Annual Report: Medical Care Advisory Committee

December 13, 2017

I. Introduction

Over the last year, members of the Medical Care Advisory Committee committed their extensive expertise, time, and energy to the intensive process that yielded the recommendations described in this report. Advisory Committee members made these considerable contributions in a spirit of mutual cooperation and with a common goal to improve the efficiency and accessibility of Medicaid services.

The role of this committee is spelled out in federal and state law to advise the Medicaid agency about health and medical care services. Specifically, the committee is to:

- Advise the division with respect to amendments, modifications and changes to the state plan for the operation of the Medicaid program;
- Advise the division with respect to issues concerning receipt and disbursement of funds and eligibility for Medicaid;
- Advise the division with respect to determining the quantity, quality and extent of medical care;
- Communicate the views of the medical care professions to the division and communicate the views of the division to the medical care professions; and
- Gather information on reasons that medical care providers do not participate in the Medicaid program and changes that could be made in the program to encourage more providers to participate in the Medicaid program.

The meeting topics for this past year have varied. We had a slow start getting organized but then met often to better understand the needs you have as it relates to the Medicaid program.

Our 2017 meetings dealt with the following issues:

- March 9, 2017 – Organizational meeting to discuss the committee's role and responsibilities
- June 1, 2017 – Received a general overview of the Medicaid program
- July 27, 2017 – Reviewed data and issues with low-birth weight babies
- August 31, 2017 – Reviewed issues pertaining to prior authorizations and other general Medicaid issues
- September 21, 2017 – Reviewed issues surrounding hospital and physician reimbursement

Throughout the process, many individuals helped inform the Advisory Committee about issues relating to their specific area of practice. We appreciate their time and expertise to the work of the Advisory Committee.

Committee members intend for their recommendations and this report to establish the foundation for their future work in improving the efficiency and delivery of services to the Medicaid population.

II. What we learned about low-birth weight babies.

Prematurity is the leading cause of infant mortality in Mississippi. Mississippi has the highest infant mortality rate in the country (about 9 babies die for every 1000 babies born live each year). 17

Hydroxyprogesterone (17 P, or 17 OHP) is the only medical intervention shown to decrease the risk of preterm births (birth before 37 weeks' gestation) in women who have had a previous preterm birth. It is a hormone that is recommended to be injected once a week for weeks 16 through 36 of pregnancy. Having a previous preterm birth is the only good predictor of preterm birth. 17P is recommended for women who have had a previous preterm, singleton (not twins or triplets) birth. This hormone treatment is quite costly; however, it decreases the risk of preterm birth by ⅓ to ½. In women who still deliver prematurely, the pregnancy often lasts weeks longer than with her previous preterm delivery.

We learned that while 17 Hydroxyprogesterone is a covered Medicaid benefit, the method by which it is obtained varies by each Coordinated Care Organization (CCO) and the Medicaid program. The Division of Medicaid reported that only 11.6% of the 560 OB-GYNs enrolled in the Medicaid program prescribed this treatment.

Another issue with preterm birth and poor birth outcomes in general is the health of the mother prior to pregnancy. In Mississippi many of our women of child bearing age are obese or overweight, and have associated chronic diseases such as hypertension and diabetes. These chronic diseases can affect the pregnancy and lead to increased preterm births as well as other associated health problems in the newborn infant. Access to regular healthcare for the women of childbearing age who have had a previous preterm birth would help alleviate this problem. If Medicaid coverage, which extends to 60 days' post-partum, were extended to one-year post-partum, women would have the ability to be healthier when they are next pregnant, thereby decreasing preterm births. The Family Planning Waiver program (which all women who have Medicaid during pregnancy are eligible for and are automatically enrolled in) does not cover disease care, only the provision of family planning services. We believe will result in overall cost savings.

Recommendation: The Committee recommends that the Division of Medicaid direct the Coordinated Care Organizations (CCOs) to educate physicians on the availability of this hormone treatment and work to make the process of obtaining the drug easier. It would also be feasible for the Division and CCOs to allow for home administration by a licensed healthcare professional to provide an opportunity for patients to receive the medication when travel is a barrier. We believe the use of a similar or same process for distribution among all Medicaid payers would benefit the program and allow for more appropriate use of the treatment to reduce preterm births.

