Medical Care Advisory Committee (MCAC)
August 9, 2019 · 1:00 PM
Woolfolk Building – Room 145
501 North West Street, Jackson, MS 39201

I. Call to Order

- Dr. Steve Demetropoulos called the meeting to order.

II. Roll Call

- Wil Ervin called role of the voting committee members and confirmed a quorum was present for voting purposes.
- **Voting members in attendance:** Dr. Thomas Dobbs (Jackson), Dr. Steve Demetropoulos (Pascagoula), Dave Estorge (Jackson), Dr. Allen Gersh (Hattiesburg), Dr. William Grantham (Clinton), Dr. Edward Hill (Tupelo), Dr. Billy Long (Madison), Dr. Shannon Orr (Madison), Dr. James Rish (Tupelo), Kent Nicaud (Gulfport)
- **Voting members in attendance via phone:** None
- **Voting members not in attendance:** Brad Mayo (Oxford), Dr. Vicki Pilkington (Jackson)
- **Nonvoting members in attendance via phone:** Senator Brice Wiggins, Chairman of the Senate Medicaid Committee and Senator Hob Bryan, Senate Medicaid Committee Vice-Chairman

III. Welcome and Introductions

- Dr. Steve Demetropoulos welcomed members and guests to the meeting.

IV. Approval of meeting minutes from May 10, 2019

- *Motion: Dr. Long*
- *Second: Dr. Gersh*
- *Meeting minutes were approved unanimously*

V. Public Comments

- Mr. Will Crump, Director of Public Health Policy at Oschner's Health Systems, presented comments in opposition of the Pediatric Cardiac Care policy being considered by the Committee. Mr. Crump spoke specifically about the removal of choice by not allowing parents the ability to conduct research and act on what they believe is the best choice for their child. He also stated that this policy was government intrusion in the practice of medicine by limiting the ability for physicians to refer patients to whom they believe would provide the best care.

VI. Old Business – Presentations

1. Medicaid Policy Updates overviewed by Wil Ervin

State Plan, Waivers, Administrative Code updates and Future Filings:

- SPA 18-0015 Disproportionate Share Hospital (DSH) Payments (Effective 10/1/18)

- SPA 19-0001 Targeted Case Management for Beneficiaries with Intellectual and/or Developmental Disabilities in Community-Based Settings (Effective 01/01/2019)
- SPA 19-0003 Non-emergency Transportation Broker Contract (Effective 02/01/2019)
- SPA 19-0004 Prescription Drug Limit Increase (Effective 7/1/2019)
- SPA 19-0005 Home Health Visit Increase (Effective 7/1/19)
- SPA 19-0006 Post-Eligibility Treatment of Income (Effective 1/1/2019)
- SPA 19-0009 Transitional Medical Assistance (TMA) (Effective 1/1/2019)
- SPA 19-0010 Dental and Orthodontic Reimbursement (Effective 3/1/2019)
- SPA 19-0011 Preadmission Screening and Annual Resident Review (PASRR) in Nursing Facilities (NF) (Effective 7/1/2019)
- CHIP SPA 19-0012 Managed Care (Effective 7/1/18)
- CHIP SPA 18-0010 (Submitted 1/9/2018, RAI Issued 11/9/18)
- CHIP SPA 19-0011 Mental Health Parity and Addiction Equity Act (MHPAEA) (Submitted 5/7/19, RAI 5/23/19)
- SPA 19-0013 Outpatient Prospective Payment System(OPPS) Reimbursement (Effective 7/1/19)
- SPA 19-0018 Treatment of Resources (Effective 7/1/19)
- SPA 19-0020 All Patient Refined-Diagnosis Related Groups (APR-DRG) Reimbursement (Effective 7/1/19)
- 1115 Workforce Training Initiative (Completeness letter received 1/22/18, CMS Review In Process)
- AC 19-032 Elderly and Disabled Waiver (Effective 8/1/19)
- AC 19-026 Electronic Signature (Effective 8/1/19)
- AC 19-009 Hyperbaric Oxygen Therapy (HBOT) (Effective 9/1/19)
- AC 19-033 Nursing Facility Discharges (Effective 9/1/19)
- AC 19-034 IL Waiver (Effective 9/1/19)
- AC 19-035 FQHC Mental Health Providers (Effective 9/1/19)
- AC 19-006 Pharmacy Limit (Effective 10/1/19)
- AC 19-029 Tribal Cost Sharing (Effective 10/1/19)
- AC 19-030 UR in ICF/IID (Effective 10/1/19)
- AC 19-038 Dental Services in Hospital and ASC Setting (Effective 10/1/19)
- AC 19-039 Dental Services in Hospital Setting (Effective 10/1/19)
- AC 19-040 Mass Adjustments (Effective 10/1/19)
- AC 19-041 Dental in the ASC Setting (Effective 10/1/19)
- AC 19-042 Incontinence Garments (Effective 10/1/19)

