MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
January 20, 2011

Members attending: Ms. Bellah, Dr. Crawford, Ms. Patti Davis for Craig Jones, Dr. Grogg, Ms. Harrison, Ms. Holliman-James, Dr. Kasulis, Dr. Post, Dr. Rhoades, Dr. Rhynes, Mr. Roye, Ms. Slatton-Hodges for Ms. White, Mr. Tallent, Mr. John Bobb-Semple for Dr. Wells, Dr. Woodward

Members absent: Dr. Aulgur, Ms. Bates, Dr. Bourdeau, Mr. Brose, Ms. Case, Dr. Cavallaro, Ms. Sherry Davis, Mr. Goforth, Mr. Machtolff, Dr. McNeill, Dr. Ogle, Dr. Simon, Mr. Unruh, Dr. Wright

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were no requests for public comment.

II. Approval of minutes of the November 18, 2010 Medical Advisory Committee Meeting

Dr. Rhynes made the motion to approve the minutes as presented. Ms. Holliman-James seconded. Motion carried.

III. MAC Member Comments/Discussion

None.

IV. Legislative Update: Nico Gomez, Deputy CEO

Mr. Gomez noted the session is underway. There are new legislators and experienced ones who have new roles. They are very interested in learning, and have unique ideas to explore. We are encouraged that they want to make informed decisions. Today is the final day for introduction of bills. For the past 2 months they have been drafting the language on their bills. This is our first glimpse at what the legislative body really wants to focus on in this session. We anticipate 1,500-2,000 bills.

The primary issue is the budget. Agencies are to prepare 5-10% reduction scenarios. House Budget hearing is 11:00 Jan. 31st. Senate Budget Hearing is Feb. 2nd, 9:30. A lot of work needs to be done and we are trying to provide the legislature and governor with meaningful information. Because the Affordable Care Act requires a maintenance of effort for state Medicaid programs, this really limits our ability to change Medicaid eligibility. If we have to assume that there's no revenue, that leaves us with the only option being reductions such in optional adult benefits or reducing provider rates. The discussion will be centered on those issues with Legislature.

Preliminary meeting have been held with the governors staff. There is a new Finance director and we anticipate more meetings with her health team after the State of the State. The Governor's budget will be presented to the Legislature on the first day of session, Monday, Feb. 7th at noon. Mr. Gomez will have a list of bills of interest at the next MAC. Mr. Gomez welcomed MAC members to contact him with their questions.

Ms. Patti Davis - given that we are in a rate cutting mode and knowing we have base rate annualizations that increase each year – Give us a feel for what that number is. Mr. Gomez replied that if we just to hold the program where it is today including the 3.25% overall provider rate cut that's in effect, we need our current budget plus $65 million; we

also have to understand that in today's base budget we have $350 million of one-time money, the majority of that, $263 million is stimulus money that will run out at the end of June. There will be little stimulus money left over for 2012. We anticipate that about $70 million stimulus money is available to appropriate in 2012. We're talking about replacing $350 million in one-time money, plus another $65 million just to standstill but there is less money to spend on all the agencies. It is a very scary proposition.

Ms. Davis asked about expressing the million dollars in percent change to the budget – Last year every 1% provider rate cut produced $8 million in state savings. This year, every 1% cut in provider rates will yield about $9.1 million in state savings.

Ms. Sandra Harrison said the last time the Board of Equalization met they said the state shortfall was about $250 million, but now the Senate and House are saying closer to $500-$600 million. The Board of Equalization meets in February to present the final number to the Legislature to write their budget. There are a lot of moving parts, which will make the number move up and down.

Dr. Keenan asked how 1,500-2,000 bills compared to a typical year. Mr. Gomez replied that is fairly typical. The House members are limited to 8 bills per member. The Senate has no limit, but there is a limit to how many bills a senator would want to carry, from a logistics standpoint. The Senate has instituted new rules, bills now have to go sometimes through 3 committees before they get to the Senate floor. If the bill gets to the floor, it may still have a tough road.

