2018 Annual Report: Medical Care Advisory Committee

I. Introduction

The Medical Care Advisory Committee works collaboratively with the Division of Medicaid to provide input on Medicaid health policy; cultivate a better understanding between the health care provider, payers, and consumers of care; and partner with the Division to enhance the delivery of healthcare to all Medicaid beneficiaries.

The committee looks at a range of issues including program design and benefits, concerns from consumers and providers, efficiency and quality of services delivered by Medicaid and the Medicaid coordinated care organizations, and trends in claims processing.

In addition to the role of the committee as outlined in federal and state law to advise the Medicaid agency about health and medical care services, the committee was tasked in the 2018 legislative session to study and advise the Division of Medicaid with respect to:

- Determining the effect of any across-the-board 5% reduction in the rate of reimbursement to providers;
- Comparing provider reimbursement rates to those applicable in other states in order to establish a fair and equitable provider reimbursement structure that encourages participation in the Medicaid program;
- Comparing dental and orthodontic services reimbursement rates to those in other states in fee-for-service and in managed care programs in order to establish a fair and equitable dental provider reimbursement structure that encourages participation in the Medicaid program; and
- Making a report thereon with any legislative recommendations to the Chairmen of the Senate and House Medicaid Committees prior to January 1, 2019.

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

Committee members intend for their recommendations and this report to improve the efficiency and delivery of services to the Medicaid population.

II. Non-Emergency Transportation

Non-Emergency Transportation (NET) is a federally mandated Medicaid service designed to ensure eligible Medicaid beneficiaries have access to and from medical services. The Division of Medicaid contracts with MTM to provide NET services. It was reported that approximately 17,500 Medicaid beneficiaries utilized this service in 2017.

The committee heard from a hospital representative of some examples of system failures within the NET program. Some examples are:

- Patients are not picked up from their medical appointment in a timely fashion forcing them to wait very long periods of time (hours);
- Some patients were not picked up at all after the NET service brought them to their medical appointment;
- Patients reported that the vehicles are dirty and smelled awful;
- Patients reported that other passengers were smoking in the vehicle even though that is not allowed; and
- Some drivers refused to pick up patients from hospitals.

The Division of Medicaid recounted that they too had heard many complaints regarding the NET program. In response, the Division issued an Invitation for Bids for a new NET contract, and the contract requirements will address these complaints and other issues.

The Division reported that the new contract will be effective February 1, 2019, and increased oversight will include:

- Increased frequency of beneficiary survey (bimonthly to monthly)
- Revised beneficiary and Medicaid provider complaint resolution
- Modified timeframes for hospital discharge
- Modified provider manual requirements
- Contractor NET provider network requirement to maintain no less than two NET providers per county
- Beneficiaries given an opportunity to choose network provider to extent possible and appropriate
- Added additional liquidated damage requirements for performance non-compliance
- Increased Call Center hours – 7:00 AM to 8:00 PM CT
- Maintain four toll-free phone lines
    - 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

Additionally, the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER) released a report, on November 6, 2018, titled *A Review of the Procurement and Oversight of the Division of Medicaid's Non-Emergency Transportation Brokerage Contract*, which details an in-depth review of the Medicaid NET program by the committee. Recommendations from the report include:

- Analyzing data in deliverable reports from the NET broker to determine whether new performance standards have improved access and reduced wait times, and
- Using corrective action plans more frequently for consistently unmet performance standards to improve the overall quality of the net program.

Recommendation: The Division of Medicaid concurs with recommendations within the PEER report, is monitoring the existing contractor on a more frequent basis, and is actively working to resolve the issues presented to ensure appropriate and satisfactory service from the current NET vendor. Upon the implementation of the new contract, the Division will monitor the contract frequently, especially in the beginning, to set the standard for expectations and delivery of services. The Committee will schedule an updated report on this program later in 2019.

III. Bariatric Surgery

The committee heard from a coalition of physicians requesting coverage of bariatric surgery for MS Medicaid patients. The physicians reported that Mississippi Medicaid is one out of three states that do not cover bariatric surgery, which they stated is the only proven known therapy that gives people long-term control of their weight. It was reported that after undergoing the most popular procedure, known as a sleeve gastrectomy, 70% to 80% of patients fall below their BMI within one year with exercise and diet and 60% to 70% will have about five years of significant weight loss. Complication rates have improved because of patient management, nutritional guidance, and required long-term patient follow up. In addition, the majority of commercial insurance companies and Medicare cover bariatric surgery as they see the benefits to covering the procedure.

