Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, May 28, 2013
1:00 PM – 4:00 PM
AHCA Conference Room C

Participants/Invitees

Members Present

Martha Pierce
Amy Guinan
Jennifer Lange
Ellen Anderson
Catherine Moffitt, MD
Robert Payne, DDS
Stan Whittaker

Members Not Present

Secretary Chuck Corley
DOH Representative
Richard R. Thacker, DO

AHCA Staff Present

Justin Senior
David Rogers
Stacey Lampkin
Karen Chang
Heidi Fox
Marie Donnelly
Ronique Hall
Michele Logan
Carla Sims

Welcoming Remarks/Introductions

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

Old Business

- **Review of January Meeting Minutes**

Carla Sims explained that the minutes of the January 29, 2013, MCAC meeting had been sent to committee members for review in February, 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.

- **Neurological Injury Compensation Association Funds (NICA) and Transitional Living Facilities**

Ms. Sims shared that at the last MCAC meeting Dr. Richard Thacker requested information on the use of Neurological Injury Compensation Association (NICA) Funds by Transitional Living Facilities.

Referring to the handout information provided by David Oropallo with the Agency for Health Care Administration's Health Quality Assurance office, Ms. Sims noted that the Neurological Injury Compensation Association was created by the Florida Legislature in 1988. NICA is a statutory organization that manages the Florida Birth Related Neurological Injury Compensation Plan used to pay for the care of infants born with certain neurological injuries. NICA ensures that birth-injured infants receive the care they need while reducing the financial burden on medical providers and families.

Ms. Sims also noted that only physicians are identified on the NICA web links, as participating providers. It appears Transitional Living Facilities in Florida are not receiving monies directly from this fund.

- **Accountable Care Organizations – Explanation of the Concept**

Next on the agenda was a brief overview of Accountable Care Organizations (ACOs) by David Rogers, Assistant Deputy Secretary for Medicaid Health Systems. Mr. Rogers noted that ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs function similarly to Provider Service Networks (PSNs) in Medicaid.

Medicare offers several ACO programs, with contract arrangements usually lasting 3-5 years. Mr. Rogers mentioned the following ACO programs:

- Medicare Shared Savings Program (MSSP), which is a group of providers that offer a tangible structure to deliver care to Medicare beneficiaries. Similar to fee for service (FFS) structure in Medicaid.

- Pioneer ACO Model, which is a program designed for early adopters of coordinated care. This model uses more mature/established systems.

Participating in an ACO is purely voluntary for providers. In addition, individuals participating in a Medicare ACO maintain all their Medicare rights, including the right to choose any doctors and providers that accept Medicare.

For additional information on ACOs, Mr. Rogers suggested committee members visit the CMS Accountable Care Organization website at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

Dr. Payne asked if there are ACOs in Medicaid, and Mr. Rogers advised that the term, Accountable Care Organizations (ACOs), is strictly a Medicare term. However, Provider Service Networks (PSNs) in Medicaid function similarly.

Dr. Payne then asked if there were at least 23 applicants to provide statewide managed care. Mr. Senior stated that here were more than 23. He then reminded meeting participants that the Agency is in a blackout period with regard to discussing Managed Medical Assistance (MMA), and that he would therefore not be able to answer any questions in that regard.

- **Update from Department of Juvenile Justice (DJJ) on Where Kids Go When Released**

Carla Sims advised participants that questions were asked at the last Medical Care Advisory Committee meeting related to DJJ youth. While DJJ staff were unable to make the meeting, they provided the following information:

- In response to the question posed by the Committee related to where youth live once released from DJJ services, DJJ staff advised that they do not maintain this information in the Juvenile Justice Information System (JJIS). However, based on information in JJIS, they know the youth's home county, as well as the program type of the youth's next placement following completion of a residential commitment program (if they have one). They also provided a table showing the number of youth that completed a residential program in FY 2010-11, which is the most recent completion/release information available, that identifies the youth's home county and next program placement.

  In addition, DJJ advised that in FY 2010-11, 5,737 youth were released from residential programs. Of those, 90% (5,184) completed the residential program.

- In response to the question from the Committee related to the percentage of youth that return to DJJ facilities or enter the criminal justice system, DJJ staff advised that of the 5,184 youth that completed a residential program in FY 2010-11, 41% (2,111) recidivated (reoffended) within twelve months of program completion.

