

Medical Care Advisory Committee

Minutes of March 17, 2016 Meeting

Participants

Committee Members Present

Russ Elbel (Chair), Andrew Riggle (Vice-Chair), RyLee Curtis, Debra Mair, Adam Cohen, Jonathan George, Mark Brasher, Kevin Burt, Danny Harris, Mark Ward, Sara Carabajal-Salisbury (on phone), Tina Persels (on phone), Pete Zeigler (on phone), Nate Checketts

Committee Members Excused

Steve Mickelson

Committee Members Absent

Jackie Rendo, Michelle McOmber, Laval Jensen, Jason Horgesheimer, Donna Singer

Guests

Dr. Cosgrove (Utah AAP), Jessie Mandle (Voices for Utah Children), Joyce Dolcourt (LCPD), Kelly Peterson (Healthy U)

Welcome

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

Minutes of December 17, 2015 Meeting

Approved with correction: Director's Report Inter-Governmental Transfer change ITG to IGT.

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>.

R414-303-8 Former Foster Care Youth & Independent Foster Care Adolescence. This amendment expands coverage to foster care youth who reside in Utah and were in foster care in any State at the time they turned 18 years old. Coverage continues for these individuals through the month they turn 26 years of age. This rule was filed on December 30, effective March 8.

R414-15 Incorporations by Reference. Quarterly adoption of the Medicaid State Plan Amendments in all of our provider manuals to January 1 2016. Filed December 31, Effective March 8.

R414-320 Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver. 5 year review or renewal so there are no changes to it. The department will continue this rule because it defines coverage and eligibility for Utah's Premium Partnership for Health Insurance or UPP program and because it spells out application requirements, notice requirements, and reimbursement policy. Filed February 1. Effective another 5 years on that same date.

R414-2B Inpatient Hospital Intensive Physical Rehabilitation Services. Consolidates the scope of inpatient intensive physical rehabilitation services in the Medicaid Provider Manual. No changes. Just deferring to our provider manual. Filed February 1, effective April 1.

R414-373 General Requirements for Home and Community Based Services Waivers. Clarifies eligibility start date for the Home and Community Based Services or HCBS Waiver. Updates a citation in the rule text and makes other technical changes. Filed for public comment on March 8, first possible effective date March 9.

Question: Was R414-303-8 a legislative change and how many people would it impact? Response: The Affordable Care Act opened up this group. It was not a requirement, it was an option. It impacts approximately 60 people.

Question: R414-373 is clarifying eligibility start date a change? Response: The 'Form 927' helps us communicate with DWS about the start date and this clarifies that once we submit the 927 what the official start date is.

Budget Update

Eric Grant reported.

Adult enrollment has been pretty flat. Unemployment in Utah is 3.5% while the national unemployment rate is at 4.9%. Utah is one of the few states where there are more unfilled jobs than unemployed individuals.

Child enrollment increased .84% between January and February. Consistent with previous years.

People over age 65 there was a larger than expected increase. Might be due to a reporting/timing issue.

Pregnant women growth was flat after several months of decline.

CHIP had flat growth between July and November 2015 has increased by 1% since then.

PCN increased between October and November primarily because PCN had open enrollment in July and has remained open [for parents].

UPP - DWS has worked on improving their referral pathways. Since then we have seen an increase. We may have to close enrollment for adults for the first time.

Ethnicity Report

Information was presented by Andre Baksh and Nate Checketts. A handout was provided that addressed a request made by the committee during a previous meeting. 2 charts were supplied, one which separated Hispanics and Non-Hispanics by the different coverage groups that the state covers. (Adults, People over age 65, People with Disabilities, Children, CHIP, PCN, Pregnant Women). In addition, a second chart was supplied for each of the coverage groups, but indicated individuals who indicated they were White, Pacific Islanders, Asian, Native American, Black, or stated 'Other'.

It is very important to note that information received is self-declared by applicants. No comparison to overall population demographics was made.

A member of the committee asked if this report will be part of the annual Medicaid report. Nate commented that it is not included today, but Division leadership may discuss this going forward.

