Medical Care Advisory Committee

November 1, 2019

MISSISSIPPI DIVISION OF MEDICAID

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State Plan Amendment (SPA) Updates

SPA 19-0011 Preadmission Screening and Annual Resident Review (PASRR) and Specialized Services

- Approved effective July 1, 2019

SPA 19-0013 Outpatient Prospective Payment System (OPPS) Reimbursement

- Approved effective July 1, 2019

SPA 19-0018 Treatment of Resources

- Approved effective July 1, 2019

SPA 19-0020 All Patient Refined-Diagnosis Related Groups (APR-DRG) Reimbursement

- Approved effective July 1, 2019

SPA Updates

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 19-0019 Graduate Medical Education (GME)

- Submitted 7/10/19, effective 10/1/2019

SPA 19-0021 Pediatric Congenital Heart Surgery

- Submitted 9/27/19, effective 9/1/2019

Waiver Updates

1115 Workforce Training Initiative

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

Independent Living (IL) Waiver amendment

- Approved 10/28/19

Elderly and Disabled (E&D) Waiver amendment

- Submitted 9/30/19

Administrative Code Updates

- 19-043 Leave Days (eff. 11/01/2019)
- 19-024 New Provider Enrollment (eff. 12/01/2019)
- 19-044 NP/PA Collaborative Agreement (eff. 12/01/2019)
- 19-047 Physician Administered Drugs Prior Authorization in the Outpatient Hospital (eff. 12/01/2019)
- 19-048 Physician Administered Drugs Prior Authorization in the Physician Office (eff. 12/01/2019)

Administrative Code Updates

- 20-008 Therapy Progress Notes (eff. 01/01/2020)
- 20-003 Provider Peer Review Protocol (eff. 01/01/2020)
- 20-010 Out-of-State Provider Enrollment (eff. 01/01/2020)

Old Business

- Dental Subcommittee - update

MISSISSIPPI DIVISION OF MEDICAID

MEDICAID MEDICAL CARE ADVISORY COMMITTEE

DENTAL WORKGROUP PRESENTATION

NOVEMBER 1, 2019

OUTLINE

- Contributors
- Groups reviewed
- Currently reimbursed procedures
- Procedures to be considered
- Statistics
- Risk Mitigation
- Conclusions

CONTRIBUTORS ON THE FINAL PRODUCT

- Mark Livingston
- Stacey Brookerd
- Richard Akin
- Eric Hyde
- Curtis Bishop
- Jeff Gamblin
- Tracy Buchanan
- Wil Ervin
- Jason Griggs

GROUPS REVIEWED

- Diabetes: nutritional issues and potentially suppressed immune function
- Pregnancy: opportunity to impact 2 patients by treating only 1
- Developmentally Delayed: de facto pediatric population

CURRENTLY REIMBURSED PROCEDURES: >21

- Limited exam: $38.69
- Periapical radiographs:
  - Series: $63.00
  - First: $12.60
  - Additional: $11.34
- Bitewing radiographs:
  - One: $12.69
  - Two: $20.30
  - Three: $24.75
  - Four: $28.56
- Panoramic radiograph : $51.79
- Extractions:
  - Simple: $78.76
  - Surgical: $119.13
  - Soft tissue impaction: $149.38
  - Partial bony impaction: $198.76
- Alveoloplasty:
  - With exts, 4+: $118.20
  - With exts, 1-3: $103.43
  - W/o exts, 4+: $192.08
  - W/o exts, 1-3: $162.53

PROCEDURES TO BE CONSIDERED

- Comprehensive exam: $40.73
- Prophy: $***
- Fluoride:
  - Topical: $15.27
  - Topical Varnish: $23.80
- Periodontal Therapy:
  - 4 or more teeth/quad: $105.01
  - 1-3 teeth per quad: $60.80
- Anterior restorations:
  - 1 surface: $69.25
  - 2 surfaces: $88.38
  - 3 surfaces: $127.16
  - 4 surfaces: $127.95
- Posterior restorations:
  - 1 surface(A/C): $66.10/81.12
  - 2 surfaces(A/C): $85.55/106.18
  - 3 surfaces(A/C): $103.43/131.91
  - 4 surfaces(A/C): $125.98/161.59

2018 REVIEWED GROUPS: OVER 21

- Total beneficiaries: 362,568
- Diabetic (Primary/Secondary Dx):
  - Beneficiaries: 64, 093
  - Spending: 7,328 benefits totaling $2,950,577.69
- Pregnancy:
  - Beneficiaries: 28,997
  - Spending: 2,546 benefits totaling $773,319.42
- Developmental Delay:
  - Beneficiaries: 8,942
  - Spending: 1,993 benefits totaling $639,636.73

DIABETES

ENTIRE GROUP

- Sample size: 7281
- Mean: $405
- SD: $723
- Current spend: $2,950,578
- CS+1SD: $8,128,024
- CS+2SD: $13,485,470
- N>$2500: 118
- Spend>$2500: $526,723

OUTPATIENT ONLY

- Sample size: 7163
- Mean: $338
- SD: $423
- Current spend: $2,423,855
- CS+1SD: $5,456,058
- CS+2SD: $8,488,261

PREGNANCY (COE)

ENTIRE GROUP

- Sample size: 2546
- Mean: $304
- SD: $467
- Current spend: $773,319
- CS+1SD: $1,961,380
- CS+2SD: $3,149,441
- N>$2500: 22
- Spend>$2500: $77,982

OUTPATIENT ONLY

- Sample size: 2524
- Mean: $275
- SD: $333
- Current spend: $695,337
- CS+1SD: $1,537,035
- CS+2SD: $2,378,733

DEVELOPMENTAL DELAY

ENTIRE GROUP

- Sample size: 1986
- Mean: $322
- SD: $754
- Current spend: $639,637
- CS+1SD: $2,136,633
- CS+2SD: $3,633,628
- N>$2500: 40
- Spend>$2500: $177,433

OUTPATIENT ONLY

- Sample size: 1946
- Mean: $238
- SD: $395
- Current spend: $462,204
- CS+1SD: $1,230,089
- CS+2SD: $1,997,974

IMPACT OF ER/OR/INPATIENT

ER/OR/INPATIENT

- Sample size: 180
- Spend: $782,138
- Average: $4,345

TOTAL OUTPATIENT: ALL GROUPS

- Sample size: 11,633
- Spend: $3,581,396
- Mean: $308

EXPENDITURE RISK MITIGATION

- Current $2500 limit
- Restorations: set a max number/year
- Cleaning/Periodontal Tx: max number per year or reimburse only once every 2 years
- Teeth can't be filled once extracted
- Pregnancy has a time limit; even if coverage is 60-90 days postpartum
- Self-limiting access to care: dentists with patient pools paying UCR will not displace these patients for the lower level of reimbursement

CONCLUSIONS

- Prevention and Maintenance are preferable to Emergent Care
- Medical Care is keeping us alive longer than our teeth
- We know what repetition will get us; déjà vu
- Further research is ongoing; denied claims used to extrapolate potential costs
- Questions???

Old Business

- Provider Satisfaction Surveys
- 3 Year MCAC Recap (2017 – 2019)

3 Year MCAC Recap

1. Recommended Standardized Credentialing
2. Increased Access to Primary Providers and Medication Coverage
3. Low Birth Weight Babies and 17 Hydroxyprogesterone
4. Prior Authorization
5. Mississippi Hospital Access Program (MHAP)
6. Medicaid Reimbursement Study

3 Year MCAC Recap (cont.)

7. Nonemergency Transportation (NET)
8. Long-Acting Reversible Contraception
9. EPSDT and Sports Physicals
10. Behavioral Health Hospital Readmissions Pilot Project
11. MississippiCAN Quality Improvement
12. Pediatric Cardiac Services
13. Cigarette User Fee

3 Year MCAC Recap (cont.)

14. Dental Coverage Improvement
15. Provider Satisfaction Survey
16. Bariatric Surgery Policy
17. Prosthetics Coverage
18. Address High Risk Pregnancies
19. Innovative Practices
20. Long Term Services and Supports
21. Pharmacy Best Practices and Management of High Utilizers
22. Shared Savings/Value Based Reimbursement

New Business

- Post-Partum Coverage – Mississippi Chapter, American Academy of Pediatrics (MSAAP)
  - Presented by Dr. Renate Savich and Dr. Charlene Collier

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Mississippi Effort for 1 Year Postpartum Medicaid Coverage

Renate Savich, MD
Chief, Division of Neonatology and Newborn Medicine
Charlene Collier, MD, MPH
Associate Professor of Obstetrics & Gynecology
Mississippi State Department of Health

Reason for 1 Year Postpartum Coverage?

National effort endorsed by AMA

1. Reduce maternal mortality in Mississippi through complete postpartum Medicaid coverage
2. Reduce prematurity and infant mortality in Mississippi

Outline

- US and MS data on maternal mortality
- US and MS data on infant mortality
- US and MS data on prematurity
- Risk factors for prematurity
- Financial impact of prematurity in US and MS
- Uninsured mothers in MS
- Prevention of prematurity in MS by expansion of health care coverage

Key Findings from MS Maternal Mortality Review

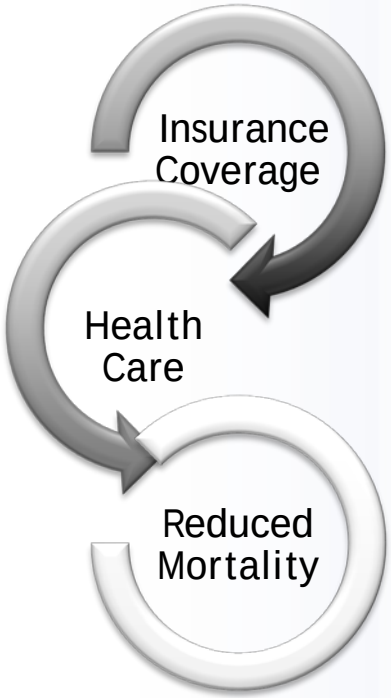
- Cardiovascular conditions and hypertensive disorders of pregnancy were the two most common causes of pregnancy-related death in Mississippi.
- Suicides and overdoses accounted for 11% of all maternal deaths.
- 86% of pregnancy-related deaths occurred postpartum, including 37% after 6 weeks.

The Majority of the Postpartum Deaths in MS were Preventable

- Continuation of hypertension treatment
- Cardiovascular disease screening and treatment
- Mental health treatment
- Substance use treatment

First Recommendation of the MS MMRC

"Given the number of postpartum deaths, extend Medicaid eligibility for the postpartum period from 60 days to one year after delivery"



National Effort for 1-year Postpartum Medicaid

- June 2019- American Medical Association endorsed 12 month postpartum Medicaid

- American College of Obstetricians & Gynecologists President Ted Anderson MD

  "Already, federal statute covers a baby born to a mother on Medicaid through the first year of life. That baby's mother needs the same level of access to care. Closing the critical gap in coverage during this vulnerable time can mean the difference between life and death for some women"

- 7 states including Texas, Georgia and South Carolina have legislative/regulator action to establish 12 months postpartum coverage

- Multiple state maternal mortality reviews recommend 12 month coverage as central strategy for reducing maternal death

Infant Mortality in the US-2017 Data

WORST STATE : Mississippi-8.73 per 1000 births

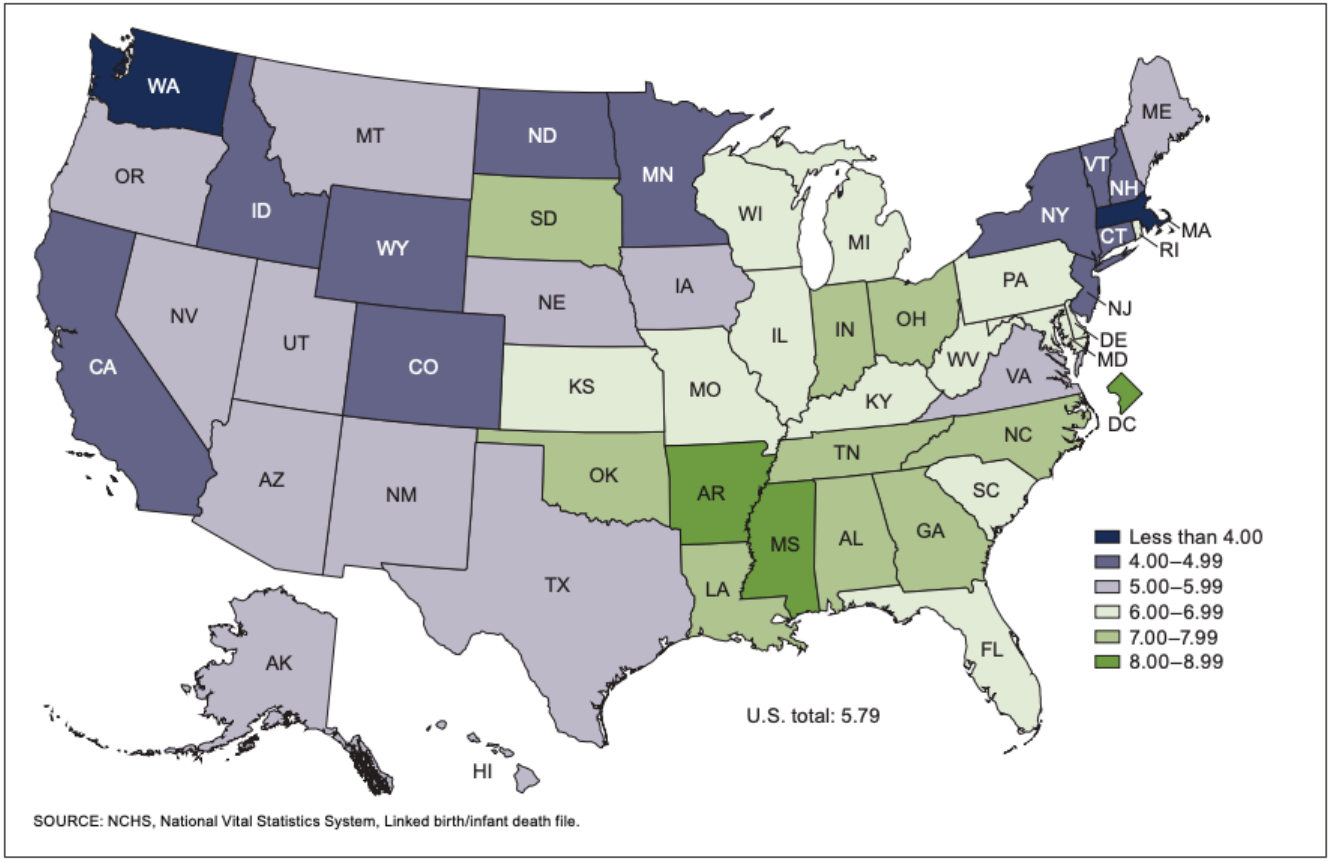


Figure 3. Infant mortality rates, by state: United States, 2017

Ely, NVSR: Vol 68, Aug 1, 2019

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Health Disparities in Infant Mortality

