Medical Care Advisory Committee
July 16, 2013 Meeting Minutes

Present	**Not Present**
John Barber	Sue Berkowitz
William Bilton	Richard D'Alberto
Dr. Charles Darby	Dr. Tom Gailey
Diane Flashnick	Dr. Greta Harper
Alicia Jacobs	Chief Bill Harris
Lea Kerrison	Dr. Amy Picklesimer
Bill Lindsey	Jackie Richards
Gloria McDonald	Timothy Stuart
J.T. McLawhorn	Nathan Todd
Melanie Matney	Rhonda L. Johnson-White, PhD
Dr. Kashyap Patel	
Gloria Prevost	
Crystal Ray	
Dr. Lynn Wilson	
Lathran Woodard	

The Agency Director welcomed members. MCAC member stated more time is needed to review agenda and handouts and asked for items to be distributed in a timelier manner. Agency Director committed to distributing agenda and all handouts a week in advance.

Advisement presented by Jeff Saxon:
Nursing Facility Rate Updates Effective October 1, 2013: SCDHHS will update the Medicaid nursing facility rates based upon the most recent cost report information available and the infusion of the $5 million state fund appropriation provided by the SC General Assembly (which converts to approximately $16.9 million total funds on an annual basis) for nursing facility rate rebasing efforts during SFY 2013/2014. SCDHHS intends to update the Medicaid nursing facility rates effective October 1, 2013 using the fiscal year ending September 30, 2012 cost report information. Based upon the additional funding provided by the SC General Assembly for nursing facility rate rebasing efforts, SCDHHS will: update the cost center standards based upon the FYE September 30, 2012 Medicaid cost reports; update the deemed asset value and market rate of return factor for October 1, 2013 Medicaid rate setting purposes; update the owner/lessor/relative compensation guidelines for the annual cost of living increase provided to state employees during SFY 2013; apply a 3.60% inflation factor in the calculation of the October 1, 2013 payment rates; apply a 2.9241% budget neutrality factor in the calculation for the October 1, 2013 payment rates in order to ensure that nursing facility expenditures remain within nursing facility budget projections for SFY 2014; and amend the county occupancy qualification factor from 90% to 85%. This change will exempt counties with a county occupancy rate of 85% or less from the minimum occupancy requirement of 92%. SCDHHS will submit this State Plan Amendment to CMS by August 15, 2013.

Advisement presented by Deirdra Singleton:
Changes to the National Medicaid Pooling Initiative (NMPI) Supplemental Drug Rebate Agreement (SRA): The objective of this advisement is to discuss the changes to the National Medicaid Pooling Initiative (NMPI) Supplemental Drug Rebate Agreement (SRA). The State Plan Amendment (SPA) will facilitate SC Medicaid's continued participation in the

NMPI supplemental rebate program. No changes to provider reimbursement, benefit design, beneficiary cost share, or preferred drug list (PDL) status will result from this SPA. The specific modifications being made to the SRA template include: clarifying the terms under which supplemental rebates accrue for partial quarter invoicing, revising the Confidentiality provision, revising the Notice provision to reduce the administrative burden on the State, revising the Participating State Amendments (PSAs) to reduce the administrative burden on the State by linking the PSA to the Contract and not the individual manufacturer, providing for the Participating Agreement to renew automatically for on-year terms, as long as the controlling agreement between Magellan/Provider Synergies and Participating State is active, removing tiers from the bid grid and adding potion to use alternative supplemental rebate calculation types to allow for different rebate accrual calculations than Guaranteed Net Unit Price (GNUP).

Advisements presented by Michael Jones:

Children ineligible for Medicaid as a result of the elimination of income disregards: The objective of this advisement is to affirm the state's compliance with the federal mandate to provide CHIP coverage to children who lose Medicaid coverage due to the elimination of disregards under MAGI. The Affordable Care Act requires states to maintain coverage under CHIP for children who lose Medicaid coverage due to the elimination of disregards under Modified Adjusted Gross Income (MAGI) methodologies. This protection applies only to children enrolled in Medicaid on December 31.2013 who lose eligibility at their first MAGI based renewal due to the elimination of disregards. SC does not currently provide a separate CHIP program, but will be required to create a special eligibility group under CHIP for this population. This protected status remains in place until the child's next scheduled renewal (i.e. 12 months). The children impacted in this change are already enrolled in Medicaid; therefore we are not projecting any additional costs. Also with the enhanced CHIP funding for these children the State will be required to provide fewer State dollars for these children. MCAC members asked questions regarding the impact this would have on enrollment, if this was a national disregard, if this was only for children and if SCDHHS would track the number of children; Michael Jones and John Supra answered all questions.

