

Members

Rep. Timothy Brown, Chairperson
Rep. Don Lehe
Rep. Suzanne Crouch
Rep. William Crawford
Rep. Charlie Brown
Rep. Peggy Welch
Sen. Patricia Miller
Sen. Ryan Mishler
Sen. Brandt Hershman
Sen. Jean Breaux
Sen. Timothy Skinner
Sen. Earline Rogers



SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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Authority: IC 2-5-26

MEETING MINUTES¹

Meeting Date: September 18, 2012
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., the House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 1

Members Present: Rep. Suzanne Crouch; Rep. William Crawford; Rep. Charlie Brown; Sen. Patricia Miller; Sen. Ryan Mishler; Sen. Brandt Hershman; Sen. Jean Breaux; Sen. Timothy Skinner; Sen. Earline Rogers.

Members Absent: Rep. Timothy Brown, Chairperson; Rep. Don Lehe; Rep. Peggy Welch.

Representative Suzanne Crouch called the meeting to order at 1:05 p.m., stating that Chairperson Tim Brown was sick and unable to attend. Commission members introduced themselves.

Managed Care Organization Update

The Commission asked Indiana's three Medicaid managed care organizations to provide the Commission with information concerning claim payments and access to providers, including specialists.

¹ These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

Pamela Staub and Minga Williams, Anthem, provided the Commission with information concerning Medicaid recipient access to enrolled providers, claim payment timeliness and reasons for claim denials. See Exhibit 1. Ms. Williams stated that the number one reason for denial of a submitted claim was that the provider submitted the claim after the 90-day filing limit.

John Barth, MHS, provided the Commission with statistics concerning provider enrollment, claims payment and claim denials. See Exhibit 2. Mr. Barth explained that a computer issue affected the claim payment statistics but that the computer problem has since been fixed. In response to questions by the Commission, Mr. Barth stated that MHS has an appeals process for a provider to appeal a claim denial.

Mr. Benjamin Moore introduced Patty Hebenstreit, MdWise, who provided the Commission with statistics concerning provider enrollment and claim payments. See Exhibit 3. Ms. Hebenstreit stated that there was an issue with claim payments in the Healthy Indiana Program when MdWise was transitioning to a different payor, which resulted in missing payment deadlines in the second quarter and the beginning of the third quarter. In response to questions by the Commission, Mr. Chris Kern, MdWise, explained that MdWise performs an annual audit to check its network for adequate recipient access to providers.

The Commission asked the managed care organizations to provide specific percentages for each claim denial reason.

Hospital Assessment Fee Update

Mr. Tim Kennedy, Indiana Hospital Association ("Association"), informed the Commission that the hospital assessment fee has been successfully implemented. Mr. Kennedy provided the Commission with background information about the assessment, including that the hospital assessment fee was passed in the 2011 budget bill, and that hospitals had not received a general reimbursement rate increase in fifteen years. Mr. Kennedy stated that the Association's goals with the assessment were to increase Medicaid fee for service payments to the Medicare level and to replace the intergovernmental transfer approach in the disproportionate share hospital (DSH) program.

Mr. Kennedy stated that for State Fiscal Year 2012, \$650 million were paid by hospitals for the assessment which leveraged \$1.5 billion and provided new money of approximately \$250 million in Medicaid managed care. Mr. Kennedy informed the Commission that 120 eligible hospitals paid the assessment, and only seven of those hospitals paid more in the assessment than what the hospital received back. Mr. Kennedy stated that five out of the seven mentioned hospitals treat very few or no Medicaid patients. Mr. Kennedy reminded the Commission that the hospital assessment fee expires June 30, 2013, and stated that the Association will be seeking an extension of the assessment during the 2013 General Assembly. In response to questions by Commission members, Mr. Kennedy briefly discussed the federal Affordable Care Act's impact on hospitals, including the Act's Medicare cuts which will result in a loss to the hospitals of \$3.8 billion during a ten-year period (2010-2020).

Electronic Claims Processing Update

Mr. Roger Arguello, HP, provided the Commission with statistics concerning claim payments for the Medicaid fee for service program, including reasons for claim denials. See Exhibit 4. Mr. Arguello explained that one of the reasons that the number of participating providers decreased in 2011 and 2012 was that in State Fiscal Year 2010, HP

weeded out providers who were not submitting claims. Mr. Arguella stated that 72 million claims were processed in the last year.

Medicaid Prepayment Review Process

Ms. Kristina Moorhead, FSSA, explained the Medicaid prepayment review process program (program) in which targeted providers are required to submit documentation with each claim for prior review by FSSA. See Exhibit 5. Ms. Moorhead stated that providers are placed on the program if FSSA has concerns with the provider's billing practices. Ms. Moorhead testified that a provider participates in the program for a minimum of six months, and is removed from the program once the provider achieves 100% accuracy in the provider's claim submissions for at least three months. Ms. Moorhead provided the following statistics concerning provider participation in the program:

- State Fiscal Year 2011- 65 providers
- State Fiscal Year 2012- 91 providers
- Currently- 95 providers- or 12% of Medicaid providers.

Rep. Charlie Brown stated his concern with the FSSA's delayed response to an inquiry he made on behalf of a constituent who was placed on the program. Rep. Charlie Brown stated that he waited for 7 months before he heard back from FSSA, and that the constituent he was assisting is a pediatric dentist, an area in which the state has a shortage of providers. Ms. Moorhead stated that FSSA can choose not to place a provider in the program if FSSA determines that the placement will cause an access issue.

