Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, June 7, 2011
1:00 PM – 4:00 PM
AHCA Conference Room B
Participants/Invitees

Members Present

Martha Pierce
Jennifer Lange
Anne Swerlick
Catherine Moffitt, MD
Robert Payne, DDS
Richard R. Thacker, DO
Paul Belcher
Secretary Chuck Corley

AHCA Staff Present

Roberta Bradford
Phil Williams
Darcy Abbott
Mike Bolin
Shevaun Harris
Rachel Lacroix
Debbie McNamara
Jenna Eddy
Carla Sims

Non-Members Present

Ray Lancaster
Ben Carotenuto
Rachel Bentley
Mary Pat Moore
Jim Saunders
Gary Rohrer
Kirsti Satterstrom
Rod Teat
Lynn Hatter
David Rogers
William Hightower
Tim Stanfield
Christine Sexton

Welcoming Remarks – Roll Call

The Medical Care Advisory Committee (MCAC) meeting began with welcoming remarks by Deputy Secretary for Medicaid, Roberta Bradford, followed by a roll call of committee members.

Minutes

Carla Sims advised that the minutes of the January 18, 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 the committee, a motion was made and seconded for approval of the minutes.

Legislative Update

Roberta Bradford then provided an update on managed care legislation, explaining that during the 2011 Legislative Session, the House and Senate passed House Bill (HB) 7107 and HB 7109, which were signed into law by Governor Rick Scott.

This legislation, which goes into effect July 1, 2011, requires the state Medicaid program to implement a Statewide Medicaid Managed Care Program. Implementation of the new Statewide Medicaid Managed Care Program must be underway by July 1, 2012, and must be complete by October 1, 2014.

The legislation also expands and improves Florida's current managed care program. The state currently contracts with 25 Medicaid Managed Care plans: 19 Health Maintenance Organizations (HMOs) and 6 Provider Service Networks (PSNs).

There are two key components to the new Statewide Medicaid Managed Care Program:

- the Long Term Care Managed Care Program
- the Managed Medical Assistance Program

The goals of the new Statewide Medicaid Managed Care Program are: to provide improved coordination of care; enhanced accountability; recipient choice of plans and benefit packages; flexibility to offer services not otherwise covered; and enhanced fraud and abuse prevention.

All Medicaid recipients are required to enroll in a managed care plan unless specifically exempted in the legislation. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

The legislation also identifies recipients that will be required to enroll in a Long Term Care or Managed Medical Assistance plan, those that may voluntarily enroll in these plans, and those excluded from enrolling in these plans.

Those recipients required to enroll in either a Managed Medical Assistance plan or a Long Term Care plan include, but are not limited to:

- Temporary Assistance for Needy Families (TANF)
- Children with chronic conditions, including foster care children
- Pregnant women
- Medically Needy recipients
- Individuals with Medicare coverage (Medicaid acts as a secondary payer)
- Persons eligible for Medicaid by reason of a disability, excluding the Developmentally Disabled (DD) population

Medicaid recipients who may voluntarily participate in the program, but are not required to enroll, include, but are not limited to:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare
- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities
- Medicaid recipients enrolled in or waiting for the home and community based services waiver for the developmentally disabled
- Medicaid recipients who are residents of a developmental disability center

Medicaid recipients excluded from enrollment in the Statewide Medicaid Managed Care Program, include, but are not limited to:

- women who are eligible only for family planning services
- women who are eligible only for breast and cervical cancer services
- persons who are eligible for emergency Medicaid for aliens
- children receiving services in a prescribed pediatric extended care center

Ms. Bradford noted that the Agency is also required to select a limited number of eligible plans to participate in the Statewide Medicaid Managed Care Program. Separate contracts will be procured for Long Term Care Managed Care plans and Managed Medical Assistance plans in each of the 11 regions. This is being accomplished through invitations to negotiate (ITN).

The following health plans are eligible to participate in the Statewide Medicaid Managed Care Program:

- Health Maintenance Organizations
- Provider Service Networks
- Accountable Care Organizations
- Exclusive Provider Organizations
- Medicare Advantage Plans that exclusively service Medicaid recipients
- Program of All-Inclusive Care for the Elderly
- Children's Medical Services Network

A question was then raised by Dr. Richard Thacker regarding federal approval of the current Medicaid Managed Care 1115 waiver. Ms. Bradford advised that the waiver is still being reviewed by CMS and that they have indicated approval would be provided by June 30, 2011.

