Medical Care Advisory Committee

August 2018

MISSISSIPPI DIVISION OF MEDICAID

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DIVISION OF MEDICAID POLICY

State Plan Amendment (SPA) Updates

SPA 17-0001 Home Health

- 9/1/18 effective date

SPA 18-0001 LTC Updates

- Approved 5/17/18

SPA 18-0002 Physician UPL

- Approved 4/20/18

SPA 18-0003 Medicaid Administration

- Approved 6/28/18

SPA Updates

SPA 18-0004 APR-DRG Updates

- CMS Submission 7/2/18

SPA 18-0006 1915(i) Community Support Program (CSP)

- Public Notice 4/20/18
- Submitted 4/27/18

CHIP SPA #10

- Submitted 1/9/2018
- RAI Issued 2/8/18

SPA Updates

SPA 18-0007 OPPS Reimbursement

- Public Notice 6/29/18
- Public Hearing 7/20/18
- CMS Submission 8/1/18

SPA 18-0008 Community Mental Health Centers

- Executive Routing

SPA 18-0009 IHS Encounter Limit

- Public Notice 5/21/18
- CMS Submission 6/19/18

Quality Strategy Report

- CMS Submission 7/23/18

Proposed SPA Updates

SPA 18-0010 Transportation

- Public Notice 6/29/18
- Public Hearing 8/3/18

SPA 18-0011 Physician Administered Drugs (PADs)

- Public Notice 6/29/18

SPA 18-0012 FQHC PADs

- Public Notice 6/29/18

SPA 18-0005 LTC Updates #2

- Public Notice 6/28/18
- Public Hearing 8/2/18

Proposed SPA Updates

SPA 18-0013 RHC PADs

- Public Notice 6/29/18

SPA 18-0014 EPSDT

- Drafting

CHIP SPA #11 – MHPEEA

- Due 9/1/18

CHIP SPA #12 – Managed Care

- Due 6/30/19

Waiver Updates

Healthier Mississippi Waiver Renewal

- CMS Submission 9/28/2017

1115 Workforce Training Initiative

- Completeness letter received 1/22/18
- CMS Review In Process

ID/DD Waiver renewal

- CMS Submission 6/14/18

AL Waiver Renewal

- CMS Submission 6/28/18

Administrative Code Updates

- AC 18-001 Therapeutic Leave – eff. 8/1/18
- AC 18-005 BCBA Telehealth – eff. 7/1/18
- AC 18-016 Home Health – eff. 9/1/18
- AC 18-017 DME – eff. 9/1/18
- AC 18-018 Transportation – eff. 8/1/18
- AC 18-019 Respiratory Therapy – eff. 8/1/18

Administrative Code Updates

- AC 18-020 ACD – eff. 8/1/18
- AC 18-021 ER Outpatient Visits – eff. 9/1/18
- AC 18-023 LTC NET Part 207 – Final 8/3/18, eff. 9/1/18
- AC 18-024 LTC Net Part 201 – Final 8/9/18, eff. 9/9/18

Proposed Administrative Code Updates

- AC 18-022 APR-DRG Reimbursement
- AC 18-025 DME O2
- AC 18-008, 18-009 – Pharmacy Reimbursement & 340B
- AC 18-037 Family Planning
- AC 18-015 Program

METABOLIC SURGERY

Average Annual Cost for Beneficiary with Diabetes and Obesity

	Distinct Beneficiary Count	CY2017 Total Paid Amount	Average Cost Per Beneficiary
Diabetes	26,202	$156,005,875.60	$5,953.97
Obesity	7,032	$26,942,980.39	$3,831.48
*Diabetes & Obesity**	2,754	$12,896,452.98	$4,682.81

**Eligible beneficiaries with full Medicaid benefits.*

Previously Proposed Metabolic Policy

Proposed metabolic procedures for beneficiaries who are obese and have Type II Diabetes:

- Open or laparoscopic Roux-en-Y gastric bypass
- Laparoscopic sleeve gastrectomy
- Laparoscopic adjustable gastric banding
- Biliopancreatic diversion with or without duodenal switch
- Approved medically necessary revision

Proposed Prior Authorization Criteria

Eligible beneficiaries must meet the following criteria:

- At least 18 years old or older (<18 years of age reviewed via EPSDT requirements)
- BMI ≥ 40 kg/m²;