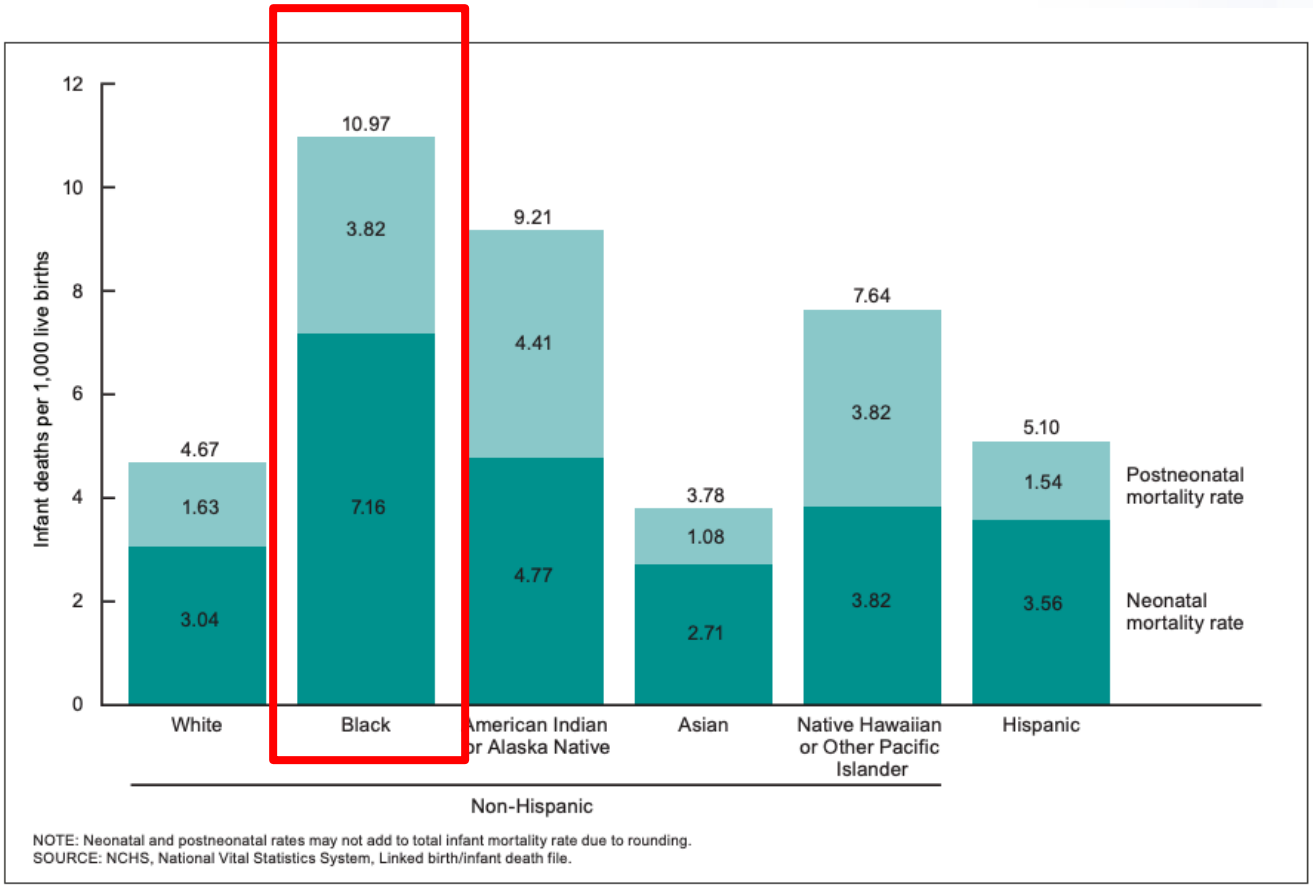

Figure 2. Infant, neonatal, and postneonatal mortality rates, by race and Hispanic origin: United States, 2017

Ely, NVSR: Vol 68, Aug 1, 2019

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- What is causing the high infant and neonatal mortality in the US?

- Main factor: PREMATURITY!

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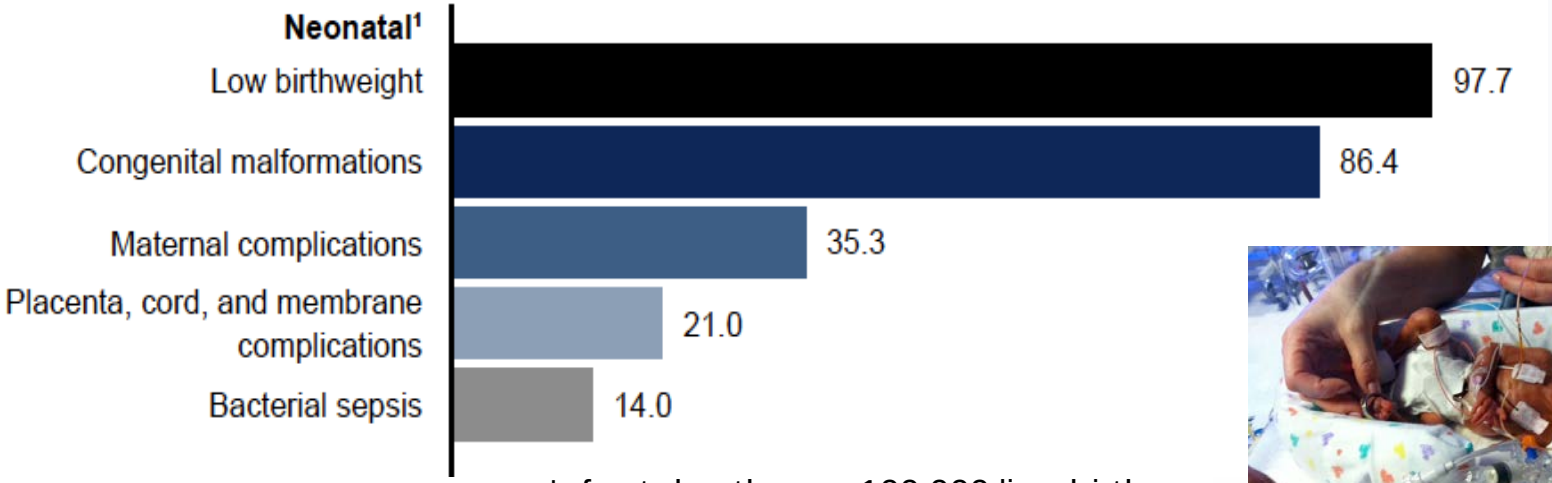
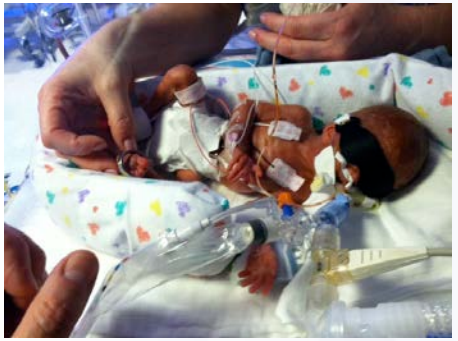
Neonatal Mortality Rates For Five Leading Causes of Neonatal Death

United States, 2016





Prematurity alone has stayed as main cause for about 1/3 of deaths for 10 years

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Ely, NCHS Data Brief: 326: Nov 2018
Ely, NVSR: 68, Aug 1, 2019

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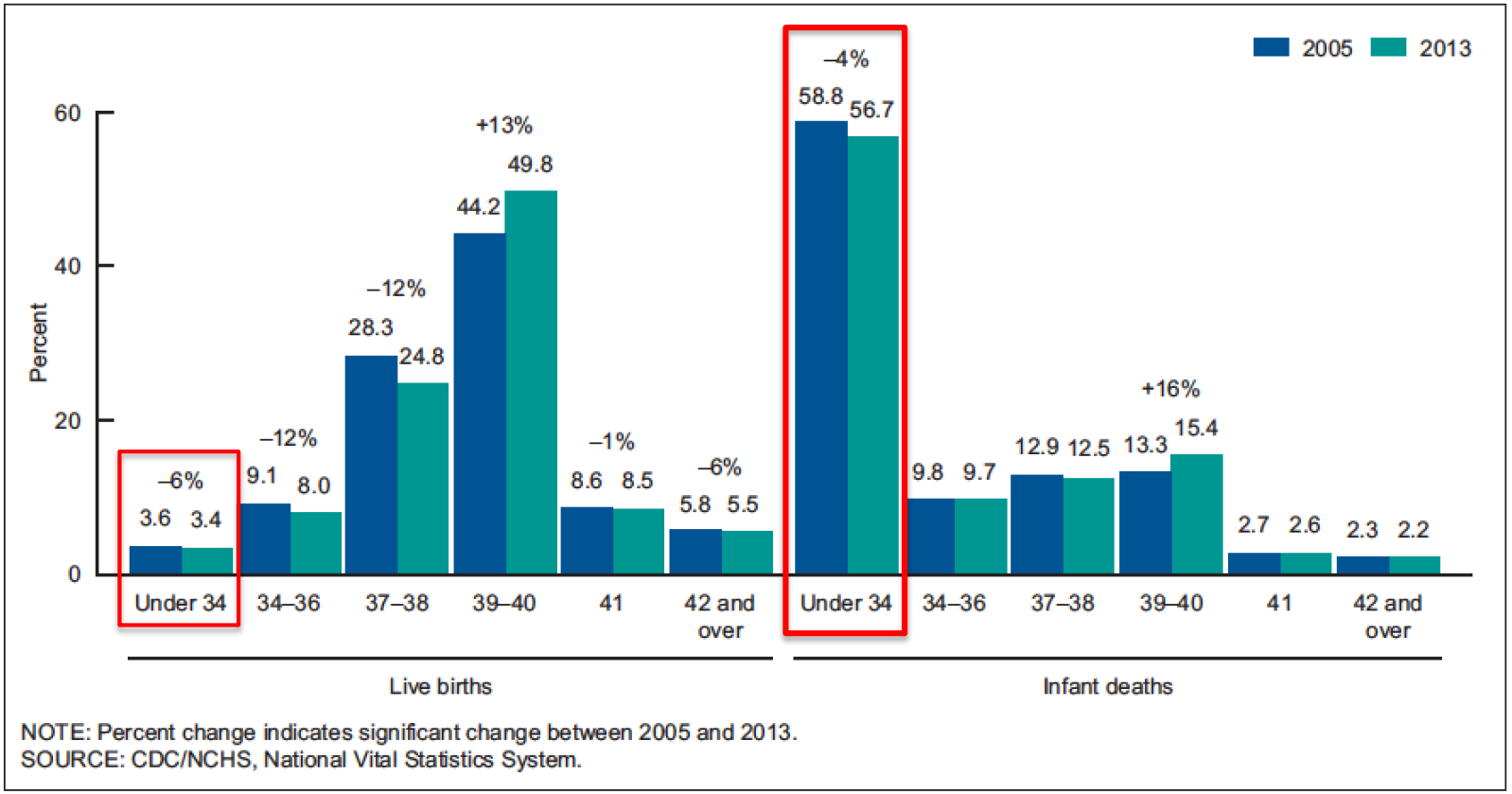
Impact of Prematurity on Infant Deaths in the US



NOTE: Percent change indicates significant change between 2005 and 2013.
SOURCE: CDC/NCHS, National Vital Statistics System.

National Vital Statistics Reports,Vol. 64, No. 9, August 6, 2015

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Premature Births

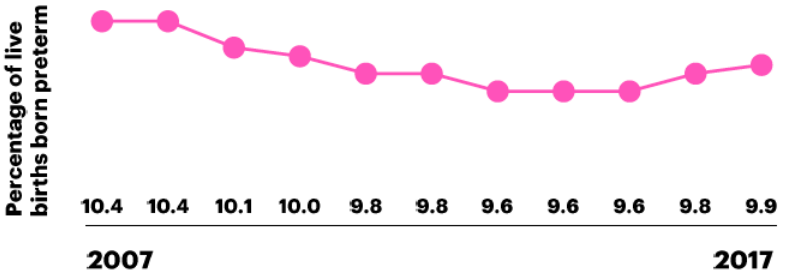
UNITED STATES

GRADE

C

PRETERM BIRTH RATE

9.9%



Preterm Birth Rate in US are INCREASING!

