
MEDICAL CARE ADVISORY MEETING

MINUTES OF MEETING AUGUST 15, 2013

IN ATTENDANCE

PRESENT

Lincoln Nehring, Russ Elbel, Kevin Burt, Jackie Rendo (for Rebecca Glathar), Michelle McOmber (by phone), Tina Persels (by phone), Andrew Riggle, David Ward (by phone), Debra Mair, and Gail Rapp (for Michael Hales).

EXCUSED

Warren Walker, Mauricio Agramont

ABSENT

LaPriel Clark, Matthew Slonaker, Jason Horgesheimer, LaVal Jensen, Greg Myers, Mark Brasher

STAFF

Kolbi Young, Craig Devashrayee, Rick Platt, Emma Chacon, Sheila Walsh-McDonald, Nate Checketts, Jeff Nelson, Tracy Luoma, Dave Lewis, Josip Ambrenac, Summer Perkins

VISITORS

William Cosgrove, Elizabeth Craig, Beau Calvin, Kelly Peterson, Alison Mathis, Lacy Stevens, Jarett LaTour, Adam Grimaldo, Doug Springmeyer, Mark Ward, Barb Viskochil, Justin Allen

WELCOME

Chairman Lincoln Nehring called the meeting to order at 1:35 and welcomed everyone. A quorum was not present, so the minutes were not approved.

NEW RULEMAKINGS

Craig Devashrayee presented the new rulemakings.

Rule; (What It Does); Comments.	Filed	Effective
<p>R414-14A-26 Payment for Nursing Facility, ICF/ID, and Freestanding Inpatient Hospice Unit Room and Board; This change is necessary to comply with the mandate for concurrent care as found in the Patient Protection and Affordable Care Act. This change will promote the ability for children to receive true concurrent care rather than having to make a choice between hospice care and skilled care in a facility. This amendment, therefore, updates the Medicaid Hospice program to reflect the hospice room and board payment rate at 100% of the amount a child would have received in a skilled nursing facility or an intermediate care facility for persons with intellectual disabilities (ICF/ID).</p>	5-22-13	7-22-13
<p>R414-1-5 Incorporations by Reference; Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services (CMS). The purpose of this change, therefore, is to incorporate the most current Medicaid State Plan by reference and to implement by rule both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Utah Medicaid Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Medical Supplies Utah Medicaid Provider Manual; Hospital Services Utah Medicaid Provider Manual with its attachments; Speech-Language Services Utah Medicaid Provider Manual; Audiology Services Utah Medicaid Provider Manual; Hospice Care Utah Medicaid Provider Manual; Long Term Care Services in Nursing Facilities Utah Medicaid Provider Manual; Personal Care Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals 65 or Older Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services Autism Waiver Utah Medicaid Provider Manual; Office of Inspector General Administrative Hearings Procedures Manual; Pharmacy Services Utah Medicaid Provider Manual; Coverage and Reimbursement Code Look-up Tool; Certified Nurse – Midwife Services Utah Medicaid Provider Manual; CHEC Services Utah Medicaid Provider Manual with its attachments; Chiropractic Medicine Utah Medicaid Provider Manual; Dental Services Utah Medicaid Provider Manual; General Attachments for the Utah Medicaid Provider Manual; Indian Health Utah Medicaid Provider Manual; Laboratory Services Utah Medicaid Provider Manual with its attachments; Medical Transportation Utah Medicaid Provider Manual; Mental Health Centers/ Prepaid Mental Health Plans Utah Medicaid Provider Manual; Non-Traditional Medicaid Health Plan Utah Medicaid Provider Manual with its attachments; Certified Family Nurse Practitioner and Pediatric Nurse Practitioner Utah Medicaid Provider Manual; Oral Maxillofacial Surgeon Services Utah Medicaid Provider Manual; Physical Therapy and Occupational Therapy Services Utah Medicaid Provider Manual; Physician Services and Anesthesiology Utah Medicaid Provider Manual with its attachments; Podiatric Services Utah Medicaid Provider Manual; Primary Care Network Utah Medicaid Provider Manual with its attachments; Psychology Services Utah Medicaid Provider Manual; Rehabilitative Mental Health and Substance Use Disorder Services Utah Medicaid Provider Manual; Rehabilitative Mental Health Services for Children Under Authority of Department of Human Services, Division of Child & Family Services or Division of Juvenile Justice Services Utah Medicaid Provider Manual; Rural Health Clinic Services Utah Medicaid Provider Manual with its attachments; School-Based Skills Development Services Utah Medicaid Provider Manual; Section I: General Information of the Utah Medicaid Provider Manual; Services for Pregnant Women Utah Medicaid Provider Manual; Substance Abuse Treatment Services & Targeted Case Management Services for Substance Abuse Utah Medicaid Provider Manual; Targeted Case Management for CHEC Medicaid Eligible Children Utah Medicaid Provider Manual; Targeted Case Management for the Chronically Mentally Ill Utah Medicaid Provider Manual; Targeted Case Management for Early Childhood (Ages 0-4) Utah Medicaid Provider Manual; and Vision Care Services Utah Medicaid Provider Manual (Updates to July 1, 2013).</p>	6-10-13	8-7-13
<p>R382-10 Eligibility (CHIP); To comply with the Patient Protection and Affordable Care Act, this amendment includes requirements for the setup of an electronic interface with the Federally Facilitated Marketplace (FFM), which implements the eligibility process for assessing whether individuals are</p>	8-1-13	10-1-13