At the request of the Committee, the Division of Medicaid proposed the following Metabolic Policy. To be eligible for bariatric surgery, eligible beneficiaries must meet the following criteria:

- At least 18 years old or older (<18 years of age reviewed via EPSDT requirements)
- BMI $\geq$ 40 kg/m^2; **OR**
- BMI $\geq$ 35 kg/m^2 **AND** at least one or more co-morbidities linked to obesity that is expected to clinically improve with metabolic surgery.

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 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 day prior to surgery
- All surgical care day of surgery procedure
- All surgical care 90 days post-surgery including any readmission associated surgeon visit
- 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

The Division reported that they anticipate cost savings from the procedure beginning the month after surgery, and we would anticipate a greater return on investment in two to three years.

Recommendation: The Committee recommends that the Division of Medicaid implement the proposed metabolic surgery policy to include that Medicaid beneficiaries must utilize a program that has been accredited by the American College of Surgeons Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. As of the date of this report there are nine accredited bariatric surgery centers in Mississippi. The Division shall also follow all patients approved for this procedure to measure outcomes and cost savings.

IV. 17 Hydroxyprogesterone (17 P or 17OHP)

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

While 17P 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 obstetricians enrolled in the Medicaid program prescribed this treatment.

Magnolia Health Plan reported that from 2016 to 2017 the use of 17P marketed as Makena increased from 101 members to 188 members with a prior pre-term birth and the number of babies delivered healthy decreased by 3%.

It was reported that for CY2017 approximately 82 Medicaid beneficiaries in the fee-for-service program received 17P for a cost of $80,500. In addition, 123 beneficiaries enrolled in Magnolia Health Plan received the injections for a cost of $489,429 while 166 beneficiaries enrolled in United Healthcare received the drug for a cost of $821,649.

The Division also reported average expenditures for early pre-term vs. full term pregnancies is overwhelming. The first year of life estimated cost for an early pre-term baby for prenatal care and an infant with complications was estimated to be $123,917. However, the cost of a full term healthy baby is $14,949 along with $10,200 with the use of 17p totaled $25,149. These numbers support the use of 17P.

Discussion with various obstetricians across the state indicates that many physicians are not aware of the evidenced-based protocols on administration and the improved outcomes associated with use of 17P. Others reported that the cost of purchasing a drug that may not be used prevented them from stocking it.

The Division of Medicaid reported that they have recently developed a new policy to allow physician administered drugs to be filed as a pharmacy claim thereby preventing the need for an obstetrician to purchase and stock the costly drug. It is expected that this will increase utilization.

Recommendation: The Committee recommends that the Division of Medicaid and the CCOs, in collaboration with the Mississippi State Medical Association (MSMA), educate physicians on the availability of the effectiveness of this hormone treatment and advise the physicians of the ability to obtain the drug from a specialty pharmacy as needed instead of purchasing the drug and holding until needed. As previously reported by the Division, the use of this treatment for members with a prior pre-term birth will result in cost savings for another low-weight or very low-weight preterm baby.

V. Long-Acting Reversible Contraception (LARC)

Long-acting reversible contraception methods are highly effective in preventing pregnancy. They last for several years and are easy to use. It is also reversible should a patient want to become pregnant. The Committee learned that LARCs such as the IUD and the birth control implant are the most effective forms of reversible birth control available. During the first year of use, fewer than 1 in 100 women using an IUD or implant will get pregnant. Over time, LARC methods are 20 times more

effective than birth control pills. It is believed that more women would use this type of birth control if their physician offered it to them. Such use would aide in preventing unintended pregnancies ensuring proper spacing between births, all which would help in lowering pre-term births. The Division of Medicaid reported that in CY2017 approximately 5,457 Medicaid beneficiaries utilized LARCs, which is only 3.4% of the eligible population.

Recommendation: The Committee recommends that the Division of Medicaid and the CCOs, in collaboration with MSMA, educate physicians on the benefits and evidenced-based protocols on using LARCs and advise the physicians of the ability to obtain the devices from a specialty pharmacy as needed instead of purchasing the device and holding until needed. The Committee will expect an updated report of utilization later in 2019.

