**MARYLAND MEDICAID ADVISORY COMMITTEE**

#####  DATE: June 28, 2012

TIME: 1:00 - 3:00 p.m.

#  LOCATION: Department of Health and Mental Hygiene

#  201 W. Preston Street, Lobby Conference Room L-3

# Baltimore, Maryland 21201

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**AGENDA**

1. Departmental Report
2. Implications of Supreme Court Decision
3. Telehealth Study
4. Exchange Update
5. Eligibility Update for PAC, Family Planning and Foster Care
6. Waiver, State Plan and Regulations Changes
7. Public Mental Health System Report
8. Public Comments
9. Adjournment

**Date and Location of Next Meeting:**

# Thursday, July 26, 2012, 1:00 – 3:00 p.m.

# Department of Health and Mental Hygiene

# 201 W. Preston Street, Lobby Conference Room L-3

**Baltimore, Maryland**

## **Staff Contact: Ms. Carrol Barnes - (410) 767-5213**

**Committee members are asked to call staff if unable to attend**

**MARYLAND MEDICAID ADVISORY COMMITTEE**

**MINUTES**

#### June 28, 2012

**MEMBERS PRESENT:**

Mr. Kevin Lindamood

Ms. Salliann Alborn

Ms. Sue Phelps

Ms. Grace Williams

Ms. Michele Douglas

Mr. Joseph DeMattos

Mr. Ben Steffen

Mr. C. David Ward

The Hon. Delores Kelley

Ms. Ann Rasenberger

Ms. Lori Doyle

Ms. Lesley Wallace

Winifred Booker, D.D.S.

Virginia Keane, M.D.

Mr. Norbert Robinson

Charles Shubin, M.D.

Ulder Tillman, M.D.

Mr. Floyd Hartley

Samuel Ross, M.D.

Ms. Kerry Lessard

The Hon. Shirley Nathan-Pulliam

**MEMBERS ABSENT:**

Ms. Patricia Arzuaga

The Hon. C. Anthony Muse

Ms. Tyan Williams

The Hon. Robert Costa

Ms. Christine Bailey

The Hon. Heather Mizeur

Ms. Rosemary Malone

#### Maryland Medicaid Advisory Committee

#### June 28, 2012

###### Call to Order and Approval of Minutes

Mr. Kevin Lindamood, Chair, called to order the meeting of the Maryland Medicaid Advisory Committee (MMAC) at 1:10 p.m. Committee members approved the minutes from the May 23, 2012 meeting as written.

**Departmental Report/Supreme Court Decision**

Deputy Secretary Chuck Milligan gave the Committee the following Departmental update:

1. Fiscal year 2012 starts next week and the Department is in the process of getting all regulations and State Plans out to execute on budget items.
2. The Behavioral Health Integration process is on-going. The next large stakeholder meeting is on July 20, 2012. Please attend if you are interested and available. You can also attend through webinar. So far it has been a very good process and hope the stakeholders feel the same way. It has been very constructive for the Department to hear the feedback and get questions, comments and suggestions.
3. Membership – The Committee has by-laws regarding attendance expectations. If members have had difficulty coming to MMAC meetings due to other obligations, the Department understands, however, we do have work to do and we need members who are going to attend meetings and participate. Kevin Lindamood will be contacting members to determine if it is difficult for them to participate. We want to make sure that we honor the work that needs to be done by honoring the by-laws in terms of attendance expectations.
4. Supreme Court Decision – The Health Care law was upheld and the Medicaid expansion has been converted into an optional expansion. States can choose not to do it. For Maryland it means everything was affirmed that we needed to be affirmed.
5. Implications of the Supreme Court Decision :
6. Behavioral Health – One of the reasons we are working on this Behavioral Health Integration (BHI) process is because in the qualified health plans that will be selling products in the Exchange, behavioral health is a covered benefit, the scope of which still needs to be defined. This benefit will be offered through commercial carriers for those individuals in the Exchange including non-Medicaid eligible adults above 138% federal poverty level (FPL).

Part of our purpose in focusing on Behavioral Health Integration is how do we, in delivering Medicaid-financed behavioral health, work with our consumers and providers and organize our delivery system model cognizant of the Exchange reality. This is not being said to in any way foreshadow that it is going to be an insurance managed care organization (MCO) kind of model because we are working through it and we are going in this with an open mind. The providers, stakeholders and consumers are aware that one of the implications of the Supreme Court decision is, if they want to serve their populations, they are going to have to work with carriers for those Exchange eligible individuals. We are trying to create some form of seamlessness for the benefit across Medicaid and commercial insurance.