eligible for medical assistance programs or are eligible to enroll in insurance and receive advanced premium tax credits. It also adds new definitions related to health care reform provisions.		
R414-301 Medicaid General Provisions; To comply with the Patient Protection and Affordable Care Act, this amendment includes requirements for the setup of an electronic interface with FFM, which implements the eligibility process for assessing whether individuals are eligible for medical assistance programs or are eligible to enroll in insurance and receive advanced premium tax credits. It also adds new definitions related to health care reform provisions. Further, this amendment clarifies the hearing process for eligibility decisions and advanced premium tax credit determinations.	8-1-13	10-1-13
R414-308-4 Verification of Eligibility and Information Exchange; To comply with the Patient Protection and Affordable Care Act, this amendment defines the requirements for verifying eligibility, and allows for the use of other electronic data sources instead of using the federal data hub. The change sets up the criteria for requesting verification from applicants and recipients.	8-1-13	10-1-13
R414-2A-6 Service Coverage; This change implements by rule the updated "three-day window" policy for inpatient hospital admissions and services.	8-5-13	10-8-13
R414-1-5 Incorporations by Reference (Emergency Rule); This amendment is necessary to comply with provisions of federal law that require the Department to provide speech augmentative communication devices to Medicaid clients who meet medically necessary criteria. For this purpose, This amendment incorporates by reference the 08/02/2013 version of the Speech-Language Services Provider Manual.	8-8-13	8-8-13
R410-14 Administrative Hearing Procedures; This amendment clarifies that the Division of Medicaid and Health Financing conducts all hearings on a de novo basis without deference to a previous decision.	8-8-13	10-8-13

There were no questions from the committee or the members of the audience.

BUDGET UPDATE

Rick Platt presented the Budget Update. In July, a total of 259,684 persons were served. Medicaid served 114 more individuals 65 and older, 157 more individuals with disabilities, 220 more children, 14 fewer pregnant women, and one more adult than in June. This represented about a 2.2% increase.

Russ asked for clarification of whether the numbers given were actual numbers or projections. Rick stated that the projection of increase for this single month was 3%, but 2.2% was the actual increase. Rick offered to present more information at the next meeting.

MINUTES OF THE PREVIOUS MEETINGS

Several committee members came in late, so a quorum was reached. Russ moved to approve the meeting minutes from the past two meetings. The motion was passed.

HEALTH PLAN JOINT OUTREACH

Russ Elbel introduced Jarett LaTour and Lacy Stevens of The Summit Group. They presented a proposal for outreach as a joint venture with the health plans. A copy of their proposal is attached to the minutes.

Jarett began with a discussion on the current state of Medicaid. Utahns are unsure what will happen to Medicaid as we enter healthcare reform. The community is in need of education overall, especially about things that affect them directly. Compared to the nation, Utah underutilizes Medicaid, meaning that many eligible people do not apply. 57% of Utahns who are uninsured are probably eligible for Medicaid. The top audiences for this outreach will be caregivers of children and people with disabilities.

