

# Medical Care Advisory Committee

Minutes of Meeting April 16, 2015

## Participants

### Committee Members Present

Russ Elbel, Andrew Riggle, Debra Mair, Sarah Carbajal-Salisbury, Jackie Rendo, Steven Mickelson, Emma Chacon (for Michael Hales), Teresa Swensen (for Kevin Burt), Danny Harris, Mark Ward, Mark Brasher, Rylee Curtis, Tina Persels, Michelle McOmer (by phone).

### UDOH Staff

Jeff Nelson, David Baldwin, Rick Platt, Craig Devashryee, Josip Ambrenac, Summer Perkins, Julie Ewing, John Curless

### Visitors

Dr. William Cosgrove, Kris Fawson,

## Welcome

Chairperson Russ Elbel called the meeting to order at 1:30 pm.

Andrew Riggle moved to approve the minutes of the March meeting. The motion was seconded and passed.

There are still vacancies on the committee for long-term care providers and the business community. Nominations should be sent to Russ.

## New Rulemakings

Craig Devashryee reported on the new rulemakings.

Russ asked whether R414-19A was meant for individuals with kidney failure who didn't qualify for Medicare. Emma replied that this rule would cover those individuals.

## Budget Update

Rick Platt presented the enrollment report.

Sarah asked why adult enrollment would be flat. Jeff Nelson explained that the eligibility threshold is very low for adults, and the Utah economy is improving. We have more people on Transitional Medicaid than we ever have before, and when people enter that program, that means their income is increasing.

Steven Mickelson asked whether we could get a breakdown by ethnicity. Russ noted that Nate has been asked for this information and Josip will follow-up to see if that can be made available.

Andrew asked why PCN enrollment is declining. Rick pointed out that enrollment is closed for PCN, so enrollment can only go down, not up. Rylee asked what the enrollment threshold is for opening PCN again. Emma said that we are watching the numbers monthly, but we have to take into account that the program may not continue after December.

## Continuous Eligibility for Incarcerated Individuals

Jeff Nelson reported on “quick enrollment” for people leaving the State Prison. The goal is to get Medicaid approved for released individuals in 5 days. The important part is to find out where people will be, since they must not live in the facility to be eligible. We will focus on those who are 65 or older, who have physical or mental disabilities, or who are pregnant. There are two main challenges with this objective: the first is that there would need to be someone at the jail to perform eligibility which isn’t necessarily an expressed desire from the jail system; and the second is how quickly individuals enter/exit the jail/prison system. In many circumstances, Medicaid finds out about a jail/prison stay at the conclusion of the stay and action/documentation on the case is done after the fact.

Jackie asked why Jeff thought that there aren’t as many people with mental disabilities at the County Jail. Jeff responded that most people who are in jail are in and out more quickly. Jeff invited Jackie Rendo to come to the advisory group. Andrew asked whether Adult Probation & Parole was involved to help shepherd individuals into Medicaid. Jeff said that AP&P was involved. Andrew asked whether there would be enrollment workers in jail and prison. Jeff said that we have some seeded workers, where we would pay half the salary of the worker. We have also looked at delegating authority to the jail or prison staff. There are eligibility staff at the Prison already. There is a DWS worker who teaches classes at the jail.

Dr. Cosgrove asked what happens to people who are homeless when they’re released. Jeff said that we can use a relative or a general delivery address as a work-around. He also asked whether we could use AP&P to connect released people with a Medical Home. Emma said that there is new funding to get people the help they need upon release, and we should discuss the issue with our mental health plans to see what we can do.

Jeff reminded us that disability determination can take a long time, and in the absence of expansion, many people who need help won’t qualify for Medicaid.

Jeff explained that we might inadvertently make the problem worse with suspension by terminating or suspending cases. We might end up terminating short-term inmates who would otherwise stay on Medicaid.

Steven Mickelson asked whether an online application could be part of the jail out-processing. Jeff explained that inmates couldn’t apply for Medicaid unless they have a release date within 30 days, because 30 days is how long DWS has to make a decision. Emma said that Illinois has found a way to extend that, and we can look at doing the same.

## Medicaid Autism Waiver/Autism Services Updates

In July 2014, CMS came out with policy guidance saying certain services should be available under EPSDT if they have a medical need. That was a significant change in our policy. This policy will eventually cover about 4200 children. We have been serving about 300 kids ages 2-7.