Medicaid Waivers Update

Mr. Shane Spotts, FSSA, informed the Commission that FSSA has made changes to the Medicaid waiver program, instituting: (1) the Family Supports waiver (FSW) to replace the Support Services waiver; and (2) the Community Integrity and Habilitation (CIH) Waiver to replace the Autism and Developmental Disabilities waivers. See Exhibit 5, pages 11 through 15. Mr. Spotts explained that the waiver waiting lists were consolidated. Mr. Spotts stated that the CIH is a needs-based waiver, meaning that an individual must meet one of the emergency priority criteria to access the waiver. Mr. Spotts provided the following statistics concerning the waiting lists for these Medicaid waivers:

- State Fiscal Year 2011: 20,000 individuals on waiting list
- State Fiscal Year 2012: 13,441 individuals on waiting list
- Currently: 9,628 individuals on FSW waiting list.

Ms. Susan Waschevski, FSSA, provided the Commission with the following information concerning the Aged and Disabled (A&D) waiver waiting list:

- July, 2010: 3,368 individuals on waiting list
- July, 2011: 5,351 on waiting list (9,910 individuals served on waiver)
- July 2012: 2,679 on waiting list (10,367 individuals served on waiver)

See Exhibit 5, pages 18 through 20. Ms. Waschevski stated that more A&D waiver slots have been released: 1,844 individuals have been approved and confirmed for a slot, while 1,790 individuals have been terminated or denied for a waiver slot.

Ms. Waschevski provided the following information concerning the Traumatic Brain Injury (TBI) waiver:

- July, 2010: 129 individuals on waiting list
- July, 2011: 138 individuals on waiting list
- July, 2012: 109 individuals on waiting list
- Currently: 94 individuals on waiting list

See Exhibit 5, pages 21 through 23. Ms. Waschevski stated that when TBI waiver slots

were released, 62% of individuals on the waiting list were terminated or denied for the waiver, and 33% were approved and confirmed. In June, 2012, 177 individuals were served on the TBI waiver. Ms. Waschevski stated that the TBI waiver expires December 31, 2012, and that FSSA has asked the federal government for a five year renewal of the TBI waiver.

In response to questions by the Commission concerning why so many individuals were denied, Ms. Waschevski stated that some individuals voluntarily withdrew their names from consideration, and other individuals were not Medicaid eligible. Commission members asked that the list be categorized differently in the future.

Indiana Check-Up Plan/Healthy Indiana Plan Update

Ms. Adrienne Shields, FSSA, provided the Commission with an update on the Healthy Indiana Plan (HIP). Ms. Shields provided the following information:

- 42,356 individuals currently enrolled in HIP
- 39,538 individual wait list, consisting only of childless adults (no wait list for parental adults)
- 4,576 individuals on waiting list have been deemed eligible after FSSA mailed out letters to individuals on wait list in July, 2011.

See Exhibit 5, page 26. Ms. Shields stated that the federal Centers for Medicare and Medicaid Services (CMS) has extended the HIP plan, which was set to expire December 31, 2012, for one year. Commission members asked for a copy of the CMS letter that extended HIP.

The meeting was adjourned at 2:45 p.m.

EX 1

On Medicare
September 2012



Anthem®

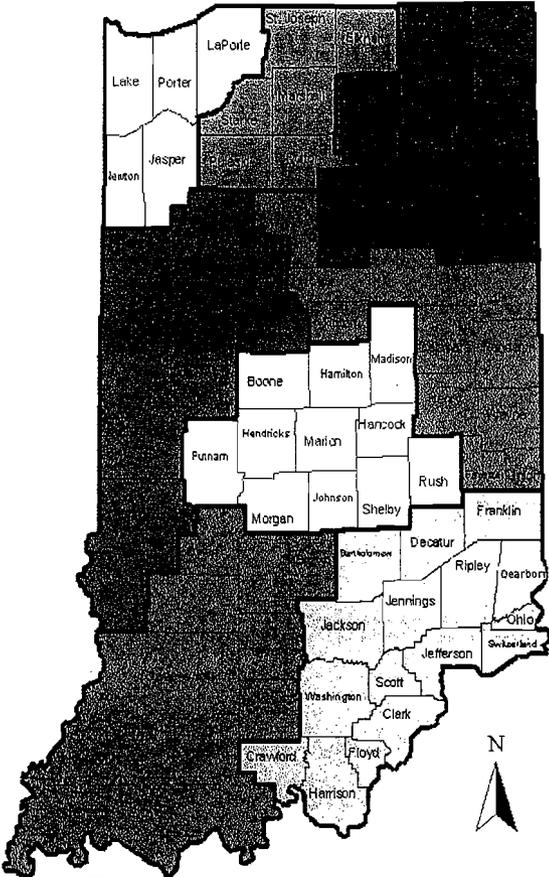
Anthem Enrolled Providers by Region

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Central	552 1/140	893 1/87	371 1/209	134 1/575	112 1/692	126 1/615
East Central	82 1/141	69 1/167	39 1/296	25 1/462	67 1/172	9 1/1,283
North Central	96 1/123	94 1/122	145 1/255	111 1/521	92 1/559	18 1/635
Northeast	137 1/150	177 1/116	31 1/662	37 1/555	37 1/555	47 1/437
Northwest	160 1/115	205 1/128	171 1/46	93 1/324	48 1/615	51 1/655
Southeast	117 1/154	111 1/163	52 1/347	48 1/376	25 1/722	87 1/207
Southwest	175 1/125	166 1/225	171 1/237	86 1/325	100 1/325	100 1/325
West Central	104 1/98	49 1/209	25 1/409	8 1/1,278	23 1/445	20 1/511

*HHW access requires that a PMP is available within 30 miles of every member's residence.