VI. EPSDT and Sports Physicals

To improve the preventive health screening rates, the Division of Medicaid is working to develop a pilot project to encourage EPSDT exams in older children by having these exams used as sports physicals. The Division will work with provider groups and targeted schools to improve EPSDT percentages in certain targeted counties, which are still to be identified. Medicaid data shows that as a child ages they are less likely to receive the recommended screenings. Approximately 54% of children aged three to five receive the necessary screenings. However, by ages 15 to 18 only 23% of Mississippi children receive a well-child screening. The national average is 49% for Medicaid children aged 15 to 18.

Recommendation: The Committee found this approach to be innovative and positive to improving health outcomes. The challenge will be to gain the support of physicians who perform sports physicals and others so as not to overwhelm clinics. The Committee would also like to see vaccinations incorporated into the pilot program.

VII. Behavioral Health Hospital Readmissions Pilot Project

In an effort to reduce costs and improve health outcomes, the Division of Medicaid is working with Hinds Behavioral Health Services to improve services and decrease the number of behavioral health hospital readmissions. Each of the CCOs has developed a Performance Improvement Plan to address efforts to improve the outcomes of Medicaid beneficiaries with mental health conditions. The CCOs are meeting monthly with the Division of Medicaid's External Quality Review Organization to ensure adequate progress is being made. Improved communications and outpatient follow-up care were identified as the best opportunity for improvement.

Recommendation: The Committee applauds the Division of Medicaid for identifying this need and working to improve the services provided to individuals with behavioral health admissions. We look forward to following the outcomes of this project.

VIII. Quality Metrics from MississippiCAN Program

Quality metrics seek to measure the degree to which evidence-based treatment guidelines are followed, where indicated, and assess the results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives at various levels.

The Committee is committed to working with the Division of Medicaid and the CCOs to improve the Medicaid program. An overview of each plan's program improvement activities, results, achievements and opportunities will ensure our Medicaid program as a whole continues to improve.

Recommendation: The Committee recommends that the Division of Medicaid review the quality metrics for the CCOs and follow these regularly, set goals for improvement, address barriers that keep us from meeting goals, and adjust goals to get the most benefit. We will seek an update in 2019 of each of the quality initiatives noted in this report such as the use of 17P, LARC use, use of sports physical as a means to perform an EPSDT screen, and a review of behavioral health hospital admission and follow-up care to determine if these efforts are supporting health care improvements for the Medicaid population.

IX. Pediatric Cardiac Services at UMMC

UMMC Children's Heart Services requested a recommendation from the Medical Care Advisory Committee in support of requiring all pediatric heart patients (including in-utero patients) needing surgery to be directed to UMMC with the exception of those living in border counties. UMMC reported 100-150 cases of out-migration per year of pediatric cardiac patients to other states, including Louisiana and Tennessee. This resulted in an approximate state revenue loss of $15 - $20 Million annually.

The Medical Care Advisory Committee will continue to gather information in an effort to make a recommendation at the upcoming February meeting.

X. Reimbursement Study

As previously noted, this Committee was tasked with developing a study and advising the Division with respect to 1) determining the effect of any across-the-board five percent reduction in the rate of reimbursement to providers, 2) comparing provider reimbursement rates to those applicable in other states in order to establish a fair and equitable provider reimbursement structure that encourages participation in the Medicaid program, and 3) comparing dental and orthodontic services reimbursement rates to those in other states in fee-for-service and in managed care programs in order to establish a fair and equitable dental provider reimbursement structure that encourages participation in the Medicaid program.

The Medical Care Advisory Committee, assisted by the Division of Medicaid, determined that in order to establish a baseline for all discussion regarding the effect of a five percent rate reduction and study provider reimbursement rates in other states, we must first understand how MS Medicaid reimburses providers as well as the number of providers impacted by any change.

The Committee first reviewed expenditures by the Medicaid fee-for-service program as well as Magnolia Health Plan and United Healthcare. The expenditures were presented by category of service of in-state vs out-of-state providers. It was noted that in the fee-for-service program the largest expenditures are to long-term care facilities with hospital services the next largest expenditure. In the managed care programs, hospital services accounted for the largest single expenditures.

