

**ALABAMA MEDICAID AGENCY**  
**PHYSICIANS' TASK FORCE MEETING**  
**September 27, 2012**  
**4<sup>th</sup> FLOOR BOARDROOM 1:00 pm – 3:00 pm**

**Members Present:**

Drs. Don Williamson, Robert Moon, Melinda Rowe, Robert Smith, Dave Johnson, Jeremy Stidham, William Blythe, Jeffery Arrington, Marsha Raulerson (telephone), Wes Stubblefield (telephone), Steven Baldwin (telephone), Chelley Alexander (telephone), and Rao Thotakura (telephone). John Newcomb, Dianne Sims, Dawn Ellis, Jacqueline Harris, Greg Ives, Cary Kuhlmann, Theresa McCarthy-Sayer.

**Medicaid/HP Staff Present:**

Stephanie Azar, Kelli Littlejohn, Angela Williams, Ron Macksoud, Chris McInnish, Cyndi Crockett (HP), Gary Parker, Desiree' Nelson, Sharon Moore-Grimes, Jerri Jackson, Jacqueline King, Toni Hopgood, Gretel Felton, Robin Rawls, Nancy Headley.

**Welcome and Review of Minutes:**

Dr. Rowe welcomed everyone and thanked them for their attendance. The minutes from June 27, 2012, meeting were reviewed and accepted with no changes.

**Medicaid Update**

Don Williamson, M.D., Chair, Medicaid Transition Task Force, presented a PowerPoint presentation on "Medicaid, Bridge to the Future" (see attachments). He explained Alabama Medicaid's funding system emphasizing that understanding hospitals funding is crucial and no state general funds are used to fund the hospital program. Federal rules allow use of unreimbursed public hospital costs to be certified as public expenditures (CPE) eligible for federal refund. Federal share of CPE funds not paid to hospitals are used as state share to fund Medicaid shortfalls in other programs. Any changes to hospital reimbursement model may impact state match available for the system. Other sources of funding for Medicaid include \$615 million direct general fund appropriation, Intergovernmental Transfers, Provider taxes, Hospitals, Pharmacy, Nursing Home Association, Drug Rebate and CPEs.

The Centers for Medicare and Medicaid (CMS) require that the cost be derived from Medicare cost reports that are based on each hospital's fiscal year. Reconciliation is made with data that spans two years once the data is available. If the reconciled data differs from the estimates made, the State may either gain or lose dollars. CPEs are an imprecise estimate made 2 years prior to reconciliation.

Dr. Williamson discussed opportunities for efficiency. He stated an outside entity is reviewing Medicaid's data to find areas needing improvement. Methods to improve efficiency would be to lock-in patients to physicians and pharmacies to reduce blatant drug utilization, 90 day prescriptions instead of 30 day prescriptions for chronic diseases to reduce dispensing fees, and working delinquent drug rebates. Dr. Williamson stated we need to produce a predictable stable budget for 2013 and beyond.

Dr. Williamson reviewed issues facing Medicaid expanding 2013 and beyond including: Disproportionate Share (DSH) decrease of 60+% by 2019; hospital provider tax ends in 2013; a significant percent of nursing home tax expires 2013; pharmacy expenditures continued growth at 10+% for 2013; increased demand for non-institutional long-term care; increased primary care physician reimbursement funded by CMS for only 2 years; lack of providers for 40% growth in Medicaid anticipated with Medicaid expansion; and no obvious funding sources for expansion.

Dr. Williamson stated potential solutions going forward would include additional state support, a modified funding structure for hospitals not volume based, a modified delivery system that would include predictable funding, an integrated delivery system, improving fraud and abuse identification, and a way to transfer risk away from the state.

Dr. Williamson responded to the following questions: What is the administrative cost of Medicaid? 3 percent. Concerning integration of care, why isn't there a central bureau of Medicaid that can coordinate follow-up appointments with Primary Care Physicians (PCP) when a patient is seen in the Emergency Department? Dr. Williamson responded that it would probably

require a more sophisticated MMIS system. With the shortage of specialty physicians and the expansion of Medicaid, has there been any discussion of legislation to mandate that physicians continue to take Medicaid? Dr. Williamson answered that he was not aware of any discussions at the State level. DRG (Diagnosis Related Group) as a way to improve hospital reimbursement, how would that affect the federal matching of more dollars? Dr. Williamson stated that it shouldn't affect federal matching because you would still be paying out the same amounts and still certifying the same expenditures to the FEDs and pulling back the State and Federal share.