*Counts include Pediatric sub-specialties.

Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region



Anthem General Appointment Scheduling Access

Urgent Care: 95% of members treated no later than the end of the following workday after initial contact

Non Urgent, Sick: 74% of members treated within 72 hours of request

Routine, Non Urgent Adult: 98% of members treated within 6 weeks of member's request

Prenatal: 62% treated within 14 days of member's request

Preventive, Adult: 90% treated within 14 days

Preventive, Child: 84% treated within 14 days

Specialist Routine Visit within 21days: 76%

In Office Wait Time: 94% within 15 minutes

Call Back Triage: 88% within 30 minutes

Anthem Claims Payment Timeliness – HHW Physical Health

	Facility Claims* (UB-04)	Professional Claims** (CMS 1500)
% Paper Claims Paid Within 30 Days	95%	99%
% Electronic Claims Paid Within 21 Days	99%	99%
% Denied	10%	9%

*A facility claim is one billed on a UB-04 / CMS-1450 claim form by institutional providers including hospitals, skilled nursing facilities and home health care providers.

**A professional claim is one billed on a CMS-1500 claim form by physicians and professional services providers including physical, occupational and speech therapists. Specific ancillary providers are also to use this claim form.

Anthem Top Claims Denial Reasons – HHW Physical Health

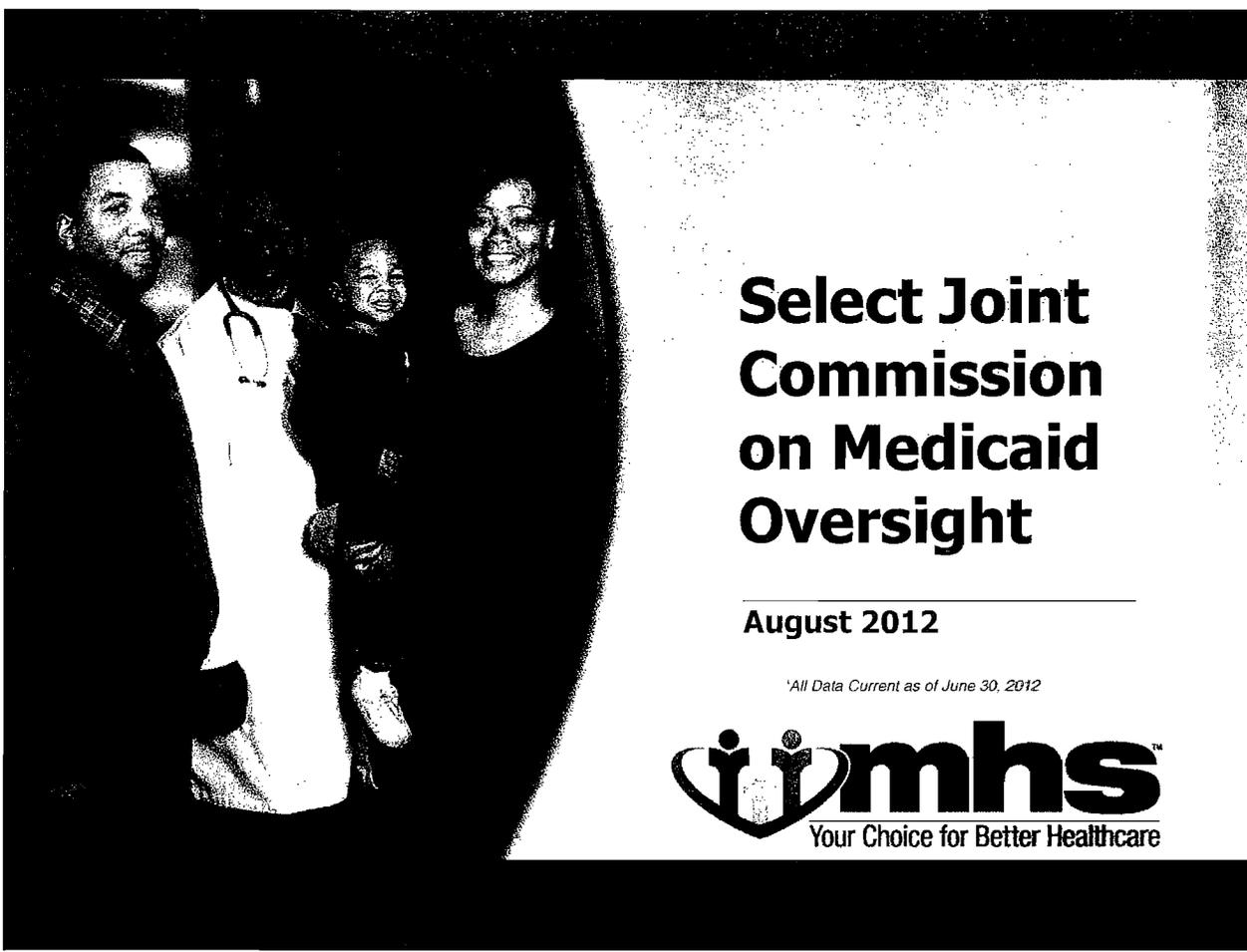
Facility (UB-04)	Professional (CMS 1500)
1. Claim submitted after filing limit	1. Claim submitted after filing limit
2. Authorization not obtained	2. Referral not obtained
3. Services rendered by non participating provider	3. Authorization not obtained
4. Referral not obtained	4. Services rendered by non participating provider
5. Non covered expense	5. Not a covered expense
6. Payment included in intial DRG payment	6. Services rendered by non- lock in provider
7. Services rendered by non lock in provider	
8. Services not medically necessary	