Dr. Moffitt said she would like to know, of those youth that return to DJJ facilities or enter the criminal justice system, how many enter because of a crime versus a violation of probation. She also asked if there is data available related to substance abuse.

Amy Guinan requested information on whether Redirection could be a better option for some at-risk delinquent youth who are currently applying for SIPP services as an alternative residential detention.

Stan Whittaker asked if there is information available on how many youth in DJJ custody have comprehension problems.

Dr. Payne said he would be interested in finding out whether there are overlapping issues.

Finally, Dr. Moffitt asked Justin Senior if the Committee could make recommendations to other agencies. Mr. Senior said he was not sure, but would look at the committee charter for direction.

Carla Sims advised that these questions would be directed to appropriate staff and responses would be provided at the next meeting.

New Business

- **Legislative Update**

Mr. Senior provided an update on recent legislation affecting Medicaid, and briefly discussed the following:

- Diagnosis Related Group (**DRG**) System- The agency has been charged with implementing a plan, by July 1, 2014, to convert Medicaid inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis-related groups (DRG) and assigns a payment weight based on the average resources used to treat Medicaid patients in that DRG. Payments will be increased, where necessary.
- Graduate medical education will now be paid separately.
- With regard to Medicaid expansion, the legislators did not vote to expand Medicaid.
- A certain group of children in the Children's Health Insurance Program (**CHIP**) services will be included in Medicaid.
- Legislation on the dental care "carve out" did not pass during the legislative session. There are still 2 Prepaid Dental Health Plans (**PDHPs**) to choose from for coverage: MCNA and DentaQuest. Beginning July 1, 2013, there will no longer be a Fee for Service option. However, dentists will have to honor any existing appointments for a 30 grace period (once an individual goes into a prepaid dental plan) for continuity of care purposes, even if the dentists don't work with the dental plans.

Amy Guinan asked if any of the HMOs are contracting with the prepaid dental plans, and if any beneficiaries opted out of the two dental care choices. Justin Senior advised that 8% of beneficiaries chose to opt out of the prepaid dental and go with FFS dental care.

- Statewide Managed Care will be in place throughout Florida by the October 14, 2014 deadline.
- The legislature also approved a primary care rate increase. Mr. Senior noted that physicians can receive the new rate increase on claims going back to January 1, 2013, if they complete the attestation form by May 31, 2013. The increased rate is equal to the Medicare rate. The required attestation form is available on the AHCA website.

Stacey Lampkin also mentioned that physicians in FFS and Managed Care will both eventually be able to receive the rate increase. However, Managed Care is still in process and has not yet received approval from Federal CMS.

Dr. Payne asked if the federal poverty level is going up to 133%, to which Justin Senior advised, the level is now 133% for children over 5, but under 19. The legislature did not vote to pass it, so it is not currently available for adults.

- Mr. Senior also noted that the Affordable Care Act gave states the option to create their own website for comparing and buying insurance policies, or using the federal system. The State of Florida has selected to use the federal system, which is called the Federally-Facilitated Marketplace (FFM), also known as the "Marketplace" or "Health Care Exchange". To participate with the Marketplace, insurance companies must be a Qualified Health Plan (QHP) approved by the US Department of Health & Human Services (HHS).

  Starting in October 2013, individuals will be able to access the Florida's FFM website to see what health plans are available in your area, find out if they're eligible for financial assistance, get quotes for the cost of each plan, and apply for an insurance policy.

Amy Guinan asked if there is an opportunity for children to opt out of Medicaid and stay with Healthy Kids. Justin said that there is currently not an option to do that. It would require an 1115 Waiver.

Ms. Guinan then asked if kids in Medicaid due to being in foster care would be affected, since the legislature did not act on legislation related to their care. Jennifer Lange advised that since such care is required by federal law, the state does not have to act on the legislation. However, if there are significant household changes, like tax filing, income, etc., Medicaid eligibility could be affected.

- **<u>Waiver Update</u>**

Justin Senior then provided a waiver update, advising that the 1915(b) Managed Care Waiver and the 1915(c) Home and Community Based Services Waiver were approved by CMS.

He further advised that Long-term Care (LTC) enrollment begins August 1, 2013 in Area 7/Orlando, with the timeline set to roll out the entire state between August 1, 2013 and March 1, 2014.

