Medical Care Advisory Committee
November 5, 2013 Meeting Minutes

Present
Sue Berkowitz
William Bilton
Richard D'Alberto
Dr. Tom Gailey
Diane Flashnick
Alicia Jacobs
Lea Kerrison
J.T. McLawhorn
Melanie Matney
Dr. Kashyap Patel
Dr. Amy Picklesimer
Gloria Prevost
Crystal Ray
Jackie Richards
Lathran Woodard

Not Present
John Barber
Dr. Charles Darby
Dr. Greta Harper
Chief Bill Harris
Bill Lindsey
Gloria McDonald
Timothy Stuart
Nathan Todd
Rhonda L. Johnson-White, Ph.D
Dr. Lynn Wilson

The Agency Director welcomed members.

Advisement presented by Jeff Saxon:
South Carolina Department of Mental Health's (SCDMH) Long Term Psych Hospital Rate Updates, Skilled Nursing Facility Rate Updates and Psychiatric Residential Treatment Facility Rate Updates Effective November 1, 2013: SCDHHS will update the SCDMH's Long Term Psych Hospital rates, the Skilled Nursing Facility rates and the Psychiatric Residential Treatment Facility rate effective November 1, 2013 based upon more recent cost report data and updated Medicare market basket rate trend factors. Effective October 1, 2012, the South Carolina Department of Health and Human Services (SCDHHS) began reimbursing the SCDMH owned/operated long term psychiatric hospitals, the skilled nursing facilities, and the psychiatric residential treatment facility on a prospective payment basis. At the time the October 1, 2012 prospective payment rates were established, the latest cost reports available that could be used in the calculation of the SCDMH provider rates were based upon the state fiscal year June 30, 2010 cost reports due primarily to SCDMH's conversion to a new accounting system. Therefore because of this unique circumstance, SCDMH has requested and SCDHHS has agreed to update the SCDMH institutional provider reimbursement rates based upon the state fiscal year 2012 cost report data. It should be noted, however, that annual rebasing of SCDMH institutional rates is not guaranteed each year. Annual aggregate expenditures are expected to increase by approximately $3.0 million (total dollars) for Medicaid fee for service individuals. However, because SCDMH receives the state matching funds for the services that the agency provides, there is no impact on SCDHHS state matching funds.

Advisements presented by Valeria Williams:
Cover Place of Service Free Standing Rehabilitative Centers for Ambulatory services only: The objective is to expand the place of service that adult recipients can receive Physical, Occupational, and Speech Therapy Services. Currently adult recipients that require physical, occupational, and speech therapies (PT/OT/ST) services receives these services in all outpatient setting except free standing rehabilitative centers. This policy will

expand the place of service to include free standing rehabilitative centers. All services provided in a private rehabilitative center are limited to ambulatory therapies. This policy change does not cover Inpatient Rehabilitative Therapy services in a free standing rehabilitative facility setting. This change will have a minimal financial impact because this service is currently covered; this change is only expanding where these services can be delivered.

Discontinue the Single Source Optician Contract: The objective is to update the State Plan to reflect the policy change that allows any willing and qualified provider to provide these services. Currently the agency utilizes a single source vendor to produce eye wear for the vision program. Effective January 1, 2014, SCDHHS will update the Vision Services policy to allow Medicaid enrolled retail optical establishments or self-employed ophthalmic dispenser (Optician) to be reimbursed by the Fee For Service program for eyeglass lenses, frames and other services as outlined in the Physician, Laboratories, and Other Medical Professionals manual for recipients under the age of 21. The estimated fiscal impact will be $3 million per fiscal year. This will cover both the FFS and MCO cost. MCAC member asked if the eye wear would be dispensed from the provider or from a lab. Val stated that SCDHHS will not dictate this; providers will make this determination.

Advisement presented by Peter Liggett

Amendments to the following 1915(c) Home and Community Based Waivers operated by the South Carolina Department of Health and Human Services: Community Choices, HIV/AIDS, and Medically Complex Children.

