Summary Minutes: Medical Care Advisory Committee
September 28 & 29, 2012
The Hotel Captain Cook, Club 2
Anchorage, Alaska

Members/Medicaid Program officials present: Tracy Charles-Smith, Chair; Lorilyn Swanson, Vice Chair; Kimberli Poppe-Smart, DHSS Deputy Commissioner; Josh Applebee, Deputy Director; Margaret Brodie, HCS Acting Director; Ron Kreher, DPA Director, Tama Carson, DPA; Deborah Kiley, DNP; Catriona Lowe; Joy Neyhart, DO; Renee Stoll, RPh; Mark Walker; Renae Axelson; Shelly Deering, RN, BSN, CCRN; Dan Kiley, DDS; Jon Sherwood, HCS; and Renee Gayhart, HCS.

September 28, 2012

Minutes of May 4 & August 17, 2012. Adopted as presented.

Update and defining of Medical Care Advisory Committee (MCAC) roles. Renae Axelson, Shelly Deering, and Dan Kiley were introduced as new MCAC members by Deputy Commissioner Kimberli Poppe-Smart. Concerns about MCAC members' shortage in the consumer and non-consumer advocate side were shared by both MCAC members and Kimberli.

Through a power point presentation, Kimberli addressed the purpose, roles, qualifications and responsibilities of each MCAC member as stated by the bylaws. To be effective at accomplishing these tasks, a list of resources was provided by Kimberli. A summary with key changes to regulations that are easy to read and user friendly was requested by MCAC members.

Kimberli called to the attention of MCAC members that the bylaws were drafted on October 29, 2005. Kimberli also pointed out that a category of member representation, such as the director of public health is missing; adding a state representative from public health or public assistance to comply with federal requirements was recommended.

Kim asked MCAC members to avoid talking about individual issues, and to focus on talking about global issues.

AK Medicaid Tribal Issues updates. Renee Gayhart, Health Care Services (HCS) Tribal Health Program Manager, who works with tribal health organizations in tribal Medicaid programs that cover birth to death Medicaid services, addressed the committee.

Renee handed a map of state of Alaska illustrating how tribal health organizations are set up by region around the state of Alaska and a report showing the Medicaid enrollment numbers per health organization. Renee stated that the main task of HCS is to help/assist tribal health organizations maintain the enrollment of their beneficiaries in Medicaid. This consist of tracking monthly enrollment that rolls into a quarterly report that helps tribal hospitals target their outreach in particular areas within the state of Alaska. Renee explained that tracking enrollment is essential to tribes because it ensures everyone that is available for services gets covered, and because it helps the tribes maintain their claim submission status.

Renee mentioned that read-only access to the Eligibility Information System (EIS) is being provided so tribal health organizations can check Medicaid eligibility status and third party liability information. Training and oversight is also given to staff due to confidentiality policy. Renee emphasized that the Tribal Medicaid activity report and Medicaid enrollment numbers per health organization report are tied together.

Renee also discussed the importance of children services and explained that community health aides have been focusing on completing as many well child exams in the outlined areas. The purpose of this has been to ensure that kids would not have to travel much to the next hub; which has free up some transportation dollars,

and also, because it was an incentive to invest in community health aides training that could bring them from the I and II to the III and IV practitioner level; so tribal hospitals can bill for those Medicaid services.

Renee reported that an increase in dollars that is going through the tribal system has resulted from an increase seen in rates and the services of the beneficiary population. Renee said that her team has been working closely to make sure native beneficiaries claim their race in their Medicaid applications because if they don't, they go in as a regular match in our system. Renee also communicated that in the last 8 quarters, $1.7 million dollars have been recovered through retro-claiming/correcting a race code that wasn't identified.

Affordable Care Act decision. Jon Sherwood, HCS, provided an update on the Affordable Care Act (ACA).

A Supreme Court decision to uphold almost all of the ACA came out at the end of June, 2012. Jon reported that while there are other suits out there and that there is always a possibility that the law can be repealed or amended by congress, the federal government and other states are moving forward under the assumption that they are going to implement the ACA. The only part of the law that was declared unconstitutional by the Supreme Court was the Medicaid expansion for adults; specifically the group 19 and 64 who are not eligible for Medicare or not already included in other groups of adults that Medicaid covers. The court concluded that the federal government cannot penalize states for not expanding coverage to the adult population. States can opt in or out at any time from taking the expansion but if they choose to expand, an enhanced federal match rate of 100% in the first 3 years and 90% by 2020 will be available. All matching rates are subject to change at any time.