Ms. Martha Pierce asked about the Developmentally Disabled (DD) Waiver and noted that she had heard there was a shortfall in funds to cover services for the developmentally disabled. Ms. Bradford advised that the DD waiver is handled by the Agency for Persons with Disabilities (APD), but that any short fall had been addressed by the legislature. Phil Williams added that he would contact APD and get back to Ms. Pierce.

Anne Swerlick asked if there were provisions for Medically Needy and MediPass. Ms. Bradford noted that once the new Managed Care Program is underway, the vision is to have these be part of the plan.

Ms. Bradford also noted that the Agency is looking at the provisions of HB 7109, but that this would require a separate federal approval process.

Paul Belcher asked if the Medically Needy spend down level was equal to the premium. Jennifer Lange stated that the answer to that question is a little tricky, since it depends on whether the premium is more or less than the Share of Cost.

Anne Swerlick asked how much AHCA pays the plans. Ms. Bradford noted that it was different depending on whether it was TANF or SSI, but it averaged about $200 per member per month.

Dr. Richard Thacker said he did not think Managed Care would be any more efficient. The big problem is getting providers to sign up to accept Medicaid.

Dr. Moffitt noted that the idea behind Managed Care was not to penalize providers, but to focus on evidence based care, providing the right care to the right person at the right location by the right provider.

Public Input Process

Ms. Bradford further explained that the Agency for Health Care Administration is required to seek federal authority to implement the Statewide Medicaid Managed Care Program. The application requesting federal authority must be submitted by August 1, 2011.

Additionally, the Agency is required by law to allow 30 days for public input prior to August 1, 2011. The Agency has opened this opportunity to the public in the following ways:

- **Public meetings**

  The Agency scheduled public meetings in each of the 11 Medicaid regions throughout the state. By law, these meetings must be advertised in the Florida Administrative Weekly for at least seven days. The notice was published on June 3, 2011 for all 11 meetings to be held June 10 – 17, 2011. Attendees will be given the opportunity to provide input at those meetings, which will be collected for consideration in the federal application.

- **Internet access**

  The presentation that will be shared at the start of each public meeting will be available on the Statewide Medicaid Managed Care Website. To access this information, visit http://ahca.myflorida.com and click the "Statewide Medicaid Managed Care" tab located on the left.

- **Email and mailing**

  Written comments can also be submitted by email to:
  FLMedicaidManagedCare@ahca.myflorida.com
  or by mail them at:

  Statewide Medicaid Managed Care Program
  Office of the Deputy Secretary for Medicaid
  Agency for Health Care Administration
  2727 Mahan Drive, MS #8
  Tallahassee, FL 32308

Budget Update

Referring to the budget handout provided, Phil Williams pointed out changes in the following line items:

Item 14 Health Maintenance Organization Rate Reduction
Item 21 Institutional Provider Unit Cost Freeze
Item 22 Hospital Inpatient Rate Reduction 12%
Item 23 Hospital Outpatient Rate Reduction 12%
Item 24 Nursing Home Rate Reduction 6.5%
Item 25 Intermediate Care Facilities for the Developmentally Disabled Rate Reduction 5%
Item 26 County Health Department Rate Reduction 10%
Item 37 Non Emergency Transportation Rate Reduction
Item 48 Medicaid Electronic Health Record Incentive Program Funding
Item 57a Increased Dental Service Fees

Medicaid Encounter Data System (MEDS) Update

Debby McNamara and Jenna Eddy, with the Bureau of Quality Management, then provided information on the Medicaid Encounter Data System (MEDS). Jenna explained that encounter data are electronic records of Medicaid-covered services provided to enrollees of, and paid by, a capitated health plan. The encounter data is submitted in federally-mandated HIPAA-compliant format from the MCO's (Managed Care Organization's) data system to the Florida Medicaid Management Information System (FMMIS).

