UTAH MEDICAID REFORM BILL – S.B. 180
DISCUSSION OF 1115 WAIVER – MEDICAID REFORM PRINCIPLES
CLIENT FOCUS MEETING – COST SHARING
APRIL 13, 2011 – CANNON HEALTH BUILDING ROOM 125
4:00-5:30 P.M.

Attendees: Russell Frandsen, Byron Okutsu, Karen Warren, Stan Smith, Amy Bingham, Richard Rosenberg, Paul Muench, R. Sanchez, MD, Representative Dean Sanpei, Senator Dan Liljenquist, Barb Viskochil, Lincoln Nehring, Sheila Walsh-McDonald, Russ Elbel, Collin Davis, Korey Capozza, Alan Pruhs, Jesse Liddell, Jim Murray, Kris Fawson, Sean Dunroe, Jim Murray, Dr. David Patton, Kevin Moffitt, Kirsten Stewart, F. Blake Anderson, John Curless, Lisa Nichols, Gail Rapp, Gayle Coombs

Gail called the meeting to order at 4:00 p.m. and had everyone introduce themselves.

Gail then began with going over the cost sharing document. She said incentives will be discussed in two weeks. Gail then had Sheila Walsh-McDonald discuss the document that she passed out to everyone in regard to cost sharing. Gail also provided everyone with a copy of the current Medicaid cost summary report entitled Comparison of Adult Medicaid Programs and a second report entitled CHIP Co-Pay Summary.

Sheila asked exactly what part of Medicaid is being shown in this document. Gail said this is specifically for all Medicaid enrollees in the four urban counties, except for people living in nursing home facilities. Sheila said that sometimes cost sharing can become a barrier for some people. She said there is evidence that when there is cost sharing, a lot of people don't use it or they drop from the program. Also, when there is an increase in the premium cost, some people drop from the program. People tend to delay care when there is a high co-pay.

It was asked how a sliding scale is done in the community clinics. It was mentioned that there are some federal regulations around how the sliding scale is set up. Each Community Health Center has to set up its own prices. Alan Pruhs explained this. Lincoln Nehring said part of our document today should be in regard to what cost choices we want them to make. It was mentioned that we don't want to create market distortions. The idea of sliding scale prices was mentioned. A lot of comments were made in regard to this and what the co-pays should be and how they affect people.

Senator Liljenquist asked how detailed do we want to be with this or do we want to be flexible like we are in the clinics. All the different barriers that some people face with health care were mentioned. Russ Elbel said he feels we are trying to make people go into primary care rather than into the ER room. He again said we really don't want people to go to the ER room for primary care and treatable conditions. NCQA standards were mentioned and having the regular physicians keeps their offices open longer each day. Russ also mentioned the abuser level in how some people abuse the use of an ER. He said he feels how people abuse the system is a totally different discussion.

Senator Liljenquist mentioned how he feels setting a limit on the payments could slow down some of the extended care that is given that is really not necessary. He said he does not want the waiver designed so that you have to do certain things. He wants to have the playing field as wide open as possible.

Lincoln said if we are going to give the plans some additional responsibility, then they have to set up and guarantee that the beneficiary has access to primary care. Gail said that CMS will probably require that we show

the co-pays for specific groups. Senator Liljenquist again mentioned the intention of the waiver. Lincoln said if we give the Accountable Care Organizations (ACOs) more authority we have to be sure that the patients' needs will be met. It was mentioned that if things are made too competitive for people to get medical help, then they won't get it and end up with their health problems getting worse. We don't want to have people have to delay their care. Gail said CMS is very descriptive and that is something we want to ask them to allow us to do something different and use something else.

Senator Liljenquist also mentioned that maybe this is looking at our outcome standards. Lincoln mentioned two ways you can control costs. You can either deny care or give them the care they actually need. Representative Sanpei mentioned that we have to be sure that the incentives are appropriate. The HRSA standard was mentioned. Representative Sanpei mentioned that co-pays are not the only thing we will need to be successful with this. There are other things that we are going to need. We are going to have whatever incentives we can in place to make sure people follow through with their care. Gail mentioned that in two weeks, this meeting will be dealing with incentives.

The co-pays for ER's and standard care were mentioned and making it so it is not cheaper to go to an ER rather than a doctor. It was mentioned that the ACO could refund some co-pays. There was a lot of discussion in regard to all this. Senator Liljenquist said you do want somebody to go to the ER if it is emergent. Different comments were made on the way the co-pays could be set up. Having co-pays on a sliding scale was mentioned. In regard to 133% of poverty level and the people in this area, what the co-pays would be was discussed. Sean Dunroe said maybe we could use the co-pays limit on that as the upper limit for co-pays. HRSA standards were again mentioned. Having a broader approach to the waiver could be better rather than having a limited approach was mentioned. It was mentioned that maybe we should be more specific about this.