Jarett continued by saying that the purpose of this joint venture is to empower the public by providing educational resources through advocates and navigators. The health plans want to ensure that those eligible for Medicaid are aware of their eligibility and of the changes in general. Even if individuals haven't been eligible, they should check if that has changed. Currently eligible individuals should be made aware of their continuing eligibility. Resources should be local. We want to be able to send people to navigators, but there should also be advocates in the community, such as at schools.

Lacy outlined the proposed plan for outreach. The Summit Group plans to use a 5-step process that came from the CHIP outreach project and can be modified as needed. First, Summit Group and the health plans will create a flyer and a brochure in both Spanish and English which would drive individuals to an online resource and to navigators. The materials would be localized to Utah and co-branded with the health plans. Second, Summit would need to get signoff on the materials from MCAC. Third, UDOH would distribute materials to community advocates with Summit's support. Fourth, the Navigators and Advocates would use the materials during the week of events for advocates from September 30-October 4. Fifth, the health plans would provide support for any other materials needed during the year.

Russ asked who the navigators would be. Jarett explained that the plans will have patient advocates. The materials would exist to provide resources to groups who disseminate information, like schools and other community organizations. If we want a list of the navigators, the health plans can provide that. Lincoln said that anyone who's going to be in the business of helping families should have these materials.

Emma Chacon pointed out that the state has the ultimate authority to approve the materials and that MCAC serves as an advisory committee. CHIP includes explicit language about what the plans can and cannot do at outreach events, which will be helpful. The playing field should be level.

Jarett said that the materials would be created based on the needs of community advocates.

Lincoln said that MCAC would be willing to review materials. He asked how the materials should be presented for approval. He recognized that MCAC's recommendation will not be final, but emphasized that the recommendation would carry weight with the state.

Russ asked whether MCAC should appoint a subcommittee to review the materials. Emma said that CHIPAC decided to use their executive committee, since the review is not a large volume of work. Jarett mentioned that a smaller group would work best for the review. Emma said that the executive committee can decide how to review the materials. She emphasized that the intent of the outreach is to advertise the program, not any plan or the plans collectively.

Lincoln asked what the volume of material is likely to be. Jarett said the materials to review would be a flyer front and back and a brochure, in English and Spanish. There haven't been many

iterations of past materials. Review would happen about yearly and we would not need to have MCAC give multiple approvals.

Andrew asked several questions: What is the timeline for the materials? When can we see a draft? What should the turnaround be in committee? The need for quick work will drive how we distribute work to the committee. Lacey replied that there is an upcoming event (referring to the week of events for advocates) and that Summit wants to have materials ready for that. She suggested a 7-day turnaround. Jarett said that Summit can have a final draft by next month's meeting. He would like to present a first draft to a smaller group before that.

Emma said that since the state has the final approval, we can use people from the division, including our Public Information Officer, for review. Emma and Kolbi will set up a meeting and invite the volunteers from MCAC. Russ, Andrew, and Jackie volunteered to be part of the committee. Elizabeth Craig suggested that we have input from the community advocacy groups. Since Matt Slonaker is part of UHPP, Lincoln volunteered him for the committee. The initial meeting should be within the next two weeks.

QUALITY MEASURES WORKGROUP UPDATE

Emma Chacon gave an update on Quality Measures. The workgroup met in June to discuss integration of behavioral health. In July, the group started to talk about quality measures for individuals with special healthcare needs. On August 7, the workgroup discussed HB141, the ER & Primary Care amendments. The workgroup and ACOs came up with 25 specific measures they mutually agreed they would emphasize. These measures will be included in the next contract amendments. The workgroup's next meeting is Nov 7th from 1-4 P.M. in room 128. They will be discussing integration of behavioral health. In the integration group, it was decided some measures need to be vetted. There are no tried & true measures. The group wants to ensure that the measures are meaningful and realistic, so the workgroup is spinning that off to the state quality committee. They will report back to the workgroup. The workgroup has a monthly meeting with ACOs, and will have PHMPs attend quarterly. The division will host a care coordinator meet & greet and training in October or early November. All PHMPs and all four ACOs (about 100 people) are invited. We will train them, introduce them to each other, etc. We will baseline where we are now in terms of care coordination and measure in maybe a year to see if care coordination has improved.