Also, that the Division of Medicaid should study the feasibility and costs to expand full Medicaid coverage for these women and present this information to the legislature as appropriate.

Please note that the MCAC is continuing to study this issue and may provide more information at a later date.

III. What we learned about the prior authorization and the implications of service limits.

Prior authorization are the two words that provoke more frustration among prescribers than just about any other. The reason is that this requires the physician or other prescriber and/or their staff to spend a great deal of time away from patient care and on the phone or computer trying to get a reply as soon as possible so as not to delay treatment. The Committee heard from the CCOs and the utilization management contractor for the Division of Medicaid regarding the processes to obtain a prior authorization for medications and services from each.

Both CCOs stated they were working to ensure a prior authorization was obtained only when necessary and they continually looked at the data to see where this requirement could be removed. They also reported that they offer a web portal for ease in obtaining a prior authorization.

The CCOs also discussed their programs for exempting certain prescribers from the prior authorization requirement based on past performance. It some instances this is called a "Gold Pass" or a means to simply report the procedure and then reviews are done retrospectively to ensure appropriateness. This type of program rewards those prescribers who ensure medical necessity based on evidence-based guidelines prior to any service/procedure.

Proper and accurate clinical documentation has always been important, but in today's healthcare environment, it has become even more imperative. Physicians and other prescribers understand the need for appropriate documentation to support the medical necessity for certain services. The Division of Medicaid and the managed care plans reported that some documentation is lacking necessary information for them to handle prior authorization requests in a timelier manner. For this reason, we believe education is needed to help prescribers understand what they are doing today and where there are areas for an opportunity to do a better job documenting.

We also learned that service limits such as physician visits and pharmacy benefit limits were designed to control costs; however, the benefit limits with the Coordinated Care Organizations are higher in those programs. The higher benefit limits allow more consistent care at a lower level such as the physician level and reduces the need for some Medicaid fee-for-service beneficiaries to use the emergency department at hospitals for basic health needs due to the fact they have used all their physician benefits. The same argument applies to pharmacy benefit limits. If a person can access their medications, then this may reduce inpatient hospitalizations as their condition may not worsen.

Providers also reported to the committee the frustrations with credentialing and the delays in allowing physicians and others to provide services. It was stated that each system is different and the approval dates may vary from one payer to another.

Recommendation: The Committee recommends that the Division of Medicaid provide more education for all prescribers including hospitals, physicians, dentists, nurse practitioners, and physician assistants, on proper documentation and the various means to obtain a prior authorization. In addition, we want to encourage the CCOs to educate prescribers on the formal "Gold Pass" process to allow more physicians to participate once they have reached the appropriate approval rates.

We would like the legislature to consider removing or at the least increasing the physician benefit limit and increasing the pharmacy benefit limit to a minimum of eight prescriptions per month.

Finally, it is believed that if the credentialing process was standardized among the four Medicaid payer systems (Division of Medicaid, Magnolia Health Plan, Molina, and United Healthcare) to provide for standard information and streamlined approval dates that services to the Medicaid population would be more readily accessible.

IV. What we learned about hospital reimbursement.

Hospital providers reported that in the Spring of 2016, CMS notified the Division of Medicaid that its methodology for distributing supplemental hospital payments through the Mississippi Hospital Access Program ("MHAP") did not comply with federal law. These supplemental payments amount to $533 million and are a significant part of the hospital's compensation for providing services to Medicaid patients. The state's share for these payments are funded entirely by hospital taxes. The Division of Medicaid has been directed by CMS to include hospitals in the development of a compliant model. To date, the Division of Medicaid has not met with hospitals to develop a new complaint methodology. The current model uses the same distribution methodology that was used for distributing Upper Payment Limit payments in SFY 2015 which was based upon a model developed in 2010 before Medicaid changed from cost based reimbursement to a DRG fee schedule. UPL payments are no longer allowed by CMS as the Division of Medicaid voluntarily surrendered the State Plan Amendment necessary for the operation of a UPL program during SFY 2016

Additionally, the MHAP program operates in tandem with the supplemental payment program that provides cost reimbursement to hospitals for services provided to the uninsured (Disproportionate Share Hospital or DSH). Each program, both MHAP and DSH, operate in a manner whereby payment decisions made in one of the programs (MHAP or DSH) has a significant impact on the operation of the other program (MHAP or DSH). The viability of Mississippi's hospitals, including rural hospitals, can only be protected if the programs operate in a manner that assures an appropriate level of cost recovery for healthcare services delivered to uninsured and Medicaid patients for all Mississippi hospitals.