Assuring Access to Care for Covered Medicaid Services

Jennifer Meyer-Smart presented on this topic. Refer to handout of brief. On November 2, 2015 CMS published a final rule implementing the Access provision that requires State Medicaid agencies to provide a medical assistance access monitoring review plan. Effective January 4, 2016 the new rule requires States to develop and update a monitoring review plan. States must make plans available to the public for at least 30 days, finalize plan, and submit to CMS. The plan is due to CMS by July 1, 2016. The final rule excludes managed care populations and focuses on fee for service only. Requires access review as part of a SPA to reduce or restructure provider payments and we also must monitor access for the affected service for 3 years after the change is in place. We are developing a monitoring plan for the following service categories for fee for service, it will be done by geographic area: primary care services; physician specialist services; behavioral health services; pre and postnatal obstetrics services including labor and delivery; home health services. It will also include a standardized, data driven process by which we will document and monitor access to care. We are currently seeking informal feedback from various groups including the MCAC. Some of the others we will be working with include Utah Indian Health Advisory Board, Utah Hospital Association, Utah Medical Association, providers, and beneficiaries. Draft of the plan will be submitted to this group by April 15. The Department hopes to receive

feedback from this group by April 22. The Department will accept public comment period during the month of May. Another draft will be presented in this group in the May meeting. Page 5 there are some sources listed if you want to read more about the rule. Krisann Bacon is the project lead, 801-538-6079, krisannbacon@utah.gov.

School Meal Demonstration Project

Kevin Burt presented on this topic. DWS coordinates with the schools using the food stamps program. If someone in the household is eligible for food stamps, that household is eligible for free lunch. Work is currently being done to see what information on medical program determination may be leveraged to determine if children may receive free or subsidized lunch. If a school gets to a certain percentage of kids enrolled in free lunch, the whole school gets free lunch. Utah hopes to be selected for the demonstration waiver and prospects appear positive with other projects that have been completed in the past. Where selection is not guaranteed, time lines have not yet been developed, but DWS and Education intend to continue the food stamp pathway that has already been established.

The Office of Education will submit to participate in the demonstration waiver as this is through FNS, not CMS.

Danny Harris asked what the enrollment trends look like and how many children wouldn't have qualified for free lunch without this program. Kevin responded that we don't have the information but that the Office of Education may supply it following any analysis that takes place. Kevin added that there are many more children enrolled in Medicaid than the food stamp program.

Debra Mair asked what kind of information may exist for families who apply for free lunch that qualify for food stamps but haven't applied. Kevin responded that it wouldn't change anything for those individuals as they would be encouraged to apply for food stamps if they were found eligible for free lunch.

Reinstatement/Suspension of Medicaid Individuals

Kevin Burt presented on this topic. If a person is incarcerated they are ineligible for medical. There could be an individual that is receiving treatment in the prison then they want to retain that coverage or treatment after. Prisons were sending in applications for prisoners still incarcerated, DWS would deny that because that incarceration makes them ineligible. DWS is allowing prisons to submit applications prior to release. DWS would hold that application knowing that the prisoner is going to be released. When DWS is notified by prison of release they can go ahead and approve the application. A large number are ineligible.

Question: When we've talked to the prison mental health staff they have said they want to do it but they don't have the staff with the time or expertise to do it. Who is working with the inmates to complete the applications? Response: The prison has the staff that is going through the process with the prisoner. They can have an outreach eligibility worker but they have to partially fund them.

Question: Are you talking about doing the same process with the Jails? Response: DWS does have workers that go to the jails. They have workers at homeless shelters. They take a high application volume but again it's a large population that fits into the coverage gap.

Question: Have you discussed how to follow up and educate the eligible population once they are approved and released? Response: Yes. We are getting the eligibility part down now and we will discuss now that people are eligible how we help them get what they need.

Director's Report

Medicaid Leadership changes.

Nate Checketts reported. Nate was appointed as acting director in December and was confirmed by the legislature in February as the new Director of Medicaid and Health Financing in addition to being the Deputy Director for the Department of Health. Emma is the division's operating director and is over the bureaus of Coverage Reimbursement and Managed Health Care. She also supervises our public information area and our health reform area. Tonya Hales is an

assistant division director and is over Eligibility Policy and Authorization Community Based Services and works with DWS. Janica Gines is the other assistant division director and is over Financial Services and Medicaid Operations. Our PRISM team and Hearings Office report to Nate.

