South Carolina Department of Health & Human Services

Medical Care Advisory Committee Meeting

Minutes of Meeting
May 19, 2009
10:00 am – 12:00 noon

Members Present:

John G. Black, MD	J.T. McLawhorn
Charles P. Darby, MD	James M. DuRant, Jr.
Thompson A. Gailey, MD	C. Earl Hunter
Lyndon Key, MD	Andy Pope, DrPH
Ralph Riley, MD	Caughman Taylor, MD
Lynn E. Connelly, R.Ph.	Sue B. Berkowitz

Members Absent:

Greta Harper, MD	
William P. Moran MD, MS	Richard K. Harding, MD
James Mercer	Sabra C. Slaughter, PhD
John Barber	

I. Call to Order – Committee Chairman

Dr. Darby called the meeting to order at 10:00 a.m. although there was not a quorum until later into the meeting. Committee members and guest were asked to sign in and introduce themselves.

II. Approval of February 24, 2008 Minutes of Meeting – Committee Chairman

Upon motion and second, minutes of February 24, 2008 meeting were approved.

III. Director's Report– Emma Forkner, Agency Director

Ms. Forkner shared what has been happening at the agency since the last MCAC meeting and provided handouts including:

- SFY 2009 Budget Reduction Update
- FY 2010 Budget
- Healthy Connections Choice Update
- Healthy Connections Kids Update
- Health Care Reform

Ms. Forkner first referred to a March letter sent to MCAC members informing that the Budget and Control Board had sent yet another letter instructing the agency to reduce another 2% from our base budget. 2% would be 16.2 million dollars. This letter also informed you that we were unable to make any reductions due to the

stimulus conditions and legislative restriction that we operate under so this reduction must be absorbed through our cash reserves.

Ms. Forkner next shared an overview of the budget noting that Mr. Wells will speak more about our month to month business. The SFY 2009 General and Non-Recurring Funds were broken down to explain the agency's budget structure and budget requests. Our 2010 budget is going to be approx 945 million – noting this is less than we had this time last year. It appears (give a million dollars or so) we will get 175.5 million – it is important to note that this is not new money. This is Medicaid using Medicaid money. 796 is our base budget– MOE looks to be about 98.6 million and then 10 million in tobacco money – including a growth factor of approximately 6.5% - lower then we are growing. For the last two years, Medicaid has received no new money from the state.

The American Recovery and Restoration Act (ARRA) passed in February. Ms. Forkner referred to her Impact of ARRA and Estimated ARRA Earned Revenue slide to explain in detail the increased FMAP funding.

Healthy Connections Choices – the program roll-out concluded May 1, 2009. Now, we are going into a period of stability. 60% of Medicaid members that have selected a MCO or MHN. Ms. Forkner shared the numbers as of April 09 and HEIDIS handouts were shared for details of what is happening in the managed care plans.

The Agency had asked the Bureau of Economic Advisors (BEA) for revised cost estimates for SCHIP coverage for children at 200%, 250% and 300% FPL. The annual updates are important as circumstances change - specifically the economy and unemployment rates. A copy of the new estimate from the BEA was provided.

Health Care Reform – Ms. Forkner introduced Kendall Quinton to provide the update on the Reform. Referring to the Healthcare Reform slide, Mr. Quinton noted that the items he shares have not been ruled out on the Federal level. Two very important – building on the existing systems and the health information exchange. Mr. Quinton referred to the Healthcare Reform Timeline to express how quickly this is moving nationally. The intent at the federal level seems to be – if you pick up a group in the interim, they are your group – similar to the clawback for Medicare Part D. Whereas if you don't and there is a federal mandate expansion; at that point, until about 2015 – at that point, state costs are phased in over a 10 year period.

Concluding, Ms. Forkner informed everyone that Medicaid will be involved in information technology funds – there are entitlement funds and a tremendous amount of grant/loan opportunities. This is a very complex program where stimulus dollars are available. There must be a statewide plan that describes how this plan operates. At the provider level, either Medicare or Medicaid will be distributing money to assist adopting electronic health records with a requirement of connecting to a health information exchange run by the state which further connects to a national exchange. In SC, we do have the technical solution for the health information exchange. On June 17, 2009, there will be a Health Information Technology Summit to begin strategic planning. It is open to the public, policy makers, university presidents, and other state leaders have also been invited.

Vl. Fiscal Report – William Wells, Deputy Director, Finance and Administration

Mr. Wells gave a more detail presentation/explanation of the stimulus money referring to his presentation slides. The stimulus must be tracked and reported. To date, $234,439,057.91 has been drawn – showing how well we can track the funds. The Comptroller General has set up a task force and the financial folks from various agencies are meeting. Mr. Wells pointed out that there are still limited details from the federal level as to what the reporting formats will be. We currently report quarterly to CMS and this is reported as well. Mr. Wells shared where we are today with our expenditures in the current year. Closing April, we are showing

about a 11.6% growth over the prior year in expenditures. As Medicaid continues to grow, we must watch very carefully as next year's budget is built on the stimulus money. Sue Berkowitz asked for copies of the slides used for the financial presentation.

V. Eligibility Report – Alicia Jacobs, Deputy Director, Eligibility and Beneficiary Services

Ms. Jacobs referred to her slides and clarified that we report everyone that is eligible – whether they received a limited or full benefit. We are up to 13,500 children in our SCHIP program. The finalized January number is at 761, 496 eligible individuals. Referring to her slides – she clarified the children and noted that this is where growth seems to be happening. There is slight growth in disabled adults, as well – qualifying under our disability program. Sue Berkowitz asked for a reminder of the historical 48/52 category – Ms. Jacobs identified these as individuals that we pay only Part B Premium. Ms. Berkowitz also requested copies of the eligibility slides. Family planning is listed under all other adults. Ms. Berkowitz asked if the percentage of other adults in family planning could be identified. Ms. Jacobs confirmed that eligibles are tracked by category. Ms. Berkowitz asked if she could get this detailed information.