OR

- BMI ≥ 35 kg/m² AND at least one or more co-morbidities linked to obesity that is expected to clinically improve with metabolic surgery

Proposed PA Criteria

Co-morbidities linked to obesity include:

- Uncontrolled Type II Diabetes
- Congestive heart failure
- Documented coronary heart disease that is reversible with weight loss and confirmed by stress test, CT angiography, coronary angiography, heart failure or prior myocardial infarction
- Significant circulatory insufficiency such as peripheral vascular disease documented with arteriography or ultrasound and brachial and ankle pressure before and after exercise
- Pseudotumor cerebri
- Obesity related pulmonary hypertension
- Moderate to severe obstructive sleep apnea documented by respiratory function studies, blood gases, sleep studies or as defined by American Academy of Sleep Medicine definitions

Proposed Innovative Metabolic Surgery Case Rate

Proposed reimbursement is through an all-inclusive metabolic surgery case rate, which would include:

- One preoperative surgery visit after decision made to operate
- All surgical care one (1) day prior to surgery
- All surgical care day of surgery procedure
- All surgical care ninety (90) days post-surgery including any readmission associated surgeon visits
- All surgical intra-operative care including performance of surgery and assistant surgeon
- All anesthesia services (pre-operative consultation, intra-operative services and post-operative services)
- Preoperative testing
- EKG, if required
- Chest x-ray (technical and professional), if required
- EGD, if required
- Labs (technical and professional), if required
- Outpatient postoperative testing

Previously Estimated Economic Impact

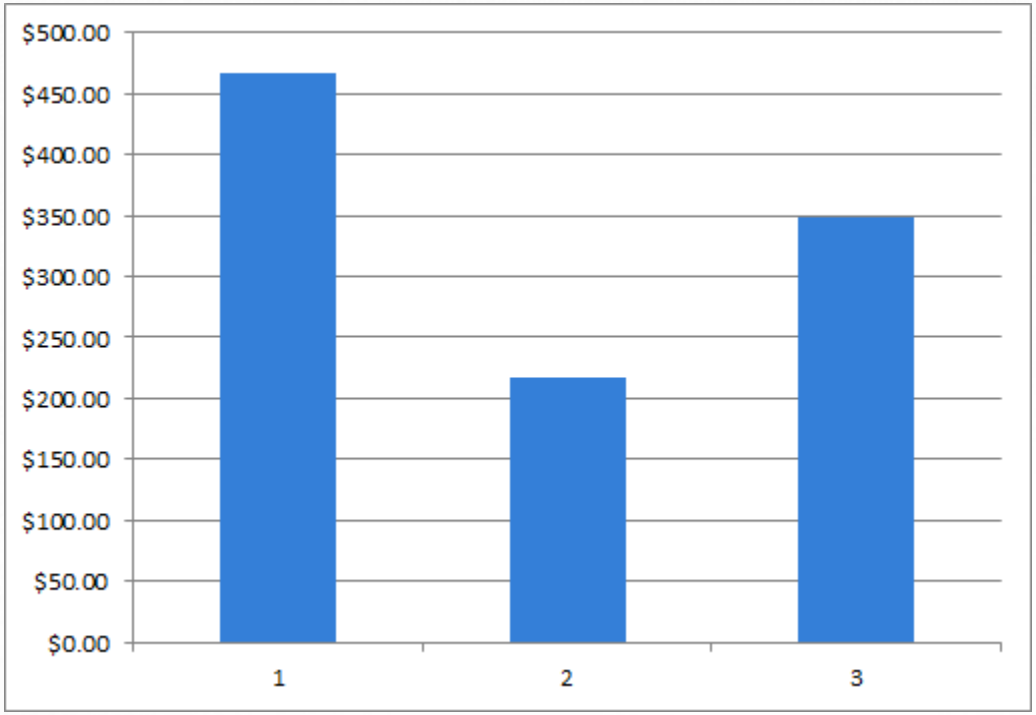
- Beneficiaries with Diabetes & Obese Eligible for Surgery = 2,754
- Estimated reimbursement for metabolic surgery and follow up care (12 months) = $25,673

  This rate is based upon inpatient surgical assumption.