Legislative Session Recap

Bills that passed:

HB247 – Medicaid Vision Amendments. It clarifies the RFP process the Division uses and makes it clear that it is in regard to Medicaid eligible individuals who may receive vision benefits. While all Medicaid covered individuals may receive eye exams, not all qualify for glasses.

HB386 Nursing Facility Amendments. Changes the moratorium requirement to reduce the number of beds by 30% when transferred. Also changes the authority of the Medicaid Director from 'shall grant' to 'may grant'.

HB437 Medicaid Coverage Expansion – addressed as its own subject.

House Joint Resolution 7 regarding Medicaid funding report requires that a report be given to executive appropriations that talks about mandatory pieces of inflation.

SB32 Hospital Provider Assessment. Reauthorizes the existing hospital assessment as its time limit was reached. A significant portion of the rates we pay hospitals today are funded through an existing assessment.

SB39 Adult Dental Services. Only partially funded. Originally something primarily funded by University of Utah Dental School. \$250,000 from school. \$1.4M from general fund. Bill passed through House and Senate. Found out later it was only a one time funding of \$500,000 which was not enough for us to offer the benefit. We will look at this bill during next year's session as it did have an effective date of May 2017 and could be funded next year. The bill requires that an amendment to be submitted by July 1, 2016. We will go forward and submit but let CMS know we will not start until we have appropriate funding.

SB140 Home and Community Base Services amendment. Gives direction to the department to review a variety of different programs related to home and community-based services. (Money Follows the Person, Community First Choice, etc.) The Department must supply a report to the legislature by June 1, 2016.

SB154 Medicaid Accountable Care Organization. Changes to Accountable Care Organization budget. If there is a major program change to ACOs, it will go into the base budget.

Changes to Appropriations:

\$35,000 reduction to our budget for telehealth network staff. 2 years ago \$1M was appropriated to shore-up infrastructure. The funding has all been awarded/equipment installed. UTN will hopefully be able to absorb this funding loss.

\$100,000 removed for nurse case management for kids with complex needs pilot that was occurring in BRAG. This area is now covered by the ACOs and was viewed as duplicative. Should be picked up by ACO. These pediatric nurses were assisting children with complex medical needs and their families.

Funding was removed from our budget due to the higher match rate now received for CHIP. Funds have been held in reserve in case something changes to reduce the rate.

We were given \$1M for nursing home rate increases.

Given \$700,000 for pediatric dentist rate increases.

Requested \$2.5M to maintain primary care physician rates. Funded \$1M of that on an ongoing basis. Rates will need to be rolled-back slightly due to the full amount not being appropriated.

Budget reduction for Autism Waiver pilot program because we moved to cover Autism services through the state plan. Enrollment in the pilot program continues to dwindle as children age-out of the program.

Last year we started a pilot waiver program for Medically Complex Children. We were able to enroll 180 children following the passing of HB199 in the 2015 Legislative Session. This year the legislature gave us another \$1M to cover an additional 60-70 children over the next 2 years. The legislation was clear that funding is to be used to cover new children and not to be used for existing covered children who's costs may be higher than initially estimated.

FY16 Supplemental need was \$8.4M, and agreed upon through Consensus. Caseload growth and other items for 2017 was \$37.1M. The estimate was reduced as some costs were not realized that were forecasted, an example being the cost of Cystic Fibrosis medications.

Outreach was funded. \$25,000 one time. We will need to decide how to spend that. We weren't given any specific direction. The Department may focus on Hispanic children as this population is particularly underserved.

Intent language:

HB7 work with pharmacy benefit and develop a plan to issue 90-day supplies of prescriptions when appropriate.

HB2 item 58 study enrollment trends for children for CHIP and Medicaid and assess the relative costs of doing our current plan of month to month eligibility vs. doing a 12 month eligibility. Study is due by August 2016.

