MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING
MINUTES
NOVEMBER 13, 2013
34th Floor Conference Room

Members Present		Phone Conference	Members Absent
Dr. Michael Brooks	Mr. Steven Barber	Dr. Sandra Reed	Dr. Hogai Nassery
Mr. Marvell Butts	Dr. William Kanto	Dr. Hugo Scornik	Dr. John Lue
Dr. Hillary Hahm	Dr. Ruth Shim		Dr. Larry Tune
Dr. Kim Hazelwood	Mr. J. Reid Wilson		Larry Brown
Mr. Dave Zilles, Advocate	Mr. A. Edward Cockman		
Dr. Lori Paschal	Dr. Jacinto del Mazo		
Dr. John Lue			

The MCAC meeting began at 10:10 a.m. with a welcome by Ms. Patricia Jeter, introductions of the Committee members, and new DCH staff. Mr. Marvell Butts, Vice Chairperson, called the meeting to order. A motion was made to approve the May 15, 2013, minutes. The minutes were approved as written.

The following agenda items were presented:

A. Overview of Molecular Genetic Testing: Argartha Russell, Director, Medical Policy Unit

Ms. Russell presented an update on the federal (CMS) change in January 2013 regarding Molecular Genetic Testing. Genetic testing falls into three major categories; focus is on the first two:

1. Biochemical Genetic Testing: State mandated testing of 38 genetic (metabolic) tests. Any newborn with positive results undergoes additional testing. The Public Health lab in Decatur is used for screenings.

2. Cytogenetics Testing: Chromosomal conditions are needed for testing to receive medically necessary interventions. Additional testing is conducted under a contract from Public Health with Emory Genetics.

3. Molecular Genetic Testing: Singe or multi-genes testing for a diagnosis and medical treatment plan.

Prior to January 2013, Medicaid paid for individual lab tests as stacking codes. Genetic lab stacking codes were terminated by CMS on 12/31/12 and new molecular genetic pathology codes became effective on 1/1/13. There is no crosswalk of the old stacking codes to the new genetic pathology lab codes; no one-to-one matching of the old codes to new lab codes. CMS added 7000 plus new lab codes. Previous Prothrombin F2 gene analysis lab stacking codes were comprised of 5 individual tests at the cost of $5 each. The new tests range in price from $40-$2,300 and may not include all charges. Previous Cystic Fibrosis CF97 gene analysis stacking lab code was comprised of 6 individual tests; under the new genetic lab code there is one CPT code. The cost for the new code is $900. Medicaid opened the generic lab codes with an age restriction up to 21 years to ensure all the metabolic screening tests for newborns are covered.

DCH has three concerns regarding the new lab coding:

1. Immediate need is to address newborn genetic tests that are mandated by Georgia law (ages 0 < 21 years).
2. Genetic tests that GA Medicaid paid under the 2012 stacking codes that needs to be matched or correlated to their new genetic pathology lab codes for adult members (> age 21 years).
3. Concerns of multiple new genomic tests coming on the market for coverage and payment.

DCH has been approached to consider coverage for several other new genetic tests:

1. MaterniT21 - CPT 81479. An unlisted genetic CPT non-invasive prenatal [antenatal] test for fetal DNA abnormality.

2. Oncotype DX for breast cancer gene markers – unlisted genetic CPT 84999 or use CPT S3854 for specific tracking of utilization and costs. DCH cannot consider testing until FDA approved.

B. <u>Overview on Medicaid Redesign: Marcy Alter,</u> Director, Aging and Special Populations

Ms. Alter provided a refresher on Terri Branning's presentation from the 8/21/13 session and an update on Medicaid Redesign. DCH assessed opportunities for enhancing outcomes and coordination of care for populations currently in Medicaid Fee-for-Service (FFS). Two key initiatives resulted:

1. Transition of members in Foster Care or receiving Adoption Assistance and Select Youth in Juvenile Justice (FCAAJJ) to Georgia Families. DCH selected Amerigroup as the single statewide Care Management Organization (CMO) to serve the eligible foster care pediatric population.
2. Implementation of Medical Care Coordination program for the ABD population.

DCH worked with partner agencies and stakeholders to develop the Foster Care/Adoption Assistance/Juvenile Justice (FCAAJJ) Georgia Families program. Following an intensive interviewing process, Amerigroup was selected as the single statewide Care Management Organization (CMO) to serve the eligible populations of approximately 27,000 pediatric members. Amerigroup will assist with transportation, outreach and ADD/ADHD medications. Any child prescribed three or more medications will be reviewed by Amerigroup. Child members that receive adoptive state benefits were also added to the list as an enrolled population. There will be a mechanism developed for the providers who are not enrolled in Amerigroup for their network.

FCAAJJ Transition Goals

A new level of collaboration between DCH, partner agencies and Amerigroup will be created by the transition of members in FCAAJJ with a focus on:

1. Development of new relationships and processes to facilitate the coordination of care for FCAAJJ members.
2. Measureable improvements in physical and behavioral health outcomes.
3. Safety and permanence.
4. Virtual exchange of health information through Georgia Health Information Technology . Providers can log into the network and view the patient's previous treatment/encounters.