In an effort to standardize case management, the agency is moving towards using similar rules and reimbursement for different types of case management. Reimbursing case management in 15 minute increments is the model that will be used to meet this objective. This model will apply to the Community Choices, HIV/AIDS, and Medically complex Children's waivers. The Centers for Medicare and Medicaid Services (CMS) mandated SCDHHS to review all Targeted Case Management (TCM) systems to improve accountability in Case Management. Due to this Federal mandate, SCDHHS staff did an extensive review of existing TCM systems to explore ways to ensure that case managers were being paid fairly, while still being held to a strong standard of quality. After numerous meetings, the decision was made to develop a standardized 15 minute billing unit for case management services. This new model must be used by all contract and independent case managers. Case Management services have always been a vital part of the Community Choices, HIV/AIDS, and Medically Complex Children's waivers and this vital service will continue. However, instead of monthly reimbursement, as currently provided, this service will be billed in 15 minute increments. The estimated impact for the Community Choices and HIV/AIDS waivers is an additional 1.2 million dollars, and the estimated impact for the Medically Complex Children's waiver is $400,000.

Advisements presented by Michael Jones:

Presumptive Eligibility for Medicaid in Hospitals: The objective is to design a Presumptive Eligibility program that results in individuals who truly qualify for Medicaid gaining access to the system through accurate screening and a full determination. Effective for services provided on or after January 1, 2014, hospitals will have the option to perform Presumptive Eligibility determinations as granted by the Affordable Care Act. Through this program, hospitals that participate in Medicaid and have not been disqualified can make presumptive Medicaid eligibility determinations for individuals who attest to a simplified set of eligibility requirements for the following SCDHHS categories: Pregnant Women, Family Planning, Former Foster Care Children to Age 26, Breast and Cervical Cancer Treatment, Infants and Children under Age 19, and Parents and Caretaker Relatives. SCDHHS will communicate the program requirements and provide training to these hospitals. Individuals who are determined presumptively eligible will be enrolled in a fee-for-service payment category based on the hospital's assessment of categorical eligibility, household income, state residency and citizenship, status as a national or satisfactory immigration status as attested by the applicant. The agency will provide all services covered under the plan,

including EPSDT, during this Presumptive Eligibility Period. Exceptions to this include individuals found presumptively eligible for family planning will receive services limited to family planning, and individuals enrolled in the presumptively eligible category for pregnant women will only receive ambulatory prenatal care. Presumptive Eligibility Periods are limited to no more than one period within two calendar years. The Presumptive Eligibility Period begins on the date the determination is made. The Presumptive Eligibility Period ends with the earlier of 1) the date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or 2) the last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date. SCDHHS will require hospitals to meet performance standards that relate to the proportion of individuals determined presumptively eligible who submit a full application before the end of the Presumptive Eligibility Period and the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the Presumptive Eligibility Period. Hospital participation in this program will determine the final budgetary impact. SCDHHS anticipates the budgetary impact to be minimal.

Medicaid Children's Health Insurance Program (CHIP): The objective is provide the qualifying ages for children and the income eligibility standards the state uses for determining eligibility under its Medicaid Children's Health Insurance Program. The Affordable Care Act mandates the use of Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for designated eligibility groups of Medicaid applicants and beneficiaries. Existing Medicaid Children's Health Insurance Programs using a net income standard must convert their existing income standards (Medicaid CHIP Federal Poverty Levels (FPL)) to MAGI-equivalent standards. Effective January 1, 2014, the minimum qualifying income level for Medicaid is increased to 133% FPL for children ages 6 up to 19, making 133% FPL the minimum income level for all children under 19. States with a Medicaid CHIP program at income standards below 133% FPL must submit a state plan amendment to reflect revised income standards, with a lower level of no less than 133% of the FPL to be in compliance with this requirement. CMS anticipates that methodology for MAGI will be cost neutral. With the enhanced CHIP funding for these children the State will be required to provide fewer State dollars for these children. Director Keck stated this was a preparation for CHIP not to be re-authorized; focus on preparing to take away CHIP match.