Claims Payment Timeliness – Behavioral Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	97%	90%
% Electronic Claims Paid Within 21 Days	94%	99%
% Denied	10%	5%

Top Claims Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. Claim submitted after filing limit	1. Authorization not obtained
2. Services rendered by non participating provider	2. Claim submitted after filing limit
3. Authorization not obtained	3. Services rendered by non participating provider
4. Referral not obtained	4. Referral not obtained
5. Non covered expense	5. Non covered expense



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August 2012

All Data Current as of June 30, 2012



MCE Enrolled HHW Providers By Region

Region	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	128	31	7	4	35	13
North Central	1/197	1/813	1/3603	1/6305	1/777	1/1940
North Central	168	37	46	16	46	15
North Central	1/226	1/1030	1/828	1/2381	1/1273	1/2540
Northeast	116	50	15	17	31	9
Northeast	1/169	1/393	1/1311	1/1156	1/755	1/2185
West Central	45	27	19	8	30	5
West Central	1/242	1/403	1/573	1/1362	1/383	1/2179
Central	296	138	66	49	116	61
Central	1/172	1/370	1/775	1/1043	1/462	1/838
East Central	107	40	24	12	39	11
East Central	1/180	1/483	1/805	1/1610	1/550	1/1756
Southwest	126	35	37	12	35	20
Southwest	1/137	1/495	1/468	1/1444	1/678	1/866
Southeast	148	59	54	32	35	23
Southeast	1/132	1/149	1/364	1/614	1/922	1/855



MCE HIP Enrolled Providers

	PMPs (Per Members)	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Statewide	828	308	252	124	364	150
	1/4	1/11	1/13	1/27	1/4	1/22



Hoosier Healthwise Regions



1	2	3	4	5	6	7	8
Northwest Region	North Central Region	Northeast Region	West Central Region	Central Region	East Central Region	Southwest Region	Southeast Region



Primary Care Providers – New Member Appointments

PMP VISIT – NEWLY ASSIGNED MHS MEMBERS	MHS STANDARD: MAXIMUM TIME TO APPT.	2012 PMP AUDIT COMPLIANCE
<ul style="list-style-type: none"> ▪ Exams / physicals for adults ▪ Family planning exam 	Within 3 months	100% 100%
<ul style="list-style-type: none"> ▪ New pregnancy visit ▪ Children with special needs ▪ Well-child check-ups 	Within 1 month	100% 98.7% 98.7%
<ul style="list-style-type: none"> ▪ Sick Visit ▪ Urgent Visit 	Within 72 hours Within 24 hours	98.7% 98.7%
Wait times in-office	One Hour or less for appointment scheduled one or more days in advance*	98.7%

*may be affected by unforeseen emergency

MHS Audits of 100% our PMPs Annually – HIP and HHW

5



Claims Payment Timeliness – Physical Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)	Overall Total
% Paper Claims Paid Within 30 Days	97 %	98 %	98 %
% Electronic Claims Paid Within 21 Days	99 %	99 %	99 %
% Denied	1 %	9 %	5 %

6



Top 10 Claim Denial Reasons – Physical Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. THE TIME LIMIT FOR FILING HAS EXPIRED	1. THE TIME LIMIT FOR FILING HAS EXPIRED
2. AUTHORIZATION NOT ON FILE	2. AUTHORIZATION NOT ON FILE
3. BILL PRIMARY INS 1ST. RESUBMIT WITH EOB	3. BILL PRIMARY INSURER 1ST. RESUBMIT W/ EOB
4. CLAIM & AUTH SERVICE PROVIDER NOT MATCHING	4. DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
5. DENIED BY MEDICAL SERVICES	5. MEMBER NAME / NO. / DATE OF BIRTH NOT MATCHING, PLEASE RESUBMIT
6. MISSING OR INVALID POA (Present on Admission Indicator)	6. CLAIM & AUTH PROVIDER SPECIALTY NOT MATCHING
7. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION	7. ROUTINE VISION CARE SHOULD BE BILLED TO OPTICARE
8. MEMBER NAME / NO. / DATE OF BIRTH NOT MATCHING, PLEASE RESUBMIT	8. CLAIM & AUTH SERVICE PROVIDER NOT MATCHING
9. NOT A MCO COVERED BENEFIT	9. PLEASE RESUBMIT TO CENPATICO FOR CONSIDERATION
10. THIS SERVICE IS NOT COVERED	10. OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT



