MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING
MINUTES
August 19, 2015
5th Floor Boardroom

Members Present	**Phone Conference**	**Members Absent**
Dr. John Lue	Dr. Helen Gelly	Mr. Steven Barber
Mr. Marvel Butts	Dr. Hillary Hahm	Dr. Michael Brooks
A. Edward Cockman, RPh	Ms. Georgina Howard	Dr. Kim Hazelwood
Dr. Lori Paschal	Dr. Lucky Jain	Dr. Hugo Scornik
Ms. Sonja Allen-Smith	Dr. Hogai Nassery	Dr. Sandra Reed
Ms. Carie Summers	Dr. Yasmin Tyler-Hill	Mr. Dave Zilles, Advocate
Ms. Arianne Weldon	Ms. Sandra Washington	
Mr. J. Reid Wilson	Dr. Bryan Williams	

The MCAC meeting began at 10:27 a.m. with a welcome by Ms. Patricia Jeter. Dr. John Lue, Chairperson, called the meeting to order. Mr. Marvel Butts, Vice-Chairman, made the motion to approve the February 18, 2015, minutes and Carie Summers followed with a motion to approve the May 20, 2015 minutes with one correction requested regarding her not being present at the May 20th session. With the acknowledgment of the correction, both minutes were approved.

The following agenda items were presented:

A. ICD-10 Overview Policy – Are You Ready? – Argartha Russell, R.N., MSA, CPHQ., Director, Medical Policy and Provider Reviews

Ms. Russell gave an overview on the current status of ICD-10 and thanked the members for agreeing to provide their Readiness Planning after DCH's ICD-10 Frequently Asked Questions is released. Ms. Russell reported that the ICD-10 test team was reviewing the ICD-10 Overview Policy in the Part 1 Manuel for revisions. Team findings revealed that some providers hadn't given consideration nor reviewed the new ICD019 diagnosis codes; "Other and Unspecified" codes may not be listed in the GAMMIS system.

Key Points:

- ICD-10 transition is to occur on October 1, 2015. It will have a major impact on every HIPAA compliant entity that uses health care information containing a diagnosis (CM) and or inpatient procedure (PCS) code.
- DCH is ending its external beta testing with interested beta testers on August 31, 2015. These are providers, facilities and external billing companies and Clearinghouses who submit test claims with ICD-10 diagnosis and or procedure codes. The aim is to test the adjudication process of billing claims with ICD-10 code sets through GAMMIS. The main testing errors are billers using invalid and or unspecified ICD-10 diagnosis codes. You must bill in some cases 5-7 characters with include numbering and alpha characters. Laterality of (R), (L), and Bilateral are included that physicians must document in a detailed, concise and clear manner to support the level of specificity being billed.
- DCH policy is drafting a banner to post in September 2015, of GA Medicaid's ICD-10 policies regarding the transition.

B. <u>NEBA (Neuropsychiatric EEG –Based ADHD Assessment Aid) Presentation</u> – Argartha Russell, R.N., MSA, CPHQ., Director, Medical Policy and Provider Reviews

Ms. Russell provided a presentation on NEBA, the first brain-wave testing system for attention-deficit/hyperactivity disorder (ADHD) in children and adolescents. A presentation was made in May 2015 to Commissioner Reese, the GA Medicaid Chief, and several other staff leaders on the new EEG Assessment tool for detecting ADHD conditions of children who may be misdiagnosed and treated with psychiatric meds. This tool was researched and developed by a local company located in Augusta, GA. The presentation was made by Dr. Snyder, Mr. Pollard, and Mr. Merry.

The MCAC was presented with a copy of the NEBA study. They offered the following feedback on whether DCH should cover the NEBA Assessment Tool for ADHD:

- The sampling size used for the FDA study was very small.
- It is too early to make any decision on a small study sample. Need more subjects to test and establish evidence based practice guidelines for physicians.
- The NEBA Company did not provide any comparative studies of the EEG Biomarker to other psychological testing tools used currently by Psychologists and Psychiatrists for ADHD.
- The NEBA study is a retrospective data collection. It does not show any correlation with experts who also reviewed the data retrospectively, It was stated "I do not see any added value of this test." by Committee members. A further evaluation needs to be done to show value of the test and any added value.
- There are no endorsements from the national associations -American Academy of Pediatrics or the College of Pediatric Psychiatry – the question is, what do these entities say about the EEG biomarker tool? The NEBA study does not address efficacy or evidence based practice.