AHCA has received a letter of agreement from the Federal Government regarding the 1115 waiver. Additionally, he noted that either within the 1115 waiver or an amendment to the "(b)(c)" waivers, a sub-committee of the MCAC will be formed for the purpose of discussing Long-term Care issues. Stan Whittaker asked if Managed Medical Assistance (MMA) will be like a "Medical Home" model. Justin said that it would be safe to say that is a possibility. Long-term Care and MMA contracts are 5 years in length.

Amy Guinan asked if handbook changes are waiting on MMA. Mr. Senior advised that the handbooks are not waiting on MMA, but that the process to make changes to the handbooks is lengthy and time consuming.

- **MEDS-AD 1115 Research and Demonstration Waiver**

Marie Donnelly, with the Bureau of Medicaid Pharmacy Services, shared information on the MEDS-AD 1115 Research and Demonstration Waiver. Referring to the handout materials she provided meeting participants, Ms. Donnelly explained that the MEDS-AD Program provides Medicaid eligibility for individuals who:

- Are disabled or age 65 or over
- Are also receiving Medicaid-covered institutional care services, hospice services, or home and community-based services
- Have incomes that do not exceed 88 percent of the federal poverty level and assets that do not exceed $5,000 for individuals or $6,000 for couples

She noted that renewal of the waiver would allow the Agency to maintain eligibility for this population, and all services would continue as in the current program. The renewal will not impact any other eligibility or service provisions of the Agency's Medicaid or CHIP programs.

In order to continue to provide Medicaid eligibility for this group, the Agency must obtain federal approval to renew the MEDS-AD Program, which is currently set to expire December 31, 2013. However, the renewal application must be submitted 6 months prior to the expiration date.

Ms. Donnelly also advised that the public notice document concerning this renewal request, instructions for how to submit comments, and a link to the Federal Centers for Medicare and Medicaid Services can be found at http://ahca.myflorida.com/Medicaid/index.shtml .

- **Family Planning Waiver**

Ronique Hall, with the Bureau of Medicaid Services, provided an overview of the Family Planning Waiver (FPW).

Ms. Hall noted that the FPW expands the provision of family planning and family planning-related services to women ages 14 through 55, losing their Medicaid coverage, who:

- Have family income at or below 185 percent of the Federal poverty level;
- Are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP) or health insurance coverage that provides family planning services.

Services available through the waiver include:

- Physical exams
- Family planning counseling and pregnancy tests
- Birth control supplies
- Colposcopies and treatment for sexually transmitted diseases
- Related pharmaceuticals and laboratory tests

Through this waiver the Agency expects to increase access to family planning services; increase child spacing intervals through effective contraceptive use; and reduce the number of unintended pregnancies in Florida.

Ms. Hall noted that extension of the waiver will allow the Agency to continue providing family planning services to the eligible population, and will not impact any other eligibility or service provision of the Medicaid or CHIP programs.

In order to continue to provide Medicaid eligibility for this group, the Agency must obtain federal approval to extend the Family Planning Waiver, which currently expires December 31, 2013. However, the extension application must be submitted six months prior to the expiration date.

A Family Planning Waiver Application may be accessed from the Department of Health website at http://www.doh.state.fl.us/family/famplan/waiver.html.

Stan Whittaker asked what providers can participate in this program, and Ms. Hall replied that this will be an extension to continue existing services, not to change anything. The same providers that are participating now will continue to provide these services: ARNPs, FQHCs, etc.

- **Update on Medicaid Health Information Technology**

Heidi Fox with the Florida Center for Health Information and Policy Analysis provided an update on Health Information Technology, specifically discussing the Health Information Exchange (HIE) and Electronic Health Records (EHR) Incentive Program.

Ms. Fox explained that the Florida HIE provides infrastructure for the exchange of health care information. Through the Florida HIE, participating providers will be able to exchange patient information regionally, statewide, and on a national level. This will enhance communications among physicians, hospitals, laboratories, health plans and pharmacies regardless of their location.

The Florida HIE is implementing two health information exchange services, the Patient Look-Up (PLU) service, and Direct Secure Messaging (DSM). The PLU service enables the search and retrieval of a patient's longitudinal health information. Using PLU, providers can query patient health records made available for patient look-up by other participating health care organizations and data sources. There is no central database of patient records. Providers, with patient permission, search for records using patient demographic information. Direct Secure Messaging is a service that encrypts electronic messages and allows for the secure transmission of emails including attachments. DSM enables the "push" of clinical documents and other patient information related to treatment, payment, and health care operations to other providers and health plans.