2. Pediatric Cardiac Care Update

- Dr. Demetropoulos reviewed the proposed policy based on need to support our existing instate UMMC pediatric cardiac surgery program along with

considerations for people who receive their care outside of the state based on where they live and to prevent undue hardship.

- Wil Ervin explained the updated policy based on Committee request. The policy now states that if someone is in need of pediatric heart surgery services they would be directed through UMMC by way of a prior authorization process with the exceptions of: 1) an emergency service exclusion, 2) if there is no access to a congenital heart surgery program with a two star or higher rating through the Society of Thoracic Surgeons. UMMC would be required to maintain a two star or higher rating. 3) County of residence exceptions – includes 15 counties that are close to or are bordering neighboring states: Amite, Benton, Desoto, George, Jackson, Harrison, Hancock, Lafayette, Marshall, Panola, Pearl River, Pike, Stone, Tate and Walthall counties.
- *Motion to approve policy:*
    - *Motion: Dr. Grantham*
    - *Second: Dr. Long*
- Committee members discussed specifics of the policy related to how prior authorization would work, how UMMC is the only place in the state currently offering these services, and whether other states have similar policies.
- Dr. Demetropoulos offered his support of the new policy as Chairman of the Committee.
- Wil Ervin explained the proposed effective date is September 1, 2019.
- *Vote to approve policy:*
    - *Policy approved unanimously.*

3. Dental Subcommittee Update

- Dr. Mark Livingston presented and reviewed data specific to dental utilization and expenditures from 2017 and 2018, across Medicaid populations. Dr. Livingston also reviewed dental extraction data explaining that extractions are "end of the road" treatments when there is not coverage to restore teeth or allow normal diets.
- Dr. Livingston also reviewed dental spend in emergency room visits and inpatient admissions.
- Dr. Livingston compared Medicaid fee schedules from the following: Mississippi, Alabama, Arkansas, and Louisiana. He explained reimbursement rates for providers were comparable to other states except for a few instances where rates were higher in other states.
- Dr. Livingston offered some initial areas for consideration for the MCAC:
    - Developmentally Delayed: pediatric population, chronological age should not be an issue.
    - Diabetics: potential impact on dietary intake; value based care.
    - Pregnancy: intended to reduce negative impact on fetus from dental abscesses, in participating sates (CO &VA) coverage extends 60 days' post-partum.
    - Discretionary spending for beneficiaries: mix and match based on illness and need, limit the type of procedures covered.

- Disincentive ED utilization for minor dental issues: encourage patients to seek care at an earlier point, reduction in benefits.
- Increase age limit for some groups: incremental approach

- Additional benefits suggested for selected populations: the subcommittee presented a list of CDT codes that they recommend adding.
- Committee members then discussed specifics presented by Dr. Livingston including opportunities in the Technical Amendments Bill to allow additional coverage, educational components, and current protocols.