Jon also stated that under the ACA, pregnant women, children, parents and care taker relatives who are part of the children Medicaid expansion group and whose income is up to 133% of poverty would not be required an asset test, only an income test in terms of financial eligibility. Also for people whose income is above 133% and up to 400% of poverty, they will be eligible for some form of tax/advanced credit that will be applied by purchasing insurance through the exchange. An expansion for children who aged out of foster care to cover them until age 26 will also be in effect in 2014.

States have until Nov 16, 2012 to decide to opt in or out of the federal exchange. If the state decides to opt in, a single streamlined application for Medicaid SCHIP, the tax credit and the exchange needs to be implemented. However, if the state decides to opt out, an alternative for approval needs to be submitted. The governor has said that Alaska will have a federal operated exchange. Alaska has still to decide if they want the federal exchange to determine or assess Medicaid eligibility.

Income methodologies for children, parents, pregnant women, and non aged or disabled adults have to be converted to the new tax based methodology Modified Adjusted Gross Income (MAGI). This will include: eliminating all deductions/disregards that are presently used, figuring out what the equivalent amount of money will be in MAGI terms, converting all of the income standards for those groups to new MAGI standards, and training all the staff in the new rules and about how to count income using tax rules. An interface between the Medicaid eligibility system and the exchange has to be created in order to pass cases back and forth and for processing. Part of the exchange process will also be to get access to a federal data hub (social security, IRS, and homeland security immigration data). Since the income rules/disregards will change, a temporary SCHIP group will need to be created for those children who lose Medicaid in our state to continue eligibility until February 2016. A new application process and notices to go along with the interface between the federal exchange and state will need to be created.

New renewal rules for people who fall under MAGI income accounting rules will include an ex-parte review; this involves looking at all the information available about the client without asking the client anything. If determined eligible, a letter informing the client about the review will be sent to the client. If a determination cannot be made based on the information available; a pre-populated renewal form that will allow them to renew online, electronically or by phone has to be sent to client.

Jon reported to be participating in the Eligibility TAG and State Operations Technical Assistance (SOTA) calls to address eligibility issues and stay informed about what other states are doing to build the new eligibility system.

Update on Division of Public Assistance (DPA) activities. Ron Kreher, DPA Director and Tama Carson, Social Services Program Coordinator provided an update on the Adult Public Assistance (APA) program and their application process to the committee.

Ron provided a short history background about the APA program; which provides the state funded supplement to the Supplemental Security Income (SSI) program administered by the Federal Government. He stated that while there are some differences in administrative procedures and eligibility criteria, the most essential difference between SSI and APA is that APA is for higher need standards. In the 2012 needs standard chart, if an individual's income is below $698 then they qualify for SSI, in the contrary, the maximum needs standard for an individual to qualify for APA is $1,297.

States have the option to opt out of providing a supplemental program. Alaska administers the APA program through the DPA field offices and a close collaboration with the SSI program, HCS; who oversees Medicaid policy, Division of Vocational Rehabilitation; who does disability determinations for certain APA recipients, as well as other agencies. APA is entirely state funded; the state Medicaid plan includes Medicaid benefits for all APA recipients, therefore, every APA decision is a Medicaid decision as well. Those decisions are in compliance with the conditions of federal law.

The general criteria for the APA program are that individuals have to be over the age of 65, also to qualify for blind and disabled services the individual has to be established as blind; which is a social security decision, and also meet the social security administration definition of a disability to be eligible for assistance. Other income and non-financial eligibility criteria has to be met.

In August 2012, there were over 19,000 APA cases; a 2% increase compared to 2011 state fiscal year 18,000 APA cases. A parallel enrollment growth in SSI cases was seen during the same period of time. The total APA yearly benefits in state fiscal year 2011 were under $60 million dollars, an average of $5 million dollars per month.

In 2010, DPA began streamlining its internal processes to better serve Alaskans in need. In 2012, the average processing/cycle times to process 8,589 applications was 32 days compared to 55 days to process 7,280 applications in 2010; this resulted in a 42% increase in efficiency processing applications.

