RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, January 29, 2013
1:00 PM – 4:00 PM
AHCA Conference Room C

Participants/Invitees

Members Present

Martha Pierce
Paul Belcher
Jennifer Lange
Anne Swerlick
Richard R. Thacker, DO
Robert Payne, DDS
Stan Whittaker
Catherine Moffitt, MD (by phone)

Members Not Present

Secretary Chuck Corley
DOH Representative

AHCA Staff Present

Justin Senior
Chris Chaney
Phil Williams
Melanie Brown-Woofter
Bill Hardin
Carla Sims

Welcoming Remarks/Roll Call

The Medical Care Advisory Committee (MCAC) meeting began with welcoming remarks by Deputy Secretary for Medicaid, Justin Senior. Mr. Senior's remarks were followed by a roll call of Committee members, including the most recent Committee appointee, Stan Whittaker, MSN, ARNP, representing the Florida Association of Nurse Practitioners.

Mr. Senior then explained that the Agency is in the middle of competitively procuring services for the Managed Medical Assistance (MMA) portion of Statewide Medicaid Managed Care. Any discussion of MMA would therefore be limited. He then read the following statement, posted on the meeting agenda:

> ***Due to the competitive procurement, we are in a statutorily imposed "Blackout Period" until 72 hours after the award and cannot provide interpretation or additional information not included in the MMA ITN documents.***
>
> ***As stated in s. 287.057(23), F.S., "Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays,* Sundays, and state holidays, *any employee or officer of the executive or legislative branch* concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. *Violation of this provision may be grounds for rejecting a response."***

Update on Proposed Legislation

Mr. Chris Chaney, Agency for Health Care Administration (AHCA) Legislative Affairs Director, provided an update on proposed legislation, explaining that proposals for the 2013 legislative session are still in the developmental stages. He briefly discussed the following proposals:

- Transitional Living Facilities
  - Proposed legislation addressing appropriate oversight of these facilities. AHCA will have primary oversight.
- Background Screenings
  - Proposed legislation related to approval from the federal government for the 3rd year of the Background Screening Grant (October 2012 thru September 2013)
- Assisted Living Facilities
  - Recommendations from the Governor's Workgroup. Legislative proposal related to certification of Assisted Living Facility (ALF) administrators and facility staff.
- Medicaid Fraud Bill
  - For Cause Terminations

Stan Whittaker asked about background screenings, noting that individuals are failing the background screening due to 20/30 year old issues on their record. Mr. Chaney advised that there is an exemption process, and noted that he would be glad to discuss the issue further if anyone was interested.

Referring to the legislative proposals discussed by Mr. Chaney, Dr. Thacker asked if Neurological Injury Compensation Association (NICA) funds can be used for Transitional Living Facilities. Mr. Chaney said he wasn't familiar with the use of these funds, but would find out and provide information to staff for the next meeting. Dr. Thacker then suggested that Assisted Living Facilities that meet a threshold of a certain number of beds, secure facilities, and those housing dementia patients should be required to have a Medical Director. He also suggested that multiple facilities could share the same Medical Director, based on geography and number of beds in the facilities.

Dr. Thacker then noted that with regard to the issue of fraud, it is fairly easy to get physician records, but financial records are much more difficult to get. Agency investigations need to be timelier. He added that he wanted to go on record as saying that the formula used by the state to determine the

degree of overpayment is flawed. If there is a required repayment, it is usually because of a clerical error. He said the Agency needs to make a distinction and send a letter to those providers saying, No Fraud Detected!

Justin Senior advised that while fraud and abuse are often lumped together, they are two separate issues. Fraud is much more serious and offenders are investigated by the Attorney General's Medicaid Fraud Control Unit for legal prosecution. Abuse cases are less serious and usually result from billing errors and mistakes. These cases are investigated within Medicaid.

Chris Chaney added that we all need to be good stewards of the state's money.

Update on Legislative Budget Requests

Phil Williams provided an update on AHCA's Legislative Budget Requests and Reduction Exercises. Mr. Williams explained that for FY 2013-2014, the Agency is **r**equesting $21.98 billion and 1,655 full time equivalent (FTE) employees. These requests are grouped as follows:

- Improve efficiency and effectiveness of current processes
  - Managed Care Network Verification - $1.5 million
  - Online Licensing and Reconciliation System - $1.7 million
  - Background Screening Grant - $496,931
  - Medicaid Electronic Health Records Incentive Program - $77.9 million

- Implement long-term programs that help improve the Medicaid Program
  - Planning for Diagnosis Code Conversion - $6.9 million
  - Enrollment Broker Services for Statewide Medicaid Managed Care –$6.9 million
  - Transfer Waiver Category Funding to the Agency - $557.9 million
  - Transfer Waiver Funding to Implement Long Term Care - $194.4 million

- Address increased workload
  - Consultant for Medicaid Reform - $420,000
  - Supplemental Appropriation for Legal Representation - $4.4 million

Referring to the information provided on funds being requested for Enrollment Broker Services, Ann Swerlick asked if these funds are for additional services. Mr. Williams advised that as additional individuals move under Medicaid Managed Care, additional staffing will be needed to appropriately counsel individuals on selecting the best plan for meeting their needs.