	5% of Eligible Beneficiaries*	10% of Eligible Beneficiaries*	25% of Eligible Beneficiaries*
Estimated Cost	$3,535,172.10	$7,070,344.20	$17,675,860.50

**Beneficiaries age 18 or older that had claim submitted with diagnosis of diabetes and BMI ≥ 35 on same claim between January 1, 2017 and December 31, 2017*

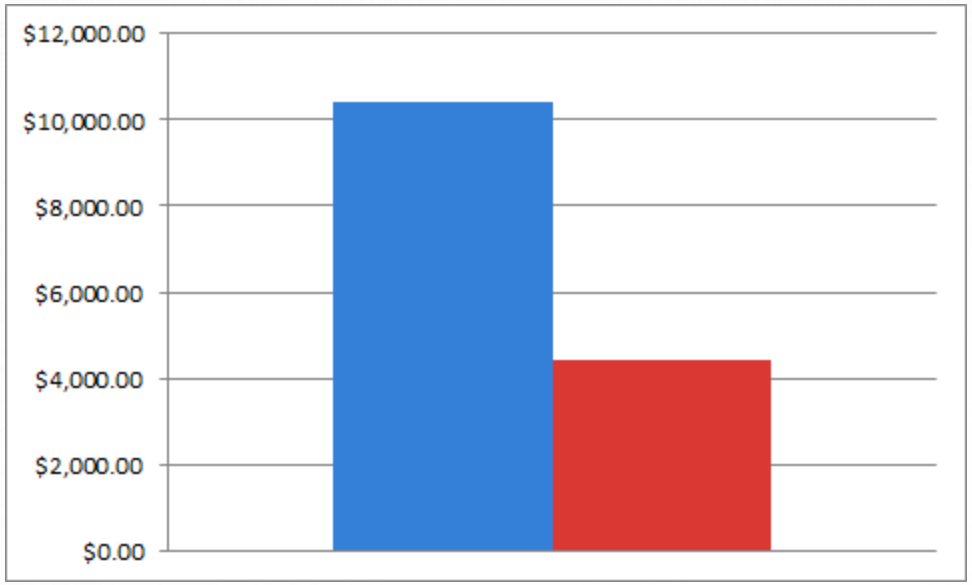
Per Member Per Month Difference Pre and Post Bariatric Surgery



1. Per Member Per Month for 12 months prior to surgery $466.92
2. Per Member Per Month for Months 1-12 post surgery $217.70
3. Per Member Per Month for Months 13-24 post surgery $347.99

Data is for 30 Medicaid members continuously enrolled in various states served by the *three* CCOs. Does not take into account inflation or differences in state fee schedules or CCOs ability to negotiate rates.

Cost of Procedure vs. Savings During 24 Months Post Procedure



*Blue Bar - Surgery month with average per member per month of $10,424.82

*Red Bar - Cost savings per member over months 1-24 post procedure, $4,417.72

NON-EMERGENCY TRANSPORTATION

Non Emergency Transportation

Currently operating Brokerage model under Requests for Proposals (RFP) #20130802

Effective February 1, 2019, will operate Brokerage model under Invitation for Bids (IFB) #20180511

- Practicable and advantageous
- Method of source selection preferred by PPRB OPSCR Rules and Regulations

Current & Future NET Oversight Activities

- Bimonthly Management Meetings
- DOM Contract Compliance Investigations
- Monthly Liquidated Damages (LD) Review
- Corrective Action Plans
- Ad Hoc Report Review
- Provider and Beneficiary Communication
- Call Calibration
- DOM Program Integrity (PI) Investigations
- DOM Participation in Facility, Beneficiary, and NET Provider Education and Conference Calls
- Review of Monthly/Quarterly Deliverable Reports

NET Changes – Effective February 2019

- Increased frequency of beneficiary survey (bimonthly to monthly)
- Revised beneficiary and Medicaid provider complaint resolution
- Revised NET provider complaint resolution process and claims appeals
- Modified payment methodology
- Modified timeframes for hospital discharge
- Contractor response requirement to DOM within 24 hours (confirmation of receipt)
- Contractor response/ resolution requirement within 7 business days
- Removal of NET transportation responsibility for beneficiaries residing in LTC facility