Current priorities in preparation for a January 1, 2014, launch include development of new workflows and policies across agencies and protocols for managing any issues post launch.

ABD Intensive Medical Care Coordination

The ABD (Aged, Blind, and Disabled) Medical Care Coordination Program initiative is scheduled to be launched in January 2014). ABD data illustrates opportunities for improving clinical, quality and financial outcomes. The impacted populations (Members) are individuals in the Aged, Blind, or Disabled eligibility category, including children with special health care needs, dually eligible individuals and individuals who are enrolled in HCBS ( ) waiver programs or who are in long-term institutional settings. *The excluded populations are* individuals in Georgia Families or in the following eligibility categories (classifications): Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualified Individuals 1 (QI1s).

DCH will continue to provide and reimburse Medicaid benefits and home- and community-based services (HCBS) through the fee-for-service delivery system. The selected vendor will coordinate with DCH sister agencies as needed, specifically to medical coordination activities and services to complement existing case management services. The timeline is contingent upon CMS' response and turnaround time.

C. <u>Status Update on ICD-10: Camille Harris</u> - ICD-10 Communication and Compliance

Ms. Harris (ICD-10 Communications Lead) and Lena Gomes (external ICD-10 testing lead) provided an update on the ICD-10 project (i.e., mandated testing, consequences of improper coding and transitioning to ICD-10) including the fact that there will not be any more extensions to the federally

mandated compliance date of October 1, 2014. This mandate affects all HIPPA covered entities but has no direct impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS). Claims that are submitted with non-compliant codes, incorrect or incomplete, will be rejected and could impact providers' cash flow and credit worthiness.

Ms. Gomes provided the following update on the ICD-10 External Testing Phase:

1. *Trading Partner Testing – Providers* (External): In this phase, testing partners will be comprised of small and large organizations that have a range of impacted transactions involving both manual and electronic submissions. Identification of test scenarios for each provider is very critical.
2. *Trading Partner Testing – Clearinghouses* (External): The objective during this phase is to make sure the trading partner transactions are validated against the implementation guides specific to the organization receiving the file.
3. *Trading Partner Testing – Payers* (External): During this phase, payer-to-payer testing validates integration with other payers like Medicare, Medicaid, etc.
4. What DCH Beta Testers should know:
    a. Not to submit production size files due to limited testing environment capacity.
    b. To limit the number of claims submitted in an 837 file to 100 claims.
    c. That a a maximum of 3 test files can be submitted.
    d. That the necessary analysis and corrections have occurred within the systems prior to files being resubmitted.

In preparation for external testing, it is recommended that providers create a list of their Trading Partners, communicate with Trading Partners to gauge their state of readiness for ICD-10 and determine the Trading Partners' test guidelines.

DCH's ICD-10 Testing Guidelines

We will use a simulated date for testing. Providers need to ensure their system will allow for the simulation. This date will need to be coordinated with other testing that is occurring within our testing environment. Prior to testing, Ms. Harris will personally notify providers of the simulated test date.

D. <u>CMO COMPLIANCE AUDIT: Marvis Butler</u>, Director Provider Services (Managed Care Unit)

Ms. Butler provided an update on the Managed Care Unit's priorities.

1. Centralized PA Portal Process
    a. Medicaid providers who are participating with a Care Management Organization (CMO) or Fee-for-service (FFS) can access one site to submit PA requests for their enrolled members.
    b. The Web submission rate for October 2013 was just under 78% for a total of 95,521.
2. Network Access Requirements
   Primary CMOs are required to have two Providers within an eight mile radius in urban cities and two providers within a 15 mile radius in rural areas.
3. PCP Provider and Pediatrician Provider Access below the required 90% benchmark
   All three (3) CMOs are contracted with Georgia Partnership for -?? to provide transportation in counties where no providers are available. Therapy providers are required to have single case agreements if they are not under contract and each CMO can negotiate the rate.
4. CMO Dental Provider Access. Amerigroup is the only CMO with deficient counties.
5. Telemedicine allows CMO members in rural and underserved communities to receive greater access to specialty care. The CMOs telemedicine network allows patients in Georgia to have access to comprehensive medical care. Telemedicine reduces travel distance.

E. <u>Update: ACA Provider Rate Increase: Argartha Russell</u>, Director, Medical Policy

Ms. Russell, reiterated that providers affected by the Affordable Care Act (ACA) rate increases should have received a notice and that the rate increase affects specific codes. New day current claims will get rate increases effective 11/1/2013. Anything prior to that will have to be resubmitted. The process is currently in process.

MCAC Members' Round Table Discussion:

- Dr. Nassery suggested looking at one county to find out their rate and asked how many are Fee for Service Providers.
- Georgia hasn't fully accepted Obama Care and has chosen not to expand medicaid. Hospitals want Obama Care accepted.
- Resolution asking the governor to accept the Obama Care was passed.

Meeting was adjourned at 12:15 pm

The next MCAC meeting is February 19, 2014 at 10 a.m. 3rd Floor 3-240 EOC Conference Room.

MCAC future meeting dates for 2014:
May 21, 2014
August 20, 2014
November 19, 2014

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS 19th DAY OF February, 2014.

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John Lue, MD, FACP, Chairperson