Paul Belcher asked about Managed Care Network Verification, and Mr. Williams explained that it is an up-front submission of providers within a network. This allows AHCA to use an automated system to confirm the adequacy of the network and to assist recipients by providing information to help them select a plan based on network providers.

Dr. Robert Payne asked if dentists were eligible to receive electronic record incentives, and if any dentists have received incentive funds under the Medicaid Electronic Health Records (EHR) Incentive Program. Mr. Senior advised that he would find out and provide a follow-up at the next meeting.

Dr. Payne also inquired as to why all hospitals have not received incentive funds. He was advised that

not all hospitals applied to participate in the Medicaid Electronic Health Records Program, and others may not have met the required standards. At Mr. Williams' suggestion, staff from the Florida Center will be invited to provide an update on the Medicaid Electronic Health Records Program at our next meeting.

Mr. Williams then explained that for FY 2013-2014, the Agency was required to complete a 5% Targeted Budget Reduction Exercise equaling $327,808,437 (State Funds). He reiterated that this was the Agency's response to an exercise, and not part of the legislative budget request.

- Reduce Reimbursement Rates
  - Hospital Outpatient - $119.5 million
  - Nursing Home - $274.3 million
  - ICF/DD - $17.0 million
  - Clinic Services - $16.1 million
  - Occupational Therapy Services - $629,391
  - Speech Therapy Services - $962,747
  - Respiratory Therapy Services - $351,230

- Limit Eligibility to Certain Eligibility Groups
  - Medically Needy - $119.5 million
  - Pregnant Women - $35.4 million

- Elimination of Certain Optional Services
  - Eliminate Chiropractic Program - $758,171
  - Eliminate Podiatric Program - $2.7 million

- Reductions as a Result of Administrative Efficiencies
  - Companion to Issues Proposed by Other HHS Agencies - $557.9 million
  - Reduce Florida Healthy Kids' TPA Contract - $2.9 million
  - Reduce Other Personal Services Category - $1.2 million
  - Reduce Contracted Services Category - $556,809
  - Eliminate Subscriber Assistance Panel - $192,319 and 2 FTE

Ms. Martha Pierce asked if podiatric services provided in nursing homes would be cut. Mr. Williams explained that all podiatric services would be eliminated, if this item is included in the final approved budget. Dr. Thacker asked to go on record requesting that podiatric services not be eliminated, but a spending cap be established for these services. Dr. Thacker further noted that it would be difficult for nursing homes and intermediate care facilities to have their budgets cut, and have additional legislative mandates added.

Pending State Plan Amendment Related to Overlay Services Available to DJJ Youth

Following up on the presentation made by Gayla Sumner, PhD with the Department of Juvenile Justice (DJJ) at the July meeting of the MCAC, Bill Hardin, with AHCA's Bureau of Medicaid Services, provided an update on the pending State Plan Amendment related to overlay services available to DJJ Youth.

Mr. Hardin advised that the application for these services was submitted to CMS as a combination SPA/Waiver, known as a 1915I Waiver. He added that CMS has until March 28, 2013 to approve or deny the request. Under this waiver, services would include mental health coverage in the community with parental involvement. He added that it is anticipated that 366 youth will participate in the pilot.

Dr. Thacker asked how medical coverage for DJJ youth is handled and where kids go when released from the DJJ system, with specific interest in the percentage of youth that return to the system. Mr. Hardin explained that while in a DJJ facility, Medicaid coverage is suspended and the youth is covered through DJJ. However, when the youth is released, Medicaid services are restored. At Mr. Hardin's recommendation, Gayla Sumner, PhD will be asked to provide additional information at the next meeting.

Paul Belcher then asked if the 1915I Waiver would include Statewide Inpatient Psychiatric Program (SIPP) patients. Mr. Hardin advised that the 1915I Waiver will allow flexibility to divert SIPP type programs into home and community based services.