Modified Adjusted Gross Income (MAGI)-Based Eligibility Groups: The objective is to modify Medicaid income eligibility criteria for MAGI-based eligibility groups and to identify which eligibility groups are covered by the State. The Affordable Care Act (ACA) mandates the use of MAGI methodology for eligibility determinations for designated eligibility groups of Medicaid applicants and beneficiaries. As part of the transition to MAGI-based methodologies, states are required to convert current income eligibility standards to a MAGI equivalent, establishing a MAGI-based income standard that is not less than the income standard in effect for each eligibility group on the date of the ACA enactment. Federal regulations also consolidate multiple mandatory and optional eligibility groups into new overarching categories including Infants, Children under age 19, Pregnant Women and Parents & Other Caretaker Relatives. Additionally, states are required to provide Medicaid to former foster children who were on Medicaid when they turned 18 or aged out of foster care, up to age 26. Through the SPA process, the state is required to specify which eligibility groups are covered by the state and to provide an income standard for each eligibility group. CMS anticipates that methodology for Modified Adjusted Gross Income will be cost neutral. However, additional costs may be incurred with the addition of individuals eligible for the newly mandated coverage groups.

Residency: The objective is to affirm state residency regulations for Medicaid eligibility and address interstate agreements and temporary absences. States are required to provide Medicaid to eligible residents of the state. The definition of residency has been modified under federal regulations, including removal of language relating to residing in the state "permanently or for an indefinite period", and replaced it with just the "intent to reside". Through the SPA process, the state is required to affirm compliance with the residency definition and to provide policies related to individuals in the state only to attend school as well as definitions of temporary absence. There will be no budgetary impact.

Citizenship and Immigration Status: The objective is to affirm the state's citizenship

regulations, reasonable opportunity options and policy options related to immigrant eligibility. To be eligible for Medicaid, an individual must be a U.S. citizen or national, or an immigrant who is in a qualified immigration status. Medicaid applicants attest to citizenship and immigration status and electronic verifications of the attestation are completed. If the individual's status is not verified electronically, paper documentation is required. During the time period when the discrepancy is being resolved, if an individual otherwise meets the eligibility requirements, the individual is provided Medicaid benefits in accordance with federal regulations for a 90 day reasonable opportunity period. Through the SPA process, the state must affirm compliance with federal regulations on citizenship and specify coverage of any optional groups of lawfully present non-citizens such as children and pregnant women prior to the expiration of a five year waiting period. There will be no budgetary impact.

MAGI Income Methodology: The objective is to align South Carolina income determination methodology with mandated MAGI-based income determination. The Affordable Care Act mandates the use of MAGI-based income determination for Medicaid eligibility for defined groups. Use of MAGI-based income eligibility helps to create consistency among states in determining Medicaid eligibility and aligns methodologies across insurance affordability programs, including premium tax credits. The state is required to affirm compliance with MAGI and specify state policy on determining family size, household composition and financial eligibility for current beneficiaries. CMS anticipates that methodology for Modified Adjusted Gross Income will be cost neutral. Existing groups affected are: Medicaid applicants and beneficiaries who would be eligible under the following categories: Low Income Families) LIF), Partners for Healthy Children (PHC), Family Planning (FP) and Optional Coverage for Women and Infants (Pregnant Women).