INDIVIDUALS WITH COMPLEX NEEDS

Emma said we have not identified performance measures for individuals with complex needs, but the discussion so far has helped to identify issues with the system. Andrew sent some very useful material to the workgroup. They will digest those materials and come back with recommendations.

HB144

We have to submit proposed rules by November 1 that attempts to identify quality measures for the ACOs, including identifying emergent vs. non-emergent use of the ER. We also have to identify an algorithm for assigning individuals to ACOs based on their performance. The ACOs don't have to do their part until 2015. The workgroup will come up with proposals and share them via e-mail.

Lincoln asked whether we have quality measures for enrollees who have been enrolled for less than a year. Emma said the division would raise that issue with the appropriate staff.

DENTAL MANAGED CARE TRANSITION UPDATE

Emma Chacon gave a report on the Dental Managed Care Transition. We are in open enrollment and it's going very well. Both plans have gone the extra mile to accommodate concerns, especially with pediatric dentists, of which we now have 32. We've had 5,200 enrollment calls since the beginning of August. For the most part, families know which plan they want. A small number of families will be auto-assigned. Families have 90 days in which they can change plans. About 45-60 days after open enrollment, families will receive a letter reminding them of their opportunity to switch.

MEDICAID EXPANSION WORKGROUP

Nate Checketts gave a report on the Medicaid Expansion Workgroup. The workgroup met on August 1 to review different options. There were 8 proposals for Medicaid expansion options that were assigned to subgroups for analysis. Subgroups are performing analysis in their specific area and will present pros and cons to the governor on September 26. Nate brought an example of the work of one of the subgroups, which is attached to the minutes. Most of the groups said they still have work to do on their proposals. The next workgroup meeting is September 5. Subgroups have been asked to have near-final presentations ready. Once the governor has received the presentations on September 26, he will meet with advisors, talk with legislators, and decide where to go next. Russ asked whether there been further discussions on how this links to the Healthcare Task Force. Nate replied that there's a charity care subgroup that also reports to the task force. They would have to report before a decision on expansion could be made. The task force probably will not have expansion recommendations.

ACA-RELATED MEDICAID ELIGIBILITY CHANGES

Jeff Nelson gave a report on eligibility changes. We are 45 days away from a huge change in eligibility. DWS has been a great partner in making the changes to the eligibility system to accommodate the coming changes. As new regulation is being approved, it has to be incorporated into the system. Overall, we have a positive outlook. We're really trying to take care of the Medicaid & CHIP recipients.

Some changes include Modified Adjusted Gross Income (MAGI). That means we're looking at households and income differently and removing the asset test in certain situations. Specifically, pregnant women and children will no longer have an asset test. This requires new information that we don't currently gather, so we need to know how to move people over with incomplete information. Do to the new income evaluation, there will effectively be a change in the percentages for eligibility in comparison to the Federal Poverty Limit (FPL). The deductions to income have gone away, but we have adjusted the poverty limits up a little to accommodate that. In our state, we anticipate the level for children 0-5, which is at 133% today, would move to 139%. Pregnant women would be the same. Kids 6-18, who currently have a limit of 100%, would have a limit of 133%. In addition to that, there's a 5% income disregard. There will be a new online application

effective October 1 and a new combined application that will include SNAP (Food Stamps), child care, Medicaid, and CHIP all in one as well as a medical only application and will hopefully be approved in 30 days. We're working on a new presumptive eligibility program for hospitals. We already have two presumptive eligibility programs: Baby your Baby and foster care. Hospital presumptive eligibility is new. We need to build a framework for this. We have a few months left to have that ready by Jan 1.