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Premature Births

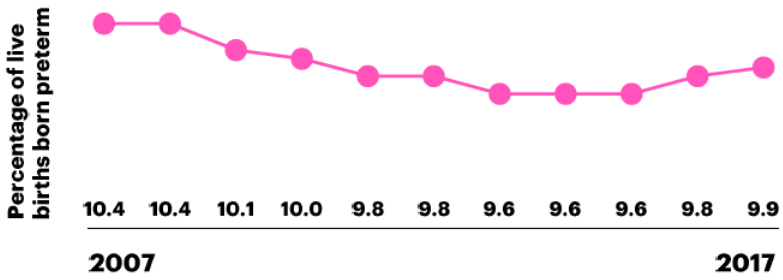
UNITED STATES

GRADE

C

PRETERM BIRTH RATE

9.9%



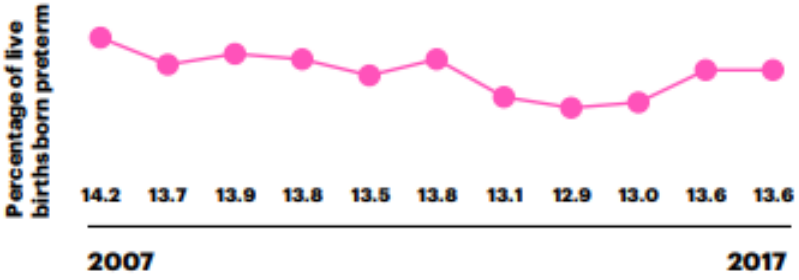
MISSISSIPPI

GRADE

F

PRETERM BIRTH RATE

13.6%



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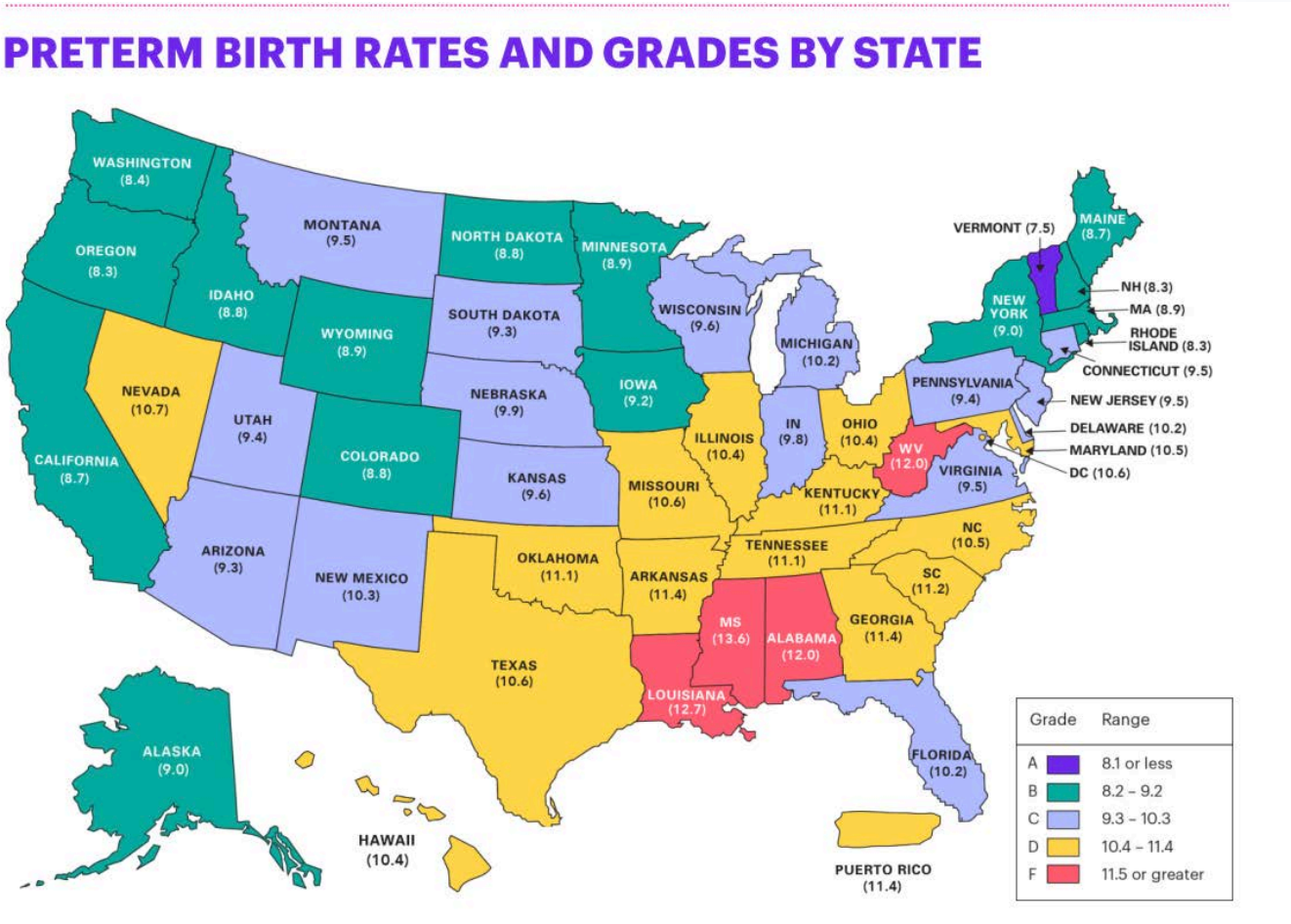
Preterm Birth Rates by State 2017



Again, MS is the highest!

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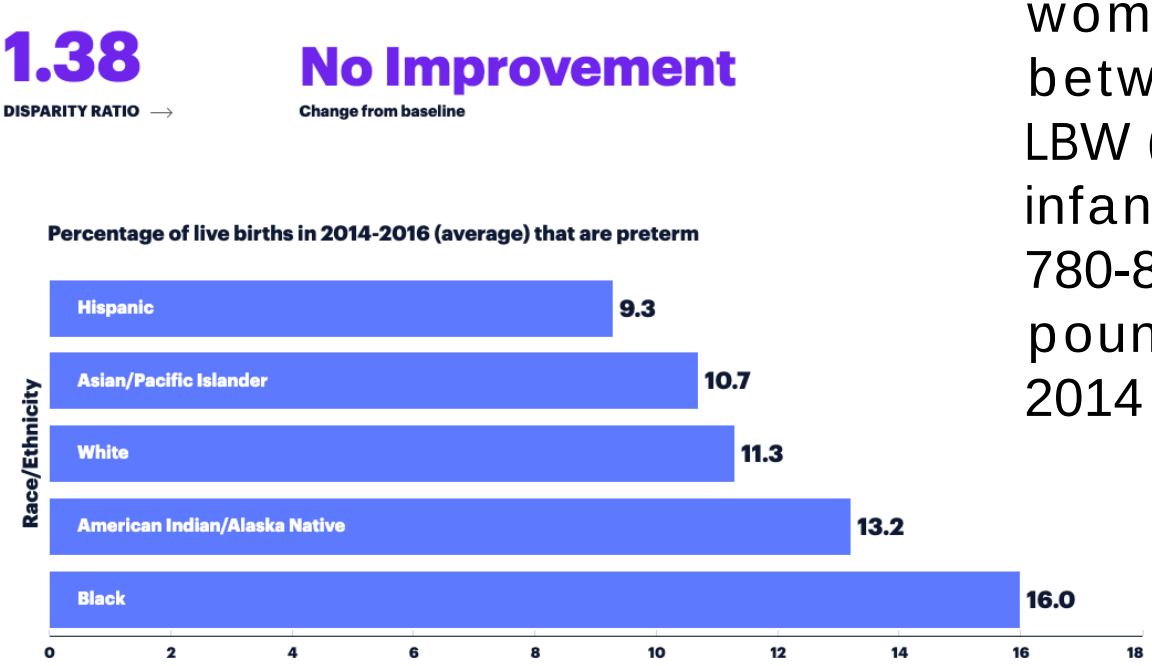
Preterm Births and Health Disparities in Mississippi



Annually Mississippi women deliver between 4333 to 4387 LBW (< 5.5 pounds) infants and between 780-817 VLBW (< 3.3 pounds) infants during 2014 and 2017.

*In Mississippi, the preterm birth rate among **black women is 44% higher** than the rate among all other women.*

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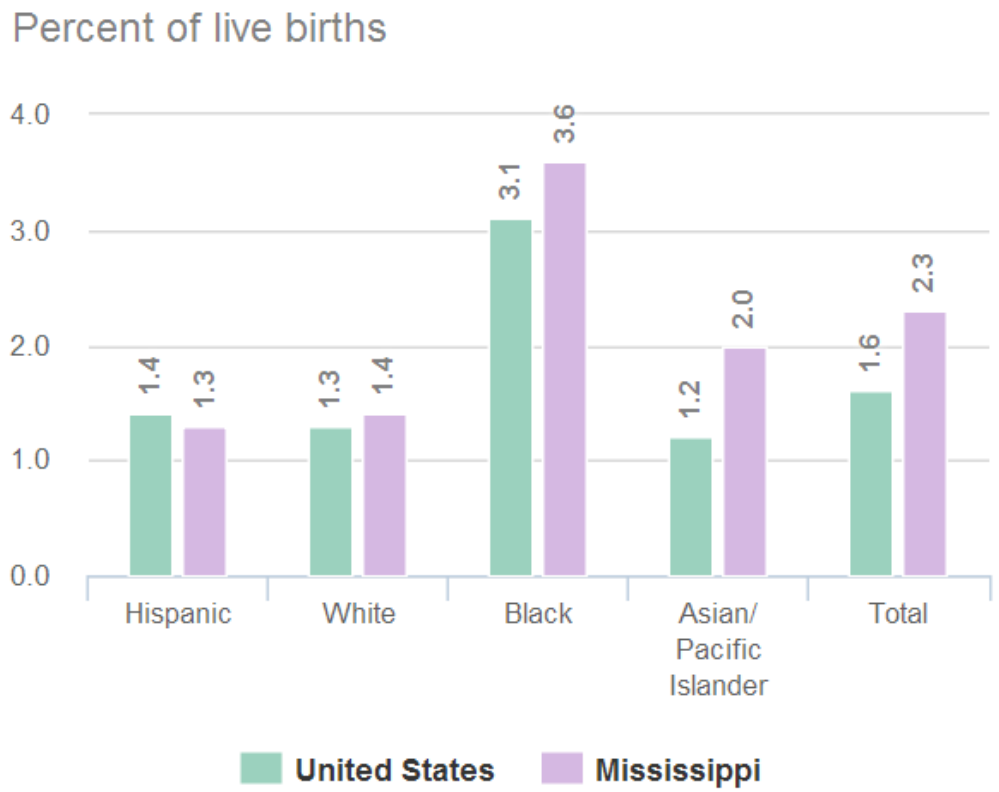
Very Preterm by Race/Ethnicity

Mississippi and US, 2014-2016 Average



Less than 32 weeks
Most expensive Babies!

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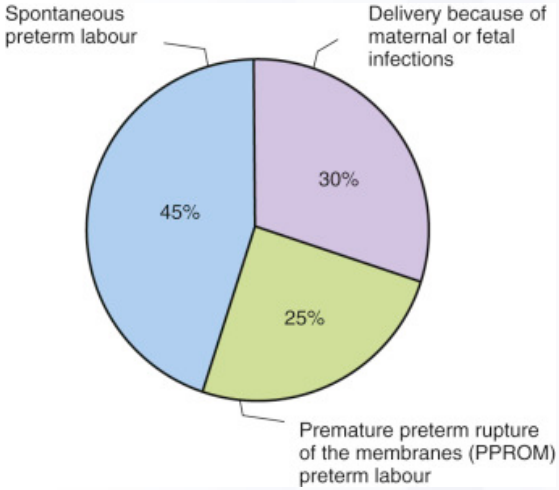
Known Maternal Risk factors for Premature Delivery



- Having a **previous premature birth**
- Pregnancy with twins, triplets or other multiples
- An interval of **less than six months** between pregnancies
- Conceiving through in vitro fertilization
- Problems with the uterus, cervix or placenta
- **Smoking cigarettes** or using illicit drugs

Known Maternal Risk factors for Premature Delivery

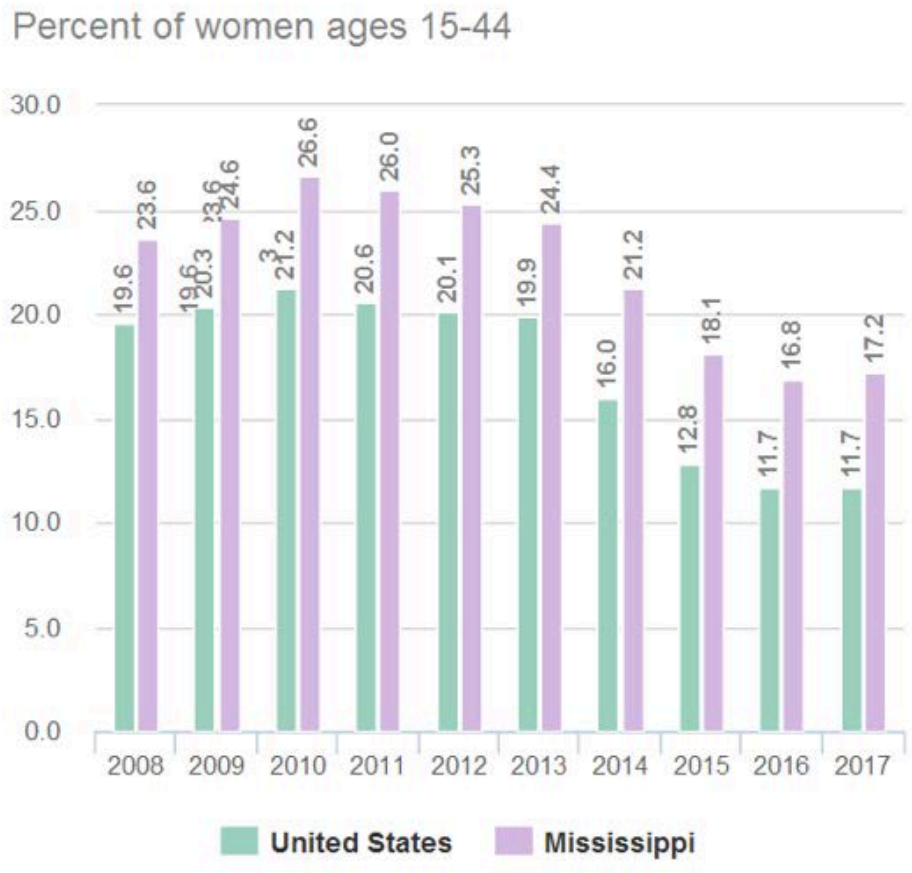
- Some **infections**, particularly of the amniotic fluid and lower genital tract
- Some **chronic conditions, such as high blood pressure and diabetes**
- Chronic medical illness (such as heart or kidney disease)
- Being underweight or **overweight** before pregnancy
- Stressful life events, such as the death of a loved one or domestic violence
- Multiple miscarriages or abortions
- Physical injury or trauma

- What About Current Health Insurance Coverage?