V. New Business

1. Long Term Care – Opportunities for Improvement

- Drew Snyder explained the heightened focus on community based services and issues related to the 1999 Olmstead Decision.
  He provided a summary of what was presented in the May MCAC meeting: DOM had a total of 45,463 unduplicated participants receiving services through Long Term Services and Supports in 2017. Of those 44% were located in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities, and 56% were on one of the five HCBS waivers. We have rebalanced in terms of people but not in terms of spending. The 44% who were in the institutional setting represented 71% of total LTSS spending in FY17, and the 56% on the waivers represented 29% of LTSS spending. The relatively smaller population in institutions cost significantly more than those receiving services in the community.
  The Olmstead Decision concluded that people with disabilities cannot be unnecessarily segregated into institutions and must receive services in the most integrated setting possible. Consequently, the federal government has been urging states to balance LTSS spending between institutional care and home and community based settings.
  Mr. Snyder explained that we are lagging nationally on the rebalancing side and argued that DOM needs to increase access to community based services, while ensuring optimal quality and performance across the long-term care spectrum.
  Opportunities for improvement for community based services:
  - Formulate a process to better manage the wait lists for waiver slots that includes prioritizing based on individual needs and circumstances.
  - Placement/Admission based care setting needs of the individual – assess the most appropriate setting for care – skilled nursing or home and community based setting
  - Waiver amendments/consolidation to enhance or customize services to best support person centered service plans
- Nursing Facility Case Mix Reimbursement: Nursing facilities collect information on each of their patients to complete a document called a Minimal Data Set, which they report to the Division on a regular basis. The Division uses a "Resource Utilization Group" classification model – or RUG – to calculate the acuity level for each patient based on the Minimal Data Set information, and this acuity level is called their Case Mix Index. Case Mix Indices within a nursing

facility, for the cost report period, are averaged together to be used to determine an appropriate per diem rate for that facility. DOM rebases the costs within those rates at the beginning of each year, and adjusts them quarterly based on a more current quarterly index average.

- Issues with Case Mix Model:
    - Centers for Medicare and Medicaid Services (CMS) released a proposed rule requiring the use of a Patient Driven Payment Model (or PDPM) for the payment of Medicare Part A nursing facility stays to replace the RUG Model effective October 1, 2019.
    - Nursing facilities with the highest quality ratings comprises the smallest percentage of overall nursing facilities. 29% of nursing facilities had a four or five-star rating, compared to 71% which had a three-star or lower rating.
    - To rebalance overall LTSS spending, DOM might consider rebalancing the higher percentage of low-quality per diem rates by rewarding improvements in certain quality measures.
    - There are two important details about the way the Case Mix Index nursing facility rates are calculated. One is that it factors in the Minimum Data Set information for all patients within a facility – not just those on Medicaid, but also those on Medicare and other forms of insurance or who pay for the care themselves (private pay). It also factors in additional services that Medicaid reimburses for outside of the Medicaid nursing facility per diem, such as therapy, radiology and lab services, and pharmacy services. This creates the potential for reimbursements that cover services for non-Medicaid residents.
    - Proposed revisions to this calculation method – such as averaging only the acuity levels of the Medicaid residents when determining the direct care component of the facility's rate – could net savings which we could use to create a value-based payments pool. Out of that pool we could reward nursing facilities that improve on certain quality measures.
- Dual Integration:
    - $260 million spend on Medicare Part B premiums
    - $56 million spend in state dollars in Medicare Part D premiums
    - Crossover Claims
    - Another complex component of Medicaid reimbursement that impacts Long Term Care spending, but also extends beyond nursing facilities, has to do with individuals who are covered by both Medicare and Medicaid.
- The Committee briefly discussed LTSS as an area with opportunities for cost savings along with issues related to medically complex cases and limits in what facilities are able to except them. Dave Estorge stated that UMMC is ready to partner with someone to allow other choices and have a policy discussion.

