

Medical Care Advisory Committee

Minutes of December 17, 2015 Meeting

Participants

Committee Members Present

Russ Elbel (chair), Andrew Riggle (vice chair), RyLee Curtis, Tina Persels, Sara Carabajal-Salisbury, Kris Fawson (for Debra Mair), Mark Ward, Kevin Burt, Danny Harris, Jonathan George (by phone), Pete Zeigler, Steven Mickelson, Michael Hales

Committee Members Excused

Mark Brasher, Debra Mair, Jackie Rendo

Committee Members Absent

Jason Horgesheimer, LaVal Jensen, Michelle McOmber, Donna Singer

Guests

Dr. William Cosgrove MD (Utah AAP), Dr. Kim Michelson DDS (UDOH), Jessie Mandle (Voices for Utah Children), Joyce Dolcourt (LCPD), Tracy Altman (UUHP), Claire Mantonya (by phone)

Welcome

Russ Elbel called the meeting to order at 1:34 p.m.

Introduction of New Member

Russ Elbel introduced the newest member of the committee, Adam Cohen, who is representing the business community and consumer populations. Mr. Cohen is a CEO of Odyssey House which helps individuals who may have substance abuse rehabilitative needs to access medical, psychiatric and behavioral health services as well as inpatient/residential services.

Minutes of October 15, 2015 Meeting

RyLee made a correction to the minutes where “Mark Shaw” was referenced when it should have been “Kumar Shah”.

Mark Ward requested clarification regarding the Medicaid expansion discussion where it may have been implied that a formal vote was held by the Senate when it was not. Public comment was made however that the Senate as a body was not in support of *UtahAccess+*.

Andrew made a motion to approve the October 15, 2015 minutes with the correction to be made. Tina seconded the motion and it was passed.

New Rulemakings

Craig Devashrayee reported on the new rulemakings for the Division. Information on these changes has been posted online at: <http://health.utah.gov/mcac>.

Russ asked what the impact to Managed Care was with respect to R410-14. Emma stated that the stages of the hearing process that exist today with the ACOs will not be changed. The alterations to the rule change how hearings are handled at the Department level. Previously, appeals to the Department were formal, potentially allowing a de novo (from the beginning/new) hearing/appeal.

Tina had a question on R414-1a and what consolidating referred to. Craig clarified that the rule was being updated to defer to the policy manual instead of being redundant and restating what is in the manual.

Budget Update

Adult enrollment, as expected, continues to stabilize. Utah's unemployment rate in November was 3.6% while the national rate was 5.0%. In addition, Utah has been listed as one of seven states by the Conference Board which currently has more unfilled jobs than the number of unemployed.

Child enrollment decreased by 0.6% between October and November, which is consistent with previous years. Effects of ACA (tax penalties and CHIPicaid) should now have run their course.

People over Age 65 enrollment growth depends on a combination of population growth and economic conditions. As such, given Utah's improving economic conditions, the rate of growth in this group is expected to be positive but slow.

People with Disabilities enrollment growth like the elderly is dependent on a combination of population growth and economic conditions. Like the elderly, the rate of growth in this group is expected to be positive but slow.

Pregnant Women enrollment continues to decline. This trend is consistent with declining pregnancies among Utah's teens and an improving economy. Improving economic conditions would likely lead to a shift from Medicaid to employer-based health insurance.

CHIP enrollment growth continues to be flat.

PCN/UPP enrollment increased between October and November. PCN has been trending upward since July 2015. This growth is attributed to PCN having open enrollment.

During the October MCAC a request was made to provide figures on the number of cases/ratio between UPP and PCN. UPP was found to have approximately 6.8-7.0% of individuals, about 900-1000. PCN is in the range of 12,000-13,000.

Information on marketplace enrollment impact in October was also requested. The Department performed an analysis of July-November 2015 compared to July-November of 2013. An increase of 14.8% determinations (both accepted and rejected) can be observed. An approximate 3% increase in Medicaid enrollment can be observed during that period. It is unknown however if there is a direct correlation between this increase enrollment and possible impacts of the Federal marketplace.

Steve Mickelson commented that enrollment trends for PCN have historically had sharper increases than the current enrollment. Michael elaborated that it has depended on which PCN group has been targeted for enrollment – those with dependents and those without dependents. The Department aims for a specific ratio of PCN recipients with and without dependents. Currently, enrollment is open for those with dependents. An increase may be observed next month as enrollment for those without dependents just began.