Recommendation: The Committee recommends that the Division of Medicaid solicit input from Mississippi hospitals regarding a preferred methodology for distributing supplemental payments. The goal of the supplemental payment programs is to ensure access for patients covered by Medicaid programs. To that end, the Division of Medicaid and/or the Mississippi Legislature should ensure that both the Disproportionate Hospital Share (DSH) payments and MHAP are allocated to hospitals so that no hospital receives less than its federally defined need for such payments (OBRA Limit).

V. What we learned about physician reimbursement.

The committee learned that Division of Medicaid and the Coordinated Care Organizations would like to change reimbursement to physicians. No details or plans were provided except to say that they wanted to pay physicians based on performance quality measures. This methodology is very concerning to the committee as no information was provided leading us to think it has not been thought out sufficiently. It is unclear how these entities plan to evaluate the performance quality of physicians. Such as the current two Coordinated Care Organizations use two different sets of criteria to evaluate inpatient hospital admissions, the two plans – soon to be three plans - could more than likely use varying degrees of performance quality measures. For example, one plan may say a physician excels in quality measures while another say's that same person is not meeting performance measures.

Recommendation: The Committee recommends that the legislature allow the plans to develop pay-for-performance programs currently allowed for in state law (43-13-117(H)(1)(c)) and to evaluate the effectiveness of those programs, but not allow the Division of Medicaid nor the CCOs to lower the reimbursement below 90% of the current Medicare rate to any physician. We feel strongly that as the Division of Medicaid considers any pay-for-performance methodology that all programs/plans should be presented both to the Medical Care Advisory Committee and be open for statewide comment by

Mississippi Providers before any final decision is made. Furthermore, the insurance providers must provide evidence that these standard have been show to improve patient outcomes.

VI. Upcoming Study Topics

We want legislative members to be involved in this process and hear the issues presented. We would also be interested in looking at any topics that are of interest to the legislature. As we begin our work in 2018, the MCAC will begin with reviewing the Medicaid non-emergency transportation program. We will look at reported problems of people trying to get to medical appointments and the difficulties they face; failure of the transportation provider picking up patients after appointments in a timely manner; and the failure of the transportation provider to transport patients from a hospital setting to their home or other setting such as a nursing home.

VII. Summary

The Committee learned a great deal over the past year and look forward to learning more in 2018. We think that this is an important committee that could contribute to better functioning of the Division of Medicaid. In the coming year, as we learn more about the Medicaid program we hope the Division of Medicaid will recognize the value of this committee and will actively seek our input prior to developing policy, not afterwards. We believe our efforts this past year have shown our desire and interest to be a partner and advise the Division on issues from the entire Medicaid provider community.

We also ask that you evaluate your appointees and replace those who have not attended a meeting in person by asking them to resign so you can appoint someone who is enthusiastic about being a part of this committee. We cannot maintain a quorum or have a meaningful discussion unless we have a group committed to attending. Thank you for your help on this I know that you want us to be successful and to help the Division to be successful as well.

Medical Care Advisory Members

Members: Dr. Steve Demetropoulos (Pascagoula), Chair: Chris Anderson (Jackson), Dr. Allen Gersh (Jackson), Dr. Edward Hill (Tupelo), Dr. Jerry Martin (Oxford), Brad Mayo (Oxford), Dr. Shannon Orr (Madison), Dave Estorge (Gulfport), Dr. James Rish (Tupelo), Dr. William Grantham (Clinton), Dr. Vicki Pilkington (Jackson), Dr. Mary Currier (Jackson)

Ex Officio Members:
Senators: Appropriations Chairperson Buck Clarke, Medicaid Chairperson Brice Wiggins, Public Health and Welfare Chairperson Dean Kirby, Medicaid Vice-Chairperson Hob Bryan
Representatives: Medicaid Chairperson Chris Brown, Public Health and Human Services Chairperson Sam Mims, Appropriations Chairperson John Read