Mr. Gomez said we will have a supplemental request for $15 M for this year and we are working on the letter to the Governor. After session last year, 2 major events left a hole in this year's budget. The 1% health insurance payer fee was defeated by the State Supreme Court. Just before that, Congress extended the stimulus money from Jan. 1 to June 30th. We had authority to spend some of that money, but did not have authority to spend all the money we needed to fill in this year's budget. We are going to ask for $15 million of the extended stimulus money in order to finish this year on budget. That $15 million would leave us with zero margin. We're running an insurance program that will care for close to 900,000 people this year, $4.5 billion, with zero margin. We have no cash flow as we have had in the past. We typically use cash flow to pay providers on schedule each month, each cycle. To the extent we don't have that cash flow, it doesn't mean the providers are not going to get paid, but they may not get paid a quickly. We probably will not have that problem until close to the end of the fiscal year, but this needs to be on everyone's radar screen as a possibility. It is not a shortfall, it is a cash flow issue.

V. C-Section Update: Dr. Sylvia Lopez

Dr. Lopez reviewed the C-Section Update handout and the high rate of c-sections. Over the next 8 months we will collect claims data and calculate the primary c-section rate for doctors and hospitals. We will then send the information back to them. The hospitals will be listed by name, but individual providers will be listed by a unique provider number assigned by OHCA.

Phase 2 will begin September 1st. For providers who have reached the benchmark of 18% or less, there will be no change in the process. For providers who have not met the benchmark, nursing staff at OHCA will perform a manual medical chart review for all operative deliveries. If medical necessity for the operative primary delivery is not documented, we will reduce payment to the vaginal rate (complicated vaginal rate for hospitals). Please refer to the handout for further information.

Dr. Grogg noted that PLICO does not allow vaginal birth after cesarean (VBAC). Dr. Lopez confirmed that repeat C sections are not included, only primary C sections. A PLICO representative has been at the meetings and heard the discussion.

Dr. Crawford said we should be looking at quality, ultimately a successful outcome for mom and baby. Dr. Lopez replied that that when we begin reviewing medical records, we will be able to garner clinical information. We will build a database to track quality information. The state of Ohio, has built such a database for their sites.

Dr. Crawford - Since physician groups have different insurers, it would be interesting to see if there is a difference in c-section rate based on insurer. Dr. Lopez replied that we might not be able to get that from medical review, but might look into other resources

Ms. Patti Davis commented that she is a little troubled this was presented at the OHCA Board, and now this is the first time for the MAC to hear about it, and the perinatal group will hear the final outcome. This seems a little reversed. Dr. Lopez replied that it was most important to initially sit down and talk to the obstetricians and hospital administrators whom this was going to impact directly. We had a good turn-out at the initial meeting, we lost a few of the obstetricians at the second meeting. They communicated their concerns and what they thought was and was not realistic. The final product was only presented at the Perinatal Task Force as a concept. It wasn't until after listening to the input that we recently firmed-up the project. Information will be sent out next week to the obstetrical inpatient providers and hospitals with a minimum of 6 deliveries of SoonerCare patients per quarter.

IV. Financial Report: Carrie Evans, Finance Director

Ms. Evans reviewed the financial transactions through the month of November. For more detailed information see MAC information packet. There were no questions from members.

A. Budget Request, Juarez McCann, Chief Budget Officer

Mr. McCann updated the MAC on the obesity program. The members' Fit Logic program includes an electronic scale, pedometer and online education. The program is for those who weigh 360+ lbs and have a secondary condition. Ms. Patti Davis asked about cost. It is $70,000. Dr. Crawford asked if the criteria would be sent out to everyone. Yes

VII. SoonerCare Operations Update: Cassell Lawson, Director of Opportunities for Living Life

Mr. Lawson reviewed the SoonerCare enrollment report and the Long Term Care Flow Chart. Dr. Splinter noted that Mr. Lawson mentioned 32,000 in the Insure Oklahoma program, and we plan on moving the eligibility level up from 200% to 220%, which should bring in an additional 5,000 recipients. Cynthia Taylor, an Oklahoma SoonerCare physician in Norman, was the first physician in the nation to receive a check through the electronic health records incentive program. The whole program should turn out to be about $300 million. The funds are all federal and the grant comes from the American Reinvestment and Recovery Act. There were no questions.

