

Medical Care Advisory Committee

Minutes of August 18, 2016

Participants

Committee Members Present

Andrew Riggle (Chair), Dr. William Cosgrove, Mark Brasher, Sara Carbajal-Salisbury (via phone), Debra Mair, Danny Harris, Steven Mickelson, Donna Singer (via phone), Mark Ward, Peter Zeigler, Nate Checketts, Adam Cohen, Doug Springmeyer, Jenifer Lloyd.

Committee Members Excused

Jonathan George

Committee Members Absent

Kevin Burt, Michelle McOmber, Jackie Rendo

Guests

Jessie Mandle-Voices for Utah Children, Lincoln Nehring-Voices for Utah Children, Micah Vorwaller-UHPP, Corina Lena-Premier Access, Kim Michelson-Oral Health Program, Tracy Altman-UUHP, Ed Drering-UAHC, Kris Fawson-USILC

Welcome

Andrew Riggle called the meeting to order at 1:30 p.m. Andrew welcomed members.

Approval of Minutes

Jenifer Lloyd moved to approve the July 21, 2016 minutes. Donna Singer seconded the motion. All approved. None opposed.

New Rulemakings

Craig Devashrayee – New Rulemaking

Craig spoke on rule **R414-19A Coverage for Dialysis Services by a Free-Standing State-Licensed Dialysis Facility**; This amendment clarifies definitions, eligibility requirements, service coverage, and reimbursement for dialysis services performed in an end stage renal disease facility. Filed for public comment on June 13, 2016 and effective date is August 10, 2016.

R414-505 **Participation in the Nursing Facility Non-State Government-Owned Upper Payment Limit Program**; This new rule ensures agency compliance with reporting requirements found in the Code of Federal Regulations, and defines participation requirements in the Nursing Facility Non-State Government-Owned Upper Payment Limit program. Filed for public comment on June 13, 2016 and effective date is August 12, 2016.

RM414-513 **Intergovernmental Transfers**; This new rule specifies source-of-seed payment requirements for all intergovernmental transfers, to comply with reporting requirements found in the Code of Federal Regulations. Filed for public comment on June 13, 2016 and effective date is August 12, 2016.

No questions on rules.

Jeff Nelson – Eligibility Update

Jeff provided a handout on Medicaid totals and reported that adult, pregnant women and children enrollment has decreased in the last month, and showed a slight increase for people with disabilities and people over age 65.

Jeff requested input regarding the blue line graphs provided on both Medicaid Totals and Medicaid, CHIP, & PCN-Number of Persons graph. Duplicate blue line graphs are the same in both boxes. Is it necessary to show the blue line graph again on the second page Medicaid, CHIP, & PCN – Number of Persons graph? It was agreed to omit the Medicaid only graph and include the Medicaid, CHIP & PCN graph.

Jeff Nelson – 12-Month Continuous Eligibility for Children

Jeff reported that House Bill 2 from the 2016 Legislative Session, requires the department to look at a policy change for eligibility. The policy is called the 12-month continuous eligibility. This policy is in place in the CHIP program, and the goal is for eligible children to stay in the program for twelve months. Would Medicaid benefit from adopting this policy? It was explained that in the Medicaid program children are only eligible month-to-month, and if there is any change (such as an increase in income) that month this would mean ineligibility, and they are taken off the program. The goal is to keep children with continuous coverage to meet their medical needs without a lapse. This policy would mean keeping children on the Medicaid program longer. Looking at this policy, we are evaluating what this means to the state and what the cost would be.

There were findings in the CHIP program that eligible children showed an average stay on the program of 11.1 months. The Medicaid program showed a higher eligibility average stay of 11.5 months. Children 0 to 5 years old and children 6 to 18 years are averaging 12 months. We would attribute all of this to ACA and MAGI. Analysis showed some eligible children were not being covered this long. It was a surprise to note that children with disabilities only show the average stay of 6 to 7 months, and it was explained circumstances might have occurred for this group such as a death or a move out-of-state. It was reported that if this policy is implemented, it means adding more member months to the program (overall) and additional cost. The report is due the end of August.

Dr. Cosgrove questioned if DOH is looking at the cost of month-to-month eligibility and the cost of members coming off and on Medicaid. There is a lot of cost throughout the medical community in regards to these children coming off and on Medicaid. Jeff said it is a guess, but yes, we have looked at this, and DWS does have a cost per decision. Jeff stated they have looked at 23 other states that have this policy in place and how they have implemented. This is included in the report. Part of the weakness of the analysis is that we're looking back in time. This may not translate into the actual experience of the children, and the "churn" of eligibility which occurs when children lose coverage at review and then re-enroll in Medicaid or CHIP shortly after.

