Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, August 31, 2010
1:00 AM – 4:00 PM
AHCA Conference Room C

Participants/Invitees

Members Present
Martha Pierce
Jennifer Lange
Amy Guinan
Robert Payne, DDS
Richard R. Thacker, D.O.
Paul Belcher
Joseph Chiaro, M.D.
Chuck Corley

Members Participating by Phone
Catherine Moffitt, M.D., F.A.A.P.

Non-Members Present
Mary Pat Moore
Jim Saunders
Judy Glisson

Staff Present
Tom Arnold
James McFaddin
Phil Williams
Beth Kidder
Melanie Brown-Woofter
Heidi Fox
Shelisha Durden
Michele Hudson
Catherine McGrath
Carla Sims

Introductions – Welcoming Remarks – General Discussion

The Medical Care Advisory Committee meeting began with introductions and welcoming remarks by Secretary Tom Arnold.

Secretary Arnold thanked committee members for the work they have done and explained that this would be his last committee meeting, as he was retiring. He further noted that Liz Dudek had been named Interim Secretary for the Agency for Health Care Administration effective the following day (September 1, 2010), and would be participating in future committee meeting.

He then turned the meeting over to Phil Williams, who thanked Secretary Arnold for all he had done for the Agency, the committee, and the citizens of Florida.

General Discussion (continued)

Continuing with introductory remarks and comments, Phil shared that Congress approved and the President signed into law an extension to the federal medical assistance percentage (FMAP). Congress extended the current stimulus FMAP that has been provided under the American Recovery and Investment Act, which had been a federal medical percentage of 67.64%, as well as the FMAP step down to 64.81% in January - March 2011. There will be another step down to 62.93% in April - June 2011. As a result, in state fiscal year 2010-2011, there will be a blended FMAP of 64.83%, which equates to the funding need of $509 million less general revenue. However, contingency language or back of the bill language assures full FMAP would continue.

Phil also advised that there are substantive legislative proposals underway by the Agency Management Team (AMT) and bureaus. The Agency is being asked to prepare a plan for reducing the 2010-2011 current year budget by 5% and the 2011-2012 budget by 15%. The target reduction equates to $950 million in state share and a $2.5 billion reduction overall. However, the agency must maintain all eligibility programs, so Medically Needy and Meds AD must be maintained, as part of this reduction requirement.

Minutes

Referring back to the agenda, Mr. Williams advised that the minutes of the May 18, 2010, MCAC meeting had been sent to committee members for review in advance of this 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.

Medicaid Reform Update

Phil noted that the next item on the agenda was an update on Medicaid reform. He added that at the last MCAC meeting in May, the Agency was working on the submission of a waiver renewal for the 1115 Medicaid Reform Waiver. That waiver renewal was submitted to the Centers for Medicare and Medicaid Services (CMS) on June 30, 2010. Since then the Agency has begun a dialogue with CMS on their review of that submission. Phil advised that the Agency anticipates that some changes will have to be made with regard to the Low Income Pool (LIP) program, and the Opt Out program. All of the special terms and conditions related to the Low Income Pool program are specific to years one through five of the waiver. There would need to be some revisions to special terms and conditions of the Low Income Pool program for the extension period. In addition, currently under the Opt-Out provision, if a family chooses the Opt-Out route, the terms of Employer-Sponsored Insurance apply to the entire family. If services for children provided by Medicaid are not available through the Employer-Sponsored Insurance, these services are not being provided to the children.

Referring to the August 17th letter from CMS, which was provided to meeting participants, Tom Arnold pointed out that in the last paragraph CMS stated that they look forward to working with the state in the coming months towards renewing the Florida Medicaid Reform Demonstration. He added that in his conversations with the management of CMS, they indicated that the waiver will be renewed in the timeframe necessary for the Florida Legislature to make decisions about what they want to do with any expansion of the Medicaid Reform Waiver.

Medicaid Health Information Technology Update

Referring back to the agenda, Phil introduced Heidi Fox, with the Florida Center for Health Information and Policy Development, who gave an update on Medicaid Health Information Technology.

Heidi explained that the American Recovery and Reinvestment Act provides funding to encourage eligible providers to adopt, implement and upgrade a certified Electronic Health Record (EHR) system. She then advised that her presentation would focus primarily on the HER incentive program.