2. CCO – Pharmacy Best Practices and Management of High Utilizers

- Dr. Becky Waterer and Dr. Amit Prasad presented for Magnolia Health Plan and UnitedHealthcare on what are the most common disease states that lead to high

utilization of healthcare resources among Medicaid beneficiaries in Mississippi including:

- Diabetes Mellitus, Hypertension, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease/Asthma, Attention Deficit Hyperactivity Disease (ADHD) in children

- What can be done to better manage these disease states?
- Dr. Demetropoulos stated he would like to look at these numbers each year and push it out to providers so that they can improve.
- What data do we have to see how well we compare to other surrounding states in these measures?
  - Comparison of Magnolia Health Plan Metrics to other Centene Medicaid plans 2018: chose some surrounding states and looked at the specific measures and we are doing better than some. The state that is most like Mississippi is Missouri. Magnolia will continue to try to do better to improve numbers.
  - Comparison of UHC Metrics to other Medicaid plans 2018: Did not have data from a lot of different dates. Was expecting the numbers to be lower but will continue to improve them.
  - Comparison of Molina Health Plan Metrics to Other Molina Medicaid Plans 2018: Same as other plans.
- What more can and should we be doing?
  - Continue efforts to educate providers and members on quality care measures: Quick Reference Guides, Quality Coordinator visits to individual providers and facilities.
  - Explore adding quality measures in to value-based contracts with provider groups and facilities.
  - In 2019, the Division of Medicaid has established quality targets for all Coordinated Care Organizations and failure to meet the specified targets will result in a financial penalty.

3. Provider Satisfaction Surveys

- Wil Ervin offered an update including DOMs conversations with the managed care companies and that Dr. Latorre talked to Dr. Gersh about how to improve provider response rates on the satisfaction surveys. We are requiring the managed care companies to submit satisfactions surveys every year. Wil would like to propose that the division pursue the creation of a uniform satisfaction survey that would fulfill the managed care companies' requirement for an annual survey and would work together to work with the trade associations to try to push it out.
- Dr. Demetropoulos agreed that the survey should be uniform and does not need to be a lot of questions. It will need to be sent out electronically. We also need to let the providers know that we want their feedback and figure out how the division and managed care organizations can improve. Dr. Demetropoulos would like the survey to be pushed out within the next 3 to 4 months to try to get feedback and get a plan in place.

4. **Care Management Utilization**
    - Dr. Becky Waterer presented for Magnolia Health Plan:
        - What is the purpose of care management?
            - Transforming the health of our community one member at a time and achieving the improved health outcomes at the lowest cost possible. Both of these goals are accomplished through Care Coordination (member/provider/subspecialists/all available resources/healthplan), and Member Education and Empowerment
        - Elements of Care Management
            - Preventative Medicine, Care Gap Closure, Population Health Management, Social Determinants of Health, Care Coordination, Provider Collaboration, Disease Management, Complex Case Management, Emergency Room Diversion
        - All Magnolia Health Plan members with any need physical, behavioral or Social Determinant of Health is eligible for Care Management Services at some level. Members with chronic and high risk illness are where we seek to go first for improved outcomes and quality of life.
        - There are different levels of Care Management:
            - Complex Case Management: members who have high utilization of ER and or Inpatient stays. Catastrophic Diseases such as Cancer, Transplant.
            - Care Management: Typically at a lower risk and more stable but have a Chronic 5 diagnosis: Diabetes, Cardiovascular Disease, Chronic Respiratory Diseases, Cancer, Stroke.
            - Disease Management: Members who are stabilized but benefit from Health Coaching and Healthy Lifestyle Choices and education. Smoking Cessation and Weight Loss Programs are in this category.
            - Care Coordination: Social Workers manage these members for: Benefit education, assistance with doctor appointments, transportation, and social determinants of health, DME needs and Needy Meds. Program.
        - Currently there are 5,589 Magnolia Health Plan Medicaid/MSCAN members enrolled in Care Management Services. Current Medicaid/Magnolia Population is 204,106. That is 3% of the population in Care Management Services. Because the duration of care management varies based on several issues, we anticipate that in calendar year 2019 we will have over 10,000 members enrolled in Care Management Services at some level. This represents 5% of the Magnolia MSCAN population.
        - Individuals can enroll in care management through Self-Referral, Provider Referral, Utilization Management Referral, Claims Referral, High Risk CM Referral, State Agency Referral, Caregiver Referral
        - All members receive care coordination in Welcome Packets, Newsletters and Website Notifications. Members must agree to Case Management services. Many members do not need direct Care Management as they