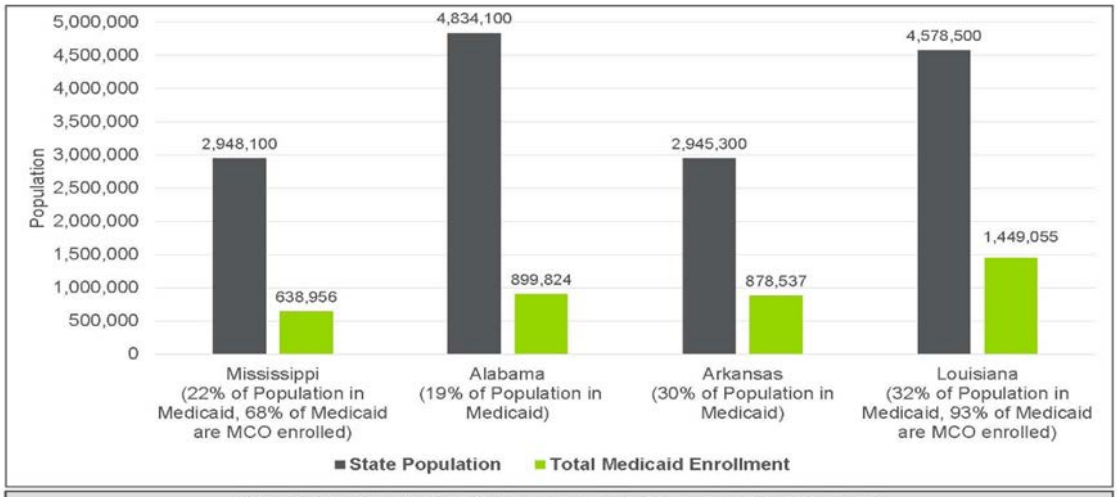
A review was also done of the number of providers enrolled by provider type from SFY2012 to current. We also looked at the number of providers enrolled in the program vs. those that rendered a service with a paid claim for a Medicaid beneficiary. It was noted that overall provider enrollment has increased in most provider types.

Next, the Committee heard from Navigant Consulting regarding their findings from a study of Medicaid reimbursement policies. Navigant compared the Mississippi Medicaid program to the Medicaid programs in Alabama, Arkansas, and Louisiana. The Committee is conscious of the fact that you cannot compare any state Medicaid program and expect same results as there are many other factors that must be considered to ensure appropriate reimbursement. For this reason, the study included information on Medicaid enrollment, managed care enrollment, health insurance status, health status, provider supply, and access to primary care services.

The following charts reflect the Medicaid program highlights from each of the four states in the study.

Section II – Landscape

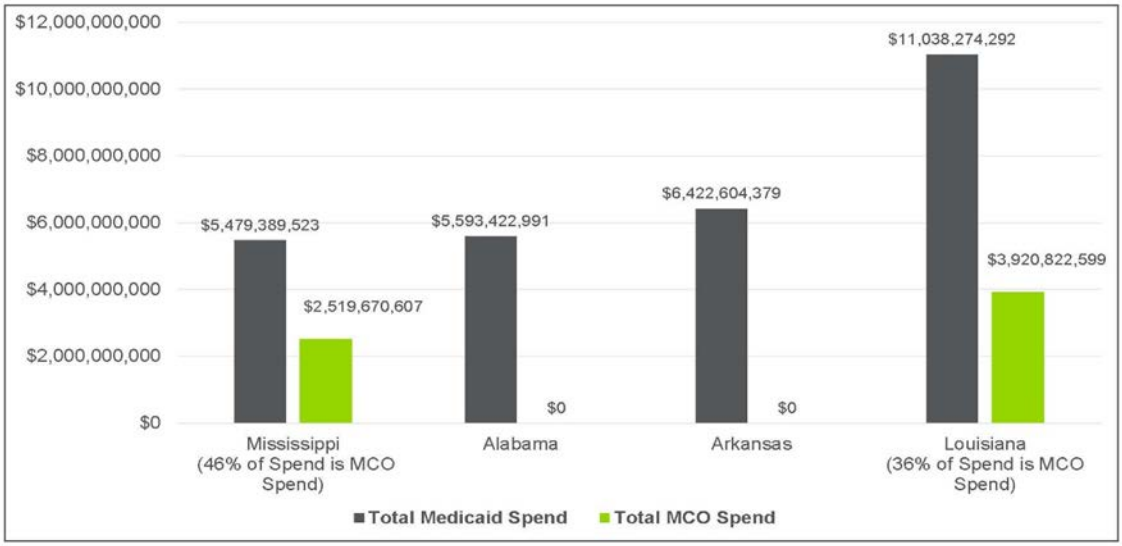
COMPARISON OF PEER STATES' POPULATION, MEDICAID ENROLLMENT, AND MEDICAID MANAGED CARE ENROLLMENT