Health Insurance Exchanges

Justin Senior noted that the Affordable Care Act mandated that states have a Health Insurance Exchange, but allowed states three options in establishing the Health Insurance Exchange:

1. The federal government would establish the Health Insurance Exchange
2. The state would establish the Health Insurance Exchange
3. There would be a federal/state partnership

Mr. Senior further explained that the Health Insurance Exchange will serve as a marketplace where health insurance products can be purchased. It will also provide information on Medicaid subsidies and eligibility.

Florida has not made a decision as to how the Health Insurance Exchange will be handled. The decision must be made by the Governor and Legislature. However, if it is decided that the state will be responsible for the Health Insurance Exchange, AHCA will probably not be the responsible agency.

Mr. Senior added that Health Insurance Exchanges are required to be up and running by October 1, 2013, with choice opportunities available by January 1, 2014.

Access/Continuity of Care, and Provider Credentialing

Melanie Brown-Woofter explained that Florida Medicaid recipients currently receive medical services through one of the following systems: Fee-for-service, MediPass, or Managed Care. The 2011 legislature directed the Agency for Health Care Administration to create the Statewide Medicaid Managed Care (SMMC) program. This SMMC program is designed to emphasize patient centered care, personal responsibility, and active patient participation; provide for fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program; and implement innovations in reimbursement methodologies, plan quality and plan accountability.

Ms. Brown-Woofter further explained that the responsibility for credentialing network providers, as well as conducting background screenings has been delegated to the plans. Plans are required to

credential providers when they join the plan and again every 3 years. If providers participate in multiple plans, they must be credentialed by each plan. In addition to being a Medicaid provider, a provider can also be a MediPass provider. However, after being enrolled as a Medicaid provider, there is an additional credentialing process in order to also be a MediPass provider.

Stan Whittaker shared his concerns with how the Medicaid Managed Care Waiver would impact the role of Nurse Practitioners. He noted that currently Nurse Practitioners encompass 20% of the Medicaid workforce, serving thousands of Medicaid patients. While many Nurse Practitioners have their own practices, they work with and through physicians, some of whom do not accept Medicaid. These Nurse Practitioners provide Medicaid services that are directly reimbursed under fee for service from Medicaid. However, under the new managed care system, Nurse Practitioners will not be able to continue to provide care to Medicaid recipients, unless the physicians, with whom they work, become Medicaid providers.

Ms. Brown-Woofter noted that Nurse Practitioners can be individually credentialed, but must work under the supervision of a credentialed Medicaid provider. She noted that changes may need to be made in the Nurse Practitioners Act, to address Mr. Whittaker's concerns.

Dr. Thacker asked who sets the fee scales and if there are any exclusionary issues with the plans related to who is excluded or included. He was advised that fee scales are set by Plans and Providers, and that AHCA sets the maximum number of recipients in each plan, and plan enrollment cannot exceed that number. However, plans do not pick and choose which recipients to service. Recipients choose their plans.

Dr. Payne asked how many Managed Care Plans there are in Florida, and Melanie advised there are 23 Managed Care Plans statewide.

Mr. Whittaker asked what will happen to MediPass under Statewide Managed Care. Ms. Brown-Woofter advised that under Statewide Managed Care, MediPass would be going away, but Fee-for-Service Medicaid and Managed Care would continue.

Review of HMO Marketing and Prohibitions

Melanie Brown-Woofter then provided an overview of HMO Marketing, explaining that under the current 2012-15 Health Plan Contract, permitted and prohibited marketing activities are identified as follows:

- Permitted Health Plan Marketing Activities
    - Health Plan participation in health fairs/public events
    - Health Plan distribution of community outreach materials
    - Branding advertisements (print, fliers, posters, radio and television) approved by the Agency
    - Health Plans may have registered community outreach representatives that attend the health fairs/public events

- Prohibited Health Plan Marketing Activities:
    - Engaging in marketing practices that are discriminatory (based on actual or perceived health status per sections 409.912 and 409.91211, F.S.)

- Registered marketing agents
- Contacting recipients directly or indirectly - no “cold calls”
- Offering gifts for enrollment
- Giving away promotional items in excess of $5
- Paying commission to community outreach representatives for new health plan enrollees
- Dissemination of materials that are fraudulent or misleading (example – stating that a recipient must enroll in the health plan or lose Medicaid benefits)

Next Meeting

The next meeting has been tentatively scheduled for Tuesday, May 28, 2013. The following topics were suggested:

- Update from DJJ
- Update on Medicaid Electronic Health Records Program
- Legislative Update
- Waiver Update
- Encounter Data
- Neurological Injury Compensation Association Funds (NICA) and Transitional Living Facilities
- Accountable Care Organizations – Explanation of the Concept

Adjourn

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