HB2 and SB3 Remove 5 year bar for children. 200-300 children might become eligible. Requires a state plan amendment to be approved. The timeline for implementation is unknown.

Carry forward authority was provided for PRISM project funding.

ACOs will receive a 2% funding increase to cover caseload growth and program growth.

SB3 directive to study issues surrounding individuals who are kept out of nursing facilities (see SB 140).

An area of interest to watch moving forward will be any legislation that discusses the Federal Poverty Level limits for the expansion bill. HB437 did not include specific parameters and future bills may provide amounts.

Michael Hales asked about the intent language that was included in HB3 surrounding tobacco cessation and its impact on the Department/Division. It states that the legislature intends in order to decrease tobacco use and to use state resources all Medicaid coverage will adhere to the United States preventative services recommended evidence base practices which are proven to reduce tobacco use including both counseling and all FDA approved methods of pharmacy therapy with no or minimal cost sharing by the DOH. Do we know what that is intended to do other than what the department is already covering? Nate responded that there was not any discussion with the Department nor a request for a fiscal note. Sheila Walsh-McDonald indicated that she believed that the language was requested by the American Heart Association.

Medicaid Expansion

Nate commented that the program passed through HB437, sponsored by Rep. Dunnigan, did not provide a name for the program. It includes 3 main parts:

1. For the Preferred Drug List (PDL) to include psychotropic drugs. A 'dispense as written' provision was included to allow existing medication regimens to continue if they have been found effective. If savings of \$750,000 in general fund is not achieved by October 2019 then that 'dispense as written' requirement will be removed and we will go to the more traditional prior authorization process that we use. Psychotropic drugs will remain a carve-out of the ACO benefit.

2. Hospital Assessment. Will bring in approximately \$13.6M from hospitals. Creates IGT from University of Utah and non-state government owned facilities and an assessment on private hospitals in order to cover the cost of expansion populations and to increase hospital reimbursement for the entire population for outpatient hospital services.

3. Expansion to 4 Different Populations

a) Adults with dependent children. Income levels are based on a dollar amount right now, not an FPL percentage. Given current amounts, it will go up to 55% FPL including the 5% poverty disregard it will be 60% FPL effectively. Estimated to be about 3,800 parents. A state plan amendment will be completed, but it may need to be submitted as a waiver.

b) Adults without dependent children who are chronically homeless or receiving housing support after being homeless. The department will set rules/define what the definition of 'homeless' will be. The HUD definition could be used which defines 'homelessness' as either 12 months continuously or 4 periods or more of homelessness in the previous 3 years. We may choose to include disabling conditions as a factor as well. DWS numbers show about 100-200 chronically homeless and 1,000-1,300 receiving assistance in supportive housing. Will use a 12-month continuous eligibility policy to ensure that program changes that may occur won't interrupt coverage.

c) Adults without dependent children who are 'criminally involved' with substance abuse/mental health issues. Estimates from Substance Abuse & Mental Health could mean possibly 40,000 people in this group. Many of those are almost \$0 income. Department will have to establish criteria, but some variables under consideration are income, diagnosis, drug count/mental health court, involvement with probation/parole, etc. Given that the expansion is intended to cover 16,000 individuals between all 4 populations, only a portion of the 40,000 in need will receive benefits.

d) Adults without dependent children who have substance abuse/mental health issues but are not 'criminally involved'. Still working on defining this group. The Department intends to seek clarification from the sponsor to confirm legislative intent regarding coverage of this group.

12,500 slots are available for adults without dependent children.

Our to-do list/time-lines: We are meeting with state agencies now (Corrections, DWS, Substance Abuse & Mental Health, etc.). In early April we will meet with constituent groups. Toward the end of April we will invite the community to discuss. The Indian Health Advisory Board and MCAC will be consulted during our formal public comment period which will likely begin in May. We are required to conclude public comment and submit the request by July 1.

RyLee asked about the IMD waiver. HB437 also requires for the state to seek a waiver to use Medicaid funds to serve individuals short-term. Currently prohibited, but there may be a way using a 'continuum of care' argument that CMS may agree to allow some method of reimbursement.

Adjourned 3:36 p.m.