Danny Harris asked if they are looking at other eligibility groups of children. Jeff stated yes, DOH is looking at all eligibility groups of children. Jeff added that only groups of children were reviewed, not adult groups.

Andrew questioned the short average stay of children with disabilities and requested further analysis. Jeff agreed on further analysis. Andrew asked if several years of data would provide a better view.

Doug clarified that the report will not report what the cost would be, but will call out the potential savings. Jeff stated this is correct, we will note it in the report that there is administrative savings that were not found.

Dr. Cosgrove commented that there is a cost to providers to deal with those that have lost eligibility and then regained. He asked if it would be helpful for the report if providers tried to figure out the cost for this. Will the report show the groups and cost to the providers? This is a difficult way to quantify anything to show how to offset the cost, but examples are helpful. Examples were given.

- Provider might schedule appointments for patients and later find out they do not qualify. This cancels the appointment at a cost to the provider. They then re-schedule again after realizing they do qualify at a later date.
- Billers are affected as well. Retracting funds from a visit for not being qualified then finding later they qualify.
- Another population that is experiencing costs are the beneficiary themselves.

Dr. Cosgrove asked what is involved in each eligibility determination and what does the family have to show to qualify. There are several eligibility factors; citizenship, state residency, level of income or assets. Information is also collected by the data services which plays into each individual's eligibility and finding the best fit. To qualify, income eligibility information may be collected by the federal data services, matching federal taxes, pay stub, or last effort by calling their employer. To apply, this can be done electronically by internet, fax, a call, or visiting in-person at any of the DWS locations. The question was asked what the percentage is of needing to collect additional proof for eligibility. The numbers were not known, but DWS may be able to answer.

Jesse Mandle asked if the report will look at age. Jeff stated the report will be broken down by the child groups, by age, and cost.

Kolbi Young – Medicaid Outreach Funding

During this past legislative session, the Division of Medicaid and Health Financing received \$25,000 for program outreach. With the federal match the total came to \$50,000. Feedback on the Division's direction to use these funds was provided by meeting with various community partners and advocacy organizations. Recommendation from these groups was to implement grass-roots, door-to-door methods of outreach. It was their experience this one-on-one, in-person tactic builds trust within the communities. It was found that funding was not significant enough to purchase mass media or replicate advertising as was done in the past. Outlined are some areas that would have the most impact.

- Recommended and supported was a **social media ad campaign**. Social media sites like YouTube, Facebook and Twitter can specifically target certain demographics and geographic locations. It was estimated spending \$5,000-\$10,000 for this campaign.
- Develop a **“Coverage for Kids” landing page** that has more information about both CHIP and Medicaid which links them to the application and respective websites.
- Focus on updating and promoting CHIP. CHIP has a strong and recognizable brand that has been built over the years. The current **CHIP website** was designed and launched ten years ago. This would improve usability and mobile compatibility.

- Enhancing the Spanish page to make the information more interactive. DOH will do the work which will significantly reduce costs for this type of project. Estimate spending \$5,000-\$10,000 for web development.
- We are in discussions with a program within DOH called **Bridging Communities and Clinics** administered by the Office of Health Disparities. They have been operating for several years to improve community health in populations and areas affected by health disparities. They will coordinate community events and help community members get access to health insurance and a primary care provider. This is in the initial stages of discussions and negotiations,

Question was asked if outreach will be done to reach pregnant women or individuals on the PCN program. No, this funding is specifically for outreach to children.

Jenifer Lloyd stated they just received a CHIPRA grant for community outreach. Their primary community focus is Latino children. Kolbi added that this outreach money will also be focused on the same group. Jenifer stated she will be reaching out to Kolbi to possibly coordinate.

Jessie Mandle asked if there will be metrics or an evaluation to show value. Kolbi stated tracking will be available by tracking the links clicked, etc.

Question was asked if this program will capture the rural areas and will the outreach information be in Spanish. Yes, with the social media ad campaign this will find the rural and state-wide communities. Spanish information will be provided.

Tracy commented that the ACO's do outreach and would be more than happy to help with outreach to have dollars go further.

Andrew asked if Bridging Community and Clinics has done Medicaid and CHIP outreach before. Kolbi stated they have done this before (as well as other services) and that is why we are partnering with them. They also already have contracts and contact with other community groups.

Doug suggested that there is a consensus on written material that we can all use. He stated there is outdated CHIP material being used.

Dr. Cosgrove asked if we can enlist commercial partners like grocery store, gas stations, etc. Kolbi stated this is something we could look at, but we focused on what we think is feasible with the time and money we have.

DOH Introductions

It was asked by an attendee that all UDOH staff in the room introduce themselves. This was done.

