MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING
November 7, 2012
5th Floor Board Room

Members Present

Mr. Steven Barber
Dr. Michael Brooks
Mr. Marvell Butts
Mr. A. Edward Cockman
Dr. Jacinto del Mazo
Dr. Hillary Hahm
Dr. Kimberly Hazelwood
Dr. John Lue
Dr. Hogai Nassery
Dr. Lori Paschal
Dr. Hugo Scornick
Mr. Dave Zilles, Advocate

Members Absent

Ms. Jennifer Hale
Dr. William Kanto
Dr. Ruth Shim
Dr. Larry Tune
Dr. Sandra Reed
Mr. J. Reid Wilson

The Medical Care Advisory Committee (MCAC) for the Department of Community Health (DCH) began at 10:10 a.m. with a welcome by Ms. Patricia Jeter. She mentioned the new technology, WebEx, that the Department will be using to connect and allow viewing from computers or laptops with microphones, which will also provide the ability for member to be interactive from a distance. She then introduced the committee members.

Mr. Marvell Butts, Vice Chair Person, then called the meeting to order. A motion was made to approve the August 15, 2012, minutes at the end of the meeting.

Medicaid Updates - Mrs. Argartha Russell, Director - Medical Policy

Mrs. Russell summarized changes, updates and new initiatives within DCH and stated the following:

- There is a mandate for budget cuts in 2013 and 2014
- A centralized portal for PAs thru HP for both FFS and CMOs will be implemented
- Foster children will be serviced through a specialized managed care CMO. DCH is working with the Department of Family and Children Services for a smooth transition to take place effective January 1, 2014.
    - ➢ Recommendations for the modified redesign is:
    - ➢ Focus on the top 2 – 3 strategic goals rather than all the goals
      One of three existing contracts will be awarded
    - ➢ Redesign initiative is moving foster care populations into a Case Management Medical Care Home concept
    - ➢ Supplefication Project
        - Provide enroll in a CMO or DCH you must complete a separate application
        - The Department is looking at a centralized process as one portal with a standard application submitted thru HP and applicable to CMOs
    - ➢ GMCF
        -
- CMO IT workgroup working thru parameters

ICD-10 process is being implemented with the assistance of a DCH internal clinical team to perform the mapping of ICD-9 codes to ICD-10 for system readiness with the start date of October 1, 201 4, – no negotiation. This new coding initiative will have a very definite impact on private practices, health centers and hospitals. An ICD-10 webinar will be available to providers by HP for providers in August 2013. A notice will be place on remittance advices..

Prepare code; mapping with 10/21 claims date will not pay. DCH is 50% mapped ICD 9 to ICD 10. There is no ICD 10 Reference Manual

Beta Tester – contact Mrs. Russell at arussell@dch.ga.gov or staff. Beta Testing will be effective early spring.

- Provider resources Clearinghouse; engage and ready for transition with Diagnosis codes and equivalent. Engage the Department with communication
- The Department will not accept claims prior to October 1, 2014.

Elective Delivery prior to 39 weeks - Dr. John Lue

Dr. Lue provided information pertinent to the reasons why elective delivery prior to 39 is not a physiological advantage to the newborn and the potential disadvantages.

Early Elective of Labor

- Induction of labor without an accepted medical or obstetrical indication before the spontaneous onset of labor or rupture of membranes.

Elective Cesarean Section

- Scheduled primary or repeat cesarean section without an acceptable medical or obstetrical indication before the spontaneous onset of labor or rupture of membranes

Gestational Age Confirmation

- ACOG criteria for determining term gestational age:
  - Ultrasound measurement before 20 weeks gestation to establish accurate gestational age.
  - Documentation of fetal heart tones for 30 weeks using Doppler ultrasonography.
  - Confirmation that it has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test was obtained.

Gestational Weeks

- Late preterm:
  - The period from 34 0/7 to 36 6/7 weeks gestation.
- Early term:
  - The period from 37 0/7 to 38 6/7 weeks gestation.