Eligibility Process: The objective is to implement a single streamlined application with appropriate addendums for Medicaid eligibility and to provide electronic access to the application process. Also, to implement a redetermination process under which Medicaid beneficiaries are not required to provide additional information if sufficient information is available to renew eligibility. The Affordable Care Act mandates the use of a single streamlined application for eligibility determination for Medicaid and other insurance affordability programs. Applications, addendums and instructions will be available in electronic and paper form. The state may opt to utilize either the federally developed application or develop an alternative application. States developing their own application must seek federal approval through the SPA process; South Carolina will utilize an alternative application. Additionally, federal mandates require that Medicaid eligibility be renewed annually without requiring additional information from the beneficiary if sufficient reliable information exists to renew eligibility. Through the SPA process the State must also attest to compliance with federal requirements on application and redetermination processing. The use of an electronic point of access to the application process has the potential to save cost on printing and postage with fewer paper applications sent to applicants. However, this also presented the potential for an increased number of applicants and ultimately beneficiaries. It is anticipated that the revised process will be cost neutral. MCAC members had questions regarding the disregards, training and printed materials. All questions were answered by John Supra and Michael Jones.

Single State Agency: The objective is to provide state statutory citation, certification and description of the legal authority under which the Single State Agency administers the State Plan. Federal Medicaid regulations mandate the designation of a Single State Agency charged with administration of the Medicaid program. The Affordable Care Act provides a new option to delegate eligibility determinations and appeals to the Federally Facilitated Marketplace (FFM). While South Carolina will not implement this option or changes to the designation of the Singlet State Agency, The State is required to provide state statutory citation for this legal authority, certification signed by the Attorney General identifying the single state agency, organizational structure and how the Medicaid agency fits in with other health, human service and public assistance agencies. There is no anticipated budgetary impact.

John Supra, Deputy Director and CIO, Office of Information Management presented on the following:

Medicaid Eligibility Enrollment Trends: FY2013 preliminary June 2013 enrollment is 999,339. 92,000 children were added through the Express Lane Eligibility (ELE); original projection was approximately 78,000. FY 2013 trends are consistent with other states. FY 2014 enrollment projection is 1,030,495 (31,156 or 3.1%) without ACA impact with 12,221,731 member months. There are approximately 170,000 currently eligible but not yet enrolled in Medicaid; the focus will be on enrolling these individuals.

Eligibility SPAs: There will be 27 separate State Plan Amendments (SPAs) (7 groupings from CMS). The majority of these SPAs are based on CMS templates and some are not applicable. These SPA changes will formalize the State's plans on eligibility related changes including: MAGI conversion (mixed model), populations below 133% FPL (expansion), use of streamlined application, handling of appeals, FFM (exchange) type-assessment and handling of hospital presumptive eligibility. SCDHHS is still awaiting guidance from CMS and still working on remaining analysis and decisions for the following: coverage for out-of state Foster Care Children; income calculations for monthly or projected annual amounts, allowing prorated or predicted increase/decrease of certain incomes and 12-month continuous eligibility for adults and potential changes to Transitional Medicaid Assistance (TMA).

Edit Correction Form (ECF) Phase-Out: The current process allows ECFs to be generated for rejected claims and providers are able to re-submit claims with corrections and additional information. The current process is a holdover from primarily paper-driven claims processes. The reasons to phase-out ECFs are: ECFs are not tracked in MMIS or any other system, which results in delayed processing or re-submittals, ECFs will not be supported in MMIS replacement and/or future systems and ECFs (or ECF-like) processes are not practiced by most (possibly all) other payors in SC and in Medicaid programs. The planned transition is as follows: earliest phase-out will be October 1, 2013 for newly created ECFs and December 31, 2013 to submit any outstanding ECFs; this may adjust based on provider input. Providers will be required to submit a new claim for rejected claims; this approach is standard insurance industry practice. The current processes where ECFs are central to handling corrections, additional information, and documentation are being analyzed and provider/stakeholder input is being collected. New processes are being developed and provider communications, training/education are being planned. The expected results from this phase-out are improved communication regarding claims status and faster claims status responses. This will eliminate the need for duplication of effort and re-submittals and ensure claim status is accurate and up to date as well as available 24/7 and it will reduce paper and manual processing/handling.

Deirdra Singleton, Deputy Director, Health Services presented on the following:

MHN TO MCO Transition: 52,985 United Healthcare members will transition to Wellcare on September 1, 2013, 12,976 Carolina Medical homes members will transition to Wellcare on December 1, 2013. PCCM Model (MHN) conversion to MCO: 151,588 SC Solutions members will transition on December 1, 2013 and 16,593 Palmetto Physician Connections/Advicare will transition on December 1, 2013. Deirdra discussed the MCO transition timeline.