Financial eligibility is different for HCBS waiver clients. We include many children who would not normally qualify for Medicaid. We are working with CMS to see if there’s a way to extend the waiver for the population who are already in services until the children turn 7. The current waiver authority expires 9/30/15.

Another issue is trying to determine what coverage will look like. We have been working with pediatricians to draft that policy. We had a public meeting on March 31, as well as a phone conference call to solicit feedback. Since then, we have had meetings with local mental health authorities and other stakeholders to solicit feedback.

The most consistent concerns that we've heard are about the services that we cover and the necessity for qualified providers. Our proposal is to have Master's or Doctorate prepared supervisors and board-certified providers. We're actively pursuing an effective date of July 1.

Andrew asked what providers' response has been like, and whether we have the capacity to serve the anticipated need. Tonya replied that we won't have 4200 clients right away and it's difficult to assess what provider infrastructure may exist at this time.

Tina pointed out that diagnosis is a huge barrier for many families. Tonya replied that this was a big challenge for the waiver program—families had to have a diagnosis for entry. Medicaid covered families will have the coverage to get that diagnosis. We're discussing what types of providers can make that diagnosis, but our intent is to keep the diagnosis with psychologists and physicians. Tina pointed out that ABA is controversial. She also said that kids with ASD often have co-occurring mental health issues, and care should be coordinated with the mental health plans.

Russ asked whether there will be an ASD-specific provider manual. Tonya said that there will be. There will also be a few paragraphs in the Member Guide about ASD services. ABA will be a carved-out benefit, but the criteria for some other therapies like OT, PT, and speech therapy may change.

## HB28 Stakeholder Meetings

Emma Chacon reported. HB28 is Medicaid Management of Emergency Department Use. This is a bill requiring us to convene a group to look at alternatives to ED care, including increased access to primary care, alternative settings for super-utilizers, etc. This is a lofty task, but an important one.

We have scheduled a meeting for May 15. This will be the beginning of the discussion, but there will be additional meetings for broader input. Andrew asked what the state of the evidence is for inappropriate use of the ER. Is there any solid data from Utah that says this is really a problem? Emma replied that this question would be the first part of the discussion. We will pull data to see if the problem is related to certain conditions, certain groups, access issues, etc.

## Director's Report

Emma Chacon reported for Michael Hales.

As a result of the last session, the State will expand mandatory ACO enrollment into 9 additional counties on July 1. They are Cache, Rich, Morgan, Box Elder, Tooele, Wasatch, Summit, Iron, and Washington. We expect that 86,000 additional Medicaid enrollees will be on ACOs in July.

We are scheduling local stakeholder meetings for May 6 in Logan and May 11 in St. George, then May 20 in the Salt Lake area. We want to hear from consumers and providers and talk through any issues or concerns. We've already worked through a number of requests with the ACOs. They have already provided their networks to us and we are going through those lists to ensure access. Our sense is that most providers will probably contract with most of the ACOs. We are working hard to ensure that

people are not surprised. We will be sending notice to members in the next few weeks, we will do an interim MIB in May, and the ACOs have already been working with providers in the communities. May 20-June 20 is our annual Open Enrollment, and this will be for the newest 9 counties as well as the urban counties, and we have submitted an amendment to our 1915(b) waiver. We have met with our behavioral health plans as well to encourage coordination between case managers in both of those worlds.

### Federal legislation

HR2, the Medicare Access and CHIP Reauthorization Act: This bill provides appropriations for CHIP. Without this bill, CHIP would have ended September 30. This bill also maintains the 23% bump in funding.

CHIP is a set pool of money. The states are provided an allotment two years at a time, and we're to fund it from that pool.

This bill also permanently authorized the QI program and Transitional Medicaid. Those QI cases that were terminated will be reinstated retroactively, and we won't have to go through this fire drill every year. The DSH reduction is delayed until 2018.

Supreme Court ruling on provider rates (Armstrong v. Exceptional Child): Back in 2009, an Idaho provider sued the state over the Medicaid reimbursement. The State ruled in favor of the provider. The US Supreme Court reversed the ruling. They said that private Medicaid providers do not have the right of independent action against the States. HHS would put pressure on the State if there was a question of inadequate access to care.

There was a discussion about the MCAC membership, and a suggestion for additional representation on the MCAC. Michael looked at the current composition and the bylaws. Consumers can be no less than 51% and membership should be no more than 19. There are already 19 seats, so there isn't any flexibility. That said, concerns can always be submitted to Michael or to Josip for consideration on future agendas.

### Adjourn

With no further business to consider, the meeting adjourned at 2:55.