NET Changes – Effective February 2019

- Require Contractor to place damages assessed on their public website
- Modified Provider Manual requirements
- Contractor NET provider network requirement to maintain no less than 46 contracted NET providers
- Contractor NET provider network requirement to maintain no less than 2 NET providers providing transportation services per county
- Beneficiaries given opportunity to choose network provider to extent possible and appropriate
- Contractor must document and retain results of call center audits and provide to DOM quarterly and upon request
- Contractor must report number and types of vehicles used during month

NET Changes – Effective February 2019

- Additional liquidated damage requirements
- Modified corrective action plan requirements
- Required NET provider claims to be submitted to DOM fiscal agent as encounter claims
- Added fixed wing air ambulance transportation
- Automatic Call Distribution (ACD) system answers all calls within 1 ring
- Average monthly speed to answer after initial automatic voice response is 40 seconds or less
- Average monthly abandonment rate is no more than 4%
- Monthly report with appropriate staffing based on Call Center Sufficiency Standards

NET Changes – Effective February 2019

- Increased Call Center hours – 7:00AM to 8:00PM CST
- 4 statewide toll-free telephone numbers
  - Receipt of requests for NET transportation services
  - Report ride is more than 15 minutes late
  - Receipt of complaints and grievances made by beneficiaries, their family member, guardian, representative and MS Medicaid providers
  - NET provider complaints

NET Liquidated Damages

- Deliverable reports due 15th day of month following reporting month (failure to meet standards may result in assessment of damages)
- NET Broker is notified of noncompliance via email and certified mail
- Upon identification of performance failure or noncompliance, DOM reviews performance failures and verifies noncompliance (RFP# 20130802)
- Liquidated damages may be assessed (Section 1.33.2) due to noncompliance and amount is deducted from payments
- Unless specified otherwise, NET Broker receives written notice of failure that might result in assessment of damages and proposed amount (15 days to dispute)
- Unless specifically set forth, DOM may, at its sole discretion, assess damages between $1 and $5,000 for each failure that occurs or remains uncorrected

QUALITY

Preventive Dental and EPSDT Screenings

FFY 2016	Age Groups						
	<1	1-2	3-5	6-9	10-14	15-18	19-20
Eligibles	22,181	53,595	72,485	102,271	102,698	63,532	10,376
Dental*	52	11,042	43,073	63,505	59,319	27,869	3,307
Percentage of Eligibles	0.23%	21%	59%	62%	58%	44%	32%
EPSDT*	21,406	40,132	39,040	31,285	34,009	14,691	1,172
Percentage of Eligibles	97%	75%	54%	31%	33%	23%	11%

**Data based on total eligible beneficiaries receiving preventive dental services and at least one initial or periodic screening.*

Eligible population is based on total eligible beneficiaries who should have received at least one initial or periodic screening.

Preventive Dental and EPSDT Screenings

FFY 2017	Age Groups						
	<1	1-2	3-5	6-9	10-14	15-18	19-20
Eligibles	21,772	52,077	69,169	95,350	103,775	55,744	10,603
Dental*	55	11,066	41,002	60,722	61,989	25,315	3,674
Percentage of Eligibles	0.25%	21%	59%	64%	60%	45%	35%
EPSDT*	21,039	39,608	38,111	30,327	34,267	12,657	1,223
Percentage of Eligibles	97%	76%	55%	32%	33%	23%	12%

**Data based on total eligible beneficiaries receiving preventive dental services and at least one initial or periodic screening.*

Eligible population is based on total eligible beneficiaries who should have received at least one initial or periodic screening.

Long Acting Reversible Contraception (LARC) Utilization

	Fee for Service	Magnolia Health	United Healthcare	Total	% of Eligible Population
CY 2016	1,208	2,047	2,222	5,477	3.3%
CY 2017	1,200	2,082	2,175	5,457	3.4%

17-P Reimbursement

	CY 2015		CY 2016		CY 2017		CYTD 2018	
	Unique Benes	Total Reimbursement	Unique Benes	Total Reimbursement	Unique Benes	Total Reimbursement	Unique Benes	Total Reimbursement
Fee for Service	101	$99,356	80	$108,706	82	$80,500	38	$25,442
Magnolia	115	$314,484	124	$344,646	123	$489,429	58	$111,088
United Healthcare	167	$787,349	198	$871,637	166	$821,649	45	$172,394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