### **Topics of Discussion**

#### **Childhood Lead Poisoning Prevention Changes Alabama Department of Public Health (ADPH)**

Dawn Ellis, MPH, RN, ADPH, presented a PowerPoint presentation on "Childhood Lead Screening Recommendation for Alabama" (see attachments). The Alabama Medicaid Agency requested Alabama Childhood Lead Poisoning Prevention Program (ACLPPP) to analyze community-level data on risk of lead exposure to determine if Alabama has adequate data to demonstrate that universal screening should be discontinued in favor of a targeted screening approach. As recommended by Center for Disease Control (CDC) and American Academy of Pediatrics (AAP) in 1997, Alabama only screens those children with a greater risk of having an elevated blood level (EBLL). Risk factors include, living in older housing, having a sibling or playmate with an EBLL, visiting frequently or living in structures with deteriorated, damaged, or recently remodeled lead-painted surfaces, and being Medicaid eligible. The data revealed that only 4 counties in Alabama did not have any children with EBLL and 48 counties had at least 1 child with EBLL during 2009 - 2011. ACLPPP concluded that Alabama does not have adequate data to recommend targeted screening and recommended that Alabama continue universal screening for lead poisoning. They also recommended using the same screening policies for Medicaid-eligible children as children in the general population and revising the Blood Lead Screening and Management Guidelines in order to be in compliance with federal requirements. Dawn responded to questions. Where should lead screening be performed? Dawn responded that screenings are generally done at the pediatrician or primary care doctor's office. Is there a Medicaid DRG for lead screening? Dr. Moon answered there is not a DRG but there is a CPT (Current Procedural Terminology) code. How often are we seeing children with this problem (EBLL)? Diane Sims answered that 500 children had confirmed elevated blood lead levels out of the 40,000 children screened last year.

Dianne Sims, BSN, RN, ADPH, presented a PowerPoint presentation on "Recommendation on Low Level Lead Exposure and Primary Prevention of Lead Poisoning" (see attachments). On November 10, 2010, CDC's Advisory Committee for Childhood Lead Poisoning Prevention (ACCLPP) formed an ad hoc Blood Level workgroup to recommend how to best replace the term "level of concern" regarding adverse effects of blood lead levels (BLLs) at less than 10 micrograms/dL in children. The CDC accepted ACCLPP's recommendation to redefine the level at which children are considered to have too much lead in their blood and to focus the nation's attention on preventing lead exposure. CDC recommends lowering the reference value from 10 micrograms/dL to 5 micrograms/dL. CDC also recommends implementing a primary prevention policy that reduces or eliminates exposure to risk factors before the onset of disease.

#### **MedSolutions Alabama Medicaid Annual Report**

Theresa McCarthy-Sayer, Account Manager, MedSolution Program Alabama, presented a PowerPoint presentation on "Alabama Medicaid Program Savings Update March 2011 through February 2012" (see attachments). She recapped what recipients were covered under the Radiology Management program as follows; Certified as Children through the SOBRA (Sixth Omnibus Budget Reconciliation Act) Program, Certified through the Medicaid for Low Income Families Program, Refugees, and Certified for Supplemental Security Income (SSI) (just over 600,000 members). She reviewed the savings for measurement period March 2011 through February 2012 which totaled \$4,533,865 Net Savings. Overall savings since inception March 2009 is \$11,812,457 with an average membership of 565,802. Utilization on the program has not gone up to where it was before the program was started.

#### **Updates Patient Care Network Alabama Dr. Robert Moon and Chris McInnish**

Dr. Moon gave a brief introduction to the group regarding the Networks. He stated that there are four Regional Patient Care Networks of Alabama (PCNA) and those networks hire their own Medical Directors, Policy Directors, and Case Managers (Nurse Case Manager, Social Work Case Manager, and Community Health Workers) to help clients with compliance with their doctor's appointments, medications, and to help improve patient outcomes. The Networks recently expanded to the Mobile and Washington County areas in July of this year. Dr. Moon stated that we are changing the methodology on how we pay the Networks which is currently awaiting approval from CMS. Chris McInnish gave a brief update on the Mobile Network stating that they have a Medical Director, have had their first board meeting with good attendance, they are getting their offices and core staff set up.

