MARYLAND MEDICAID ADVISORY COMMITTEE

DATE:	Monday, March 25, 2019
TIME:	1:00 – 3:00 p.m.
LOCATION:	Senate Office Building, Education, Health, & Environmental Affairs Committee Room 11 Bladen Street, Second Floor Annapolis, Maryland 21401

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AGENDA

I. Departmental Report

II. Home and Community Based Settings – (Rebecca Oliver)

III. Behavioral Health Update – (Barbara Bazron, Dep. Sec., Behavioral Health Admin.)

IV. Medicaid legislative update/overview – (Chris Coats, Health Policy Analyst Advanced)

V. Waiver, State Plan and Regulations Changes – (Mark Leeds, Director, Office of Long Term Services and Supports)

VI. Public Comments

VII. Adjournment

Date and Location of Next Meeting:
Thursday, April 25, 2019
Maryland Department of Health
201. Preston Street, Lobby Conference Room L-3
Baltimore, Maryland 21201

Staff Contact: Edward J. Miller – (410) 767-0247
EdwardJ.Miller@maryland.gov

Committee members are asked to contact staff if unable to attend!

MMAC MINUTES
February 25, 2019

MEMBERS ATTENDING

Ben Steffen
Adeteju Ogunrinde, M.D.
Isabella Firth
Vincent DeMarco
Shannon Hall
Winifred Booker, D.D.S.
Donna Fortson
Sue Phelps
Del. Morgan
Rachel Dodge, M.D.
Linda Dietsch
The Hon. Joseline Pena-Melnyk
Kerry Hawk Lessard
The Hon. Shirley Nathan-Pulliam
Norbert Robinson
Michael Spurrier
The Hon. Matthew Morgan

Call to Order and Approval of Minutes

Ms. Vickie Walters, Chair, called to order the meeting of the Maryland Medicaid Advisory Committee (MMAC) at 1:12 p.m. Committee members approved the January minutes as written.

Departmental Report

Dennis Schrader, COO and Medicaid Director, informed the Committee about the personnel changes and updates occurring in the Department of Health. We have created a consolidated office of Enterprise Technology that will be evolving in the future. I would like the committee know that Craig Smalls is retiring on April 1, 2019, we will miss him dearly. We will be able to move through this transition fairly well. The PRU (problem resolution unit) has been consolidated and moved it to the Director of Provider Services - the nursing home community was concerned about the Unit - so we took aggressive action to fix this. On the pharmacy side, I decided to make this unit report directly to me.

Urban American Indian Health and Health Services in Maryland

Kerry Hawk Lessard, Executive Director of Native American LifeLines, MMAC member, and Shawnee descendant, discussed Urban American Indian Health and Health Services in Maryland. (*Please see attached Presentation*).

Highchair Dental Care

Winifred Booker, D.D.S., presenting on Highchair Dental Care and February being the National Children's Dental Health month. The dental home should be established by no later than 12 months of age. (*Please see attached Presentation*).

Medicaid Legislative Update

Chris Coats discussing the Medicaid legislative update. We are in the middle of session; the 45 day (official midpoint) was last Friday. Hearings are coming up for the bills that were introduced in January. Some of had hearings, but the rest will have them in the coming weeks. On pharmacy, we expect lots of activities on this issue. Most of the bills would attempt to lower costs or research the cost of drugs, such as HB768 that would create a Drug Advisory Board. On miscellaneous, HB974 would authorize enrollees to get out-of-state provider care from SUD services. SB609 would require coverage for drugs that treat "contagious diseases and HB962 would require coverage for Hepatitis C drugs. When we get closer to crossover, votes will happen and we will have a better idea at passage and implementation.

<u>Questions</u>

Q) Dr. Dodge: What prompted the behavioral health carve in? Didn't we just carve it out?
A) Dennis Schrader: It is my guess that MCOs wanted this, but that's pure speculation.