Scheduled

- A planned induction or cesarean section that is scheduled for either elective or non-elective/medically indicated reasons.
  - Acceptable indications for Delivery<39 weeks Gestation

ACOG: Examples of maternal or fetal conditions that may be indications for induction of labor

- Fetal Demise
- Post term pregnancy
- Premature rupture of membranes
- Gestational hypertension, pre-eclampsia, eclampsia, chronic hypertension
- Maternal medical conditions, e.g., diabetes, renal disease, chronic pulmonary disease, antiphosphollpid syndrome
- Fetal compromise, e.g., severe intrauterine Growth Restriction (UGR), Isolmmunization, Oligohydramnios

The Joint Commission: National Quality Core Measure PC=01 – Specification for “Conditions justifying delivery < 39 weeks”

- Placetal abruption, placeta previa, uspecified antenatal hemorrhage
- Fetal demise, fetal demise in prior pregnancy
- Rupture of membranes prior to labor (term or preterm)
- Gestational hypertension, preeclampsia, eclampsia, chronic hypertension
- IUGR, oligohydramnos, polydramnios, fetal distress, abnormal fetal heart rate, isolmmunization (RH and other), fetal-maternal hemorrhage, fetal malformation, chromosomal abnormality, or suspected fetal injury

Higher Ventilator use among infants delivered at 37 weeks gestation

A baby’ brain at 35 weeks weighs only two-thirds of what it will weigh at 39 to 40 weeks

Summary

- “The odds of serious neonatal complications increase with decreasing gestational duration”
- Common serious morbidities include:
  - Respiratory complications
  - Sepsis
  - Hypoglcemia
- Preliminary data indicate that these risks are not diminished despite amniocentesis documentation of a mature lung profile.

QI interventions effective in reducing elective deliveries <39 weeks

GA Results: 93% decrease in EED

Medicaid/CHIP Provider Screening and Enrollment – Mrs. Linda Wiant, Director of Pharmacy Services

Ms. Wiant gave an overview on Medicaid/Chip Provider Screening and Enrollment.

New Federal Requirements for Providers for payment
CMS–6028–FC

- Mandates enrollment of all providers who order/refer/prescribe – anti fraud initiate

Ordering/Referring/Prescribing Providers

- Two Phases
  - Enrollment of physicians and other providers
    - All providers who order or refer services or prescribe drugs
    - All enrollment will require an NPI
    - Does not impact providers who are already enrolled and receive payment for their services
    - Examples of impacted providers: Physician’s Assistants, Hospitalists, E.R. physicians
  - Exploring online access to enrollment information

Ordering/Referring/Prescribing

- Two Phases

    - Claims editing
        - Services requiring an order/referral, such as DME
        - Prescriptions
        - Claims must have an NPI
        - Provider must be enrolled, even if they do not bill claims
        - Claims without ordering/referring/prescribing provider NPI will be denied

Special situations: interns/residents

Enrollment Process

- Through the web portal: https://www.mmis.georgia.gov/portal/default.aspx
- Mail:

HPES Provider Enrollment
PO Box 105201
Tucker, GA 30085-5201

- Abbreviated Process

Ordering/Referring/Prescribing Providers

- Timeline: -possibly early Spring – depends on the contractors
    - January 2, 2013: Enrollment opens
    - March 1, 2013: Messaging for pharmacy claims
    - April 1, 2013: Edit is live for all claims

<u>Long Term Supports</u> – Ms. Catherine Ivy, Director – Aging and Special Populations

Ms. Ivy gave an update on Georgia's Long Term Supports and Services Programs

Overview of the Money Follows the Person Program

- Single largest investment in Medicaid Long-Term Support Services
- 43 States and D.C. utilizing $2.25 billion
- Grant through the Federal Deficit Reduction Act of 2005 and amended through the Affordable Care Act of 2010
- Shift Medicaid long-term spending from institutional to home and community-based services (HCBS)
    - Georgia's rebalancing efforts now ± 44%

Important Events in MFP in Georgia

- Original CMS Award to Georgia
    - 2007 - 2011
- Interagency Agreement Award
    - Options Counseling and Transition Coordination to the Division of Aging July 2011
- Current CMS Award
    - 2012 – 2016 with activity continuing through 2020
- Proposed population Expansion 2012
    - Children and youth with serious emotional disorders
    -

Balancing Incentives Program

- Awarded through application as of July 2012 – September, 2015
- Applies enhanced 2% federal match to the following:
    - All long term care waiver programs
    - Targeted case management programs

  - Home health services
  - Community mental health services

CMS Requirements
- Single Point of Entry or No-Wrong-Door Entry for community-based long term care services
- Conflict free case management systems
- Standard assessment for all programs
- Continued rebalancing toward 50% goal by 2015
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Georgia’s Decision to Apply for BIPP
- Use BIP to enhance existing strengths
- Identify challenges
- Capitalize on a web-based eligibility system being built
- Use existing partnerships to meet the BIP requirements
  - Continue cross-training activities to facilitate the “No Wrong Door” entry to LTSS

- SOURCE and CCSP co-exist in one waiver – taking referrals October 1st.