### **Patient Care Network-Reports from Medical Directors**

Dr. Wes Stubblefield, Medical Director, East Alabama, gave an update on the East Regional Network via telephone. He stated that they had conducted the last round of medical management meetings for the quarter and that the meetings had been modified from one large meeting to multiple smaller meetings. Dr. Stubblefield gave out Physician's Report Cards at the meetings that had a 1 – 5 rating letting the physicians know how well their communication was being received by the office staff. The report included information about the number of health home patients and the total cost of care vs. their peers and non network peers. He stated that focusing on the flu shot was a great way to provide cost-effective care to their patients on a broad basis. They asked all of their PMPs (Primary Medical Physicians) to commit to telling them how they do their current callback systems for flu shots and asked them to commit to one method and to reach out to the Network if they needed help making personal phone calls. The Network encouraged their providers to use the evidenced- based Asthma Protocols. He stated that Transitional Nurses are providing medication reconciliation lists for all patients within the 5 day timeframe from discharge. They currently have relationships with East Alabama Medical Center (EAMC), Russell Medical Center (RMC), and Lake Martin Hospital and are working on Columbus Hospital to get to their patients in a timely manner while they are inpatient and then to transition them home. Dr. Stubblefield mentioned that they have instituted a Newborn follow-up program specifically at EAMC and RMC to ensure that all newborn patients are entering the medical homes and making sure that their newborn screening and newborn hearing screening information is making it into the medical home and that these patients follow up with the doctor they have identified. He stated that they are working with hospital staff to make sure they have relevant contact information which is the #1 problem so far. Dr. Stubblefield stated they now have a full-time Clinical Pharmacist and that they are now a licensed Food Bank provider. He stated the #1 need in the Network is transportation. He stated one of the future projects is to work with sickle cell patients transitioning them from pediatrics into the adult population.

Dr. Chelley Alexander, Medical Director, West Alabama was not available by telephone to give her update. Chris McInnish gave a brief update for the West Alabama PCNA. Due to a problem with only one provider in Tuscaloosa accepting newborn patients, a lot of newborn patients were not showing up for their 1<sup>st</sup> two-week visit. The Network started this past spring sending Case Managers into the hospitals everyday to setup follow-up appointments with the newborn mothers. They worked an agreement with that provider to see patients on a certain day and the Case Managers also met with the moms at the appointments to address any other needs they might have. Attendances for the two-week visits are now up to 97%. They are also in the process of setting up a group of Psychiatrists to provide pre-consulting to the PMPs.

Dr. Jeremy Stidham, Medical Director, North Alabama gave an update on the North Regional Network. He stated in regards to newborns, they have the "Best Start Maternity Program" that sends them a daily list of the patients with needed care after the hospital transition. They have a Transitional Care Nurse who makes the appointments with the PMPs for the newborns. They have an agreement with Huntsville Hospital who has a mobile unit that go out to the needed neighborhoods to provide flu shots. Dr. Stidham said there is a dietician they are hoping to hire soon to help deal with obesity issues. They hope to get more of a grass root effort in the neighborhoods where they might be able to financially incentivize some of the community leaders to get with their communities about better ways to cook, eat, and live their lives. Chris McInnish stated that Huntsville Hospital is requested to do research utilizing patients inside of Huntsville to look for patterns of chronic conditions to see if there are tools or neighborhoods that are starting to increase risk factors for chronic conditions.

Dr. Moon expressed his appreciation to Dr. Stidham for stepping in as Medical Director for North Alabama. He commented on the shortage of Psychiatrists in Alabama stating that access to Medicaid patients is very low. The initiative by the West Alabama Network to make this resource available to the doctors in their areas might make a huge difference in people's lives and hospital admissions. Dr. Moon informed the group that Medicaid does not pay for Registered Dieticians but the Networks have in their budgets the freedom to utilize dollars to spend on areas they have identified as problems.