HCBS Settings Rule Update

Tonya Hales reported. In March of 2014 CMS issued information on a new rule that requires the state to assure that the settings which HCBS services are delivered in are home-like and don't have the effects of isolating the individuals receiving services.

Each state needed to prepare a Statewide Transition Plan to evaluate where they were and how compliance will be achieved. CMS provided feedback on a letter dated October 8th and held a call with the state on October 23rd.

An element of the Transition plan includes a provider self-assessment to find initial areas of non-compliance. A draft of this tool has been published on our website and is available for public comment through January 15th. The modified Statewide Transition Plan is also available for comment through the 15th of January as well.

Andrew asked if Tonya could briefly walk through the major points of feedback which CMS had on the draft plan and how the state intends to incorporate the feedback. Secondly, one of the major components of the rule is an overall shift in philosophy on how the individual receiving HCBS services perceives the receipt of services and their integration into the community. Tonya responded that CMS feedback surrounded the level of feedback on items in the plan. For example, the state outlined that a provider self-assessment process would be used. Additional detail/specifics was largely requested. In regard to the participant's experience, this will happen in an iterative process. When responding to the provider self-assessment, an expectation was given that the provider answer to specific individuals rather than general policies that the company may have. Additional discussions have been had surrounding the use of participant experience surveys.

Steve asked about individuals who want to be served at home, but the home may have limiting factors. Tonya commented that individuals who reside in their own home or the home of family members do not necessarily apply – the rule applies primarily to the settings which providers offer services in. Residential providers will definitely be an area of heavy focus during the review.

Andrew requested that if anyone knows of individuals or anyone who may be interested in participating that it would be greatly appreciated. Providers seem to have very good representation at the meetings held so far, however consumer advocate representation is very limited.

PRISM Updates

Jason Stewart reported. In recent meetings with the MCAC, a February 1, 2016 date was discussed with the committee for the roll-out of the provider enrollment portal. During testing, significant defects have been found - more than initially anticipated. For this reason, and other operational considerations, the release date has now been changed to 7/1/2016.

Currently, a re-credentialing process for providers is already underway and is a requirement of the ACA. Having both projects occur simultaneously may be confusing and require significant work by providers. Additional changes with respect to Electronic Health Records incentive payments are also being made. These are scheduled for May, so it made sense to complete training and have everything ready for July.

The Medicaid Information Bulletin also discusses impacts to providers. In order to log into PRISM, providers will need to create a UMD account. For those who may have created an account for the purpose of using the eligibility look-up tool, they have already done this and can continue using those accounts. For those that may not have completed this, we encourage them to do so. Information can also be found on additional topics such as browser compatibility.

Many providers have already agreed to participate in testing sessions. Approximately 200 providers have agreed to assist – for anyone who is interested in system testing, they can email prism@utah.gov.

Director's Report

Governor's Budget Proposal

Michael provided a handout to committee members.

During Tuesday's Subcommittee meeting the proposals were discussed. On page 1 of the handout (page 79 at the bottom) FY16 recommended adjustments are listed. \$5M in CHIP being returned as unexpected CHIPRA funds were received during the fiscal year. \$19.6M in supplemental funding is requested; \$15M from general fund, \$4.6M from restricted account for current fiscal year. During last session, no additional funds were appropriated which is the main reason for this funding request.

On page 80, items for SFY17 are listed. \$17M returned due to higher federal match (100%) on the CHIP program. Every state got a 23% increase to match rate, Utah was at 80% previously. Future budgets will likely address this as a one-time funding request until a change in Federal policy may occur.

Continue Medicaid rate enhancement for physicians - \$2.5M ongoing. \$2.5M one-time funding was previously allowed. The one-time funding expires June 2016. Without additional appropriation, primary

care reimbursement would be at 85% of what Medicare pays versus the approximate 95% Medicare reimbursement today.

\$20M ongoing request for caseload, inflation and program changes. This would allow the \$19.6M supplemental amount for FY16 to be funded ongoing. Consensus figure was \$35M, and with \$20M being provided in this line item, additional supplemental funding would likely be required next year.

Adult dental restoration for individuals with disabilities. The U of U school of dentistry is proposing to restore some of the funding by transferring funds (which would be eligible for Federal match) to the Medicaid Department. Initially, discussions to restore services for both elderly populations and disabled populations were had, however the estimated cost would be approximately \$3.3M. If looking to serve individuals with disabilities only, approximately \$1.6M would be required. Of this, the U of U would supply \$600k and \$1M of general fund would also be required.