23% of the total United States population is enrolled in Medicaid

Section II – Landscape

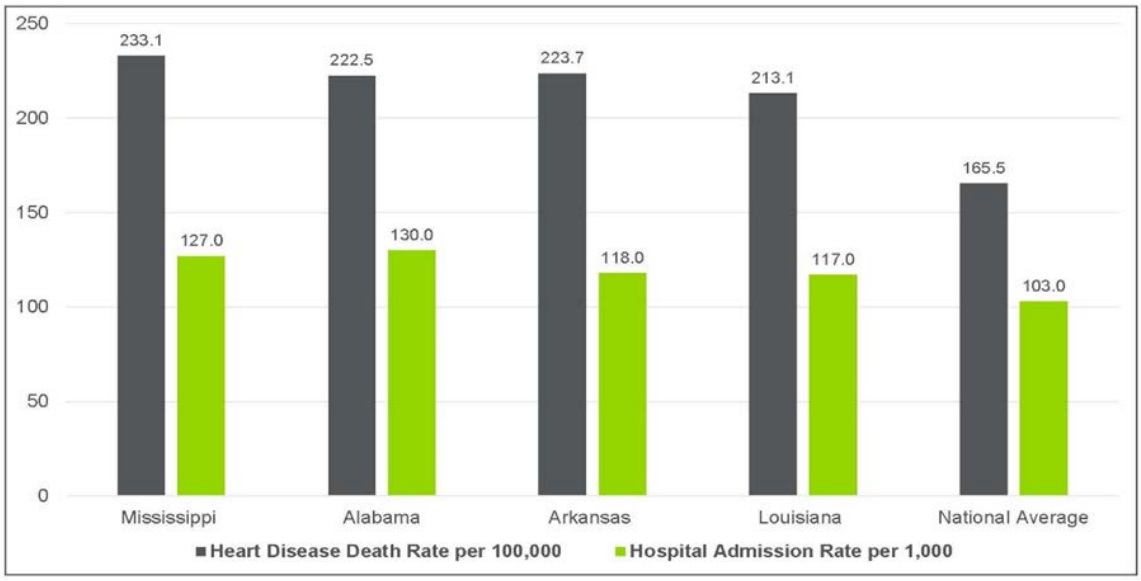
COMPARISON OF PEER STATES' TOTAL MEDICAID AND MCO SPEND



MCO spend accounts for 43% of the total Medicaid spend in the United States

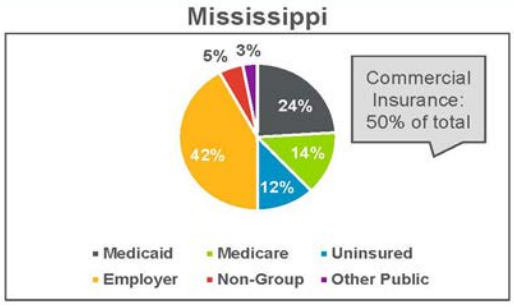
Section II – Landscape

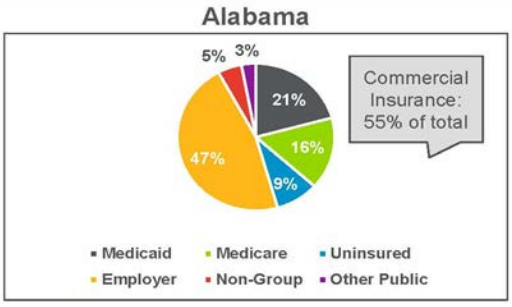
COMPARISON OF MISSISSIPPI, PEER STATES' AND NATIONAL SELECT HEALTH STATUS INDICATORS