Q) Winifred Booker, D.D.S.: Why was HB1200 withdrawn?
A) Chris Coats: That just happened, so I have no information on that. I can forward you that answer when I find out.

Home and Community-Based Services Waivers

Mark Leeds, director of LTSS, discussing both the history and purpose of state plans and waivers, as well as Home and Community Waivers. (*See Attached Presentation).*

<u>Questions</u>

Q) Dr. Dodge: Is there a methodology for who gets served first for those on the waitlist?
A) Mark Leeds: When there is a waitlist, we screen the individuals; we have algorithms for our methodology. For example, risk of institutionalization is one. The Autism waiver is first come first serve. We also have the two new waivers to get access to those on the waitlist.

Q) Dr. Dodge: Is REM under the model waiver?
A) Mark Leeds: REM is under the 1115 waiver. It's still a waiver, but under the 1115 waiver - so they do not have to be served under the capitation of the MCOs. It is Fee-For-Service program. A person can be in both REM and the 1915(c) waivers discussed earlier.

Q) Dr. O: What makes some of these waitlists so long? The autism waiver is 5,583 people long and the number of "approval slots" does not seem to be able to cover this. The other waivers do not seem to have as much as a noticeable issue.
A) Mark Leeds: For the most part, it is due to budget constraints. The budget drives how many participants the waiver can serve. Therefore, if the budget was higher (included more monies) for the waiver, more participants would be able to get served through said waiver.

Q) Dr. O: Following up on my previous question, if a participant is referred by a practice and they are on the waitlist, are they denied services?
A) Mark Leeds: It depends, the participant may be Medicaid eligible and receive services that way, but they would have to qualify for Medical Assistance/FPL. We look at the child's income when making that determination.

Q) Dr. Dodge: Are there Medicaid eligible kids that are taking the autism waiver spots?
A) Mark Leeds: That is likely the case.
Q) Dr. Dodge: Why is that? That seems counter-intuitive. It would limit services to those would could otherwise gain services through the waiver.
A) Mark Leeds: The waiver covers some treatment options outside the scope of Medicaid services. These specialized services, like intensive individual support services, are not covered under Medicaid. The waiver is an enhanced package compared to the state plan coverage.
Q) Dr. Dodge: Could we get numbers on how many Medicaid patients are in the waiver?
A) Mark Leeds: We will follow up.

Waiver, State Plan and Regulation Changes
These reports have been distributed. There is one regulation change - a technical change on chronic hospitals. We have a number of regulations that have just completed comment period. We are making a change on the psychology supervision of technicians. The other regulations have final approval and should be adopted as proposed. We have responded to a comment on the State Plan Amendment for Family Planning and are waiting for approval there. There are three waivers for DDA and these have been out for public comment and should be submitted to CMS soon. In regard to concerns brought up earlier about informing Native American services about our waivers, plans, and regulations, we do submit these reports to the Native American community for review.

Behavioral Health Update

Barbara Bazron, Deputy Secretary and Executive Director of the Behavioral Health Administration, updated the Committee on programs in the Behavioral Health sector. This presentation was not on the Agenda, but we will be putting behavioral health on the Agenda as continued placeholder moving forward. We have moved ahead with our behavioral health systems activity that was required by the Legislature in the budget act. These services will be integrated and managed at the jurisdictional level. We have just gotten SUD into the FFS system. Our goal then becomes developing a system of management that allows for that type of service integration. We have begun to work with advocated and local leaders to develop the definition of the functions to perform system management. The jurisdictions have done their own self-assessment on where they see themselves on system integration and are developing their own plan in their communities to determine what model they will use to integrate SUD. We submitted our year two SOAR grant for $33 million. We have been told by SAMSA that those who submit the year two SOAR grant will get a supplement, so we will be getting another monies supplement for the implementation of SOAR. We must focus on harm reduction by focusing on those individuals who are currently using - it is important to begin this process by having discussions with individuals who are currently using and distributing fentanyl strips to test their drugs before using.

Public Comments
None.

Adjournment