Heidi noted that eligible professionals are non-hospital-based physicians, dentists, nurse practitioners, and certified nurse midwives, as well as physician assistants (PA) practicing predominantly in a Federally Qualified Health Center or Rural Health Clinic (FQHC) directed by a PA. Eligible professionals who practice in hospital owned outpatient clinics also qualify for the incentive program. She further noted that eligible professionals must meet the patient volume requirement of 30% Medicaid over a 90-day period. For pediatrician, the volume requirement is 20% Medicaid. Eligible professionals practicing in Rural Health Clinics or FQHC must have a patient volume of 30% needy individuals, while pediatricians in these settings must have a needy patient volume of 20%.

Eligible professionals may receive an incentive payment from either Medicaid or Medicare, but not both, with a maximum of $21,250 the first calendar year and $8,500 for each additional year of eligibility, for a maximum of $63,750 over a six year period.

Heidi also explained that the American Recovery and Reinvestment Act provides funding to encourage eligible hospitals to adopt, implement and upgrade a certified EHR system. Eligible hospitals are acute care hospitals, critical access hospitals and children's hospitals.

Acute Care Hospitals must have a CMS Certification Number (CCN) with the last 4 digits of 0001 - 0879 or 1300 - 1399. This covers short-term general hospitals, cancer hospitals and critical access hospitals. Under the definition of the final rule, acute care hospitals and critical access hospitals must have an average length of patient stay of 25 days or fewer and have at least a 10% Medicaid patient volume. Children's Hospitals must have a CCN with the last 4 digits of 3300 - 3399. Children's hospitals do not have patient volume requirements for Medicaid incentive program participation.

Incentive payments to eligible hospitals are based on a complex formula in which a base incentive

amount of $2,000,000 for each hospital is modified by the number of Medicaid discharges, bed days and other factors. Eligible hospitals can receive incentive payments over a minimum of 3 years and a maximum of 6 years.

In order to receive payments eligible hospitals must submit the following information to CMS in the first payment year:

- Name of the hospital
- National Provider Identifier (NPI)
- Business address and phone
- CMS Certification Number (CCN)
- Taxpayer Identification Number

Hospitals participating in multiple states must choose only one state to receive payments from. Additionally, hospitals meeting Medicare meaningful use requirements are deemed eligible for Medicaid incentive payments and can receive payments for both Medicare and Medicaid.

Heidi explained that this project is still in the planning stages. Once the plan is submitted and approved by CMS, AHCA hopes to launch the plan in April of 2011.

Heidi asked for the committee's thoughts on the Electronic Health Record (HER) incentive program, and referred them to www.cms.gov/EHRIncentivePrograms/ for more information and details on the project.

My Access Account

Moving on to the new business, next on the agenda was a presentation on ACCESS by Jennifer Lange from DCF. Jennifer noted that while the committee had asked her to discuss the My ACCESS Account program, she had brought Judy Glisson from DCF with her as a program expert.

Referring to the handouts provided, Judy walked meeting participants through the My ACCESS Account program, explaining that information is available in the system for both customers and providers. The system allows customers to: view all current benefits; view the date benefits will be available; see when the next review is due; view current and future appointments; view benefit account history; view verification needed; view information on when the Department received documents the customer submitted; and print a temporary Medicaid card. In addition, the system allows providers to: view current Medicaid benefits; view the date Medicaid benefits will be available; see when next review is due; view current and future appointments; view benefit account history; view verification needed; view personal identification number (PIN).

Judy noted that everybody who has ever applied for Medicaid has an account. Once that application has gone into the DCF mainframe for review by DCF staff, additional information can be input. For protection against identity theft, DCF staff makes sure that the individual's Social Security Number is never displayed for anyone to see. In addition, other identifying information is used to assist staff in

making sure they are talking to the right person. If there is anything that does not match exactly, access to information is denied.

Currently about 45% of Medicaid beneficiaries or 1.5 million people are accessing information through their My ACCESS account. However, DCF's hopes to reach their goal of 70% usage in the near future.

Miami Home Health Pilots

Next on the agenda were a series of updates by Beth Kidder, Bureau Chief for Medicaid Services.

