differentiating between primary care NPs and specialists, so we didn't. The NP community will be an important part of the delivery system.

MMIS Update

We will begin rolling out segments of the system. On March 30, we will go live with a new Medicaid website. Not all of the web pages will change right away; some will roll out later. We will have the provider eligibility lookup tool live on that date. We are planning a concerted outreach effort so providers will know how to use the lookup tool in anticipation of the July 1 rollout of the new Medicaid card.

Adjourn

With no further business to consider, the meeting adjourned at 3:40.