VIII. Policy Rulemaking Review: Kelly Shropshire, Director, Program Integrity & Accountability

Mr. Shropshire reviewed a presentation on Permanent Error Rate Measurement (PERM)

and Medicaid Recovery. It is a Federal program, originally managed by CMS to ensure proper payment. It began as the payment accuracy measurement (PAM) program. While working with CMS we had a very good relationship and opportunity to provide input. OMB took it over and changed the name and approach from payment accuracy to payment error rate measurement, and it got a little more difficult. When it was a demo, the states conducted the reviews. It fit in easily with what we do routinely, it was just another audit. Now the federal contractors perform the reviews. A new mandate became effective October 1, 2005, requiring the states to be reviewed every 3 years. We never agreed to that, this is a very comprehensive review. For the federal government to come in and say they want to come back every 3 years did not make a lot of sense to us, because each time we would have to re-educate providers and ourselves, but that is the way It is now. We were in the first cycle in 2006 of 17. At the end of the end, we reported an error rate of 2.51%, which was excellent. We just completed our second PERM review. It looked at Title 19 services only; our error rate for 2009 was 1.24%, the lowest in the cycle. Of all reviews done up to date, there have only been 2 states with a lower error rate. It took a lot of work on our part and that of the providers and we are quite proud of that.

Other on-going federal initiatives and audits related to ensuring proper payment were briefly discussed. The contractors receive data on roughly 40 million claims a year, for about 3 years. There are 2 different nationally-known vendors doing analytics and trying to identify potential problems. They run it back by us, they let us know what they've found, have us look at it, and a lot of the time, at least on the surface, they have found something that could potentially be a problem. Often we have already addressed it, and tell them so. It affects our resources: for IT, it is difficult to meet the volume of requests we get from auditors. We have hired an FTE just to coordinate these different efforts. The affect on providers is limited right now, because the auditors are not out in the field, they're not discovering anything new.

There is a new audit group, Recovery Audit Contractor (RAC), similar to the others, but structurally a little different. The other contractors are contracted with the feds. We are required to contract with one of these contractors through and RFP (Request for Proposal) and the fees are incentive-based. The vendor will be paid based on how much they actually recover from the audits. Some of our considerations: – Are Physicians, RNs or certified coders doing the audits? What is the review methodology; how are records requested; what is the length of audit look back what is the appeals process how do they coordinate with other audit groups?

If a provider is selected for an audit, they need understand what the RAC is and exactly how it works. They will have a records request, a variety of audit correspondence, possibly appeals, and possibly overpayments.

Ms. Patti Davis asked if we anticipate some of the bidders to the RFP might be the federal contractors. Mr. Shropshire believes that is possible.

Dr. Woodward asked if these would be desktop audits. Mr. Shropshire replied they could be a combination of both field and desk audits. Dr. Woodward said a concern in pharmacy is extrapolation. Dr. Woodward provided an example: let's say you drive to the grocery store once a week, and one time you run a red light and the sheriff asks, "How long have you been going to the grocery store and how often do you go?" "Four years. Once a week". "Well since you ran it this time, you must have run it the last 3 years: So in this case the auditors can go back and pick up all the claims that were similar for that period of

time and recoup the money". Mr. Shropshire confirmed that extrapolation and how it is applied is a concern.

Mr. John Bobb-Semple asked if we anticipate an increase of RACs as the health care reform bill comes into effect over the next several years. Mr. Shropshire - it is hard to say. Time will tell if they are successful.

Ms. Patti Davis said she started her career in the Inspector General's office, and in the health care industry now, we have the Dept. of Justice, Inspector General, Medicaid Fraud Division, the RACs, Oklahoma Foundation for Medical Quality, for medical necessity, and all of that, and that's a lot of regulatory oversight. The regulatory burden is staggering in terms of records requests etc. Sometimes we wonder why they all can't together and figure it out? Mr. Shropshire said this was presented at the Board last week and there certainly is a saturation point, and we may be there.

IX. Action Items: Joseph Fairbanks, Policy Development Coordinator

Explained to the MAC that we will be posting Rule changes in the future online to facilitate public comment.