Beth first provided background information on the Miami Home Health Pilots, explaining that in 2009, the Florida Legislature passed Senate Bill 1986 giving the Agency for Health Care Administration (Agency) more authority and resources to fight fraud and abuse in the Florida Medicaid program. It increased the requirements for reimbursement of home health services under the Medicaid program and authorized the Agency to implement pilot projects in Miami-Dade County to prevent overutilization of home health services and to verify and monitor the delivery of home health services in the recipient's place of residence.

Beth advised that there are currently two pilot projects underway in Miami-Dade; Telephony and Comprehensive Care Monitoring.

In April, 2010 the Agency entered into a three-year contract with Sandata Technologies, Inc. for an anti fraud and abuse initiative, known as Telephony. Telephony uses Interactive Voice Response Authentication (IVRA) technology to verify the presence of a direct care home health service provider, i.e. nurse or home health aide, in the recipient's place of residence. The nurse or home health aide's voice is recorded in Sandata's speaker verification system, and at the beginning and end of each home health visit, the nurse or home health aide will call Sandata's toll-free number to "check-in" and "check-out". The IVRA system will verify that the voice recorded during the check-in and check-out calls matches the voice of the service provider previously recorded on their system.

Sandata electronically transmits claims for *verified* home health visits to the Agency's fiscal agent. This transmission will occur if the information from the IVRA system matches the Medicaid recipient and prior authorization files. This will help ensure that claims submitted for reimbursement of home health visits are for visits that were prior authorized, and have been verified through the IVRA system. Providers in the pilot area will not be able to submit claims for home health visits provided **July 1, 2010** and after directly to the fiscal agent; they must be submitted through Sandata's Management System.

In addition, beginning July 1, 2010, the Agency extended its existing contract with Keystone Peer Review Organization (KePRO), the peer review contractor for utilization management of home health services, in order to implement a Comprehensive Care Monitoring program for home health services in Miami-Dade County. This program utilizes licensed registered nurses to conduct face-to-face

assessments of recipients receiving home health visits in their place of residence to determine if appropriate services are being provided.

Based on the outcome and findings from the assessment, KePRO may determine that a more intensified review is required, which may include:

- Consultation with the physician ordering the services;
- On-site visit to the home health agency performing the services; and
- Review of the recipient's past six (6) months medical records furnished by the physician and/or home health agency.

KePRO will utilize their findings in the prior authorization determination process for home health visits, which will help to validate and supplement the information in their system and ensure recipients receive the services needed.

New Payment Methodology for Emergency Department Services

Beth advised that there are no easy answers to her next topic: New Payment Methodology for Emergency Department Services. While patients are evaluated in the emergency department to determine if care being sought truly requires emergency treatment, care is often provided whether deemed an emergency or not.

AHCA has therefore been working with hospitals in trying to develop some alternatives, like referring patients to retail clinics and urgent care facilities. However, Beth noted that it is important for people to have a primary care physician and be connected to a medical home where they can receive appropriate types of treatment, and won't feel the need to go to the Emergency Room (ER) to be treated when it is not truly appropriate.

Dr. Moffitt agreed that as an ER physician, it is hard to turn Emergency Room patients away without providing care. However, while there are certainly times when the ER is appropriate, maybe this is an opportunity for us to work with facilities to try to reinforce that their primary duty is to do a medical screen to determine whether an emergency medical condition exists or not. And once that determination is made to all work together to first and foremost redirect the individual to the medical home.

Beth thanked Dr. Moffitt for her comments and added that, while we are just beginning the dialogue, we need to be creative and move forward in a way that alleviates some of the burden on hospitals, the Medicaid program and, most importantly, gets recipients appropriate care in an appropriate setting.

Pursuing the Money Follows the Person Grant

Next, Beth briefly discussed Section 2403 of the Affordable Care Act (ACA) of 2010, which extends the Money Follows the Person (MFP) Rebalancing Demonstration from 2011 to 2016. This will allow states already participating in the program to continue strengthening their demonstration programs and will allow additional states to participate.

Beth noted that CMS has made a number of changes in the MFP processes. Some of the changes identified are:

- CMS has streamlined the Money Follows the Person application and grant reporting requirements to reduce the workload to states.
- The amended demonstration will allow for transition of individuals in nursing homes with a length of stay of 90 consecutive days or more, excluding rehabilitation days covered by Medicare.
- CMS has modified the definition of Assisted Living Settings that qualify as transition destinations. States will be allowed to place individuals in facilities without a bed limit.
- The MFP demonstration grant will offer enhanced Federal Medical Assistance for the provision of certain demonstration services during the 12 months after an individual transitions.
- The MFP demonstration grant will provide full reimbursement for specific administrative costs associated with the operation of the program. Such costs may include personnel, outreach, training, travel and information technology infrastructure to accommodate MFP reporting requirements.