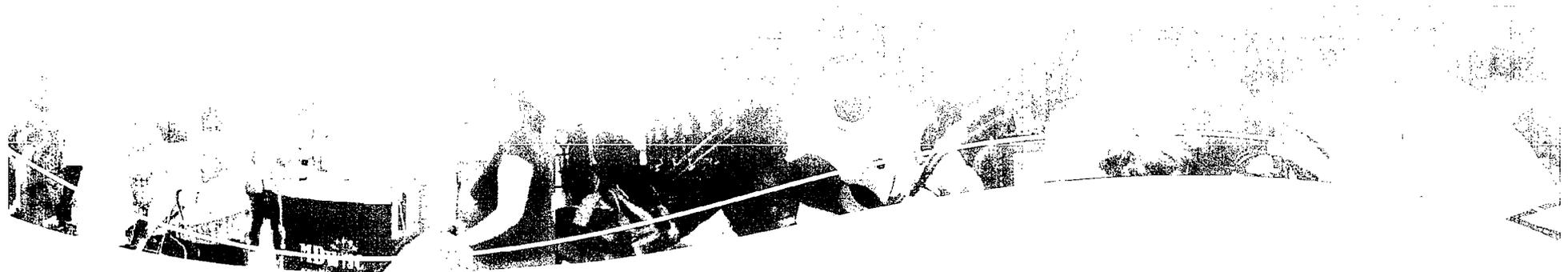
Claim Processing Timeliness – Behavioral Health

	Facility Claims (UB-04)	Professional Claims (CMS 1500)	Overall Total
% Paper Claims Paid Within 30 Days	99 %	100 %	100 %
% Electronic Claims Paid Within 21 Days	100 %	100 %	100 %
% Denied	14 %	9 %	10 %



Top 10 Claim Denial Reasons – Behavioral Health

Facility Claims (UB-04)	Professional Claims (CMS 1500)
1. THE TIME LIMIT FOR FILING HAS EXPIRED	1. BILL PRIMARY INSURER 1ST. RESUBMIT W/ EOB
2. REVENUE CODE IS NON-COVERED WHEN BILLED WITH HCPCS / CPT-4 CODES	2. THE TIME LIMIT FOR FILING HAS EXPIRED
3. BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB	3. BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET
4. INVALID REVENUE CODE & HCPCS / CPT-4 PROCEDURE COMBINATION BILLED	4. SERVICE HAS EXCEEDED AUTHORIZED LIMIT
5. REVENUE CODE CAN ONLY BE BILLED ONCE PER DAY	5. AUTHORIZATION NOT ON FILE
6. DUPLICATE SUBMISSION	6. COVERAGE NOT IN EFFECT AT TIME OF SERVICE
7. RESUBMIT WITH CORRECT MODIFIER	7. PLEASE REBILL WITH SUPERVISOR'S NPI
8. AUTHORIZATION NOT ON FILE	8. OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
9. PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY	9. DUPLICATE SUBMISSION
10. INSUFFICIENT INFO FOR PROCESSING, PLEASE RESUBMIT WITH PRIME'S ORIGINAL EOB	10. INAPPROPRIATE DIAGNOSIS FOR BEHAVIORAL HEALTH SUBSTANCE ABUSE SERVICES



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September 18, 2012

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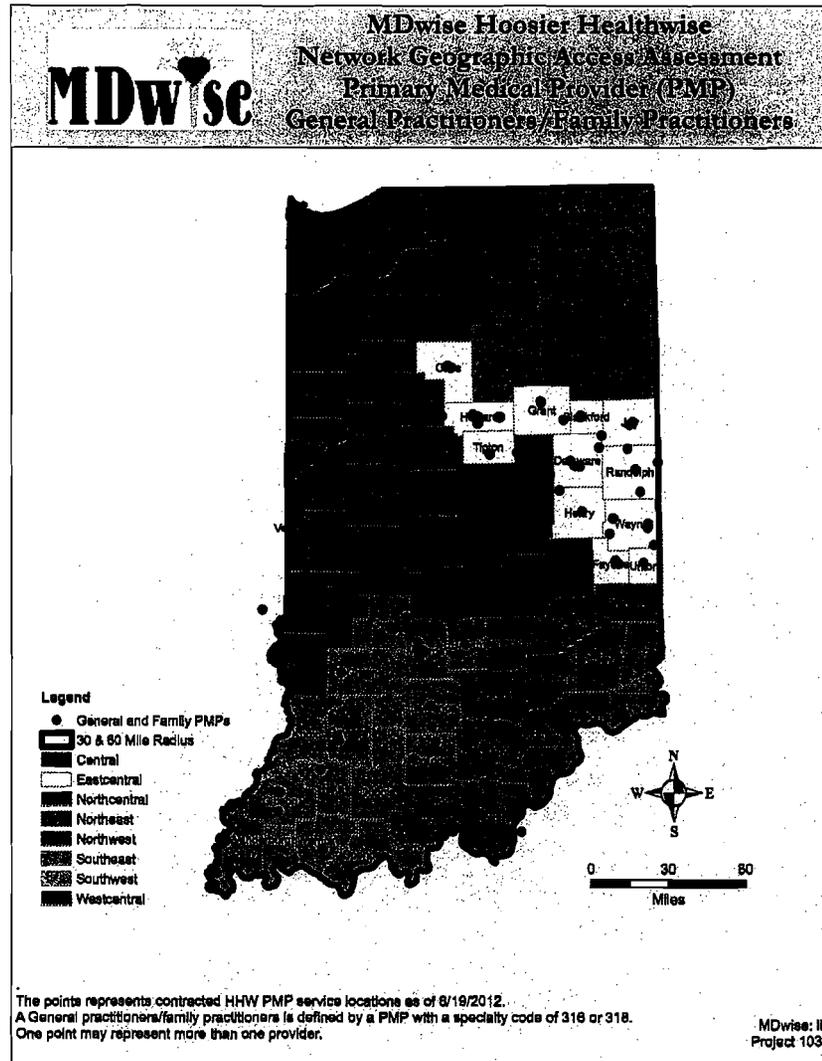