- Data from 2009: 34.6% of MS women had NO insurance coverage in the month before pregnancy (one of the worst in the US)

Uninsured Women

- United States and Mississippi, 2008-2017



MS has much lower coverage for women compared to rest of US

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Cost of Prematurity

In 2007, the Institute of Medicine reported that the cost associated with **premature birth** in the United States was **$26.2 billion** each year. Here's how the numbers add up:

- $16.9 billion in medical and health care costs for the baby
- $1.9 billion in labor and delivery costs for mom
- $611 million for early intervention services.
- $1.1 billion for special education services.
- $5.7 billion in lost work and pay for people born prematurely

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Costs for Prematurity-Not just at Birth

- The average cost for infants hospitalized in neonatal intensive care units is **around $3,000-$4,000 per day**. While the average cost to an employer of a healthy baby born at full-term, or 40 weeks of gestation, is **$2,830**, the average cost for a premature baby is **$41,610**. (Some over $1,000,000!!)

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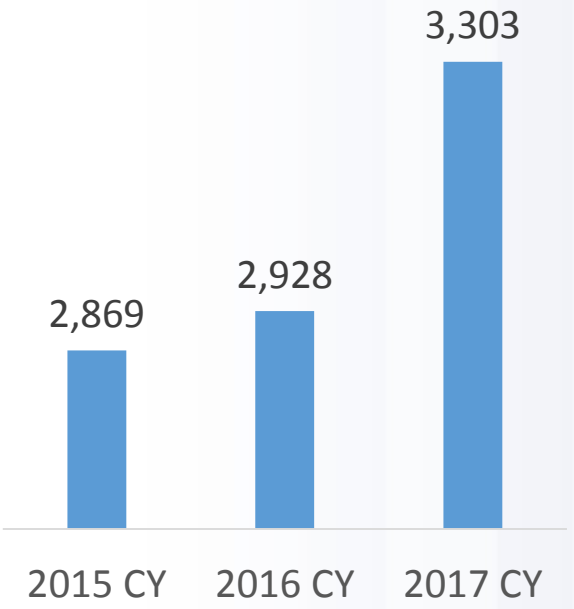
Current Situation

- In 2015, 1 in 9 babies (11.4% of live births) were low birth weight (LBW) in Mississippi.
- LBW inpatient cases for Medicaid increased by 10% in Mississippi from CY2015-CY2017
  - 40% of the cases had birth weights less than 2000g
  - 3,303 inpatient cases reported in CY2017
  - On average, 19% of these patients are treated at UMMC
  - 40% of the cases were early delivery for maternal diseases
- Mission: decrease low birth weight deliveries for women in Mississippi
  - While decreasing unintended pregnancies and managing chronic medical conditions (i.e. hypertension, diabetes, sickle cell, obesity)

Source: MHA inpatient discharge data; Article "States with Best Healthcare" National Center for Health Statistics and Final Natality Data



# of Medicaid LBW Inpatient Cases

Pulled from MHA Dimensions. Includes all Medicaid inpatients seen between CY2015-2017 that were low birth weight, which was identified using APR-DRGs listed below. APR588, APR589, APR591, APR593, APR602, APR603, APR607, APR608, APR609, APR611, APR612, APR613, APR614, APR621, APR622, APR623, APR625, APR626.

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What is the Added Cost of Prematurity?

		Cost difference			Length of stay, d	
GA, wk	*n*	Percent increase[b] (%)	95% CI (%)	*p*-Value	Median	IQR
23	105	1,145	1,043–1,26%	< 0.01	0	0–1
24	129	3,969	3,665–4,307	< 0.01	28	0–105
25	146	5,609	5,206–6,054	< 0.01	91	73–107
26	183	5,348	5,003–5,725	< 0.01	76	64–88
27	217	4,905	4,613–5,222	< 0.01	66	56–78
28	279	3,971	3,760–4,197	< 0.01	56	48–68
29	317	3,163	3,004–3,333	< 0.01	46	40–55
30	416	2,629	2,513–2,753	< 0.01	38	32–47
31	568	1,915	1,841–1,993	< 0.01	29	25–37
32	904	1,339	1,297–1,382	< 0.01	21	17–28
33	1,304	833	810–857	< 0.01	14	11–19
34	2,707	470	460–480	< 0.01	8	6–13
35	4,810	178	175–182	< 0.01	4	3–6
36	9,842	76	75–78	< 0.01	3	2–4
37	22,990	18	17–19	< 0.01	2	1–3
38–40	257,309	Ref	Ref	Ref	2	1–2
41+	45,924	4%	4–55	< 0.01	2	1–2

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Walsh, Am J Perinatol Rep 2019;9:e76–e83

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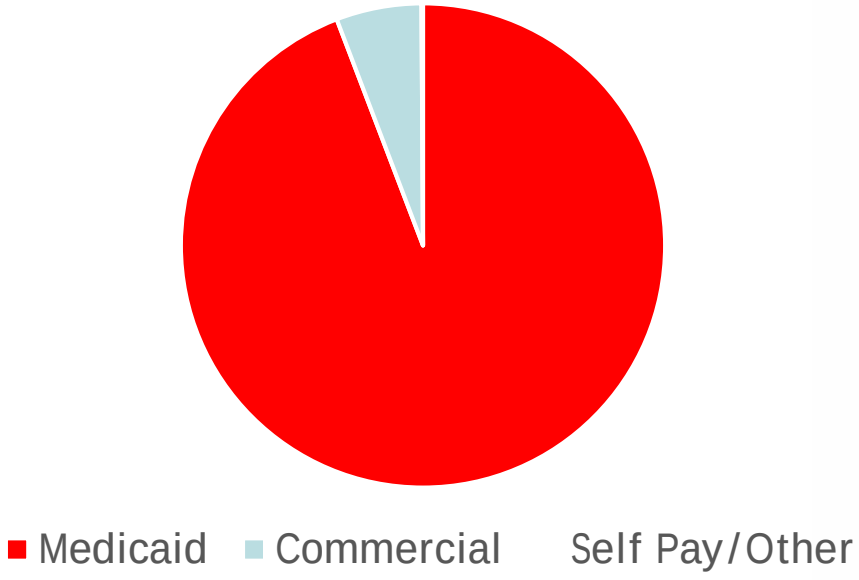
UMMC NICU Charges by Payor

- **Medicaid**: 94.2%
- Commercial charges: 6.5%



2018 data

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What Will It Cost MS Medicaid?

Options for Achieving 12 month PP care

- Federal cost sharing via Section 1115 Waiver
- Modification of existing Family Planning Waiver to include full scope

What is known?

- Some cost estimates by states, no published savings analyses (NJ - $6,715 per beneficiary)
- South Carolina will be first with waiver review by CMS in 2019

What services are anticipated/needed beyond Family Planning?

- Primary care and chronic disease management- Blood pressure assessment and management, cardiovascular disease screening and treatment, diabetes care
- Mental health care- Antidepressant therapy, Substance use treatment
- Emergency Trauma Care

One MS Medicaid Insurer Data

2017 # of pre-term babies: 311 (Births: 1,841 16.9% Preterm)

- These babies have now been followed from birth in 2017 until July 1, 2019

- The average cost of each of these babies is $56,970 (this is not a totally accurate number, in that some of these babies may have lost their eligibility and we just look at the total medical spend for that group….this probably underestimates the amount spent- I think DOM quoted about $90K for the first year of life for very low birth weight babies)
- Cost: $17, 717,670 for 311 preterm babies

2018 # of pre-term babies 313 (Births:1,829 17.1% Preterm)

- Average spend per baby as of July 1, 2019 $49,402,96 (this group will obviously get close to the $90K DOM quotes if they continue the same spend for an additional year)
- Cost $15, 463,126 for 313 babies

2019 # of preterm babies 116 (Births: 710 16.3% Preterm) (6 months of data)

- Average spend so far per baby $24,597.12 many of these babies have not yet even had claims submitted since some are still hospitalized and the facility may not be doing any interim billing…

Cost: $2,846,624 so far….

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Cost Savings of Prematurity Prevention

Mississippi State: 38,398 births/year

- If we prevented prematurity in 5% of these mothers who deliver preemies
  - Cost Savings $885,883.50 **to this plan**

    Est. $2.7 million savings to state for all
- If we delayed prematurity by 2 weeks in 10% of MS mothers
  - Savings of MILLIONS of $$$
  - Would have to be offset by increase in caring for mothers for additional year after pregnancy

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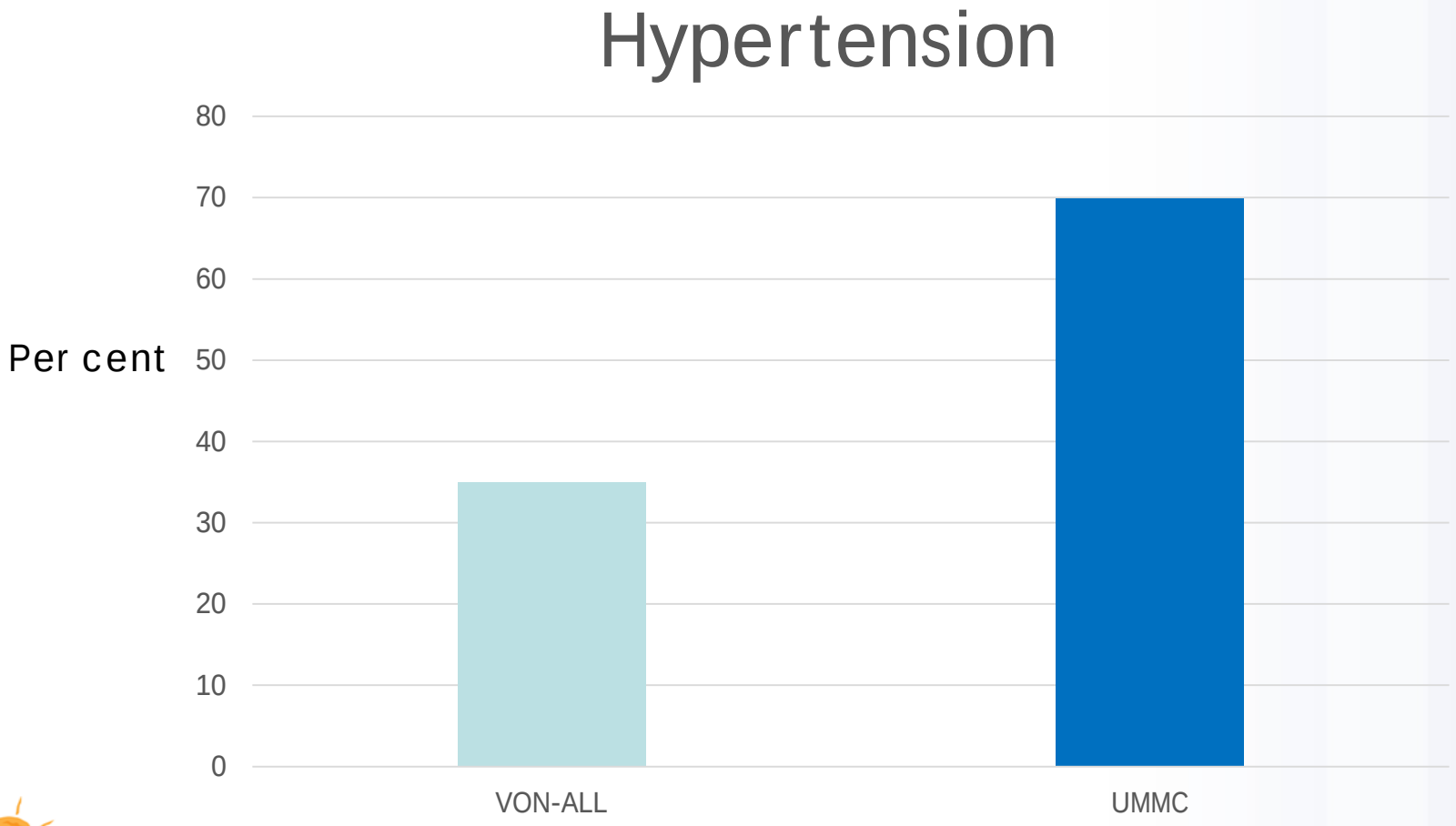
- Poor Health of Mississippi Women
  - What do we need to address for their Health Care?

Maternal Hypertension at UMMC in VLBW-Double the Rate!