have stable conditions and do not have Rising Risk or worsening disease processes. With the average Care Manager carrying a caseload of about 100 members, Magnolia would need over 2,000 care managers alone, which they believe to be neither cost effective nor reasonable.

- Care Management Services include Care Coordination, Education, Encouragement, Empowerment and Participation in one's own health by our members. Complex Case Management, Population Health Management, Care Coordination, Disease Management, Social Determinants of Health, Provider Collaboration, Care Gap Closure, Preventative Medicine, and Emergency Room Diversion.
    - Quality is tracked by HEDIS measures and DOM specific quality expectations
    - Birth Outcomes are tracked monthly
    - Claims review tracks compliance with certain things such as flu shots
    - ER utilization, Inpatient readmissions and Medication adherence are tracked to determine Care Management effectiveness
    - Health Risk Assessments are tracked
    - Resource referrals are tracked to see how effectively we are meeting our members' Social Determinants of Health needs
    - Care Manager performance is monitored for production, audited for effective member outreach and outcomes

- Dr. Amit Prasad presented for UnitedHealthcare:
    - Whole Person Care is a holistic, integrated care management and coordination that addresses members' medical behavioral and social needs. The care team addresses social factors: lack of housing, food insecurity, utility needs, violence, and transportation.
    - The care teams use a compassionate, high-touch approach to address members' clinical, behavioral and social needs.
    - Whole Person Care objective:
        - Connect members to the appropriate level of care
        - Engage members and remove barriers to self-care, therapeutic intervention, and social supports - with the intent to prevent unnecessary acute admissions and emergency department visits
        - Ensure appropriate engagement with and support for highest risk members
        - Educate in chronic condition management, behavioral health and substance use disorders
        - Success metrics:
        - Reduction in utilization (inpatient, readmission, ER, improved community tenure)
        - Enhanced quality (HEDIS measures)
        - Reduction in total cost of care
    - The approach is to identify at-risk members, provide local personal care and enhance experience through a single contact.

- Whole Person Care is a population health model where members are engaged in their health and wellbeing that is not driven by diagnosis. It addresses the medical, behavioral, social determinants of health and functional needs or the members. The engagement strategy is through field and telephonic based member outreach and local based care team models. Members are identified through: internal algorithm, direct provider/member referrals, inpatient transitions in care, and health plan referrals. Development of Plan of Care or Health Action plan is created to close barriers in care.
- Care coordination: The UHC team provides data-driven, evidence based care coordination for all high-risk members.
- Identifying members most at risk: The blended identification and stratification (ID/Strat) process includes: Behavioral health, medical, pharmacy, and social determinants of health. This helps identify individuals for intervention using: condition-specific triggering events, HEDIS measures, Utilization and/or risk markers.

- Dr. Joiner presented for Molina:
  - Dr. Joiner, for the sake of time, let the committee know that Molina's care management program was very similar to the other two CCOs and reiterated that it was a very important part of what they do.
- Committee members then discussed specifics regarding care management including the need for intensive management, education of providers in managed care models, and needed communication and coordination between case management providers.

VII. <u>Final Comments/ Action Items</u>

- Dr. Demetropoulos- Next meeting is the last meeting of the year. We will have the Dental Committee report, additional follow-up on long term care and the satisfaction survey.
- Plan to move forward with a winter meeting in Jan. – Feb, 2020.

VIII. <u>Next Meeting</u> – Friday, November 1, 2019

VIII. <u>Adjournment-</u> Dr. Demetropoulos adjourned the meeting.