Gail asked how Molina would implement a progressive co-pay strategy. A co-pay for all ER visits was mentioned. Having the co-pay up front was again mentioned as being a good way to go. The ER's behavior would also have to be modified in regard to this and sending people to clinics rather than the ER. Senator Liljenquist said we have to remember that we are looking at bundled payments here. That the doctors need to think about costs and the revenue was also mentioned by Senator Liljenquist.

John Curless mentioned how some other states started having a doctor triage people that came into the ER and then send them to a clinic if that was better for them. This saved them a lot of money. Senator Liljenquist said that people have to be trained and given the incentive to refer people to a clinic if that is the best place they should go rather than the ER. People should not have the right to receive primary care in the ER room.

People being located into a medical home when they are on Medicaid was mentioned and this is the people who are abusing services. Gail said on Medicaid we do our best to locate them into a medical home. Barbara Viskochil said due to the EMTALA Law, you cannot turn anyone away from the ER room. It was mentioned that we need to come up with some kind of an incentive to stop people from abusing the ER room. It was mentioned that we need to make this pretty easy to understand or else it will just make things more difficult for everyone. It was mentioned that a system will have to be put in place to recognize a lot of these things.

The sliding scale concept was again mentioned. How much somebody's health care is their responsibility was mentioned by Senator Liljenquist. Sheila mentioned how you can't time illness and how a lot of people on Medicaid do not have the money for these co-pays. It was mentioned that 65% of ER visits are non-emergent. We need to find a way to change this.

Russ mentioned that he feels the co-pays should be at two levels - one for emergent and one for non-emergent. Would the hospital want things this way or would we leave it to HRSA to decide this? Senator Liljenquist said that we are all sensitive to all these things and want to make sure we don't put up hurdles so people cannot get the care they need. Senator Liljenquist mentioned that we could have an upper limit that would be set at the minimum plan of 133%. That would be the maximum co-pay. People being able to see a published co-pay schedule was mentioned for people enrolling on Medicaid. Senator Liljenquist said we would want the flexibility to be able to change this quarterly. He said we would have to have this boxed in with some limitations.

Jim Murray asked if there are currently any limitations on an ACO doing this now. Senator Liljenquist said we want to give providers all the flexibility we can. He said he wants to be sure we get the outcomes right. Sean Dunroe mentioned the difficulty in trying to determine what is emergent or non-emergent. He said that in the provider market, they cannot distinguish between emergent or non-emergent care and he does not feel Medicaid should be able to do that. Sean also mentioned the co-pays and generic pharmaceuticals and name brand pharmaceuticals. Less is always charged for the generics.

Representative Sanpei said we need to make sure the things are written into the waiver so they can do these things, in regard to pharmaceuticals and medical visits. Gail said the upper limit on co-pays is set by CMS. Sheila Walsh-McDonald said we need to be sure that we don't exceed the 5% limit on costs.

Whether Medicaid tracks whether the co-pays are being paid was mentioned. Different co-pays that Molina uses were mentioned. Gail mentioned how Medicaid now has about seven different capitation payment categories for people on Medicaid. Senator Liljenquist mentioned how having to make co-pays all the time could change some people's behavior. Gail said we need to look at whether we are looking at co-pays across the board or not. It was again mentioned that an ER cannot turn people away, but they could triage people and then send them to a clinic. It was mentioned that there needs to be an incentive for an ER to triage people out of the ER. Collecting up front or doing a sliding scale with premiums was mentioned as a way to help with this.

Lincoln mentioned that to keep people in the ACO's they need a plan that will work and not have people dropping off of Medicaid or CHIP because they cannot afford it. Sheila mentioned doing a state policy in regard to a 12-months condition eligibility on Medicaid. It would be a 12-months condition eligibility with a federal match. It would be costly for Medicaid to do this. Gail said you would have to come up with a lot more state match to do this. There were a lot of comments in regard to this. Gail said we will continue to have a spend-down program so those Medicaid enrollees would not be in an ACO. A lot of things that you should look at in regard to this were mentioned.

Gail said we will be asking for a lot of things from CMS and we will have to wait and see what CMS does with these requests. Russ again mentioned whether children should be included in the co-pays. Sheila said she feels we really need to look at the area that CMS has already carved out. These populations need to be addressed soon.

The meeting next week will be on Wednesday, April 20th, at 3:30 p.m. in regard to the capitated rate setting process and data requirements.

The meeting adjourned at 5:35 p.m.