Andrew stated that services in Salt Lake County would be rendered by the U of U, which is mainly what the \$600k in seed funding would cover. The \$1M in general fund would be for services outside Salt Lake County. Michael confirmed this was the case and that if the U of U could not meet the needs of individuals, they may need to subcontract with other providers.

RyLee asked where services will be delivered, exclusively at the University, or at clinics throughout the County? Michael responding that access to care will be a key piece of the bill. If only utilizing one provider, a waiver will be required through CMS.

Danny Harris confirmed that the funding is not be acquired through a provider assessment and that the U of U would be transferring funds through an IGT (Inter-Governmental Transfer). Michael confirmed this is correct.

Steve asked if a provider would be able to drive in from an area like Tooele to the U in order to receive services. Michael indicated that this would be intended to be a statewide program with services available to all individuals enrolled in Medicaid who may have a disability.

Pete asked if the original request also included seniors and what may have happened in those discussions. Michael stated that the Governor's budget last year included a recommendation to provide dental services to both the elderly and disabled. It was submitted but not passed due to funding limitations during the 2015 session. During that process, budget estimates found that covering each of the elderly and disabled would be approximately \$1.6M for each group. In this proposal, by targeting individuals with disabilities, this will allow more individuals to be served due to cost per user in each of those groups.

\$10M in ongoing general fund is being proposed to target the uninsured poverty gap. This would be a program to be designed and named in partnership with the legislature. The program is to be designed

around the principles of employment and self-determination, maximizing the taxpayer dollar and assisting the state's vulnerable populations.

Jessie Mandle asked if there is any additional explanation around the inflation number. Michael stated that the Executive Appropriations Committee received a consensus brief on how the figure was developed. That document is available online at the EAC webpage, under materials, December 7th meeting – the consensus brief should be there. Autism services that recently became a State plan benefit that used to be limited to children on the Autism Waiver is one example of an expense that is addressed. Nate also stated that new prescriptions that the state is required to cover is also included. Michael elaborated with an example of a new drug which treats cystic fibrosis that is very expensive. The 2% ACO increase is also included but it does not cover new expenses that the ACOs may be incurring, such as the coverage of new prescriptions. Something important to note is that the ACOs are not required to supply Autism services at this time – that remains a carve-out service.

Page 83 discusses FY17 recommended adjustments which require further evaluation. \$1M one-time general fund request for the Medically Complex Children's Waiver. HB199 sponsored by Rep. Redd was intended to be a 3-year pilot program. This additional appropriation would allow the state to serve approximately 65 additional children in the final two years of the pilot.

Joyce asked if this would be used to target the waiting list. Michael clarified that the waiver programs operated by the Department of Health do not use an open enrollment period. If the appropriation was received we would evaluate what assistance we could offer to families who previously applied so they would not have to submit a new packet.

Medicaid Expansion Updates

No formal proposals have been rolled out at this time. Areas of discussion have included a full Medicaid expansion, 100% federal match on a partial expansion to the poverty level, a program to target individuals in the coverage gap who are medically frail, or perhaps a program targeting a specific percentage of the federal poverty level. Anything other than a full expansion would require the state to submit an 1115 waiver.

Legislative Updates

The hospital assessment is up for renewal, a bill is likely to be filed shortly to extend.

The Preferred Drug List (PDL) bill was discussed in Interim Committee. It was voted out of the committee, but will be debated. Individuals who have found a working combination of drugs will not be required to use drugs exclusively on the PDL.

The dental bill for individuals with disabilities which involves the partnership with the U of U that discussed earlier.

A bill file for the Community First Choice option has been opened, but no specifics are known at this time.

Senator Christensen has a file opened for OIG amendments, but the specifics are not known.

Social Services Appropriations Subcommittee

This was the third meeting of the interim was held, usually only have two. Building blocks were presented by several state agencies.

The Legislative Fiscal Analysts also proposed several budget effectiveness reviews. The committee has not been given any new funding at this time and in order to fund any new initiatives, they may be required to reduce funding of existing items.

For state FY16, supplemental adjustments included the use of the 3% max from nursing restricted account for administration. Listed as one-time, then ongoing. (FY16 & 17). The nursing home assessment allows for 3% of all collected money to be used for administration. In FY16 general fund money was taken out of nursing home funding and increased the assessment to draw general funds. \$77k would be taken out of the nursing home restricted account and put it into the Department's administrative budget. Existing Department funding could then be reduced and those funds distributed to other areas.