The Agency will apply for up to $200,000 in CMS-funded MFP planning grants, and will coordinate with its partner agencies to schedule public meetings with stakeholders to determine the target populations to be served. Beth added that the committee's input would be appreciated.

Pre-paid Dental Plans

Phil then introduced Melanie Brown-Woofter, Bureau Chief for Health System Development, who discussed Florida's Pre-paid Dental Plans. Referring to the handouts provided to participants, Melanie advised that this was a synopsis of the prepaid dental plans in Medicaid, as well as the proviso language that was passed this past legislative session. Melanie explained that in 2004, the Agency contracted with its first prepaid dental plan, which is in Miami Dade County, and serves children under 21. To provide dental services to Medicaid recipients, this program works in conjunction with managed care in that manage care plans can choose to provide dental services, these are optional service– they aren't required to provide dental services. Some plans choose to provide dental services for children. However, if the children are enrolled in an HMO that does not provide dental services, they receive dental care through the prepaid dental plan in Miami. Children are targeted through these plans since the dental care provided in Medicaid is for preventative and restorative services, such as those related to treatment of cavities, filling, etc. However, Medicaid only provides emergency extractions and partial and full dentures for adults.

Melanie noted that AHCA currently operates two prepaid dental plans in Miami-Dade under the 1915(b) managed care waiver and anticipates submitting a waiver amendment to federal CMS to initiate expansion of prepaid dental programs to other geographic areas of the state. She then asked the committee for any thoughts they had on expansion of the pre-paid dental plans.

Dr. Payne noted that there are currently not enough dental providers who take Medicaid, and with the new health care initiative, there will likely be an influx of new Medicaid recipients needing dental services. He added that expansion of prepaid dental programs to other areas of the state is greatly needed and would be welcomed.

CHIPRA Quality Demonstration Grant

The next initiative on the agenda was an update on the Child Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant by Catherine McGrath from the Bureau of Medicaid Quality Management.

Catherine explained that on February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which seeks to improve access and quality of care provided to children.

She noted that on February 22, 2010, the Centers for Medicare & Medicaid Services awarded a total of $20 million in first-year CHIPRA Quality Demonstration Grant funds to 10 states: Colorado, Florida, Maine, Maryland, Massachusetts, North Carolina, Oregon, Pennsylvania, South Carolina, and Utah. Eight of the 10 grantees will test a recommended set of child health quality measures, seven of the ten states will use the funds to implement health information technology (HIT) strategies, and two states specifically plan to test a new pediatric electronic health record format being developed under CHIPRA.

These projects will be conducted over a five-year period, with cumulative grant awards totaling $100 million. Including both single-state projects and multi-state collaborations, 18 States will participate in these projects.

Florida, along with its grant partner Illinois, has been chosen by the Centers for Medicare and Medicaid Services (CMS) to receive nearly $11.3 million to improve child health outcomes over the next five years. The Florida-Illinois team is one of ten grantees funded in early 2010. The grant will build on current work in both states to improve health outcomes of children served by public programs, specifically KidCare in Florida and All Kids in Illinois, creating a higher level of accountability for the effective use of public funds.

Florida and Illinois will use this grant to improve health outcomes for children in both states by enhancing access to information for use by providers, consumers, and state agencies. Both states will work with physicians, hospitals, community health centers, and other health care providers on quality improvement initiatives to improve birth outcomes, lower the burden of disease, and reduce health care costs. In addition, the grant will support work already underway to spread a medical home model of care for children throughout the states, and to monitor and improve the quality of care delivered through the medical home.

Catherine advised that a CHIPRA Quality Grant Steering Committee has been established to direct grant activities, comprising key representatives from the Florida Agency for Health Care Administration and the Illinois Department of Healthcare. She added that she would be glad to take any suggestions or answer any questions committee members may have.

Final Comments/Meeting Adjourned

Phil thanked meeting attendees and speakers for their participation and asked members to send any topics of interest for the next meeting to Carla.

At 4:30 p.m., the meeting was adjourned.