Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, March 13, 2012
1:00 PM – 4:00 PM
AHCA Conference Room B
Participants/Invitees

Members Present

Martha Pierce
Amy Guinan
Paul Belcher
Robert Payne, DDS
Richard R. Thacker, DO
Secretary Chuck Corley

Members Not Present

Jennifer Lange
DOH Representative

Participating by Phone

Catherine Moffitt, MD

AHCA Staff Present

Justin Senior
Phil Williams
Melanie Brown-Woofter
Kelly Bennett
Damon Rich
Carla Sims
Susan McPhee (by phone)

Welcoming Remarks/Roll Call

The Medical Care Advisory Committee (MCAC) meeting began with welcoming remarks by Deputy Secretary for Medicaid, Justin Senior, followed by committee member introductions.

Minutes

Carla Sims advised that the minutes of the October 25, 2011, MCAC meeting had been sent to committee members for review prior to the meeting, and asked if there were any questions or comments. With no questions or comments by committee members, a motion was made and seconded for approval of the minutes.

Statewide Managed Care Update – Mr. Justin Senior gave an update on Statewide Medicaid Managed Care, noting that all deadlines to date have been met; in June, 2011 public

meetings were held to solicit public comment, and on August 1, 2011, the state submitted the required documents to seek federal authority. He also noted that the Agency chose to implement Medical Assistance Managed Care through amendments to the 1115 Waiver, and that a 1915 (b)(c) combo waiver was submitted for implementation of the Long-term Care Managed Care component. Mr. Senior said that the next deadlines would be for the data book and procurement document, which are not federal deadlines, but required by Florida Statute.

The Long-term Care Managed Care component of the Statewide Medicaid Managed Care program will be implemented first. Implementation dates for the Long-term Care Managed Care component are:

- The Agency must begin implementation by July 1, 2012.
- The Agency must complete implementation in at least one region by October 1, 2013.

The Agency must competitively procure plans to serve the Long-term Care Managed Care population. The Agency is also required to conduct simultaneous procurements for Long-term Care Managed Care plans in each of the 11 regions. The Agency anticipates release of the Invitation to Negotiate (ITN) no later than July 1, 2012.

In preparation for the release of the procurement that will secure contracts with health plans to participate in the Long-term Care Managed Care component of the Statewide Medicaid Managed Care program, the Agency for Health Care Administration will release the Long-term Care data book. The data book will provide relevant background information that prospective plans will find useful in the development of their ITN response.

The Medical Assistance Managed Care component of the Statewide Medicaid Managed Care program will be implemented second. Implementation dates for the Managed Medical Assistance component are:

- The Agency must begin implementation by January 1, 2013.
- The Agency must complete implementation in at least one region by October 1, 2014.

The Agency must also competitively procure plans to serve the Medical Assistance Managed Care population and must conduct simultaneous procurements for Medical Assistance Managed Care plans in each of the 11 regions. The Agency anticipates release of the ITN no later than January 1, 2013.

Paul Belcher asked how SB 730 fits into the Long-term Care Managed Care plan. Justin advised that there is a great deal of complexity with regard to the special needs plans, noting that 87-90,000 people will be enrolled in long term managed care and 83,000 of those are dual eligible.

Managed Care Waiver Update – Mr. Senior again briefly noted that the 1915 (b)(c) combo waiver which covers Long-term Care and Home and Community based services was submitted to CMS on August 1, 2011 and responses were posted on line.

He also noted that with regard to the 1115 Medicaid Reform Demonstration Waiver, the Agency sent the requested information to the Centers for Medicare and Medicaid Services (CMS) regarding the waiver. CMS sent back a list of 45 questions requesting additional information. Mr. Senior noted that Agency staff has conference calls with CMS weekly to discuss operational issues, including LIP. Mr. Senior also explained that the SMMC legislation calls for a mandatory opt-out program. The Agency submitted a State Plan Amendment (SPA) making the opt-out mandatory for people who have employer sponsored health insurance, when it is more cost effective than them becoming Medicaid recipients. CMS approved this and the transition is being handled through a third party, with a reasonable transition time provided.