\$16M of the CHIP program budget was taken out of the SFY17 budget due to the program match rate. Also from FY16 is the non-lapsing CHIP balance of \$6.4M. \$8.5M out of the Medicaid restricted account. This is the amount of money the Department didn't spend out of Medicaid line items in FY15. The account was intended to hold reserve funding for a time of need and it is being proposed that the funds be accessed.

A nurse pilot program that the Department has been running in Bear River to help with care coordination for children with disabilities is being recommended to end. This is due mainly to the fact that the counties are now covered through the ACOs.

A proposal to reduce staff at ORS that who do recovery on third party insurance has also been made. This may have significant impact to the Department as those recovery efforts have assisted in recovering \$170M from other insurances.

Potential changes in the coverage of low-cost generic medications is also being proposed. This would change the existing methodology and alignment with Medicaid month to month eligibility and the 30-day provision of medications. Low-cost generics would be identified that could be supplied every 90 days in order to save funds on dispensing costs, co-pays, and the lost cost of the generic.

RyLee asked about possible vision coverage. Michael discussed a group previously who were looking to provide vision care. There were conditions attached that coverage needed to be supplied state-wide and

needed to be done at a cost that was at or below what the state pays for pregnant women and children. The group was unable to do it on an aggregate level, and a contract could not be awarded. A additional proposal may be received.

IHS coverage

CMS provided an opportunity for states to provide comment on a draft for a proposal that may allow for 100% federal funding for services provided in an IHS facility. Utah did comment on the proposal.

Currently the policy reads that 100% federal funding for services provided in an IHS facility could be received, but if an American Indian/Alaska Native receives services outside of an IHS facility, it is only eligible for standard match. This may allow IHS to subcontract with other facilities and receive 100% reimbursement if other requirements are met.

Comment was provided as logistics and compliance may be difficult with the current wording of the draft.

1332 Waivers

This waiver will become available in January 2017. This was authorized through the ACA and is also known as a 'state innovation waiver'. It provides the states with the option to innovate/be flexible with populations higher in income.

This was partially under the assumption that all states as a result of the ACA would be covering populations up to 138% of the federal poverty limit. If the state wanted to then expand income limits higher than 138%, this would provide a framework and the ability for the state to receive 95% of what the federal marketplace would be expending on a policy for the individual. Where Utah has not extended coverage at this time, it seems unlikely that this will be pursued.

New guidance issued by Department of Treasury and the Department of Health and Human Services on the 1332 waivers and they stated that coverage needed to be comparable to the federal marketplace. Cost sharing could not be more restrictive. Standards of coverage, affordability, comprehensiveness are required. This does not give the Department the rumored flexibility or allow the Medicaid program to bypass regulations as many have suggested. Additional information can be found in CMS publication 9936-N.

CMS Rule: Assuring Access to Care for Covered Services

CMS published a rule several years ago that was not finalized. In the past few months, the Supreme Court ruled on the *Armstrong v. Exceptional Child Center* legal case in which a provider was attempting to sue the state for its reimbursement rates. The Supreme Court stated that the provider did not have standing to sue the state but that CMS has a responsibility to assure access to care for covered services, part of which may be reimbursement rates.

CMS has a 1/4/16 deadline for public comment as sections of the rule have changed.

States will be required to develop a medical assistance access monitoring review plan and the MCAC will have a role in this process. The plan will be due to CMS by July 1, 2016 and will be an agenda item in upcoming months.

Certain data requirements are outlined and specific services that the state must include in the plan are: primary care services, physician specialist services, behavioral health services, pre/post-natal obstetric services, and home health services.

In addition, if a State Plan Amendment (SPA) is being submitted that reduces any rates, a study must be submitted with it that demonstrates that the change will not have a detrimental effect to access. This regulation would only apply to fee-for-service providers as Managed Care has its own requirements. Regular reviews on a 3-year cycle are required, or when a rate reduction is proposed.

PCN Updates

PCN has been extended through the end of February 2016 while public comment is being examined. The Department believes a December 2016 renewal period will be allowed. It appears the PCN program will need to be addressed on an annual basis given the work in recent years with CMS.

RyLee asked if PCN coverage is lost, would that be viewed as special enrollment period and allow for an exception to open enrollment periods. Michael responded that he believes that is the case.

Adjournment

With no further business to conduct the MCAC convened at 3:40 p.m.