2014 MCO Contracts: SCDHHS is restructuring 2014 contracts to facilitate the agency's three pillars: payment reform, clinical integration and hot spots and disparities. Some of the milestones are: 2014 contract effective date has been delayed until July 2014; plans will be required to sign amendments in October 2013 for extension of current contracts until July 2014. SCDHHS is hosting CCIG stakeholder meeting on August 15 with additional meetings through the year. Deirdra discussed various changes for the 2014 Contract and thetimeline. MCAC Members had questions regarding input from stakeholders and the impact on MCOs. It was also mentioned that if any members were interested in the state site visits to e-mail Sheila Chavis.

SCDuE Demonstration: This program is a three year demonstration to integrate and

coordinate care for beneficiaries with both Medicare and Medicaid and to purchase quality health outcomes through a person-centered model that delivers care at the right time and in the most appropriate setting. The target population for SCDuE is full-benefit dual eligibles, age 65 and older, non-institutional and non-PACE. SCDuE enrollment begins July 1, 2014. SCDHHS is negotiating Memorandum of Understanding (MOU) with CMS. The MOU is an operational agreement between SCDHHS and CMS and includes changes to the model as described in the original proposal. Participating health plans will be selected once the MOU is finalized and fully executed.

Melanie "Bz" Giese, Program Director, Health Outcomes Initiatives presented on the following:

Health Access at the Right Time (HeART) Initiative—Charleston Promise Neighborhood (CPN): SCDHHS is working with CPN and IFS to review data and Medicaid eligibility with four schools: James Simons Elementary, Sanders-Clyde Creative Arts, Mary Food Elementary and Chicora School of Communications. There are approximately 1700 children enrolled in these schools and the majority of them will be enrolled on Medicaid. SCDHHS will help facilitate a shared eligibility worker for the 4 CPN schools and possibly the entire Charleston County School District. SCDHHS will offer a training session on how to bill Medicaid for the service provider and CPN is hiring a Nurse practitioner August 1st. SCDHHS is developing a turn-key packet to describe the sustainability model for other schools in the state to replicate from start to finish and CPN and SCDHHS will partner to host a fall health fair to engage parents and the community in the CPN program while encouraging Medicaid enrollment. Director Keck answered MCAC member question regarding whether this would include a Mental Health component.

Obesity: SCDHHS submitted a SPA to recognize licensed dietitians as a new provider type which is currently under review by CMS. On June 20th, SCDHHS hosted an external stakeholder meeting to review our current status on obesity. Attendees included but not limited to MCOs/MHNs, LDs and Physicians. Physicians will utilize two codes: G0402 U5 and G0402 U6. After six visits SCDHHS will require internal medical review. Licensed Dietitians will utilize two codes: S9470: National counseling, dietitian visit service provide by a licensed dietitian and S9452: Nutrition classes, non-physician provider, per session service provided by a licensed dietitian. Again after 6 visits SCDHHS will require internal medical review. SCDHSH is in final review of how to enroll as a Medicaid provider (will apply to all providers and on website). SCDHHS is also working closely with the SC Academy of Nutrition and Dietetics during this process and creating a list of all LDs. SCDHHS will initiate a statewide education campaign with provider offices throughout the state. Anticipated launch date is October 1, 2013. Bz answered MCAC member questions regarding the start date of the educational campaign.

Beth Hutto, Interim Director of Finance and Administration presented on the following:

Budget process, FY14 overview and FY14 year to date budget. SCDHHS has loaded the 2014 budget and currently planning 2015 budget. SCDHHS budget planning process is aligned with goals and strategic planning. SCDHHS started July 1 with a $6.4 budget. There has been a budget increase due to the Express Lane Eligibility. Beth gave an overview of the financial performance as of May 31, 2013.

Kim Cox, Director, Office of Communications presented on the following:

New logo. Kim answered MCAC member questions regarding the costs associated with new logo and if Medicaid card would be changed.

Meeting Adjourned

Next meeting scheduled for Tuesday, September 17, 2013 10:00AM to 12:00 PM