Primary Medical Provider (PMP) Access Standards

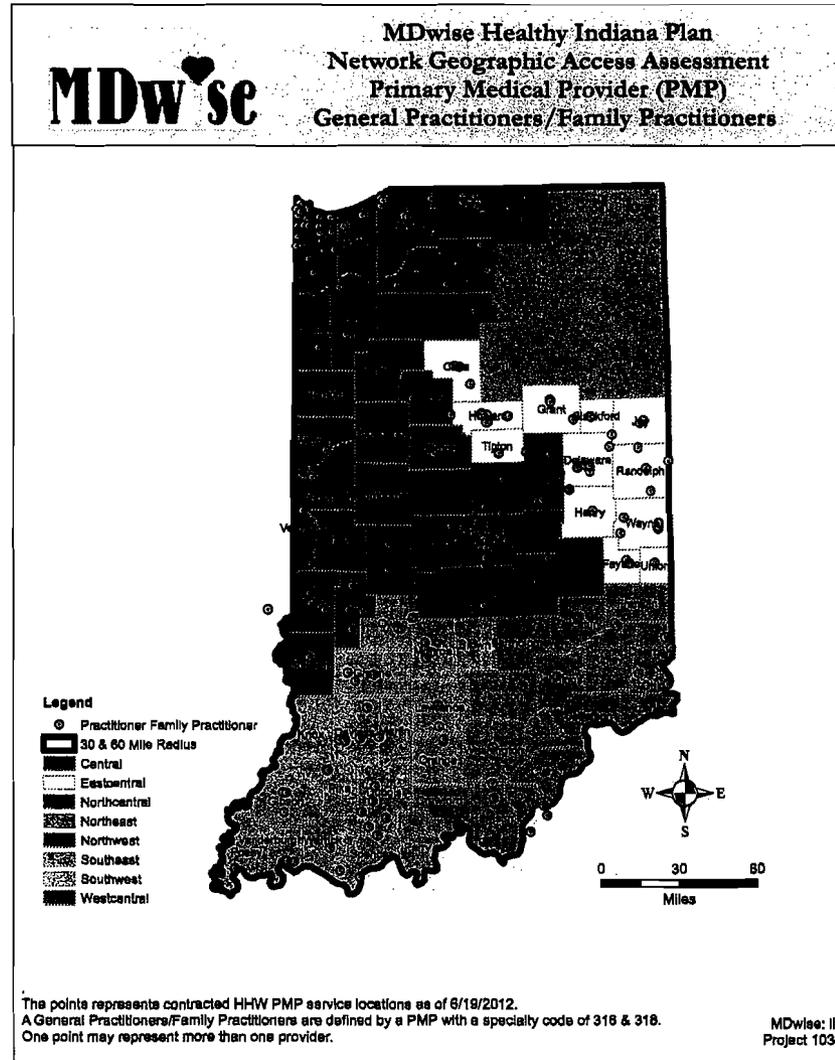
- PMPs should adhere to the following access standards in providing care to MDwise members.
- Appointment Category Appointment Standards includes:
 - Urgent/Emergent Care Triage 24 hours/day
 - Non-Urgent Symptomatic 72 hours
 - Routine Physical Exam 3 months
 - Initial Appointment (Non-pregnant Adult) 3 months
 - Routine Gynecological Examination 3 months
 - New Obstetrical Patient Within 1 month of date of attempting to schedule an appointment
 - Initial Appointment Well Child Within 1 month of date of calling to schedule an appointment
 - Children with Special Health Care Needs 1 month