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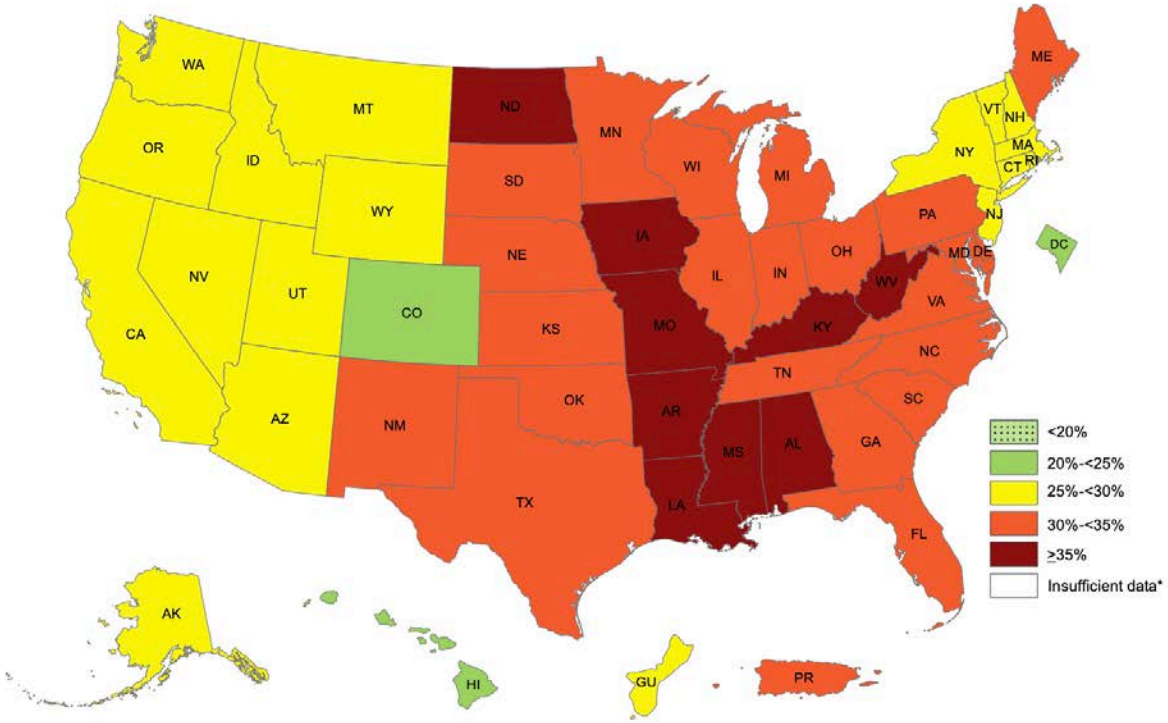
Obesity in US: 2018 Data



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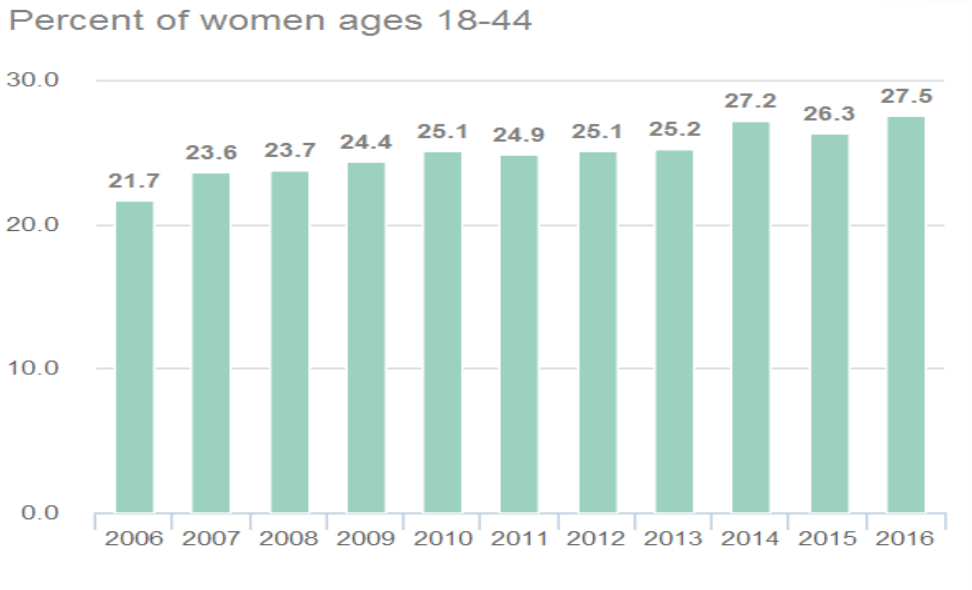
Increasing Obesity Among Women of Childbearing Age

United States, 2006-2016



Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention

What is Influencing Disparities on Infant and Maternal Mortality?

- Poverty/lack of insurance
- Obesity
- Diabetes
- Hypertension
- Stress-epigenetics
- Alcohol and tobacco, other drug use

Prevention!

- Improve health of mother before conception
  - Diabetes
  - Treatment of Sickle Cell
  - Obesity
  - Hypertension
  - Heart disease
- Enhanced prenatal care
  - Physician Care
  - Group care
  - Home visits
  - Prompt treatment of premature delivery

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Prevention

- Contraception
  - LARC
- Teen pregnancy prevention
- Inter-conception pregnancy delay
- Progesterone for those at risk
- Tobacco cessation programs
- Screen multiple times for postnatal depression and mental health issues

Getting Mothers Into the Health Care System Earlier

We can:

- Have early and appropriate referral of mothers at risk
- Deliver babies at risk where there are NICUs and a multidisciplinary team

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What to do? $$$$$$

- We are now faced with a choice to either:

  1) invest in preventative medicine in order to save millions of dollars for our state

  2) continue to pay for high-cost interventions for preventable conditions

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We can do this!!!

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New Business (cont.)

- Long Term Care
- Pharmacy Care Coordination
  - Presented by Bob Lomenick and Wes Pitts

MISSISSIPPI DIVISION OF MEDICAID

Pharmacy Services in the Medicaid Population

Medical Care Advisory Committee

November 1, 2019

Pharmacy Stakeholder Group

mipa
MISSISSIPPI INDEPENDENT PHARMACIES ASSOCIATION

mississippi Pharmacists Association

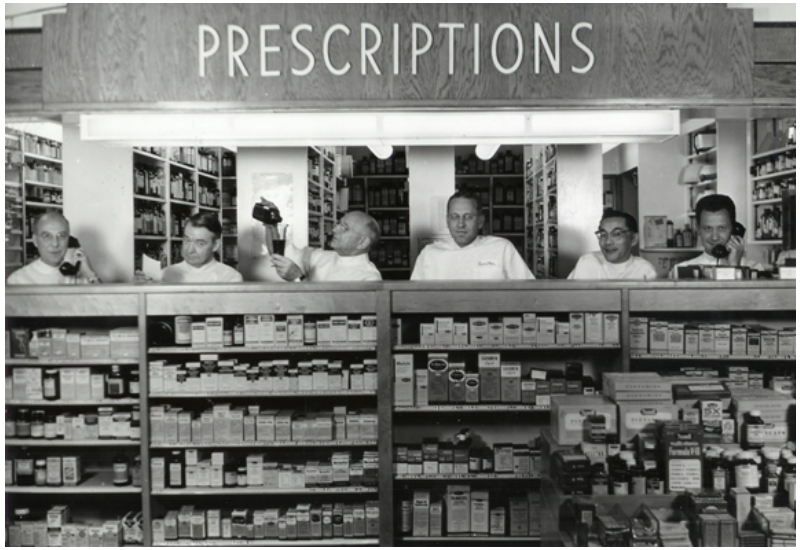
MSHP

Magnolia State MSPS Pharmaceutical Society

THE UNIVERSITY of MISSISSIPPI
SCHOOL OF PHARMACY

CPESN MISSISSIPPI

The profession of pharmacy has changed



www.Leachgarden.org

“The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians”

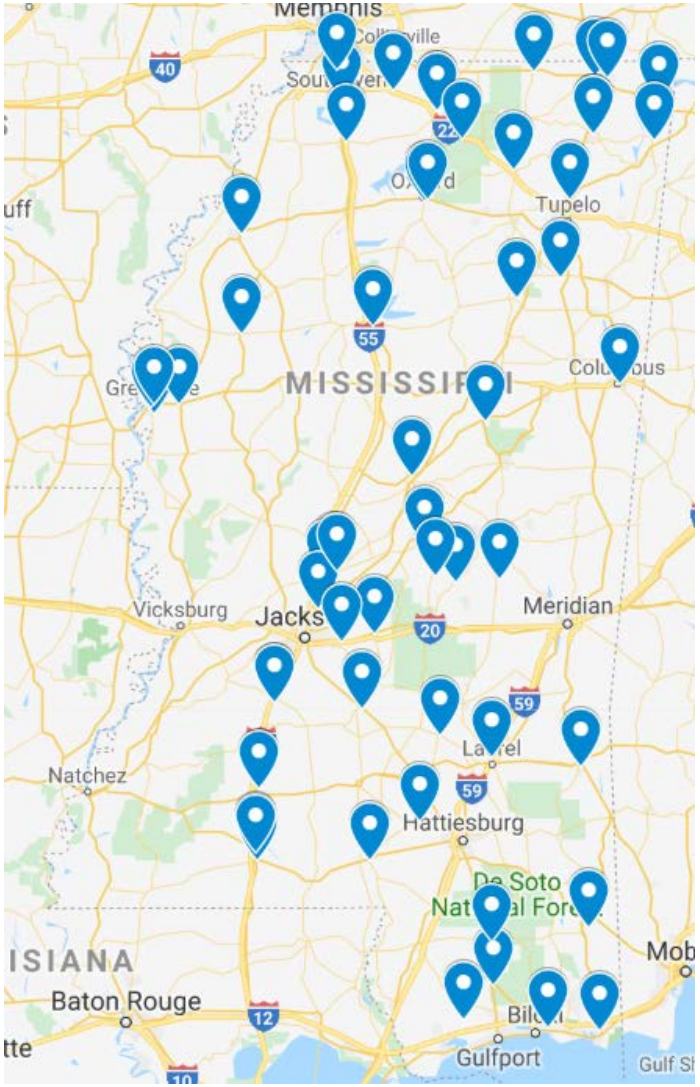
The most accessible healthcare provider

Community Pharmacy Enhances Services Network

- An accountable pharmacy organization

- USA
  - ~2500 pharmacies in 46 states
  - Owned by National Community Pharmacists Association & Community Care of North Carolina

- Mississippi
  - 58 pharmacies
  - Population per pharmacy: 51160
  - Percent of population within delivery radius: 87.3



CPESN Mississippi Participants

Required Services		
Comprehensive Medication Mgmt 89%	Medication Adherence Program 91%	Immunization Program 89%

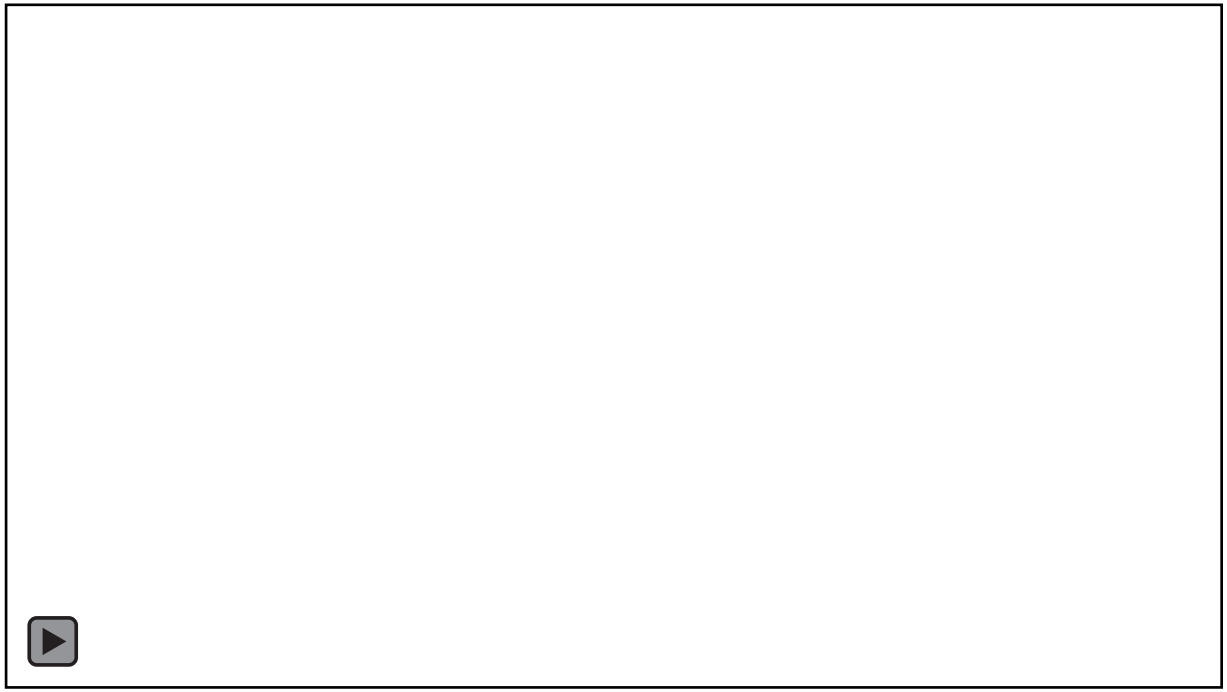
Optional Services *(others not shown here)*		
Medicare Part D Plan Counseling 96%	Immunization Clinics (off-site) 69%	Nutrition Counseling 47%
Hospice Dispensing 91%	Non-sterile Compounding 62%	Medication Disposal 42%
Vitamin/ Supplement Counseling 80%	24-hour dispensing services 62%	Diabetes Education Program 40%
Home Delivery 78%	Blood Glucose POCT 53%	Topical Pain Protocol 40%