The new system is based on electroencephalogram (EEG) technology and was cleared by the US Food and Drug Administration (FDA) in July 2015. NEBA is requesting coverage by Georgia Department of Community Health (DCH) and access to DCH expertise and partnership opportunities for ongoing cost savings research. According to NEBA research, a clinician integrating NEBA would improve accuracy by 17%; an 88% accuracy level and reduce over-diagnosis from 34% to 3%.

If DCH does provide coverage, there will be a cost to DCH and a cost to the provider. In addition, participants must be off their medications for two weeks and child participants must be able to sit still for 20 minutes to participate in the treatment. FDA has given approval to proceed with other clinical tests; details about clinical studies are considered vague. The testing population consisted of 275 children.

The MCAC made the recommendation that DCH should not cover the NEBA test as it is presented right now for the above reasons.

C. <u>Centralized Credentialing Verification Organization (CVO)</u> – Lynnette R. Rhodes, Esq., Associate Chief, Medical Assistance Planning

Ms. Rhodes provided a presentation on the Centralized Credentialing Verification Organization Project. The primary focus of the project is to design a streamlined electronic credentialing process with a single point of entry. Under the current credentialing process, providers are required to submit four (4) credentialing applications (one for each CMO and a separate

application for Fee for Service) before being validated. Under the new process, DCH would be the credentialing authority at the request of CMOs. Providers will be notified of their credentialing status via GAMMIS; CMOs shall accept the State's credentialing decision and cannot not ask for additional information related to the credentialing decision.

Credentialing Committee

There will be a single Credentialing Committee responsible for reviewing provider information gathered by the CVO and making credentialing decisions (approvals or denials), consulting Peer Review Specialists when necessary will review results of site visits, and assist in developing or revising policies and procedures. Provider applications will be put in one of three categories;

(1.) Clean - Meets standards with no adverse findings;

(2.) Denied - Does not meet standards with adverse findings

(3.) Requires Review - Low Risk/High Risk

Under the new process, credentialing and contracting are separate and distinct; successful credentialing does not guarantee the provider will be enrolled in the CMO network. CMOs may not use the contracting process to circumvent credentialing decisions.

Effective December 1, 2015, all providers will be credentialed and re-credentialed through the new CVO, with the exception of Independent Practice Associations and Provider Hospital Organizations. CMOs will be responsible for delegated credentialing and re-credentialing for the latter.

D. Transition of Care Presentation - Janice Carson, MD, Assistant Chief, Performance, Quality and Outcomes

Dr. Carson provided a high level overview on Transition of Care. The Transition of Care metric is meant to track the transmission of relevant information sent from the hospital to the member's PCP or other care site to assist with follow up care. The Georgia Hospital Association's Care Coordination Council, comprised of GHA, hospital, nursing home, home health, Medicaid managed care, and DCH representatives was formed to reduce all cause, all payer hospital readmission rates to 9% by December 2015. DCH is a member of the Council and has created a Transition of Care Record form for the purpose of providing evidence that a patient information was transmitted to the receiving entity. CMS guidelines state that the transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

E. MCAC Members' Round Table Discussion (general discussions on topics presented and to be presented)

Dr. Lue opened the discussion of topics and presenters that the Committee would like to have in future sessions. The following were requested:

1. Transition of care statistics
2. CVO updates
3. The new CMO
4. Decision on NEBA

5. DBHDD and dates for deinstitutionalizing patients into the community.

Meeting was adjourned at 11:54 a.m.

The next MCAC meeting is February 17, 2016 at 10 a.m. 5th Floor Boardroom.

MCAC future meeting dates:

May 18, 2016
August 17, 2016

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS 18th DAY OF November, 2015.

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John Lue, MD, FACP, Chairperson