Advisement presented by Robynn Mackechnie

Enhanced Health Screening services within the Family Planning eligibility category: The purpose of the benefit design for Family Planning eligibility category should be to produce the best health outcomes for the mother and newborn child. This requires a more comprehensive and proactive assessment of the health status of males and females of childbearing age participating in the program. Currently, beneficiaries in the Family Planning payment category receive access to family planning examinations, counseling services related to pregnancy prevention, contraceptives, laboratory services related to family planning, and sterilizations. The proposed change involves the expansion of the benefit to add a primary care examination, similar to the biennial physical exam currently available for FFS beneficiaries, for Family Planning beneficiaries. There will be increased expenditures of approximately $6.5 million annually. Director Keck stated this would help people have the healthiest outcome. It will provide more comprehensive health screenings and give SCDHHS more insight into population that is important to this agency.

Michael Jones, Program Director, Eligibility enrollment and Member Services Management:

Medicaid Eligibility Enrollment Trends: FY2014 June 2014 enrollment updated projection is 1,132,000. FY2014 member months updated projection is 12, 813,000. ACA impact from currently eligible but un-enrolled member updated projection for June 2013 is 94,000 (reduced by 25%). ACA impact from currently eligible but un-enrolled member months projection for FY2014 is 521,600. Some strategies for identifying and enrolling eligible but

un-enrolled is looking at SNAP/TANF Adults (DSS) and Reduced lunch children (DOE). MCAC member asked about the ability for SCDHHS to connect to outreach events because this is where you can find eligible individuals that are not currently enrolled. Michael Jones stated that events can be e-mailed to him or Bryan Kost and arrangements can be made for SCDHHS staff to be at the event to take applications.

Online Application Launch: This has been a successful launch since October 1st. Over 17,000 unique visitors and over 9,000 accounts created online. Of these accounts created, over 4,200 applications submitted online and over 32,000 total applications (online & paper) receipted. Initial data shows citizens are able to complete the process including remote identify proofing (RIPD) with 1,100 of initial 1,300 successful. RIPD is technologies the system allows to identify if you are who you say you are. 1st test was 80% successful; 2nd test this week. Planning updates in November were to work towards account transfer functionality with Market Place and other updates to improve the flow, performance and prepare for January 1. For January 1—complete MAGI application process (trying to make this a seamless application process) and new system becomes system of record for MAGI population. MCAC member asked if TEFRA applications and Appeals would be online. Robynn Mackechnie stated the TEFRA applications are not currently online but in the future both TEFRA applications and Appeals will be online.

Eligibility Process Improvement: There were 28,000 pending cases the first part of October. To date over 24,000 pending cases have been processed. The remaining 4,000 are awaiting information request(s) from applicant. 80 to 90% of these cases are Long Term Care Cases, which take more time to determine eligibility. All but 200 of these cases have been touched but the goal is to have all 200 touched by the end of the week. SCDHHS is logging renewals to make sure Medicaid is continuous. The goal through December is to eliminate the renewal backlog and to start January 2014 with all work up-to-date. Consultant firm is working collaboratively with DSS and SCDHHS to determine short and long-term process improvement efforts across the departments; this is part of the WSS effort. MCAC member asked if the 28,000 backlogged cases included renewals and Michael answered no they were strictly applications. Another member wanted to know how old some of the backlogged cases were and Michael answered some went back as far as 2010. Michael explained MAGI Eligibility slide and stated the current income standards and the new MAGI income standards are on the SCDHHS website. Michael also discussed Transitional Medicaid and Renewals. SCDHHS has not received any guidance yet from CMS on Transitional Medicaid after December 2013; program sunsets December 2013. SCDHHS plans to keep program "as-is" at least through June 2014. SCDHHS will analyze data of beneficiaries in the program and who may be exchange/subsidy eligible. MCAC member asked about Former Foster Care Children. Michael explained any child eligible for FC in SC at the age of 18 can come back and apply for Medicaid. Effective January 1, 2014, former FC children can be eligible to the age of 26. Director Keck asked if these children would automatically be re-enrolled and Michael said not at this time. Transparency Initiatives: Greater transparency and accountability into DSH funds through claims level detail; identifying more information. Accountability that each patient has been informed and educated about various payment options by 1) ensuring patients get through the right door; 2) ensuring patients understand their obligations and 3) ensuring DSH funds are used as intended for uninsured. All of this is a big change in mind-set. SCDHHS is working with SCHA to develop policies for transparency and accountability. MCAC member asked if SCDHHS would be giving more explanation about the Explanation of Benefits (EOBs). Michael said he would follow up on this and Director Keck stated the new system will make this process easier.