HHW PMPs: General/Family Practitioners



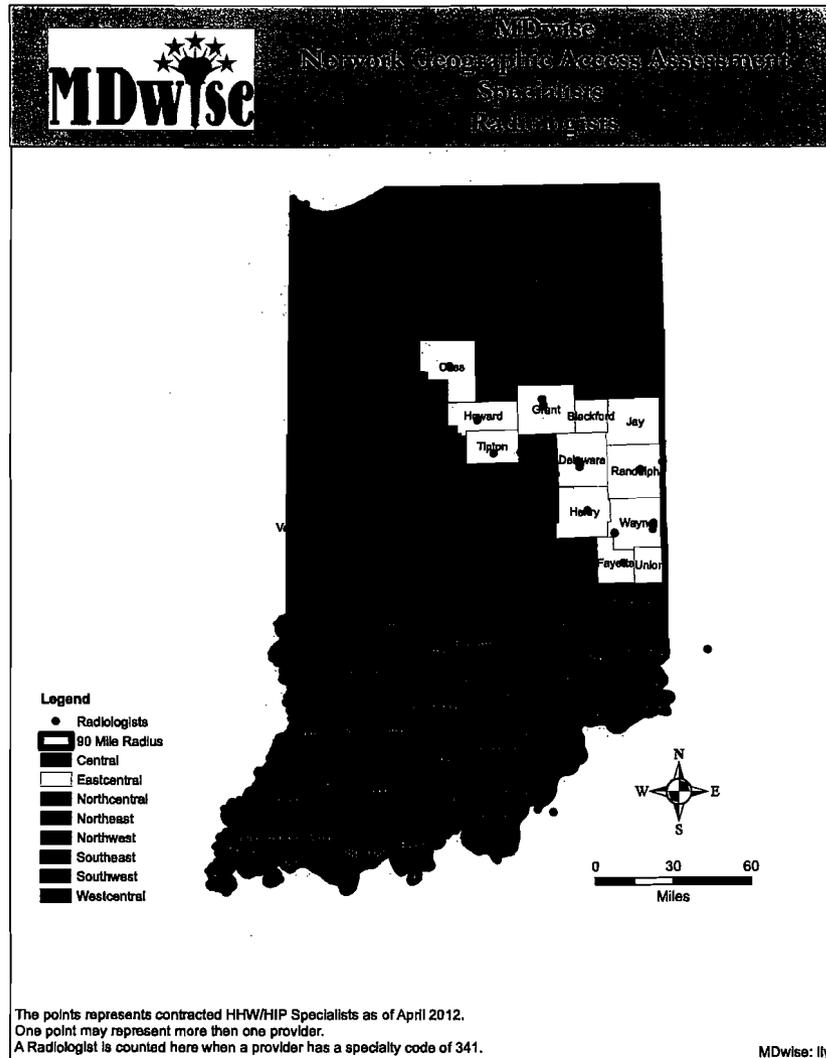
HIP PMPs: General/Family Practitioners



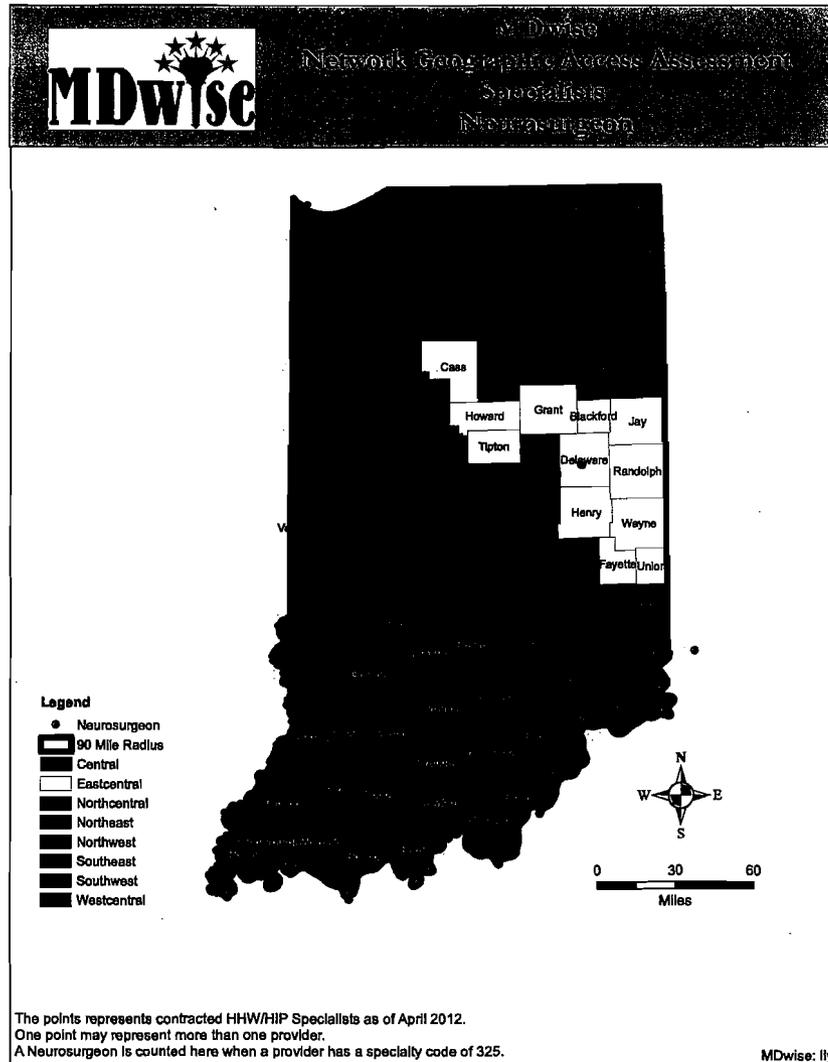
Specialist Access Standards

- MDwise also requires the following standards to be maintained regarding patient accessibility to specialist referrals.
- Appointment Category Appointment Standards includes:
 - Emergency 24 hours
 - Urgent 48 hours
 - Non-Urgent Symptomatic 4 weeks