DPA is working on integrating new technologies to increase efficiency. By 2014, DPA is expecting to have several projects up and running such as the new Eligibility Information System (EIS), Electronic Document Management to digitize applications and documentation, an online application system and a fully integrated statewide phone system.

Essential Health Benefits. Josh Applebee, Health Policy Deputy Director talked about Essential Health Benefits to the committee.

Josh presented a graph illustrating the three different benefit tiers of the ACA: The essential health benefits, the benchmark benefits and standard Medicaid. Essential heath benefits are a new market place of insurance that will be sold through the exchange, where eligibility will be determined, people will be put into a Medicaid bucket based on income and different levels of federal assistance people will qualify for, and where people over 400% of the federal poverty level can buy coverage through the exchange. The essential health benefit plan is going to be the minimum plan that can be sold in the exchange.

In December 2011, each state was directed by the secretary of Health and Human Services to establish their own essential health benefit plan that included a standard of coverage and the following categories of service: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services that includes behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services that include oral and visual care, as well as to comply with all state law.

Josh explained that the second layer of the ACA, Benchmark Benefits, only applies to all states that choose to opt in to the Medicaid expansion. Individuals eligible through the Medicaid expansion mandate must receive coverage that meets or exceeds the benchmark benefits package; this includes all the essential health benefits plus extra Medicaid paid services such as: Early periodic screening diagnoses, treatment for children, non-emergency transportation, family planning and services through federally qualified house centers.

Under the third layer of the ACA, standard Medicaid, benchmark exempt populations will receive a benefit package that will include all the essential benefits, any additional benefits that are part of the benchmark, and additional services such as: long-term services that support home health care.

The essential benefits floor will only apply to those policies sold in the exchange/market place. Insurance policies sold outside of the government exchange will also be available. If the exchange is done through the state, it is the state decision to determine what the entrance requirements are to sell insurance through the exchanges. If is a federal exchange, then it is a federal decision. No guidance has been provided about the state and federal exchange requirements; however, the established of the essential benefit package creates the floor for all policies in the exchange.

Josh and Division of Insurance Director, Bret Kolb, have been working together in setting up an entire process to take the proposed three largest small group policies and applying the additional ten coverage areas to see how they fit. A public webinar, open stakeholder's meeting and take public comments to work towards a process that will select Alaska's essential benefit coverage and create the floor for the exchange will be available. The state is waiting on the federal government to make final determinations since a lot of the decisions are being held at the federal level. The state's dateline to turn in the Essential Benefits blue print to the federal government is on Nov 16, 2012.

Medical Homes. Kimberli Poppe-Smart, Deputy Commissioner and Josh Applebee, Health Policy Deputy Director addressed the committee.

A pilot project for patient centered medical homes; which is a case management way of providing services to improve health care delivery is in the process of being set up. Public Consulting Group (PCG) has been hired to come up with a pilot project framework that will outline what providers will need to build a functioning patient centered medical home model. The project purpose is to take care of people, increase levels of preventive services, and keep people out of emergency departments, as well as to save money.

Since behavioral health is a significant factor for the Medicaid recipient population, the department is working on developing an integration of behavioral health here in Alaska. The department is also interested in providers who are willing to participate in the reverse integration; this consists of behavioral health centers bringing someone to address their physical concerns in to the behavioral health practice.

Josh reported that a consultant is currently working on developing a list of standards that practices will meet at the end of year one. The consultants are also working with behavioral health providers to address public comments and feedback, as well as to design an application that clinics can fill out to apply for the pilot project. Outcomes of the pilots are being developed.

To control cost from the Medicaid program, four different pilots are being implemented: rural, non-rural, tribal and non-tribal. Blue-Cross is partnering with the department on this project.

Josh Applebee was invited by the committee to provide an update on the next MCAC meeting.

Medicaid Director's report. Kimberli Poppe-Smart, Deputy Commissioner gave a presentation about the Healthcare Reform.

Kimberli reported that oil production and income from oil in Alaska is declining; whereas Medicaid state spending has gone up over the last decade. Oil production has gone down 5% and state spending has increase 7 ½ % per year over the last decade; this is attributed to health care cost (Medicaid, Chronic and Acute Medical Assistance (CAMA) program, Alaska Care, State Workers Comp, Department of Corrections,

Division of Juvenile Justice and Union Trust Funding for insurance) which have gone up 9.4 % per year. Health care cost went from $856 million in 2001, to $1.9 billion in 2010; the impact of the high cost is related to more beneficiaries, higher expenditures and medical inflation. The ACA is now requiring those states that pay in Medicaid programs below Medicare rates to bump up their prices up for primary care up to Medicaid rates.