Julie Ewing – Managed Care Regulations

Julie reported that April 25, 2016, CMS issued a final rule which was the first major update to the Medicaid and CHIP managed care regulations in over a decade. The regulations are phased in terms of their implementation dates. There are several regulations from the mega-rule that are now currently in effect. One regulation that is currently in effect immediately is the regulation that reduced the amount of FFP available to the state for our external quality review organizations. Available FFP went from a 70/30 match rate to a 50/50 match rate.

There were several regulations which went into effect 60 days after publication which placed the effective date of those regulations as July 5th of this year and they are:

- Many regulations were just being cleaned-up in the existing regulatory language.
- One regulation was removed from ICD-9 references, which are outdated due to ICD-10 coding.
- Regulations which reflected new technology. For example, the marketing regulations now apply to texting.
- Submitting our managed care contracts and rates to CMS 90 days in advance of their effective date. The old regulation requirement was to submit contracts and rates to CMS without a specify deadline.
- Regulation that relates to stays in an institution of Mental Disease or IMD (still assessing this impact). The social security act prohibits Medicaid payments for individuals in an IMD between the ages from 21 to 65. The new regulations now allows a state to pay a capitation payment to a managed care plan for an enrollee who spends less than 15 days a month in an IMD. Amending PMHP contracts to reflect this requirement.

Three areas of impact to the programs in July of 2017 and July of 2018.

1. Rate settings- Old regulations had to be actuarially sound, based on utilization data, which we call encounter data, and rates had to be submitted to CMS for approval. The new regulations now set some significant rate development standards and outlines the steps the state must take in developing the rates. Those steps include requiring that we use audited encounter data, price data, and financial reports, develop a non-benefited component to the rate, make risk adjustments and other adjustments necessary to account for program changes and take into account the plan's medical loss ratio. Requires states to phase out supplemental payments over the next 10 years. A lot of managed care plans may reimburse providers outside of a fee-for-service basis using either sub-capitation models, medical homes, or quality incentive plans. The regulations provide some guidance on how we may account for those types of payment models in rate development. With these new requirements, actuaries determine how to bring rate development and rate certifications into compliance. On July 29th CMS issued additional guidance on how they expect states to deal with the supplemental payment issue.
 2. Quality measures and state oversight of our managed care plans- By July of next year, a monitoring system that needs to be in place includes: administration and management, appeals and grievances, claims management, enrollee materials and customer services including the beneficiary support system, finance including MLR, information systems, including encounter data reporting, marketing, medical management including utilization management and case management, program integrity, provider network management including provider directory standards, availability and accessibility of services including network adequacy standards, quality improvement, all other provisions of the contract, as appropriate. Must use data collected from compliance monitoring to improve performance in all areas.
- Enrollees- Public policies that CMS would like to implement is to increase a Medicaid enrollee's engagement in their own healthcare. The regulations require developing a beneficiary support system by July 2018. The beneficiary support system must include choice counseling for beneficiaries, assistance to enrollees in understanding managed care, and outreach. The regulation will impact our open enrollment next year. Required is an open enrollment for clients who are living in voluntary enrollment counties and inform them of their ability to enroll in a managed care plan or remain fee-for-service. The new regulations require us to post quality metrics and other information about our managed care plans on our website, so that we can offer enrollees an avenue to make a more informed choice on their managed care plan selection.

The biggest impact required within three years of the rule publication is developing and implementing a Medicare-like quality rating system. Beginning July 2017, there is a requirement to conduct care coordination activities for clients switching between managed care plans and clients switching between managed care plans and fee-for-service.

Questions and Answers

Where is the funding coming from to implement these regulations? It was reported the department will be requesting a building block. The amount is not known at this time. These items are under consideration for budget. How will these requirements be imposed on ACO's? When will the regulations begin? The contracts need to be in compliance July 2017. The department needs to submit 90-days in advance to CMS, which means a draft contract will be done in February. What is the 50/50 funding for? This is for EQRO. Do we have an estimate for EQRO costs? We are able to absorb these within our existing budget, as they are not a significant amount. Will there be opportunities for public input and feedback as this is developed? There will be an opportunity for public comment, and when this occurs notification will be provided. Julie will provide updates as requested by the MCAC.

Doug requested this as an agenda item every 60 days.

Executive Committee Agenda Items–

Andrew asked for future agenda items. The following future agenda items were noted:

- Medicaid services received through IHS Tribal facilities.
- Continue discussion of reinstatement or suspension of Medicaid for individuals receiving mental health care coming out of incarceration.
- 12-month eligibility discussion (this was on the agenda today).
- Discussion on Medicaid scholarships for interpreters providing services to Medicaid enrollees.
 - Nate noted this was pulled off the “parking lot” list by the Executive Committee. They weren't sure how to approach this item.