### **Medicaid Staff Programs**

Kelli Littlejohn, R. PH., Pharm. D. stated that the Preferred Drug List has been updated effective October 1, 2012 (see attachments). Also, effective October 1, 2012, smoking cessation products will be covered for Medicaid recipients on the Plan First program. Starting October 1, 2012, we will begin accepting Prior Authorizations for Synagis. Dr. Rowe commented that we use American Academy of Pediatrics guidelines for Synagis.

Gary Parker, Director, One Health Record, Health Information Exchange (HIE), clarified that the HIE is part of the American Reinvestment and Recovery Act (ARRA, aka 'Stimulus funds'). He stated that the Information Exchange is the framework that

we are building with the Stakeholder group that allows providers to share information electronically from one end of the state to the other. The database is loaded with Medicaid history from the past 4 years and it is connected to the CHIP (Children's Health Insurance Program) system for those patients. There are two primary components of the Electronic Exchange in the HIE: 1. Robust Exchange through the EHR (Electronic Health Record) and 2. Direct Secure messaging through specialized email. Gary stated that the Direct Secure messaging is currently connected to Florida and we are trying to expand to the Panhandle and South Alabama. In the next couple of weeks, we will have EAMC and Jackson Hospital connected live to the Exchange. By the end of the year, UAB and Baptist First will be connected. Discussions have also been started with Huntsville Hospitals and UAB campuses.

Gretel Felton, Eligibility, gave an update on Express Lane Eligibility (ELE) (see attachment). ELE allows Medicaid to determine eligibility using certain findings from other public need-based programs instead of having the recipients send in documentation to prove their income. Medicaid is also able to connect to DHR (Department of Human Resources) to use their information to determine eligibility. Since 2009, over 300,000 individuals have had their Medicaid eligibility determined through ELE using SNAP (food assistance) or TANF (family financial assistance). In February 2012, HP launched a secure web portal for recipients called "My Medicaid" where Alabama Medicaid applicants and recipients can open an account; check the status of their application; view their eligibility, report changes in demographics, income, and household status; change their Patient 1<sup>st</sup> doctor in certain situations; request a new Medicaid card, and check their benefit limits.

Dr. Smith commented that if we are going to have a medical home; people need to be assigned to someone. He shared an example of a recipient who had been eligible for Medicaid for 2 weeks but had not been assigned to him per patient request. He requested that Medicaid find out why this is happening and fix it to ensure patients get assigned promptly.

**Ongoing Agenda Items – Dr. Rowe:**

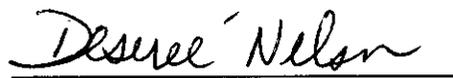
- CMS Medicaid Adult Health Measures Grant
- Alabama Perinatal Excellence Collaborative (APEC) & PACE
- Collaborative Improvement and Innovation Network (COIN) to reduce infant mortality
- Policy – Growth Hormone Criteria and Cosmetic vs. Reconstruction Draft Policy
- Ideas on how to increase involvement of PTF members, frequency of meetings, time of day and day of week for meetings, how to get input from Committee members and how to decide Topics

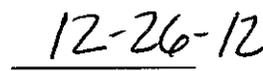
**Closing of Meeting – Dr. Rowe:**

Next meeting is scheduled for **Wednesday, December 5, 2012**, from 1 pm to 3 pm. Please send new topics at least 2 weeks in advance to [angela.williams@medicaid.alabama.gov](mailto:angela.williams@medicaid.alabama.gov).

Recorded by:

Desiree' Nelson, RN, CPC

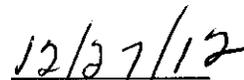
  
Program Manager, Medical Support Unit

  
Date

Reviewed by:

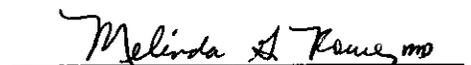
Theresa Richburg, RN

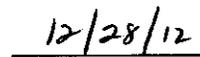
  
Director, Medical Service Division

  
Date

Approved by:

Melinda Rowe, M.D.

  
Assistant Medical Director, Health Systems

  
Date