CHIP TRANSITION

What will we do with CHIP kids moving to Medicaid? We have a proposal that we'll present to CMS. The rule changes are fairly deep. Not only are we rewriting the rules for children, we're rewriting the rules for every other Medicaid program. The new rules will go live on October 1. From October to January, we need to use both sets of rules in the system. It has been difficult to work those logistics. The MAGI calculation, change in FPL, and removal of the asset test have made CHIP kids eligible for Medicaid as of January. We anticipate about 23,000 kids will move from CHIP to Medicaid. We have proposed to CMS that we will have all the children moved by February. We're required to do it by April. Families will receive the following notices: In mid-September, a general notice explaining what is happening and why and how it might affect the family; In November, a more targeted notice would go to CHIP Plan A and CHIP Plan B families who are likely to be affected; In December, there would be an open enrollment notice. This would allow families to choose their Medicaid health plan. In January, families would receive a welcome letter from Medicaid. They would also receive a notice from DWS about the state of their case. Families may move in January; they need not wait for the mass switch. Some families will want to switch early, some will want to wait. We will try to accommodate both.

Dr. Cosgrove expressed a concern that eligibility for Medicaid is month-to-month, while CHIP eligibility is for a full year. In his view, educating families on the differences would be a challenge. Jeff replied that the state has proposed to allow families to have the same renewal date as when they were on CHIP. Medicaid eligibility does go month to month, but the eligibility re-certifications are typically every 12 months, with families being expected to report any income changes. We will do our best to identify families for the shift who are likely to be eligible for Medicaid, but it's possible that some families would move back to CHIP when their review was completed. Lincoln encouraged the department to look at how month-to-month eligibility affects program cost.

Lincoln expressed a concern that some families might have some children on CHIP and some children on Medicaid due to the differences in eligibility levels between age groups. Jeff replied that there is an option to move the eligibility level higher for children 6-18, but there is a cost to that and it would require an appropriation. The department has shortened the eligibility gap to only a 6% difference. The proposed eligibility levels are 139% for 0-5 and 133% for 6-18. This will reduce the effect. Rebecca said that it's a burden to families to have some kids on CHIP and some on Medicaid. We can't expect people to navigate that. Kevin replied that the gap exists today to a much greater extent, and while the department hasn't eliminated the problem, they've reduced it quite significantly. Lincoln encouraged the state to eliminate the gap. The rules are complicated, he said, and simplifying them helps everyone.

Russ asked when the presumptive eligibility criteria for hospitals will be released. Jeff replied that we need to have the program up and running January 1. The state needs to complete a State Plan Amendment to authorize the choices, which it is almost ready to do. The state needs to design a

system to authorize benefits for patients. It is looking for an efficient process which would get benefits out quickly. The state also needs to determine how it will get patients to apply for Medicaid after the immediate problem is solved. In addition to that, we need to design an administrative process. The state is working on both processes at once. The Health Department is working with DWS to get that done. A MIB article should come out in October.

Russ asked whether there will be additional individuals that will become eligible for Medicaid, besides the children transitioning from CHIP. Jeff said that several others will become eligible and many people could be helped. Also, the department believes it's keeping everyone eligible who is eligible today. We have no way to measure the increase in the numbers of eligible individuals. In 2014, people have to have health insurance, so more eligible people may apply.

Dr. Cosgrove asked whether the state has talked with enrollees or special groups about implementing these changes. Jeff replied that the State of Utah has not, but the federal government and several other states have. Utah has adopted changes from their work. Lincoln asked whether the MIB was the only mode of communication to providers, and Jeff replied that it is. Lincoln reminded Dr. Cosgrove that he had volunteered to provide information to the pediatric group that he works with in the form of a blast e-mail. He said that none of the providers even know that MIB exists, so the information therein may not get to providers. Lincoln asked whether the department was able to create more information to send out via e-mail regarding the eligibility changes. Jeff replied that we could look at that, but they may not read that e-mail either. Lincoln's major concern is letting providers know that CHIP families may be moving to Medicaid. Gail also mentioned that this e-mail could help providers enroll on the MIB mailing list and give instructions on how to enroll as a provider for Medicaid.

Dr. Cosgrove: All providers will have to be navigators, because most of the families will be very confused. Our staffs will have to get up to speed and at least let them know where to go. The more info we get to provider offices, the more navigators we will have. Gail: We should send a sample notice to Dr. Cosgrove. Emma: These will be fairly detailed letters, so we should get sample notices to the website and use IHC and Molina's communication systems to disseminate info.

ADJOURN

With no further business to consider, Chairman Nehring adjourned the meeting at 3:10.