**As of April 2017

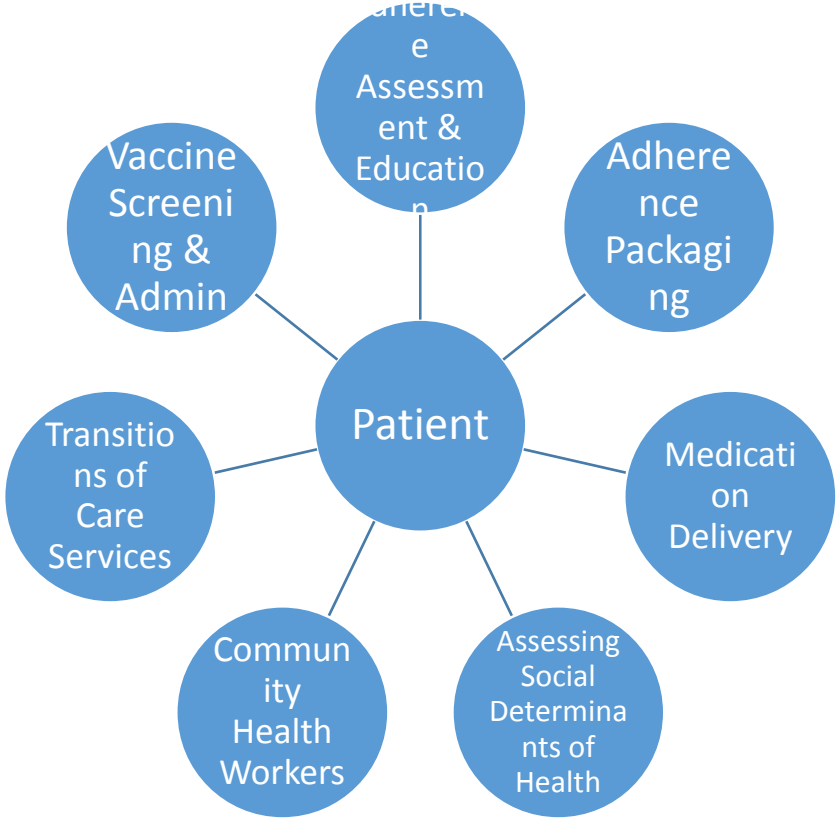
Adherence Services

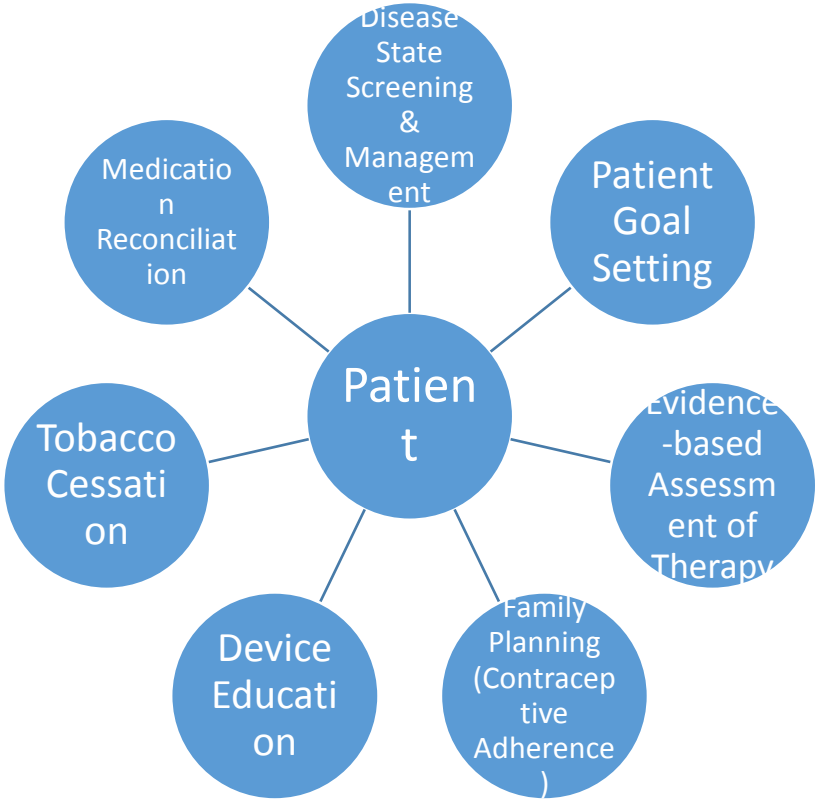
- Adherence Program is a minimum required service of CPESN Pharmacies
- Many pharmacies also incorporate adherence packaging into their services

Patient Testimonials



Pharmacy Services





Incentives for pharmacy services

Few opportunities for payment for these services

Medicare Medication Therapy Management (MTM):

- Yearly Comprehensive Medication Review ($60)
- Targeted interventions ($12)

Medicare and some private insurers

- Diabetes Self-Management and Education (DSME):
  - Group classes, up to 10 hours per beneficiary: ~$15 per 30 min
- Diabetes Prevention Program (DPP)
  - 1-2 year program (weekly x6 months, monthly x6 months, then quarterly)
  - Quality-based reimbursement (based on patient weight loss) up to $689

Asthma in MSDOM beneficiaries

Only 43.6% of beneficiaries met the HEDIS measure of AMR ≥ 0.50

TABLE 3: Mississippi Medicaid Performance on CMS/HEDIS Asthma Medication Ratio (AMR-AD)
**** Adults Only ****
(January 1, 2017 - December 31, 2017 Reporting Period)
Includes Medicaid ONLY - No CHIP

Beneficiary Characteristics		Denominator	Numerator (AMR ≥0.50)	Rate
TOTAL		1,896	827	43.6%
Age	19 - 50	1,337	575	43.0%
	51 - 64	559	252	45.1%
Gender	Female	1,416	594	41.9%
	Male	480	233	48.5%
Race	Caucasian	535	257	48.0%
	Afr. Amer.	1,182	478	40.4%
	Hispanic	4	2	50.0%
	Other	175	90	51.4%
Pharmacy Program	FFS	155	122	78.7%
	UHC	664	262	39.5%
	MAG	1,077	443	41.1%

** Rate is percentage of beneficiaries with ratio of conroller medication units to total asthma medciation units of 0.50 or greater.*

3,000+ Medicaid beneficiaries without controller therapy for their asthma

TABLE 4: Mississippi Medicaid Performance on PQA Medication Therapy for Persons With Asthma (MTPA)
(January 1, 2017 - December 31, 2017 Reporting Period)
Includes Medicaid ONLY - No CHIP

		Denominator		Numerator	Rate
PQA Suboptimal Asthma Control*		34,775		> 3 canisters of SA inhaler over 90-day period	9.1%
				3,154	
PQA Absence of Controller Therapy	Total	3,154		Suboptimal control and no controller therapy during same 90-day period	43.0%
				1,356	
	Pharmacy Program	FFS	336	138	41.1%
		UHC	1,239	545	44.0%
		MAG	1,579	673	42.6%

** PQA overall denominator includes all beneficiaries continuously enrolled, having ≥ 2 asthma medications prescription fills in 120 days and not taking medications indicated for COPD.*

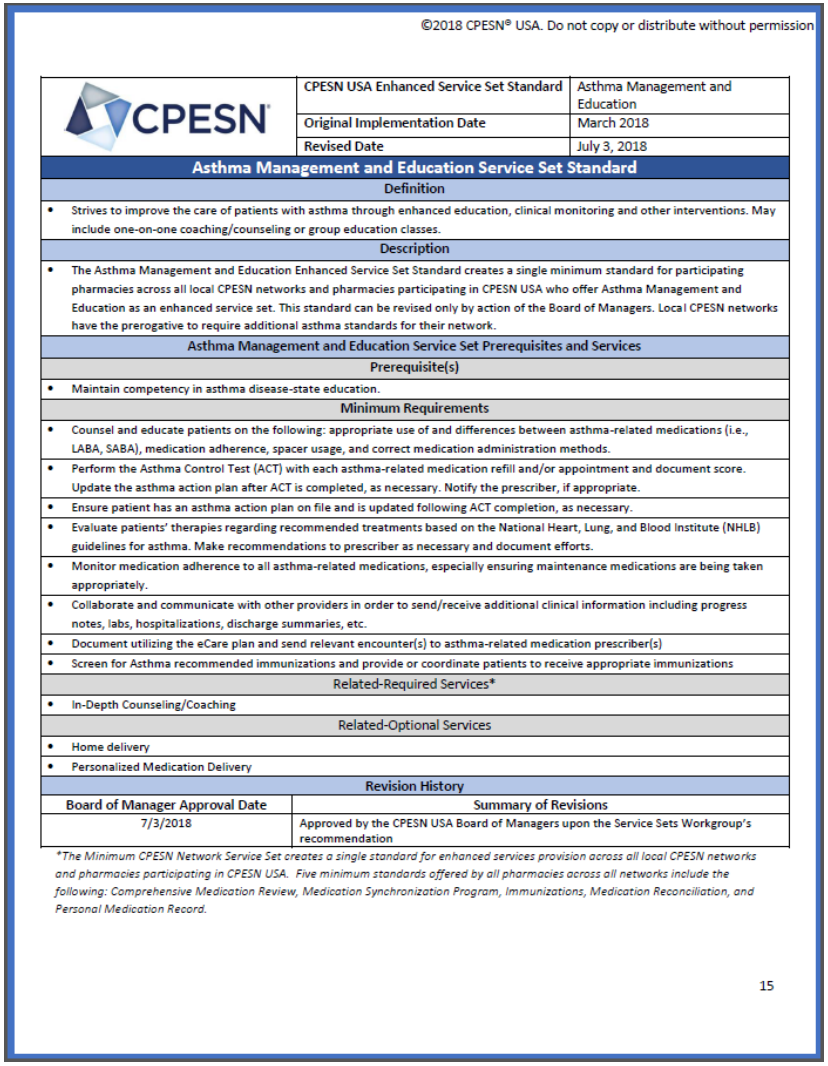
Average Adult Hospitalization (FY 2017-2019): $13,366.07

Asthma Overview and Mississippi Medicaid Performance on Related Quality Measures. *MS-DUR Board Report*. Feb 2019.

Asthma Services

Highlights

- Counsel and educate patients on use and differences of each inhaler
- Monitor adherence to all asthma-related medications
- Ensure patient has asthma action plan on file and knows how to use it
- Screen for and provide recommended immunizations



CPESN

CPESN USA Enhanced Service Set Standard	Asthma Management and Education
Original Implementation Date	March 2018
Revised Date	July 3, 2018

Asthma Management and Education Service Set Standard

Definition

- Strives to improve the care of patients with asthma through enhanced education, clinical monitoring and other interventions. May include one-on-one coaching/counseling or group education classes.

Description

- The Asthma Management and Education Enhanced Service Set Standard creates a single minimum standard for participating pharmacies across all local CPESN networks and pharmacies participating in CPESN USA who offer Asthma Management and Education as an enhanced service set. This standard can be revised only by action of the Board of Managers. Local CPESN networks have the prerogative to require additional asthma standards for their network.

Asthma Management and Education Service Set Prerequisites and Services

Prerequisite(s)

- Maintain competency in asthma disease-state education.

Minimum Requirements

- Counsel and educate patients on the following: appropriate use of and differences between asthma-related medications (i.e., LABA, SABA), medication adherence, spacer usage, and correct medication administration methods.
- Perform the Asthma Control Test (ACT) with each asthma-related medication refill and/or appointment and document score. Update the asthma action plan after ACT is completed, as necessary. Notify the prescriber, if appropriate.
- Ensure patient has an asthma action plan on file and is updated following ACT completion, as necessary.
- Evaluate patients' therapies regarding recommended treatments based on the National Heart, Lung, and Blood Institute (NHLB) guidelines for asthma. Make recommendations to prescriber as necessary and document efforts.
- Monitor medication adherence to all asthma-related medications, especially ensuring maintenance medications are being taken appropriately.
- Collaborate and communicate with other providers in order to send/receive additional clinical information including progress notes, labs, hospitalizations, discharge summaries, etc.
- Document utilizing the eCare plan and send relevant encounter(s) to asthma-related medication prescriber(s)
- Screen for Asthma recommended immunizations and provide or coordinate patients to receive appropriate immunizations

Related-Required Services*

- In-Depth Counseling/Coaching

Related-Optional Services

- Home delivery
- Personalized Medication Delivery

Revision History

Board of Manager Approval Date	Summary of Revisions
7/3/2018	Approved by the CPESN USA Board of Managers upon the Service Sets Workgroup's recommendation

**The Minimum CPESN Network Service Set creates a single standard for enhanced services provision across all local CPESN networks and pharmacies participating in CPESN USA. Five minimum standards offered by all pharmacies across all networks include the following: Comprehensive Medication Review, Medication Synchronization Program, Immunizations, Medication Reconciliation, and Personal Medication Record.*

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COPD in MSDOM Beneficiaries

- 2,915 (12.5%) beneficiaries had 1 or more exacerbations in the 18 month time period.
- 4,168 beneficiaries without a physician visit in the last 6 months before exacerbation

- 48% of those experiencing exacerbation had not filled ANY COPD prescriptions in the previous 45 days
- 3,600 patients received NO controller therapy

TABLE 1: Summary of Medicaid COPD Population *(FFS and CCOs, January 1, 2017 to June 30, 2018)*	
Total number of beneficiaries with COPD	**23,365**
Beneficiaries with stable COPD during observation period	22,171 (94.9%)
Beneficiaries having 1 or more exacerbations	2,915 (12.5%)
Total number of exacerbation events	5,269
ED visits	4,518
Hospitalizations	751
Average number of exacerbation events for beneficiaries experiencing exacerbations	1.8
Exacerbation events where patient had COPD related physician visit within 6 months	1,101 (20.9%)
Mean time to last physician visit when one occurred before an exacerbation event	69.8 days