Send agenda items to Jennifer Meyer-Smart at jmeyersmart@utah.gov.

Elimination of the 'In the Home' Requirement for DME

This agenda item was tabled for the September meeting. Doug asked for a brief overview of this. John Curless provided this, but it will be discussed in September.

Nate Chicketts – Director's Report Update

Status of Division Audits

Release of state audit report on Medicaid pharmacy claims. The auditors reported two primary sections; pharmacy claims and how they were paid, and the restriction program dealing with services, price, and drug over-utilization. It was reported prescriptions paid came to total of 4.4 million pharmacy claims. Auditor's findings after the review identified 59 paid claims in which the prescriber had passed away. This was looked into as the department would like the number to be as close to zero as possible. The department realized there are areas that need improving for future reports. We have taken back these 59 claims and referred to the OIG for possible fraud. The auditors identified 52 claims in which the member had passed away. We are improving our report to run against pharmacy claims to avoid this in the future. The second section auditors reported on was the restriction program. The restriction program is set up to identify individuals using high levels of certain types of services, such as frequent use of the emergency room, using different doctors or different pharmacies. Those individuals are flagged and are reviewed to determine if they should be on restriction. The report used to collect the data had some flaws and it was

reported the department is working on this. The department was using several different factors to determine those that need to be on restriction, and the auditor suggested one additional factor of how often the individual was on the report. Last, the auditors encouraged additional documentation.

Julie Ewing was given a question regarding the process of listing the individuals on restriction, and how they can be taken off. It was reported that prior to the formal notification of being on restriction, letters are mailed and staff call to inquire on their usage, and provide education on restriction measures. When determined to be on restriction, a notice is sent and they are informed they can appeal and have an opportunity for a hearing. We are running reports to look at if someone should stay on the list. We are looking at medical appropriateness of utilization. ACO's are also working with these clients. It's a shared partnership with them. It was suggested to give additional attention to those individuals that might not need to stay on restriction, and informing members on how to be taken off the list. It was asked how many are on the restriction list. It was reported there is a broad list of 15,000, but we need to refine this list to better identify those that may need restriction. Approximately 500 members are on restriction. An annual review is done to determine if they should stay on restriction. It was asked how member's lives are impacted by restriction. Julie explained that they are restricted to one pharmacy, one physician and one hospital. We won't pay claims if they use providers other than those they are assigned to.

Premier Access Dental Changes

Members in four counties-Weber, Davis, Salt Lake and Utah, have approximately 136,000 pregnant women and children who qualify for dental services. It was reported state law requires that these services are provided through managed care contracts. Premier Access and Delta Dental are the two plans that provide dental care. As Premier Access worked on their provider network, they introduced and expanded the use of sub-capitation with providers and established new rates. With these changes some dentists have agreed to the new terms, whereas other dentists have not. Those dentists not accepting the new terms will no longer be with Premier Access. The department is now assisting members and providers with calls expressing their concerns over the change. Members can switch to the other panel if their dentist is part of that panel. If not, they need to switch dentists. The question was asked about network adequacy and what the number is. It was stated that it is 1 dentist to 600 members. Currently Premier Access has 83,000 enrollees and 495 have asked to switch or get a new dentist. Premier has 300+ dentists on their panel. Because of the change in network, members can switch by calling an HPR. Donna requested a written brief on the Premier Access change. Nate stated we can provide something.

Other items

Medicaid expansion update- The department went through the public comment period and submitted the waiver on July 1, 2016. In review of the submitted waiver packet, CMS identified that we released for public comment the first 15-year history for the waiver for budget neutrality, but did not include what the department was proposing for the next 5 years. They asked for it to be reposted for an additional 30-day comment period. This was done July 16 through August 15 with similar comments as the first posting provided. This report is ready to be submitted to CMS, and upon validation of what is submitted, CMS will then go through a 30-day federal comment period. Meanwhile, there is on-going negotiations and discussions with CMS regarding the waiver. CMS stated they haven't approved anything before based on homeless and justice system involved eligibility criteria, but they are willing to consider this. It was asked if the parent income limit change is being submitted with this waiver. Nate responded that we are doing the two at the same time. There has been no indication when this waiver will be approved as CMS indicated there are numerous proposals to review. Notification to the MCAC members will be sent when CMS public comment period is open. Question was asked if there is somewhere the public can read the comments and responses of the waiver that was submitted. It was noted the waiver was submitted on July 1, 2016, and the public comments and responses are in Attachment 12.

Next meeting: Thursday, September, 15, 2016, 1:30 p.m. to 3:30 p.m. Room 125, Cannon Health Building

Motion to adjourn by Doug Springmeyer. None opposed. Meeting adjourned at 3:20 p.m.

DRAFT