Kimberli reported that the number of eligible people for the Medicaid program grew from 124,673 in 2008 to 149,094 in 2012; about 92% of the people eligible use the program. Medical expenditures so far in 2012 reflected $1.3 billion, numbers are subject to change slightly due to settlements that occurred from past years. Growth in Medicaid expenditures are being managed from a dollar perspective by implementing initiatives such as the national correct coding initiative which has resulted in $2.3 million dollars of savings. Other savings included about $52 million dollars from recoveries of money collected from insurance companies, Medicare, workers comp, settlements, and drug rebates.

The department mission, vision, philosophy and main priorities, as well as impacts of the expansion were discussed. Some states are waiting to make a decision about expanding after elections; an actuary is being hired to complete the department's analysis. The consultant report about the evaluation of doing or not the exchange is online. Alaska, twenty states and Washington DC are in the process of redesigning their eligibility information system. A Request for Proposal (RFP) for project management was out but the contract was not awarded. An RFP for the design of the new EIS is being put out once approval for federal funding is given.

The new Medicaid Management Information System (MMIS) is expected to be up and fully functioning in 2013. A list of new add-ons is being integrated to the MMIS project after building the functioning system first.

A trend across the nation is to look at more opportunities to share best practices for patient engagement.

A 16.3% decrease in the average cost of prescriptions was seen from promoting the use of generics and implementing changes to the pharmacy program this year.

Margaret Brodie was introduced as the Acting Director of HCS.

Reconfirm FY13 Meeting schedule. The committee confirmed their next MCAC teleconference meeting will be in Dec 14, 2012. They also identified February 8 & 9, 2013 in Juneau and May 10 & 11, 2013 in Nome, as possible dates for the following face-to-face meetings.

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MCAC Work Plan. Tracy Charles-Smith, Chair and committee evaluated the current MCAC work plan.

The committee reviewed and evaluated the current MCAC strategic work plan and agreed that it needs to be revised and that new priorities and goals need to be established. Kimberli suggested the committee to inform themselves about topic areas that could fit in the work plan; such as what the needs of the beneficiaries are in the program, and make recommendation about those topic areas generally found in the work plan. She also recommended looking at how quality outcome metrics are being measured in various areas, as well as identifying someone to participate in the stakeholder group for Patient Centered Medical Homes (PCMH). In addition, looking at opportunities to get feedback on the essential health benefits as it pertains to the Medicaid program in the case an expansion takes place.

MCAC members open forum. Committee members shared their questions and concerns about the MCAC.

Dan Kiley, DDS, Shelly Deering, RN, BSN, CCRN, and Renae Axelson introduced themselves to the committee members.

Mark Walker volunteered to participate in the stakeholder's group for PCMH.

The committee recommended more rural area meetings and utilizing more announcement tools (ex: Senior and Disabilities Services (SDS) alert, provider and recipient newsletters, state notification services, Facebook

page, etc.) to alert providers and recipients about upcoming MCAC meetings, as well as to increase public comment participation. The committee also suggested reviewing MCAC bylaws, the possibility of changing the MCAC committee name to Medicaid Care Advisory Committee and limiting public comment to five minutes.

Kimberli addressed committee member questions and concerns.

Possible next MCAC meeting agenda topics include:

- ACA Update
- Medicaid Eligibility
- Essential Health Benefits
- Medicaid Expansion
- Go over possible desired MCAC strategic work plan outcomes
- Quality Measure Metrics
- Work Plan – Committee members to send ideas and suggestions about work plan revisions to Alejandra Rico
- Invite speakers from SDS, Behavioral Health, HCS and someone from the Tri-state Child Health Improvement Consortium to share what the department is doing to measure performance and quality.
- Invite someone from DPA's staff to participate in the committee as a non-voting member.
- Review bylaws
- Continue discussion to find a more meaningful name for the MCAC. Mark Walker to send a proposal about possible name suggestions.

Public Comments

No public comments were shared by the public.