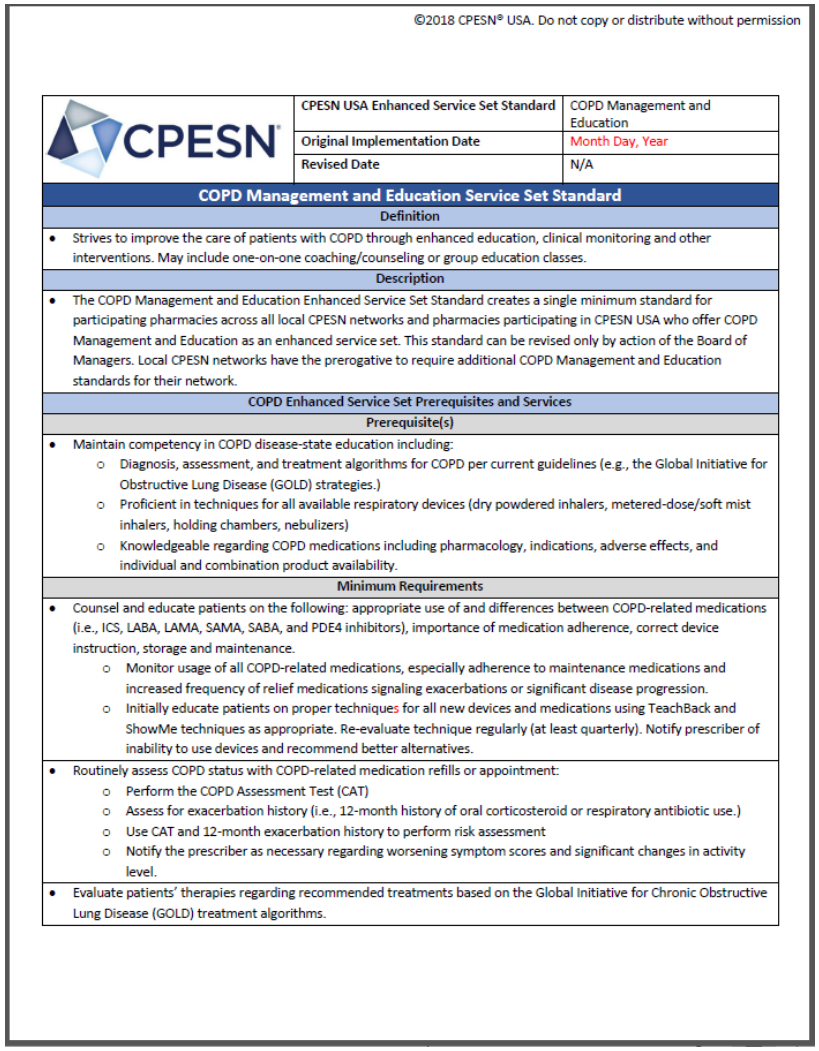
Average Adult Hospitalization (FY 2017-2019): $13,015.02

Chronic Obstructive Pulmonary Disease (COPD) Treatment Patterns and GOLD Guidelines. *MS-DUR Board Report*. Nov 2018

COPD Services

Highlights

- Counsel and educate patients on use and differences of each inhaler
- Evaluate patients' therapies based on GOLD Guidelines
- Collaborate with provider as necessary
- Monitor adherence to all COPD-related medications
- Screen for and provide recommended immunizations
- Screen for tobacco use and intervene, as necessary



CPESN

CPESN USA Enhanced Service Set Standard	COPD Management and Education
Original Implementation Date	Month Day, Year
Revised Date	N/A

COPD Management and Education Service Set Standard

Definition

- Strives to improve the care of patients with COPD through enhanced education, clinical monitoring and other interventions. May include one-on-one coaching/counseling or group education classes.

Description

- The COPD Management and Education Enhanced Service Set Standard creates a single minimum standard for participating pharmacies across all local CPESN networks and pharmacies participating in CPESN USA who offer COPD Management and Education as an enhanced service set. This standard can be revised only by action of the Board of Managers. Local CPESN networks have the prerogative to require additional COPD Management and Education standards for their network.

COPD Enhanced Service Set Prerequisites and Services

Prerequisite(s)

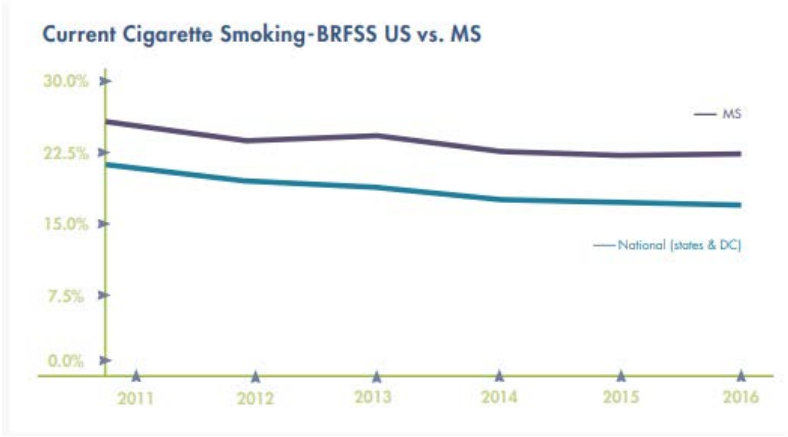
- Maintain competency in COPD disease-state education including:
  - Diagnosis, assessment, and treatment algorithms for COPD per current guidelines (e.g., the Global Initiative for Obstructive Lung Disease (GOLD) strategies.)
  - Proficient in techniques for all available respiratory devices (dry powdered inhalers, metered-dose/soft mist inhalers, holding chambers, nebulizers)
  - Knowledgeable regarding COPD medications including pharmacology, indications, adverse effects, and individual and combination product availability.

Minimum Requirements

- Counsel and educate patients on the following: appropriate use of and differences between COPD-related medications (i.e., ICS, LABA, LAMA, SAMA, SABA, and PDE4 inhibitors), importance of medication adherence, correct device instruction, storage and maintenance.
  - Monitor usage of all COPD-related medications, especially adherence to maintenance medications and increased frequency of relief medications signaling exacerbations or significant disease progression.
  - Initially educate patients on proper techniques for all new devices and medications using TeachBack and ShowMe techniques as appropriate. Re-evaluate technique regularly (at least quarterly). Notify prescriber of inability to use devices and recommend better alternatives.
- Routinely assess COPD status with COPD-related medication refills or appointment:
  - Perform the COPD Assessment Test (CAT)
  - Assess for exacerbation history (i.e., 12-month history of oral corticosteroid or respiratory antibiotic use.)
  - Use CAT and 12-month exacerbation history to perform risk assessment
  - Notify the prescriber as necessary regarding worsening symptom scores and significant changes in activity level.
- Evaluate patients' therapies regarding recommended treatments based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) treatment algorithms.

Tobacco Use in Mississippi

- 500,000+ (22.2%) Mississippians smoke (national average: 14%)
- Nearly 4,800 deaths are attributed to smoking each year
- Annual healthcare costs directed caused by smoking: $1.23 Billion
- Medicaid costs caused by smoking: $319.7 Million

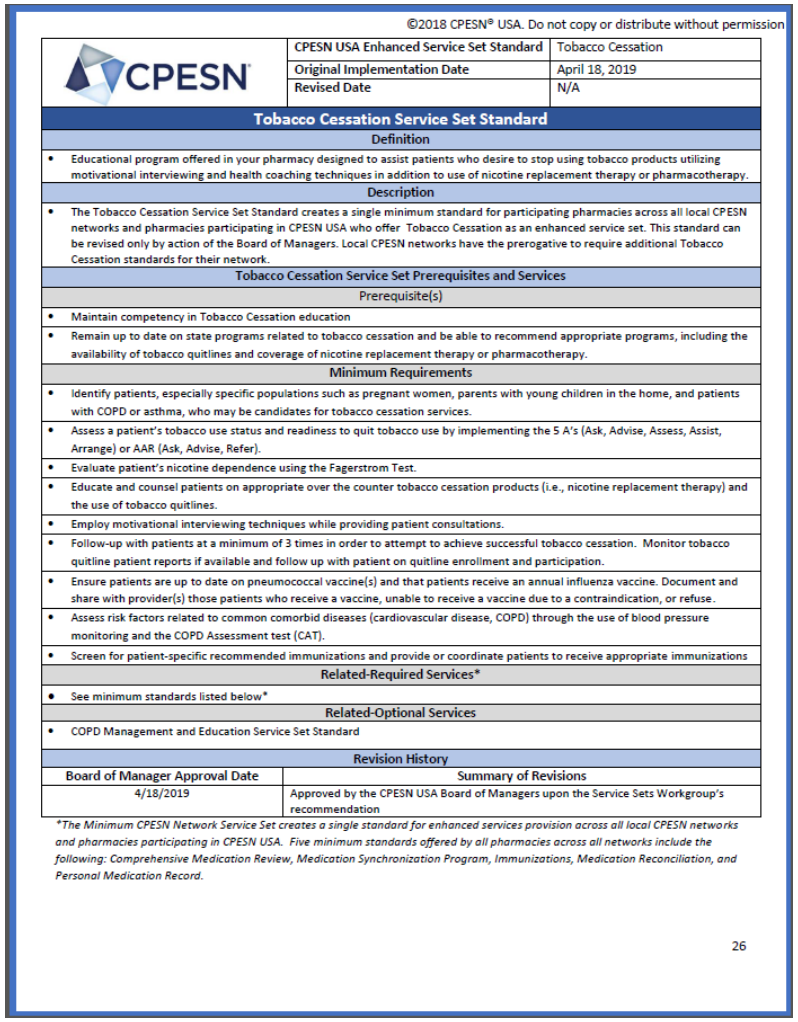


- The Toll of Tobacco in Mississippi. https://www.tobaccofreekids.org/problem/toll-us/Mississippi. Accessed 9/15/2019.
- 2018 Tobacco Report. Mississippi Tobacco Data

Tobacco Cessation Services

Highlights

- Utilize 5A's to assess patient's readiness to quit
- Employ motivational interviewing techniques
- Recommend appropriate Nicotine Replacement Therapy and/or Rx therapy
- Follow-up at least 3 times
- Screen for and provide recommended immunizations



CPESN

CPESN USA Enhanced Service Set Standard	Tobacco Cessation
Original Implementation Date	April 18, 2019
Revised Date	N/A

Tobacco Cessation Service Set Standard

Definition

- Educational program offered in your pharmacy designed to assist patients who desire to stop using tobacco products utilizing motivational interviewing and health coaching techniques in addition to use of nicotine replacement therapy or pharmacotherapy.

Description

- The Tobacco Cessation Service Set Standard creates a single minimum standard for participating pharmacies across all local CPESN networks and pharmacies participating in CPESN USA who offer Tobacco Cessation as an enhanced service set. This standard can be revised only by action of the Board of Managers. Local CPESN networks have the prerogative to require additional Tobacco Cessation standards for their network.

Tobacco Cessation Service Set Prerequisites and Services

Prerequisite(s)

- Maintain competency in Tobacco Cessation education
- Remain up to date on state programs related to tobacco cessation and be able to recommend appropriate programs, including the availability of tobacco quitlines and coverage of nicotine replacement therapy or pharmacotherapy.

Minimum Requirements

- Identify patients, especially specific populations such as pregnant women, parents with young children in the home, and patients with COPD or asthma, who may be candidates for tobacco cessation services.
- Assess a patient's tobacco use status and readiness to quit tobacco use by implementing the 5 A's (Ask, Advise, Assess, Assist, Arrange) or AAR (Ask, Advise, Refer).
- Evaluate patient's nicotine dependence using the Fagerstrom Test.
- Educate and counsel patients on appropriate over the counter tobacco cessation products (i.e., nicotine replacement therapy) and the use of tobacco quitlines.
- Employ motivational interviewing techniques while providing patient consultations.
- Follow-up with patients at a minimum of 3 times in order to attempt to achieve successful tobacco cessation. Monitor tobacco quitline patient reports if available and follow up with patient on quitline enrollment and participation.
- Ensure patients are up to date on pneumococcal vaccine(s) and that patients receive an annual influenza vaccine. Document and share with provider(s) those patients who receive a vaccine, unable to receive a vaccine due to a contraindication, or refuse.
- Assess risk factors related to common comorbid diseases (cardiovascular disease, COPD) through the use of blood pressure monitoring and the COPD Assessment test (CAT).
- Screen for patient-specific recommended immunizations and provide or coordinate patients to receive appropriate immunizations

Related-Required Services*

- See minimum standards listed below*

Related-Optional Services

- COPD Management and Education Service Set Standard

Revision History

Board of Manager Approval Date	Summary of Revisions
4/18/2019	Approved by the CPESN USA Board of Managers upon the Service Sets Workgroup's recommendation

**The Minimum CPESN Network Service Set creates a single standard for enhanced services provision across all local CPESN networks and pharmacies participating in CPESN USA. Five minimum standards offered by all pharmacies across all networks include the following: Comprehensive Medication Review, Medication Synchronization Program, Immunizations, Medication Reconciliation, and Personal Medication Record.*

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Community Pharmacy Care Management

Initial Care Planning: Comprehensive Medication Management (CMM)