<u>Provider Audits</u> - Toni Prine, Deputy Inspector General – Program Integrity
- Audits
  - ➢ Administrative Service Organization (ASO) – GMCF
  - ➢ Medicaid Integrity Contract (MIC) - CMS
  - ➢ Medicare/Medicaid Data Contract MDA MDA – CMS –
  - ➢ Medicaid Rack – Medicaid Recovery Contractor –
  - ➢ Medicare Integrity
  - ➢ Program Integrity
- When an audit is being done, check to see who they are coming to see to better coordinate with the appropriate contractor. This is the agenda for the MIC and need to do across the board. Have no control over private audits. Ms. Prine over see Managed Care, Pharmacy, Program Integrity and Rack.
- Have the ability to look back five years
- Rack is five years
- Pharmacy Bill of Rights – they have the ability to look back 2 years
- – Integrity Program can do the following Audits:
- Desk Audits
- On site Audits
- Unannounced Audits
- All other vendors, you should know when they are visiting to request records
- May do an audit on data or Category of Service
- GMCF – waiver review
- RACK has been in facilities since implemented in April
- Norstrom do the Phamacy Audits and some DME Audits

Ms. Prine’s staff consists of:
- Nurses
- Lawyers
- Pharmacists
- Accountants
- Investigators

Lock-In Program – Pharmacy geared towards Members

- If identify over use of narcotics, abuse of a drug, will try to lock the person into a particular pharmacy

Fraud hotline – on DCH Web
PDNP – Go-Live – 2014

Ms. Prine introduced her supervisor Mr. Rob Finlayson, Chief Inspector General.

Medicaid Managed Care – Ms. Marvis Butler, Director - Provider Services

Ms. Butler presented information regarding the Care Management Organizations (CMO) network access requirements with graphs.

Network Requirements
Primary Care Providers

- Two (2) within eight (8) miles - Urban Areas
- Two (2) within fifteen (15) miles - Rural Areas

Specialists

- One (1) within thirty (30) minutes or thirty (30) miles - Urban Areas
- One within forty-five (45) minutes or forty-five (45) miles - Rural Areas

Administrative Simplification Process Update
DCH CMO Centralized Credentialing
PHASE I – KEY POINTS
Purpose**:** Streamline the enrollment application process into the Georgia Medicaid program and implement a single source application to provide credentialing documentation to each of the CMOs.
Who is Eligible?

- New Georgia Medicaid program applicants (i.e. facilities, professional and ancillary providers) who **also** desire CMO network participation.

When will new process start?
1st Quarter 2012

DCH CMO Centralized Credentialing
PHASE I – KEY POINTS
What will providers need to do?

- Complete “Request for Network Participation” on specific CMO provider web portal or associated CMO vendor web site
- Follow banner message link to the joint application
- Select specific CMO(s) from list on joint application
- Complete all sections of the joint application
- Attach all current and required documents for enrollment with DCH and CMO

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Medicaid Fair and Telemedicine – Ms. Erica Dimes, Program Director - Medical Policy

Ms. Dimes gave an update on the Medicaid Fair and Telemedicine.

Medicaid Fair – November 14, 2012 – Gwinnett Civic Center

- Three (3) presentations were added
    - Audit

    - Behavioral Health in Agency
    - Net and Emergency Ambulance (the difference between emergency and non-emergency
  - ➢ CMO, HP, DCH talk one on one

Telemedicine Update

- Handbook
- The comments were edited. They will be posted next month.
- A Banner Message will go out on web.

Round Table Discussion - MCAC Members

Mr. Marvell Butts then proceeded with the roundtable discussion concerning the following topics:
Dr. Scornick – Medicaid Rates

- Pediatric Providers
- Family Medicaid Provider – 100$ Fee Schedule
- 2002 RVRS set up to get increase
- Paid per claim or supplement quarterly – effective January1, 2013
- Update next week

Dr. Hahm – Lag between Medicaid paying or FDA approved drug and injectable drug

- Submission – 30 days
- Send email to Patricia Jeter @ pjeter@dch.ga.gov

Dr. Lue requested Necu to be placed on the February 2013 Agenda.

The meeting was adjourned at 12:00 Noon.

The next MCAC meeting is February 20, 2013, at 10:00 a.m. 5th Floor Board Room

Meeting dates for 2013
May 15, 2013
August 21, 2013
November 20, 2013

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS _________ DAY OF _____________, 2012.

John Lue, MD, FACP, Chairperson