She also discussed the Florida Medicaid Electronic Health Records (EHR) Incentive Program. Through this program, incentive payments of more than $330 million have been paid to providers and hospitals that have adopted, implemented, or upgraded to a certified electronic health record system and demonstrated the ability to meaningfully use the technology. Ms. Fox also noted that 30% of Florida providers are participating in this initiative to adopt and use electronic health records either through the Medicaid or Medicare programs.

Stan Whitaker stated that when an ARNP doesn't have a DEA license, and they use the system, they get penalized 1-2%, and asked if there is any action to help with this penalty. Ms. Fox suggested that

this was outside the scope of the incentive program and that he contact the Department of Health, as they provide the license.

- **Encounter Data**

Karen Chang, Bureau Chief for Medicaid Program Analysis, provided an update on Encounter Data, explaining that Encounter Data is required by federal and state mandate and includes:

- Records of services provided to health plan enrollees.
- Documentation of health service utilization; procedures, diagnoses, dates of service, demographics, amounts and frequency of services.
- Documentation of amounts paid to rendering service providers.
- Claims submitted to the health plan are translated to electronic transactions and submitted to Florida Medicaid Management Information System.

Ms. Chang noted that encounter data collection began in 2006, and must be in federally mandated HIPAA compliant formats. Pharmacy encounter data must be in National Council for Prescription Drug Programs (NCPDP) format, version D.0. All other encounters must be in the 5010 version of X12 Professional (837-P), Institutional (837-I) and Dental (837-D) transactions.

She further noted that Prepaid Mental Health Plans **(**PMHPs**)** began submitting encounter data electronically in July 2012, and Nursing Home Diversion (NHD) Plans began submitting electronically September 2012.

As of May 2013, a total of 224,962,398 encounter claim lines have been processed.

Encounter data uses include:

- Measurement of service utilization.
- Focus on performance issues such as increased access to care and better coordination of care.
- Fraud and abuse prevention and detection.
- Cost analyses, risk adjustment and rate-setting.
- Foster process improvement and policy decision making process.
- Better cost predictability based on risk models.
- Information and analytical support for other policy bureaus.

Ms. Chang explained that:

- Fee-for-Service providers are required to submit claims directly to the Agency's fiscal agent (HP) for payment.
- Providers within a health plan network submit claims directly to that health plan.
- The health plan is required to submit the encounter to the Agency within 60 days of the end of the month in which the health plan adjudicated the claim and within 15 days after the end of the month in which a pharmacy encounter is adjudicated.

Additionally she stated that Encounter data is required, as mandated for all Statewide Managed Care Plan Types, including:

- Long-term Care
- Managed Medical Assistance

- Comprehensive
- Specialty Plans

Stan Whittaker asked if encounter data could be entered for ARNPs instead of physicians, to which Ms. Chang responded that the encounter data has to follow federal guidelines. If a physician submits his information on the encounter, then that is the only information the Agency receives/sees. If the provider/plan includes the ARNPs information it would be used.

Dr. Catherine Moffitt said she would take a request back to the Health Plan Association for considering the idea of allowing PAs, ARNPs, etc. to be added to the data.

Dr. Payne suggested that when reviewing encounter data, attention should be paid to the actual procedures not just the number of encounters. This helps determine the type of care that is being performed.

Dr. Moffitt asked if there would be connectivity between AHCA and claims data, to which Karen Chang responded that we do not have such connectivity at this point. We are currently exchanging clinical data.

Amy Guinan asked if AHCA collects data showing the number of denials. Ms. Chang responded that denial for service information is only collected if it is part of another encounter. However, it can possibly be included in the future.

Stan Whittaker asked if additional fields could be added to track encounter data for Nurse Practitioners and Physician Assistants. Ms. Chang advised that yes, additional information can be added in the loops of data, but that uniformity in the use of these optional fields would be critical.

Next Meeting

The next meeting has been tentatively scheduled for Tuesday, September 24, 2013. The following topics were suggested:

- Update from DJJ regarding:
  - Returning youth to Medicaid
  - SIPP/1915I Redirection
  - Substance abuse and reoffending
- Legislative Update
- Waiver Update
- 1115 MMA Waiver Renewal Update

Adjourn

At 3:15 p.m. the meeting was adjourned.