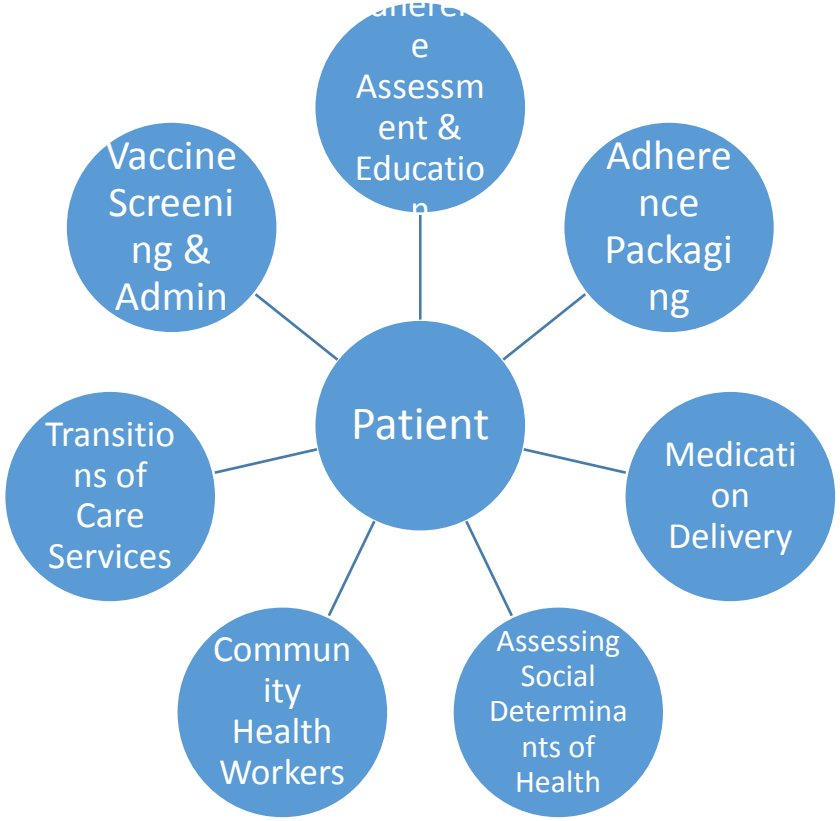
- **Medication Reconciliation:** Upon referral, the process of comparing a patient's new medication orders to a comprehensive list of existing medications that the patient has been taking (active, chronic as needed, and nonprescription including herbals and other dietary supplements) to determine potential DTPs and to avoid medication errors.
- **Comprehensive Medication Reviews:** A systematic assessment of patient-specific information to collect a current medication list, medication history, and other relevant health data including all medication therapies to identify medication-related problems (MRPs) (based on indication, effectiveness, safety, and adherence) and create a patient-specific plan to resolve MRPs, document the plan and disseminate appropriate information to the patient's other health care providers.
- **Personal Medication Records (PMR):** Provide patients with a personal medication record**.** A PMR is a comprehensive record of the patient's active medications (prescription and nonprescription medications, herbal products, and other dietary supplements).

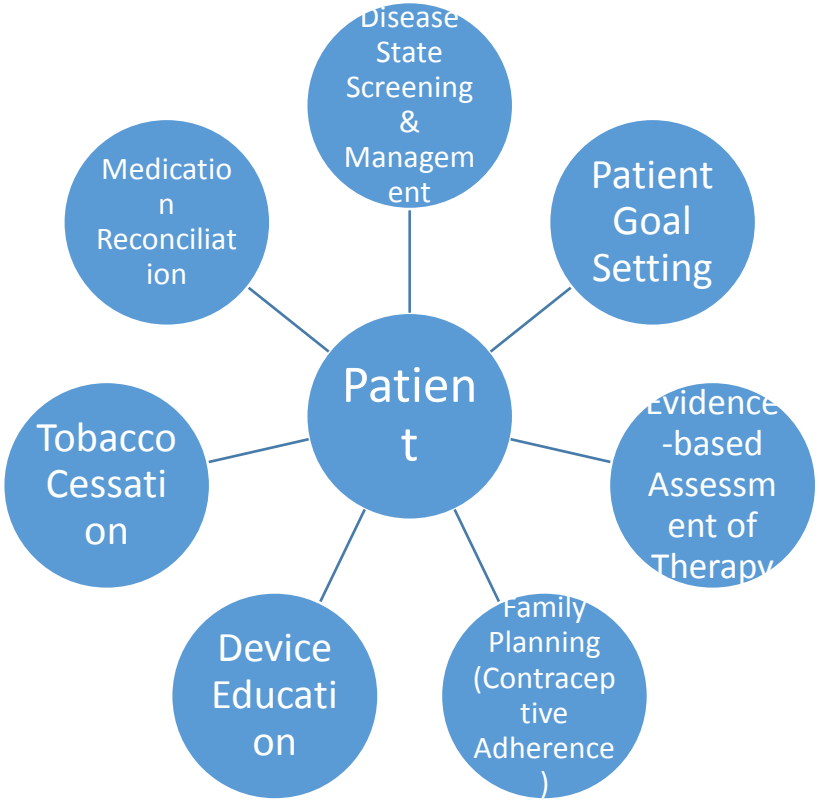
Follow-up Monthly

Follow-up Care Planning: Monthly Medication Review and Patient Assessment

- Collect current medication list, medication history, and other relevant health data
- Reassess patient health and functional goals; medication-related problems
- Implement interventions
  - Optimize medication therapy/reduce medication-related problems
  - Collect/provide/refer list of priority laboratory tests (e.g. HbA1c, blood pressure monitoring, etc.)
  - PCP referral if needed (to his/her PCP, or to a PCP if they do not have one)
  - Medication delivery (pick-up or hand-delivery)
  - Provide medication counseling and disease state education (e.g. smoking cessation, asthma/COPD, diabetes, heart failure, etc.)

Pharmacy Services

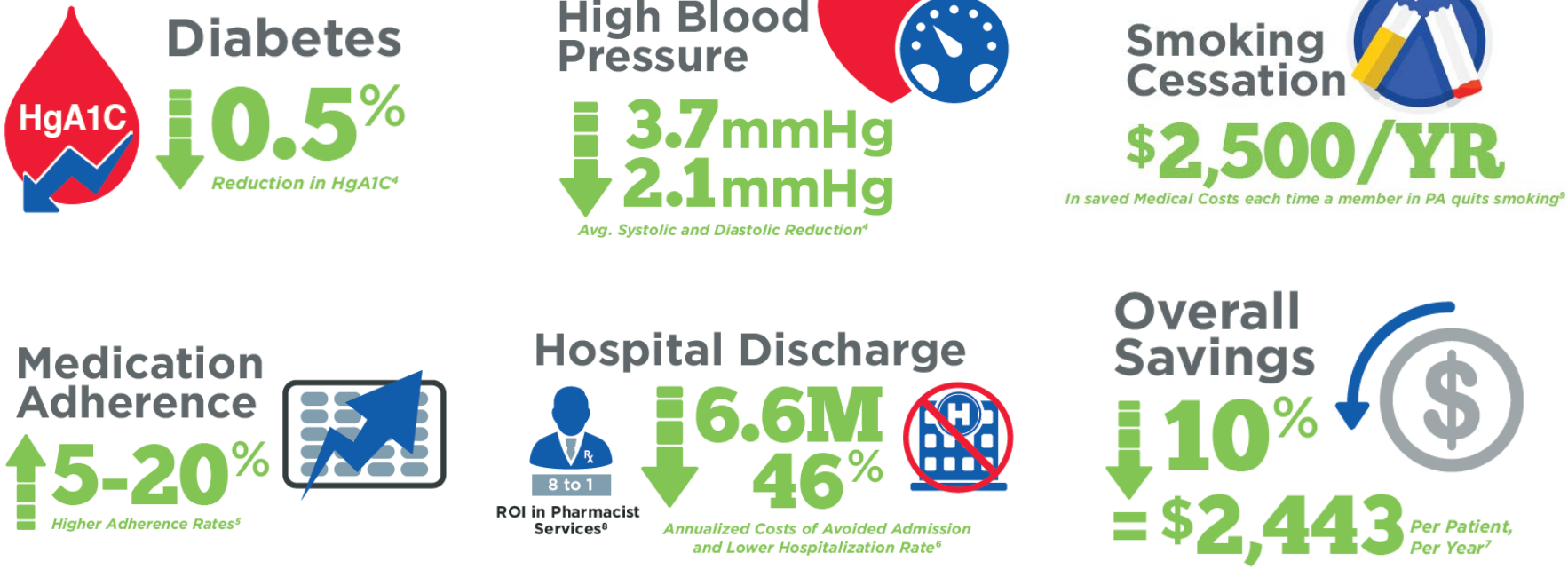




Outcomes

- Core Set Measures Required for Reporting in 2024 *(selected)*
  - Asthma Medication Ratio (Ages 5-18 and Ages 19-64)
  - Asthma in Younger Adults Admission Rate
  - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
  - Medical Assistance with Smoking and Tobacco Use Cessation

Community Pharmacy experiences



Health-System Transitions of Care Services

Nearing Discharge, hospital pharmacist:

1. Interview Patient and Review Discharge Medication List to ensure:

- ✓ Appropriate indication and efficacy for each medication
- ✓ All active disease states are appropriately treated
- ✓ Ensure cost effective medications are utilized
  - ✓ Medication preferred on MS Medicaid formulary ?
  - ✓ Collaborate with medical staff and hospital case management as indicated
- ✓ Future adherence
  - ✓ Can patient use insulin or inhaler?
  - ✓ Barriers to therapy
- ✓ No therapeutic duplications/ important drug interactions exist

2. Communicate with hospital-based providers:

- ✓ Resolve any medication-related problems prior to discharge

3. Educate patient on all discharge medications to include (but not limited to):

- ✓ Indication (Need/Therapeutic Benefit)
- ✓ Dosing (Dose, Route, Frequency, Duration)
- ✓ Side effects and Monitoring
- ✓ Importance of adherence

4. Provide handoff to Community Pharmacist:

- ✓ Verify or establish patient's Community Pharmacy Home
- ✓ Establish follow-up visit with patient's Community Pharmacy Home if Offering Pharmacy Care Management Services
- ✓ Provide detailed plan of care to Community Pharmacy
  - ✓ Overview of Visit, Future Care Plan and Follow-Up Visits, Discharge Medication List, other Pharmacist-Identified Needs

5. Post-Discharge Follow Up:

- ✓ Call to Patient/Caregiver 48-72 hrs from discharge to ensure medication access, adherence, compliance, safety, and efficacy
- ✓ Resolution of any reported Medication Related Problems, including contacting discharging physician, follow up primary care physician, and/or community pharmacy home

Health-System Transitions of Care Services

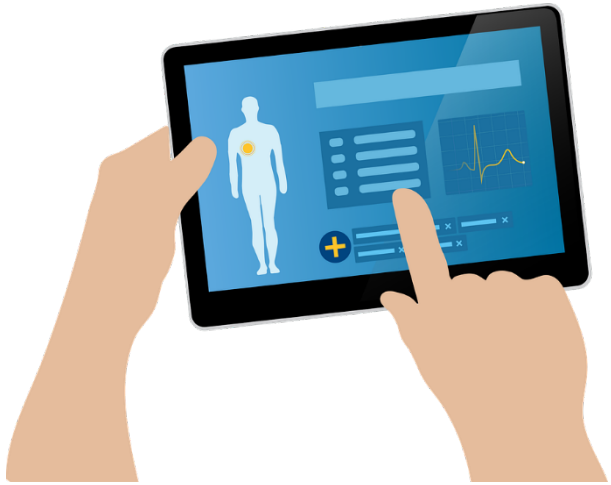
Anticipated Benefits of Pharmacist-Delivered Transitions of Care Services:

- Improvement in:
  - medication access
  - adherence
- Reduction in:
  - post-discharge adverse events
  - hospital readmissions
  - inpatient costs

- Project RED
  - *Unplanned hospitalizations were significantly reduced with pharmacist follow up post discharge*
  - *Total health care spending the 30 days after discharged dropped by 34% ($412.00 per patient)*
- *Pharm2Pharm Model*
  - *36% reduction in medication-related hospitalization rate and 2.6:1 ROI*
- *Synergy Pharmacy Solutions*
  - Cost avoidance of $25M over 2 years ($4 per member per month) and inpatient cost savings over $3.5M

Encounter Documentation

- Community Pharmacy: Pharmacist eCare Plan
- Health-system: Electronic Health Record



Billing & Payment Proposal

HCFA 1500 and a Current Procedural Terminology (CPT) Code

Pharmacist MTM CPT Codes:

CPT Code	Description	Amount
99605	first 15 min (individual face-to-face assessment and intervention with pharmacist)	$85
99606	follow-up visit or established patient, 15 minutes	$40
99607	additional 15 minute increments (used with either 99605 or 99606)	$40

Other State Medicaid Programs

Comparison of CMS-Approved Reimbursement Methodologies for Pharmacy Providers' Services

State	Covered service	Payment Model	Implementation Year
Iowa	Collaborative Drug Therapy Management	Initial Assessment: $75 Follow-up: $40 Preventative Follow-up: $25	2013
Minnesota	Medication Therapy Management (MTM)	99605, 99606, 99607 $24.00-$52.00 per 15 min	2008
North Dakota	1 initial encounter and up to 5 subsequent encounters per year Asthma/COPD and diabetes Medication non-adherence Transitions of Care	99605, 99606, 99607 $25.00 - $70.00 per 15 min	2015
Oregon	Pharmacist prescribing of hormonal contraceptives Pharmaceutical Services Guide MTM Services and Clozapine Therapy	99605, 99606, and 99607 $13.17-$28.22 per 15 min	2015 2016 2018
Wisconsin	1 initial Comprehensive medication review assessment and 3 follow-up assessments per member per year	Initial assessment: $85 Follow-up visits: $40	2012

Mercer Environmental Scan of Medicaid Coverage of Pharmacist Cognitive Services 09/23/2019

Visit Limits

Community Pharmacy services

- 1 initial visit per year, 12 follow-up visits

Transitions of Care services

- Separate from 1/month limit
- If community pharmacy does not participate in services, hospital keeps ownership and completes the service

**There could be an initial visit billed in both locations*

Questions

- ✓Next Meeting
- ✓Adjournment

MISSISSIPPI DIVISION OF MEDICAID