OHCA Initiated

10-61 DMEPOS Provider Requirements – Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules are revised to clarify OHCA's DMEPOS provider criteria. DMEPOS providers must meet Medicare accreditation standards unless the OHCA grants an exemption based on CMS exemptions, the provider is a government-owned entity, or at a provider's request. Revisions clarify that DMEPOS providers be located within the State of Oklahoma, unless the OHCA provides an exception to this requirement. Additionally, DMEPOS providers must comply with Medicare DMEPOS Supplier Standards as specified in 42 C.F.R. 424.57(c).
Budget Impact – Budget Neutral

10-66 Children's Nutrition Services - Current nutrition services policy is revised to correct references to previously revoked policy and provide clarification to current reimbursement practices and rules.
Budget Impact – Budget Neutral

Federally Initiated

10-56 Native American Cost-Sharing - OHCA cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are now exempt from SoonerCare co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services.
Budget Impact – Total impact of $876,206; State Share of $205,402

10-63 Puerto Rican Birth Certificates - Per CMS guidance and Puerto Rican law, eligibility rules are revised so that only new certified birth certificates will be accepted as verification of citizenship for Puerto Ricans who are using their birth certificate as proof of citizenship and whose eligibility for benefits will be determined for the first time on or after October 1, 2010. This rule change does not prohibit Puerto Ricans from using other forms of citizenship verification; it only applies to the use of birth certificates. When the applicant has not yet

received his or her new certified birth certificate, reasonable opportunity to obtain citizenship verification will be afforded to the applicant.
Budget Impact – Budget Neutral

10-65 Individual Indian Money Accounts (IIM) - Policy is changed to clarify OHCA's treatment of Individual Indian Money (IIM) Accounts as a converted resource. Funds and property held in IIM Accounts will no longer be used in an eligibility test. References to per capita payments are removed and the period in which money disbursed from IIM accounts can be counted as a resource is revised.
Budget Impact – Budget Neutral

Ms. Patti Davis made the motion to approve Rules 10-61, 10-66, 10-56, 10-63, 10-65 as submitted. Mr. Tallent seconded. Motion Carried.

X. New Business – Dr. Rhynes mentioned that his patients have been receiving a letter that states SoonerCare has a rule of one pair of glasses per year. A similar letter was sent out to the physicians that OHCA expects one pair of glasses and one examination per year, and addresses medical necessity. Dr. Rhynes requests that the optometric association be contacted when letters go out to the patients. If they see letters after the patients came in with them, it is hard to answer the patient's questions. Dr. Rhynes would like the optometrists to be included and requests a timely heads-up. In his personal experience, seeing 42% Medicaid, some of the parents who take the rules seriously will allow a child to go without glasses because of the letter. Another part of the letter emphasized that providers should try to re-use a frame. Frames that of the quality that wholesale for $25, cannot be practically re-used for multiple years.

Dr. Keenan said we have beaten this around in-house as to how best to apply it, and the letter was a compromise to try to address the abuses and issues that we have seen. For example, we had a mom walk into an optical shop and want to get new glasses for the child. There was nothing wrong with them, the prescription the fine. The optometrist told us the mom went outside and smashed them then came in and asked the provider, "Here, will you replace them now?"

There are also a few providers who dispense multiple glasses to patients more frequently than it appears is necessary as it might be in a case of strabismus for example. We are trying to juggle the fact that we know children, particularly between birth and 10 years of age, need glasses for their eyes to develop properly; and if they don't, they will develop amblyopia. Then there's the family that is just not paying attention or not setting standards for their children and letting the kid get away with breaking them every week. We struggled with putting a restriction on the number of glasses that we pay for. The bottom line was any rule that would require authorization or put restrictions on dispensing spectacle was going to be more demanding on the providers and could lead to situations where the kids did not get glasses they needed. We drafted the letters primarily to bring everyone's attention to the issue; and yes, they can have more than one pair because we know it's medically necessary in the kids. We will keep the issue of communication with the optometrists and all providers in mind and try to do a better job in the future.

Dr. Splinter noted that the agency had no input at all on who was eligible for the Health Information Technology stimulus money. We were upset, both about the optometrists not being included and about the restriction on PAs and others, and we made some comments nationally on that issue.

Dr. Rhynes said he is truly appreciative and we were one of the states through OHCA that spoke up for them.

XI. Adjourn – 2:55 p.m.