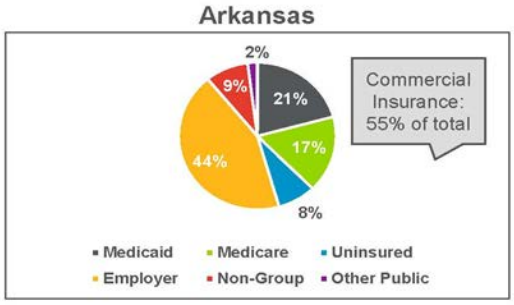


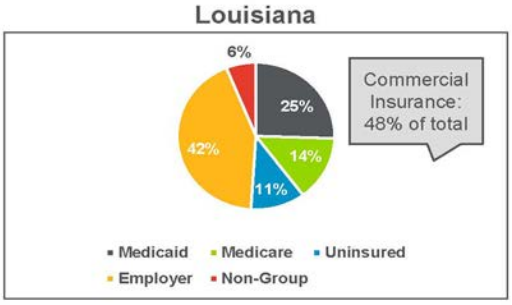
Section II – Landscape

HEALTH INSURANCE COVERAGE BREAKOUT BY STATE



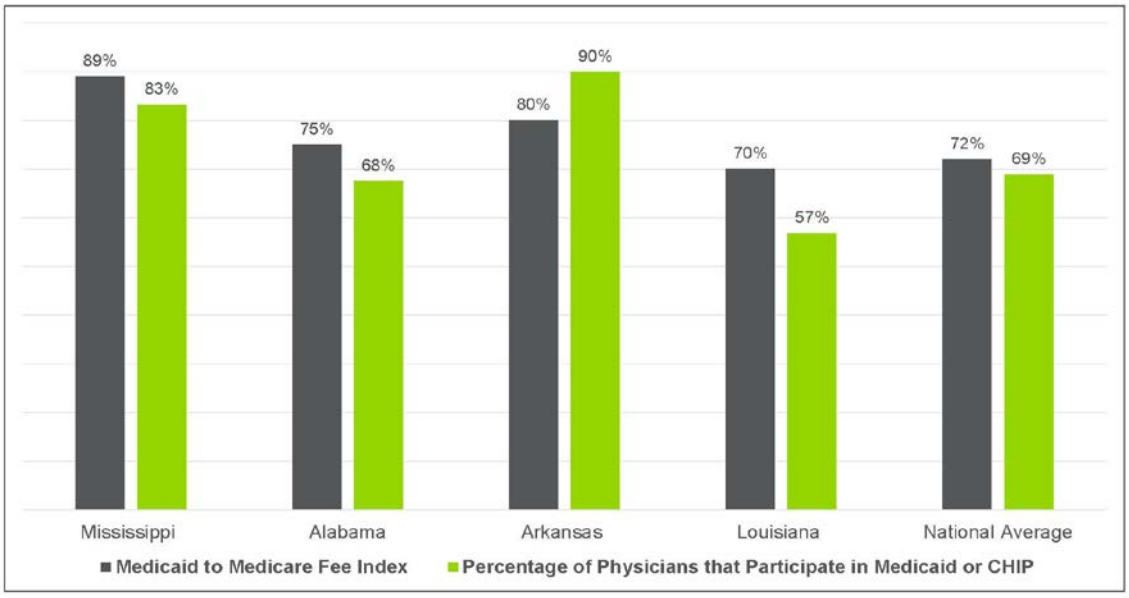






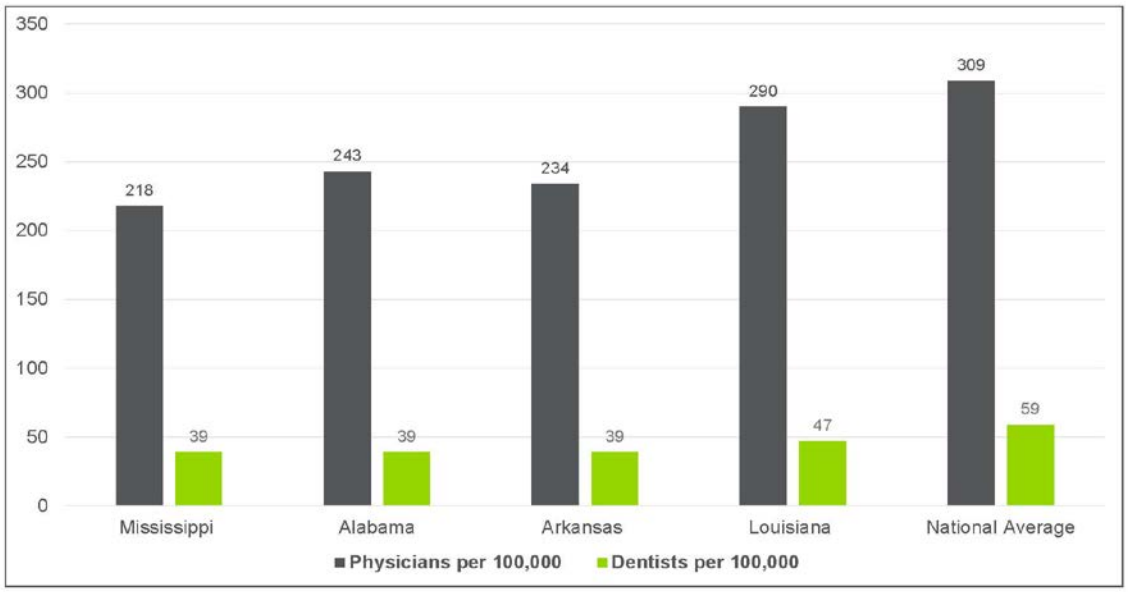
Section II – Landscape

COMPARISON OF MEDICAID TO MEDICARE FEE INDEX AND PHYSICIAN MEDICAID AND CHIP PARTICIPATION



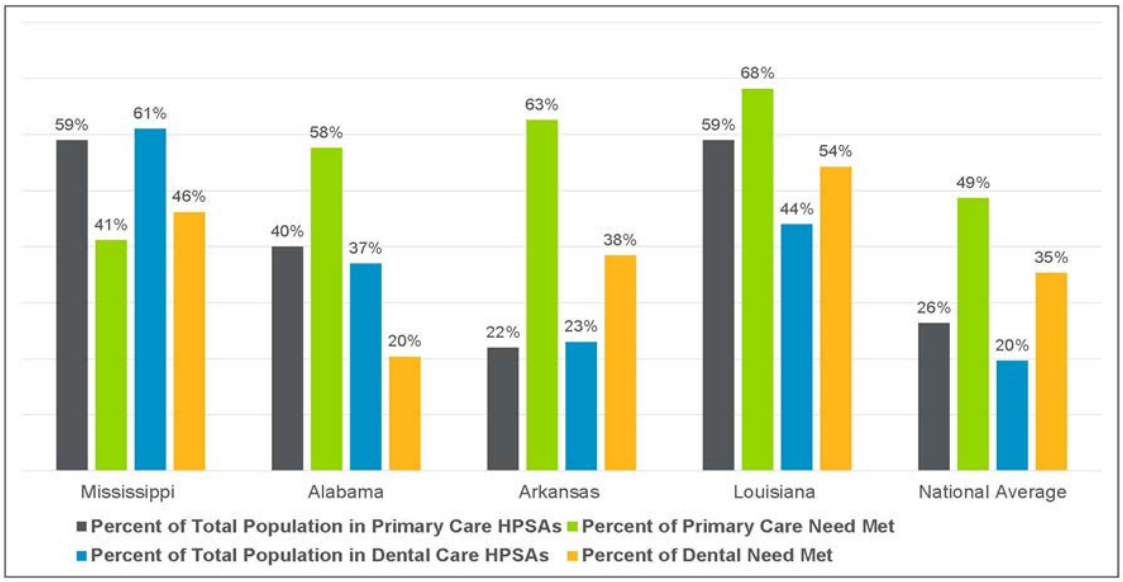
Section II – Landscape

COMPARISON OF MISSISSIPPI, PEER STATES' AND NATIONAL PHYSICIAN AND DENTIST RATES PER 100,000



Section II – Landscape

COMPARISON OF MISSISSIPPI, PEER STATES' AND NATIONAL PRIMARY CARE AND DENTAL ACCESS



Section IV – Fee for Service Rate Comparison

FEE FOR SERVICE RATE COMPARISON

- Mississippi and the peer states often follow the Medicare methodology, paying a percentage of the associated Medicare fee schedule.
- Mississippi Medicaid generally pays higher FFS rates than the ***average FFS rate*** of the Medicaid programs in the peer states for the majority of service types reviewed for this study.
- Mississippi Medicaid FFS rates as a percentage of the average of other states' rates range from 96 percent for X-Ray services (independent radiology) to 157 percent for Ambulatory Surgical Centers.
- However, Arkansas FFS rates are often higher than the rates of each of the peer states.
- Higher Medicaid rates appear to have a positive impact on Medicaid participation: Mississippi and Arkansas physicians participated in Medicaid at a higher rate than physicians in the other two peer states.

All of the information presented by Navigant Consulting indicates that there are fewer Mississippi physicians rendering services to our Medicaid beneficiaries than other states. Also, there is not enough commercial insurance coverage to make up for the reimbursement paid by Medicaid currently.

Recommendation: The Committee concurs with Navigant Consulting that before considering any rate changes the Division of Medicaid should establish the objectives of any future changes in reimbursement or delivery system change, such as the following:

- Reduction in total cost of care for each beneficiary and overall;
- Budgetary goals;
- Creation of provider networks that assure access to quality services for Medicaid beneficiaries;
- Improved outcomes;
- More appropriate utilization, i.e., utilization of services in the most appropriate settings of care;
- Provider and beneficiary satisfaction; and
- Value.