Legislative/Budget Update – Phil Williams noted that since this Medical Care Advisory Committee meeting followed closely behind the end of the 2012 legislative session, Agency staff is still trying to identify all the legislative and budget issues that might affect the Agency.

He noted that SB 730 amends Section 409.912 (4)(b), relating to prepaid behavioral health, and provides authority to the Agency to 1) extend or modify current contracts with behavioral health plans, 2) contract for managed care, and 3) extend or modify current contracts and provider agreements.

Mr. Williams also identified some of the additional items affecting the Agency under the Conforming Bill:

- The Agency must plan for and implement use of diagnosis related groups codes for purposes of reimbursement for hospital inpatient services July 1, 2013
- Home health visits are reduced from a maximum 4 to 3 visits per day
- There is a 1.25% reduction in Nursing Home funding
- ER visits are reduced to a maximum of 6 per year for non-pregnant adults
- General physician office visits are reduced to 2 per month for non-pregnant adults
- Elimination of prohibition of state employee's children being covered under the KidCare program
- Local government funding of a portion of the Medicaid program
- Expansion of Telephony Home Health monitoring program
- Expansion of home health services care management
- Expansion of PACE program into Broward, Manatee, Sarasota and DeSoto counties

Referring to the Pre-paid Dental program, Dr. Payne shared concerns over what dentists, like him, will do when prepaid dental coverage begins in his area.

Paul Belcher asked if the 6 ER visit limitation requires a State Plan Amendment, to which Justin answered, yes. Mr. Belcher then asked if this has occurred in any other state, to which Justin answered, not to his knowledge.

Amy Guinan then asked if the Agency was aware that the Department of Juvenile Justice (DJJ) budget directs DJJ to come to AHCA for behavioral health coverage. Phil Williams said he had not seen DJJ's budget, but would review it to see how the Agency might be affected.

Recipient Correspondence Update – Damon Rich with the Bureau of Medicaid Contract Management advised committee members that in 2009-2010, Agency staff developed a strategic plan for updating and improving the layout and content of Medicaid communications to recipients. To implement this plan, a team was established to review the letters sent to Medicaid recipients. Letters were reviewed for plain language content, appropriateness, timing, and language encouraging active engagement in health care decision-making. The Medical Care Advisory Committee was also asked to participate in the correspondence review process, assisting the team in reviewing and revising the four highest volume letters disseminated by the Agency.

Mr. Rich noted that revised letters were sent to recipients in reform counties in June 2010, non-reform in June 2011, and in September 2011, MediKids letters were sent. He further noted that the Agency is currently awaiting the results of a customer satisfaction survey conducted to assess the usefulness of information sent to recipients.

Mr. Rich thanked committee members for the role they played in reviewing and revising recipient correspondence.

Fraud and Abuse - Provider Termination – Kelly Bennett, Fraud and Abuse Prevention Liaison with the Medicaid Director's Office, spoke briefly about the Fraud Prevention and Compliance Unit (FPCU), which she heads. Ms. Bennett noted that the current fiscal year work plan continues to balance the ever-evolving nature of fraud, and the need to ensure processes that allow for an effective operational program. The team's priorities are: Program Oversight and Compliance (pre-enrollment provider reviews, provider monitoring, coordination with others to assist in improved process and controls), Fraud Awareness and Education (provider focused training to encourage compliance as well as topic-specific training for internal and external government partners), Emerging and Expanding Areas of Focus or Programs (such as coordination of prevention and detection in managed care), and Systems and Processes (system edits, use of technology to aid in program goals, and increased use of encounter data to address anti-fraud efforts).

FPCU's primary responsibility is to aid the Agency in overall efforts to increase program oversight and to minimize the risk of improper payments within the Medicaid program. The FPCU does not replace or duplicate activities conducted by other parts of the Agency; rather, the unit efficiently assists others in improvements, implementation of fraud prevention measures, and analysis of recommendations for program changes. The Agency has committed significant resources to aggressively fight fraud in the Florida Medicaid program, but the Division of Medicaid has a responsibility to ensure a specific focus on program oversight, implementation of utilization controls, and other targeted initiatives to develop program safeguards.