Upcoming Policy and System Changes: Presumptive Eligibility Option—1) determinations of presumptive Medicaid eligibility may be made by hospitals; 2) requires patient attestation of a limited amount of information; 3) household will be temporarily enrolled in Medicaid (60 days) until a full application and determination is complete and 4) household eligible for full Medicaid benefits. MCAC member asked if it takes over 60 days to determine eligibility will the client keep coverage and Director Keck stated it will not take over 60 days to make this determination. ICD-10 Status: There is a dedicated website to

ICD-10 at www.scdhhs.gov/icd10 and it remains on schedule, started early testing in November.

Eligibility SPAs/Updates: There are 20 SPAs that have to be submitted for October 1, 2013: MAGI Income Methodology; Use of Streamlined Application; Handling of Appeals; FFM (exchange) type; Protection for Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards. SPAs to be submitted for January 1, 2014 are Children's Health Insurance Program Income Eligibility Standards and Presumptive Eligibility.

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

MCO Transitions and MHN Conversions: 51,461 United Healthcare members will transition to Wellcare (go live date is October 1, 2013); MHNs-MCOs (Conversions): 134,982 South Carolina Solutions members will convert to Molina (go live date is January 1, 2014; 19,194 Palmetto Physician Connections Members will convert to Advicare (go live date is January 1, 2014). and 15,669 Carolina Medical Homes members will convert to Wellcare (go live date is January 1, 2014. SCDHHS is working with the plans to ensure there are adequate networks. All plans transition on January 1, 2014. MCAC Member asked if they could post this information to families and Roy Hess asked them to wait to post until letters are mailed. Deirdra stated letters have to be mailed out November 25th to let them know they are transitioning to a new plan.

2014 MCO Contracts: July 1 2014 contract is currently being worked on. SCDHHS Staff will visit six states' Managed Care Programs during the month of November. The states are as follows: Arizona, Georgia, Michigan, Ohio, Oregon, Tennessee. MCAC Member asked why these states were chosen and Deirdra stated SCDHHS wanted to look at their Managed Care programs to see what SCDHHS wants to implement in their own MC program. MCAC Member also asked what the timeline was for and Deirdra stated once the visits are completed they will engage the stakeholders in their findings.

Patient-Centered Medical Homes Incentive Program Summary (SFY2014) Deirdra discussed the two slides on the Patient-Centered Medical Homes Incentive Program.

Managed Care Quality Program: In year one (July 2012-December 2012) there were 10 different measurements requiring a minimum of one standard deviation improvement across each measurement or achieved 75th percentile. Plan NCQA data was utilized for assessment. The four key categories of measurement were 1) Prevention and Screening; 2) Chronic disease and Behavioral health; 3) Access and Availability; and 4) Consumer Experience and Satisfaction (CAHPS). In year two (January 2013-December 2013) there were 16 different measurements requiring a minimum of one standard deviation across each measurement. Plan NCQA data was utilized for assessment. In year three (January 2014-December 2014) the focus will be on targeted categories rather than specific measurements such as 1) adults—Hypertension and Diabetes; 2) children—preventive pediatric care and Asthma prevention and Quality initiative will be for a two year duration. Plan NCQA data will be utilized for assessment.

Baby Friendly Hospital Incentive: In December of 2012, SCDHHS created a $1,000,000 incentive pool for hospitals to become recognized as baby friendly by Baby Friendly USA by October 2013. 18 South Carolina hospitals applied for the baby friendly incentive. Four hospitals met the requirements: Georgetown Memorial Hospital, MUSC Women's Care, Roper St. Francis Women's Services and Waccamaw Community Hospital. Each hospital will receive $200,000 in an incentive payment from SCDHHS.

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

Budget process, FY14 overview and FY14 year to date budget. Beth gave an overview of the FY15 budget submission and the FY14 budget Year to Date. The FY15 budget submission consists of a 467M increase over FY14. This budget submission is just a starting point as the Governor's budget (to be released in January) will be the Department's budget. YTD summary shows that as of September 30, 22% of budget appropriation expended.

Meeting Adjourned

Next meeting scheduled for Tuesday, January 28, 2014 10:00AM to 12:00 PM