VI. Program Update – Transportation – LAC Report/DHHS Response, *Deirdra Singleton, General Counsel*

Ms. Singleton referred to the audit of DHHS Non-Emergency Transportation Broker System. The overall findings revealed no evidence that indicated whether an in-house management system or a broker based system is superior for minimizing cost or maximizing quality of service. This finding was puzzling due to the amount of data provided that should have enabled the LAC to draw a different conclusion. Ms. Singleton encouraged everyone to review the LAC Summary and the DHHS response included in the handouts and noted they are also available on the website at www.scdhhs.gov . The LAC was informed of the numerous benefits we have observed from having a broker system. In 2007, the University of South Carolina conducted a beneficiary survey and 88% of the beneficiaries said that they were very satisfied with the services they were provided by the broker system. Ms. Singleton noted that DHHS has a Transportation Advisory Committee and they are provided copies of both broker report cards which gives an abundance of data.

Mr. J.T. McLawhorn asked the location of our current brokerage systems. Ms. Singleton noted that both have in-state locations; one is headquartered in Georgia and the other in Missouri. Mr. McLawhorn commented that it appears that the LAC findings are inconsistent as DHHS has data that clearly points out the evidence that the brokerage system is superior. Mr. McLawhorn commends DHHS staff on a great job and report.

VII. Committee Advisement Items –

a. **Renewal of the Mental Retardation/Related Disabilities (MR/RD) Waiver**
Presented by: Sam Waldrep – Bureau of Long Term Care

Mr. Waldrep noted that Dr. Kathi Lacy, DDSN, would participate in his discussion of the renewal.
This is a renewal of one of three soon to be four waivers that the Department of Disabilities and Special Needs operates. This is a routine five year renewal. The waiver has been in place since 1991. It currently serves approximately 5,700 people and there is a waiting list of approximately 1,400. Most of the Community Based Waiver programs do have waiting lists. Because of the very tight budget times we face, this became a unique opportunity for the DDSN to look very critically at the services being offered in the waiver package. Mr. Waldrep noted that the MR Waiver probably has the richest service package of all the Home and Community Based Waivers and there are eight of those. A number of months were spent working with DDSN- discussing how similar services are operated, capped and controlled in other Home and Community Based Waivers.

DDSN went to the people receiving the services using a survey to get their input. These are very difficult decisions to be made.

Dr. Lacy noted that the survey was sent out via the mail system as well as being posted on the DDSN website. The survey asked if the waiver had to be cut, should the number of participants or services be reduced, or should services be eliminated, etc., - what would you do. She noted that the majority of responses said that they would place a limit on the services. So, this is what was done. It was decided to cap some services that are most used by people living at home with their families; however, the majority of the families using these services are not likely to be affected by a number of the services that were capped. Other survey results even suggested eliminating services by using your best judgment. Dr. Lacy said that she read every survey so that she could get a feeling for what people put into it. This is how we determined the cuts to go into the waiver renewal.

Mr. Waldrep referred to the advisement item noting the services can be divided into several categories for this action. The lists refer to services unchanged, services which limits will be placed, and the services to be removed. The services receiving limitations were also reviewed. Mr. Waldrep then referred everyone to the services that would be removed. These services were carefully considered and have low utilization. These decisions were difficult to make.

Sue Berkowitz asked Dr. Lacy questions about the survey:
Question: How many surveys were sent out?
Response: About 5,700 – got about 200 back
Question: How many web responders did you have?
Response: About 100

Mr. Waldrep interjected that when a renewal is submitted, CMS does not require public input. However, HHS and DDSN have chosen in various ways to always seek public input. Normally, a public hearing is held and have traditionally drawn approximately 40 to 50 people.

Mr. McLawhorn commended DHHS and DDSN for the public input process. He also suggested that in the future, an independent group should conduct the survey. Mr. McLawhorn asked if there were any stakeholder/advocate groups for this segment of the population in which feedback was obtained. Ms. Lacy confirmed that this had indeed been done – noting several. Mr. McLawhorn asked if the findings were consistent over all of the groups and Ms. Lacy said that they were indeed very consistent.

Dr. Darby asked for motion of approval – motion was made – second - Item was approved as presented - noting 1 opposed.

b. Change in Transitional Medicaid Assistance (TMA) policy
(Alicia Jacobs – Medicaid Eligibility and Beneficiary Services)

Ms. Jacobs reminded everyone that the TMA program is for individuals who have qualified under Low Income Families (LIF) program and because of earned income –lost their eligibility. This moves them into a federally mandated program called TMA. This is a transitional program. Beneficiaries are moved into 2 6-month periods – 1 a mandatory and 1 requiring their income be reported to determine if eligible for 2nd- 6 month period. In SC, there is a 12 month coverage period given before they are moved into TMA. Currently an individual must be eligible for LIF 3 out of the previous 6 months to move into the transitional program. The new ARRA legislation allows states to do away with this rule or state a new rule of LIF time period. SC decided that a person must qualify for LIF at least one month to be moved into Transitional Medicaid. A State Plan Amendment has been submitted for review.

Dr. Darby asked for motion of approval – motion was made – second - Item was approved as presented.

VII. Closing Comments – Committee Chairman

Dr. Darby announced that the next meeting of the committee is scheduled for Tuesday, August 18, 2009.

VIII. Adjournment