Ms. Bennett also discussed the differences between contractual (30-day notice) terminations and sanction-based (Final Order) terminations. These two types of provider terminations are often improperly intermixed and she provided some clarity regarding the two and the additional adverse implications regarding those that are sanction-based.

Role of Field Offices - Sue McPhee, Area 6 Field Office Manager, participated in the meeting by phone, explaining that the 11 Medicaid Area Offices, which are located throughout the state, represent a dynamic blend of divergent geographic, cultural, social, economic factors and conditions. Ms. McPhee noted that over the last 10 years, the number of active Medicaid beneficiaries has more than doubled, from 1.5 million in 2002 to 3.2 million in 2012. However during that same period of time, Area Office staffing has been reduced by 19%. The Medicaid Area Offices are the local eyes, ears and voices of the Medicaid Program. The Area Offices are often the first point of contact for beneficiaries and providers with questions or concerns about Medicaid.

The Area Offices are generally organized into units that work with Medicaid providers and Medicaid beneficiaries, although there is some overlap in both sections. Area office functions and responsibilities fall into two major categories – Beneficiary/Network Management and Compliance/Quality Management. Ms. McPhee provided a handout that contains more detailed descriptions of these functions and the focus areas and activities that support each function. The Area Offices:

- Provide local operational management and oversight of Medicaid provider networks
- Assist beneficiaries in navigating the health care system
- Conduct provider trainings
- Help providers with provider enrollment activities and perform random site visits as part of the enrollment process
- Handle provider and beneficiary relations – problem-solve, respond to legislative and headquarters inquiries, make appropriate referrals, answer policy and procedural questions
- Process exceptional claims (claims requiring special handling or exceptions to time limits)
- Oversee community resource development by working with community partners on Medicaid issues and participating in Medicaid outreach activities
- Monitor programs and conduct program audits
- Work closely with headquarters and other divisions within AHCA to manage program changes and implement new initiatives.

Ms. McPhee shared some statistical information about the Area Medicaid Offices, noting that each year Medicaid Area Office staff:

- Respond to over 700,000 phone calls from beneficiaries and providers
    - The Area Offices are in the process of implementing the new Contact Center system that will enable the Area Offices to manage phone calls more efficiently and obtain accurate data on call volumes, speed of answer, call length and blockage rates.

- Process over 58,000 Provider Assignment Change Requests received by fax or email.
- Process over 9,000 prior authorizations for wheelchairs and medical foster care.
- Resolve over 167,000 exceptional claims for providers
- Distribute over 61,000 publications about Medicaid policy, services, and health care information to over 30,000 Medicaid beneficiaries and community participants through health fairs, Medicaid Overview presentations, and community partnerships
- Conduct over 3,000 provider monitoring/site visits at provider offices or service locations
- Represent the Agency in over 1,000 Fair Hearing requests
- Conduct over 300 provider training sessions, with over 2,600 participants

Ms. McPhee also shared some Area Office innovations:

- Implemented the Medicaid Managed Care Pilot for Broward, Duval, Nassau, Baker and Clay Counties
- Developed user-friendly, interactive Area Office web pages to facilitate communication with Medicaid beneficiaries, providers and interested citizens. The web pages contain current provider listings for MediPass Primary Care Physicians, Dentists, Vision and Hearing Services providers, provider training calendars and registration links, information for providers on how to submit exceptional claims to the Area Offices, informational brochures, and links to community partners and other government agencies.
- Developed enhanced call tracking and fair hearing systems
- Implemented statewide scanning initiative to reduce paper usage and storage costs.

Ms. McPhee responded to committee members' questions and offered to provide any additional information committee members may want.

Next Meeting

As the meeting drew to a close, Dr. Thacker requested that specific details of questions/ comments posed by participants be included in future meeting minutes.

In addition, committee members recommended the following topics for our next meeting, which was tentatively set for May/June 2012:

- Preferred Drug List (PDL) updates
- Health Care Exchange
- Updates of Medicaid Invitations to Negotiate (ITN)
- Managed Care Providers – Non-binding letter of intent
- Department of Juvenile Justice (DJJ) – Kids not receiving mental health services

Adjourn

At 4:00 p.m. the meeting was adjourned.