Jenna further explained that MEDS was established to collect, process and store the encounter data to support reporting and information requests, including:

- Service utilization trends
- Quality of care
- Access to care
- Cost, rate and risk models

She noted that Fee-for-Service providers are required to submit claims directly to the Agency's fiscal agent, Hewlett Packard (HP), for payment, while providers within a MCO network submit claims or report encounters directly to that MCO. MCOs are then required to report complete and accurate data to the Agency within 60 days to ensure MCO data reflects the services paid by the plan.
Types of data collected include:

- Pharmacy - NCPDP format
- Professional (837-P), institutional (837-I) and dental (837-D) claims - X12 format, version 4010

Jenna added that Encounter Data collection began on July 1, 2008, with data processed for errors before being added into the system. As of May 19, 2011, a total of 100,979,227 encounter claims had been processed.

She also noted that preparations are underway for collecting Nursing Home Diversion (NHD) and non-emergency transportation encounter data and that Agency staff is currently working on migration to new HIPAA-compliant 5010 format, and NCPDP 'Version 1' format in 2011.

Additional information is available on the Encounter Data Website which can be accessed at: http://ahca.myflorida.com/Medicaid/meds/index.shtml.

Dr. Payne added that while encounter data is good he would suggest that when working with providers data should be provided by procedure code not just encounters.

Medicaid Prior Authorization Update

Shevaun Harris, with the Bureau of Medicaid Services, shared that beginning June 1, 2011, the Agency for Health Care Administration (Agency) entered into a contract with eQHealth Solutions, Inc. for utilization management, including prior authorization of the following services:

- Inpatient Medical and Surgical Services
- Home Health Services
- Prescribed Pediatric Extended Care (PPEC) Services
- Therapy Services

Ms. Harris advised that the primary purpose of this contract is to safeguard against the unnecessary medical services or inappropriate use of Medicaid. eQHealth Solutions, Inc. replaced Keystone Peer Review Organization, Inc. (KePRO) as the Medicaid vendor for prior authorization of inpatient and home health services.

eQHealth Solutions, Inc. has been the Centers for Medicare & Medicaid Services' Quality Improvement Organization (QIO) for Louisiana for over twenty-three years and has contracts for utilization management and peer review activities for the Medicaid programs in Mississippi and Illinois. In addition, eQHealth Solutions is accredited through the Utilization Review Accreditation Commission (URAC). eQHealth Solutions, Inc. is a non-profit health care quality improvement, utilization management, and health information technology organization, providing a wide range of services to their clients. Services include: prior authorization and utilization review, care coordination, quality improvement activities, medical record review, health and wellness, and quality review services for home and community based waiver programs.

Mike Bolin, also with the Bureau of Medicaid Services then briefly discussed the Utilization Management for Advanced Outpatient Diagnostic Imaging Services contract which was executed on May 24, 2011, with an effective date of August 1, 2011. There will also be a 60-day period for the implementation of the contract and a 60-day period to provide prescriber training and outreach.

Some of the benefits of Utilization Management for Advanced Outpatient Diagnostic Imaging Services are that it will:

- Provide a layer of protection to prevent billing for services that were not rendered by having prescribers request prior authorization for a procedure,
- Prevent needless overexposure to radiation,

- Reduce the number of unnecessary tests, and
- Ensure that Medicaid dollars are spent wisely.

Mr. Bolin noted that advanced imaging includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Computerized Tomographic Angiography (CTA), and Computerized Tomography (CT), provided through hospital outpatient facilities and physician offices. During the negotiations with the vendors, adding the prior authorization of ultrasounds (OB and non OB) was also discussed.

These services will be prior authorized and the prescriber must submit medical justification before the patient can receive the service. The provider will be able to submit prior authorization requests via Web portal, fax, and the call center. The turnaround time for the prior authorization is one day. Because the prior authorization is for Outpatient Diagnostic Imaging, for any urgent situations patients should be directed to a hospital.

Suggested Agenda Items for Next Meeting

Carla Sims asked committee members for agenda items for the next meeting. The following suggestions were made:

- Medicaid Pharmaceutical and Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Board
- Governmental Structure
- Waiver Renewal Update
- Legislative Update
- Budget Update
- Updates on Federal Health Reform
- Health Information Exchange and Electronic Health Records/Incentive Rollout
- ICD 10
- Respiratory Syncitial Virus (RSV) and Synagis

Final Comments/Meeting Adjourned

Committee members and speakers were thanked for their participation in the meeting and at 4:00 p.m., the meeting was adjourned.