1. The Affordable Care Act (ACA) being affirmed today means apart from the insurance coverage, we are going to be able to raise the Medicaid fees for primary care services on January 1st to 100% of Medicare. This is going to be a huge benefit to our population and to the providers who are serving that population. The legislature also approved funding for specialists who are delivering those primary care codes.
2. The State will benefit from on-going pharmacy rebates that we are receiving under the ACA because the MCOs in HealthChoice are able to tap into the Medicaid drug rebate laws which give Medicaid the best price and good rebates. Before the ACA that was not the case. The MCOs negotiated their own rebate arrangements and they were not able to benefit from Medicaid best price arrangement on the fee-for-service side. Right now that is generating over $50 million a year to the State treasury that will continue because it was a provision of the ACA.
3. Let us not lose sight of the long-term care provisions in the ACA. The focus today is the coverage, but Maryland did receive a Rebalancing Incentive Payment grant from the federal government worth $106 million between April 1, 2012 and September 30, 2015 that we will be able to keep, use and deploy for rebalancing efforts. Maryland will also be able to benefit from the Community First Choice initiative in the ACA to help improve access to attendant care services in the community as well as those supports that substitute for an attendant. We are also going to be able to raise rates for attendant care providers and other work that is happening through the Rebalancing Incentive payment and the Money Follows the Person (MFP) stakeholder process.

In addition to that, the ACA has the Health Home option that we are now going to be able to pursue to help integrate primary care and care coordination services in the behavioral health settings with 90/10 money (the Missouri type model) that has been the focus of one of the BHI work groups. It was dependent on an ACA option and this is also something we can proceed on that will improve the linkage between behavioral health services and primary care in a behavioral health delivery system medical home.

**Telehealth Study**

Laura Herrera, M.D., Chief Medical Officer for the Department gave the Committee an overview of the Telehealth Study. During this 2012 session two bills were introduced, HB 1171 and SB 781 which required state regulated private payers of Medicaid to cover services delivered through telehealth as if they were delivered in person.

This came out of a task force report that the Maryland Health Quality and Cost Council originally identified as a need to be explored in more detail in June 2010, specifically looking at challenges and solutions to advance telehealth in Maryland. The initial report was submitted in September 2010 then a leadership committee was established by Secretary Colmers lead by the Maryland Health Care Commission (MHCC) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) to explore teleheatlh in Maryland.

Three advisory groups were established to develop formal recommendations and they included a Finance and Business Model advisory group, Technology Solutions and Standards advisory group and Clinical advisory group. That report was presented in December 2011.

The thing most significant to Medicaid is the Finance and Business Model Advisory group recommendation to require state regulated payers to reimburse for telemedicine services and they should be to the same extent as health care services that are provided face-to-face as well as should be subject to utilization review.

The bill was introduced in 2012 and the Department supported the bill with amendment, specifically stating that we need to conduct a covered review. If services were deemed cost neutral that it would cover fiscal 2013. If services were not deemed cost neutral we would seek coverage for FY 2014 through a budget initiative in the 2013 legislative session. With those amendments the bill was passed and signed into law.

Now we are working on all of the research that needs to happen to determine if the expansion of telehealth would be cost neutral. Some of the things that we are working on is a review of the current literature and evidence on telehelath. Researching modalities and specific services covered by other state Medicaid agencies.

Our findings to date show that 38 states have Medicaid coverage. There are three general types of telehealth: 1) clinical video teleconferencing where you have persons on each end of a video monitor and this is typically thought of as a Hub and Scope Model with the specialist being the hub and the spoke being the primary care physician (PCP) or whoever is making the referral, 2) Store and Forward Technology which is imaging which could be radiological images, pictures of skin lesions, pictures of a person’s retina that then gets sent to a specialist; and 3) Home Monitoring which is anything that is used at home to keep someone at home and out of a more costly care facility.

Thirty eight states cover Hub and Scope teleconferencing, 16 states cover the Store and Forward Technology and 15 states cover Home Monitoring. Two states cover telephone and email but there is actual language in the bill that prohibits that. Now we are looking not only at the modalities covered but the services covered. Everything from physician consultation services to mental health to pharmacological management to end stage renal disease services. We are looking at the different costs of these services right now from home health monitoring to specialist consult to PCP, specialist on-call to hospital and the implication for the PCP and the on-call at the hospital would be in the transferring and not needing to move a patient from one facility to another where maybe the specialist doesn’t exist in the primary facility, outpatient care and inpatient care.

We’ve evaluated a number of studies and have pulled the E and M codes that Medicaid covers to start testing some assumptions for Maryland Medicaid. In July 2011 telemental health is a covered benefit in Maryland Medicaid but it is limited to 10 rural counties. Under the new language in this bill we will not be differentiating between rural, but includes all areas that do not have access to clinicians and that is inclusive of some urban areas.

Committee members suggested that they look at the child abuse initiative called CHAMP which is using a system called telecam from Utah that is high resolution transmission. There are issues but we are doing it now and we are consulting with practitioners across the state on issues of child maltreatment.

The Committee advised the Department to take into consideration in its analysis a review of addiction treatment.

The Maryland Health Care Commission and MIEMSS will continue its workgroup meetings to look at what would be the appropriate underlying technology infrastructure to support telehealth.

**Exchange Update**

Ms. Rebecca Pearce, Executive Director, Maryland Health Benefit Exchange, gave the Committee an update on the activities of the Exchange. The most important thing is integrating with Medicaid and making sure we are creating that single point of entry and the “no wrong door.”