Secondly, while a rate reduction generates immediate savings, it does not generally result in more efficient or effective care delivery. Also, with more value-based purchasing options being explored by various health systems within the state the value of a five percent reduction on those services not currently under a rate reduction would be ineffective in cost savings and delivery of care. In addition, the cost savings of the current five percent rate reduction provides less than $2 million state dollars of savings to the Medicaid program. Therefore, we see no need to continue it.

The Committee plans to continue our study of reimbursement rates and the information provided by Navigant Consulting. Due to the volume of information to be considered and the impact to the healthcare community across the state, this task needs further consideration prior to any formal recommendation. The information provided in this report only skims the surface of the issue and is not in any way intended to represent the final recommendation regarding Medicaid reimbursement policy.

As part of the continuing work, the Committee will work with the Division of Medicaid to review dental reimbursement options with the appropriate stakeholders.

XI. Cigarette User Fee

In considering issues that impact the Medicaid program we must consider all internal and external influences in order to curb the costs to Medicaid, and that includes tobacco products. Tobacco use causes one-third of all cancer deaths and a long list of other chronic health problems ranging from heart disease to emphysema.

The use of tobacco products remains the nation's number one cause of preventable death. Tobacco use is responsible for nearly one in five deaths nationwide. In Mississippi:

- An estimated 5,400 deaths are caused by smoking each year.
- 22.5% of adults and 15.2% of high school students smoke.
- 1,800 kids under 18 become new daily smokers each year.
- Over 30% of cancer deaths in Mississippi are caused by smoking.

The good news is that most patients want to quit. About half of all smokers try each year, but less than 10 percent succeed without help. Sometimes external factors help influence smokers' intent to finally put down their cigarette or other tobacco product for good. Studies have shown that adolescents and young adults are two to three times more sensitive to changes in the price of tobacco than adults. In fact, every 10 percent increase in cigarette prices reduces youth smoking by about seven percent and total cigarette consumption by about four percent.

Tobacco-related illnesses are expensive and harmful for all of us. In Mississippi, smoking is estimated to cost $1.23 billion in direct health care costs, including $319.7 million in Medicaid costs. There is also a $36 million cost to the Medicaid program attributed to exposure to secondhand smoke to Medicaid beneficiaries. Finally, Mississippi experiences $1.8 billion in productivity losses annually.

Recommendation: The Medical Care Advisory Committee recommends that our legislature implement a Mississippi cigarette user fee by $1.50 per pack to generate $166.8 million in much needed revenue for the state, prevent 22,800 kids from smoking, result in 26,500 adults quitting, and save 14,000 residents from premature smoking-caused death.

XII. Closing

The Committee learned a great deal over the past year and appreciates the increased participation by the Division of Medicaid. The work of this committee is growing and we appreciate Drew Snyder and his staff for assisting us. It is only with the commitment and input of the agency that this committee can be effective as we all work together to resolve issues and improve the Medicaid program for the beneficiaries, the providers, and the agency.

We also value the participation of the Medicaid Coordinated Care Organizations. The information provided by Magnolia Health Plan and United Healthcare has been vital in the learning process. It has been refreshing to learn of the programs each of these plans have implemented to improve the lives of the Medicaid population.

Finally, we want to thank our legislative partners for their interest and input into the learning process. Their support of our work is necessary and appreciated as we all work together to improve the delivery of healthcare to our Medicaid population.

All meeting minutes and presentations referenced in this report may be found at https://medicaid.ms.gov/resources/legislative-resources/medical-care-advisory-committee/.

We know there is much to be learned about the Mississippi Medicaid program. Nothing is ever as simple as it may first appear. As we enter 2019, the Committee would like to hear more from other provider groups regarding the Medicaid issues that plague their practice areas. We must work together to solve these issues as a means to improve the delivery of healthcare in our state. If necessary, we will form sub-groups to meet and report back to the Committee in an effort to increase the issues addressed and resolved.

Thank you for allowing us to serve on this committee.

Medical Care Advisory Members

Members: Dr. Steve Demetropoulos (Pascagoula), Chair: Chris Anderson (Jackson), Dr. Allen Gersh (Jackson), Dr. Edward Hill (Tupelo), Dr. Billy Long (Jackson), 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