The State did procure an enrollment and eligibility system through our Level One Establishment funds that will enable us to do eligibility determination for modified adjusted gross income (MAGI). It will allow us to enroll individuals and determine whether individuals belong in the Exchange without subsidies, the Exchange with subsidies or any of the MAGI programs. We are developing this in a cross functional team that includes Medicaid, the Exchange and a Project Management Office (PMO) that reports into the Department of Human Resources (DHR), the Exchange and Medicaid all interchangeably. The DHR is involved to make sure that the social services piece is not affected. That is one place that we are looking at interoperability and making sure we have this “no wrong door.”

As we move forward with the Exchange we have a number of advisory committees in place. The 2011 legislation required us to have four advisory committees in place last year and they worked so well because we have hospitals, insurers, stakeholders, advocates, etc. and by the end of all of those policy discussions everyone understood where the Exchange was going and what we were doing and really felt Maryland was moving forward in the right direction.

This year we are using the advisory committee process again. There is a Navigator Advisory committee that will be talking about what training the Navigators need to have, what the certification process should be, how is the Exchange going to ensure that we are reaching all of the cross sections of Maryland and doing it in a culturally and linguistically diverse manner, and how are we going to ensure that no individual is hurt by anything that is happening in the Exchange. This advisory committee will give us direction and feedback on thought processes as we develop the next set of policies.

We will have a Continuity of Care advisory committee. This committee will look at how we ensure an individual who might be in the middle of care and is churning between an insurance company and Medicaid won’t have to get additional care and we are not spending more than we need to spend at the detriment of the individual who is in the middle of receiving care. We will look at what Medicaid organizations and insurers are doing across the country and determine how we put that in place. This will go to the legislature to be addressed both inside and outside the Exchange because we don’t want to have any problems from an adverse risk selection.

There will be a Plan Management Advisory Committee. This committee will address such things as: From the insurance side, how do we make sure that we get all of the carriers on the Exchange and what the requirements are for the carriers on the Exchange. Also using the Exchange as a portal where people can go and search for health insurance plans and there will a comparison for the MCOs as well. What should this look like, how do we make sure the information is easy to understand and in plain English. How do we make this purchase easy to understand for individuals?

The Exchange has to be sustainable by 2015. The Financial Sustainability Advisory Committee will look at how to we might fund the Exchange by 2015 and beyond.

All of these advisory committees have someone from the Department and the Medicaid arm on them so we really are very much intertwined in everything we do and Secretary Scharfstein is the chairman of the board.

The Committee asked about parity and network adequacy. These were both just brought up in the Plan Management Advisory committee. They are looking at what network adequacy standards should be and there is a public comment period on that, which will be announced on the Exchange website.

The Medicaid Advisory Committee will be providing advice through the process for Medicaid input on how to provide continuity of care. The Committee recommended the advisory committee looking at continuity of care look at legislation in the past that made sure there was continuity of care when we moved to managed care and MCOs.

We are looking at how to line up enrollment activities. The contracted enrollment broker activity we intend to piggyback the Exchanges contracting practices. So a household at 150% where the adults are in the Exchange but the children are in Medicaid, there is a single entity helping that household choose MCOs on the Medicaid side and qualified health plans on the Exchange side. We will be jointly purchasing that with the Exchange as the lead purchasing agent.

We will also have our own direct Medicaid relationships with, for example, local health departments (LHDs) and others to the extent that they are involved, and they might not be, for Medicaid specific work. We are still teasing some of that out ourselves where there isn’t an Exchange function underneath and to have a more direct financing arrangement within the Department and LHDs, or Department of Social Services (DSS) for example to make sure there is a flow.

The Exchange is currently determining what Essential Community Providers look like and who they are in the State of Maryland and how to integrate them on the insurance side.

**Eligibility for PAC, Family Planning and Foster Care**

Ms. Debbie Ruppert gave the Committee an update on the PAC program and answered questions that were raised at the last meeting (see attached handout).

**Electronic Health Records Update**

Mr. Paul Messino, Health Policy Analyst, gave the Committee an overview of the Electronic Health Record Incentive Program (see attached handout).

**Waiver, State Plan and Regulation Changes**

Ms. Susan Tucker, Office of Health Services, reported there were no changes to State Plans, regulations or waivers this month.

We will have some regulations going out related to fee increases. There are a few increases this year in the personal care program. There will also be regulations changes related to the nursing home program. There is a regulation packet which is an annual clean-up for HealthChoice that will be coming through in the next month.

A waiver amendment was done for the Older Adults waiver to add more slots and the Committee will be given notice on that. All of the waivers (Medical Day Care, Older Adults, Living at Home and personal care rates) received a 1% fee increase.

**Public Mental Health System Report**

No report given this month.

**Public Comments**

Ms. Robyn Elliott and Ms. Ann Ciekot both of Public Policy Partners made comments related to the Health Care Exchange.

**Adjournment**

Mr. Lindamood adjourned the meeting at 3:00 p.m.