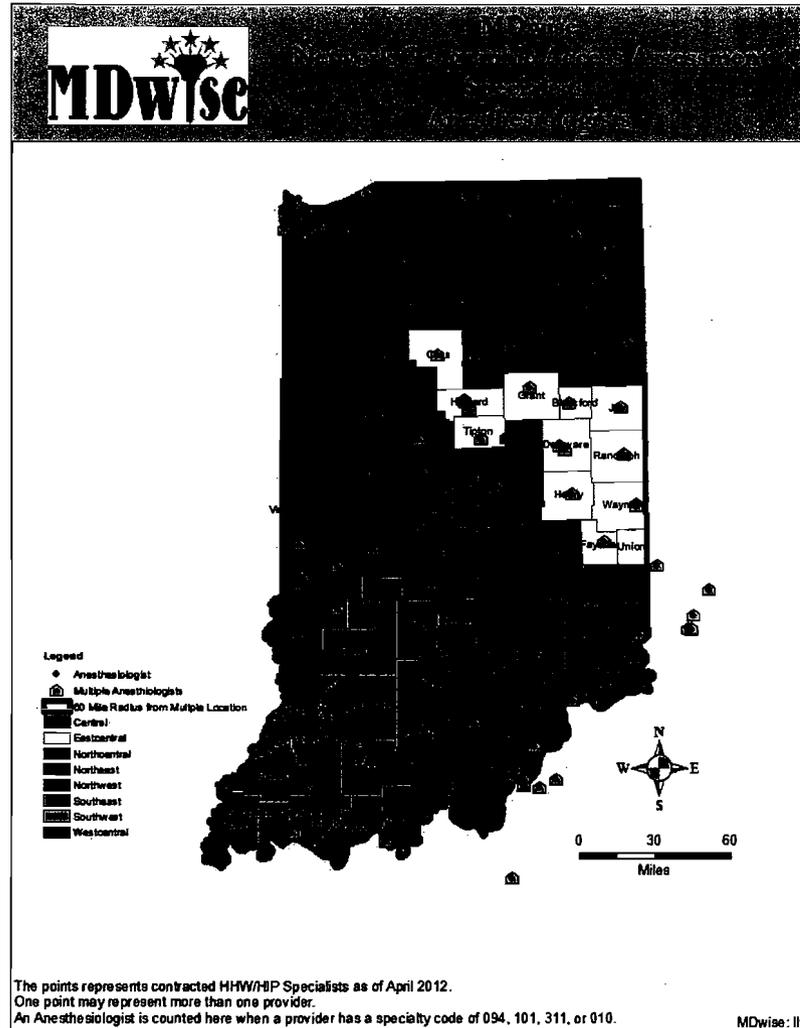
MDwise Specialists: Radiologists



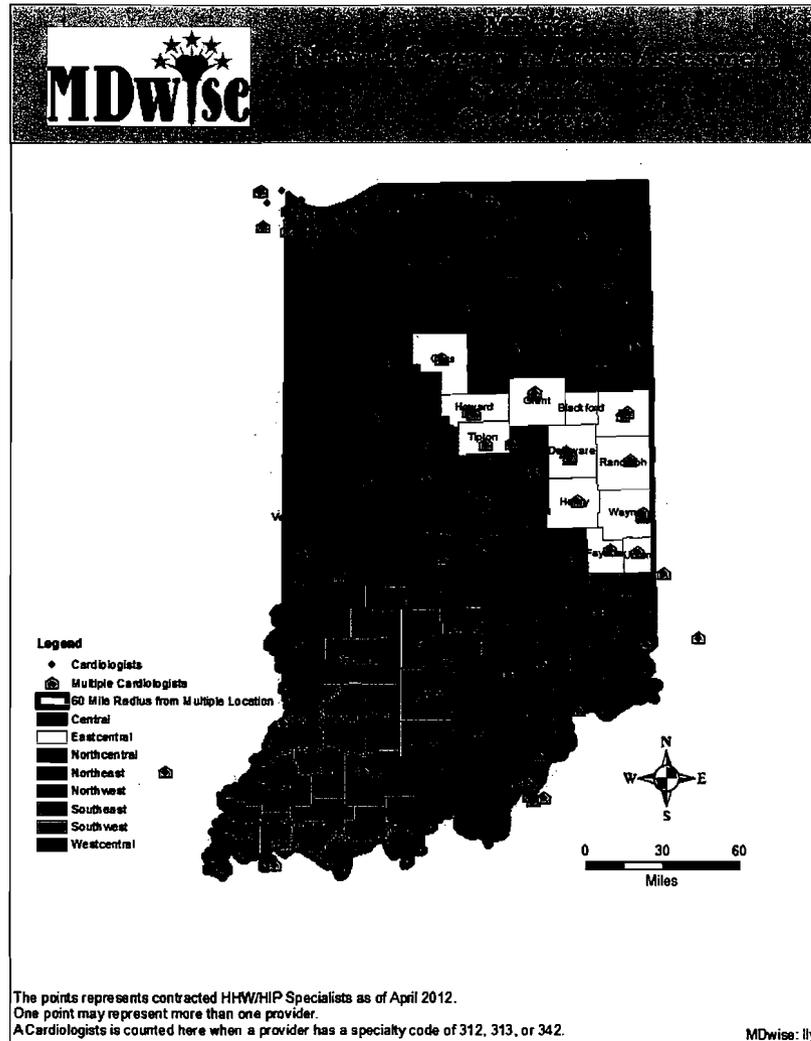
MDwise Specialists: Neurosurgeons



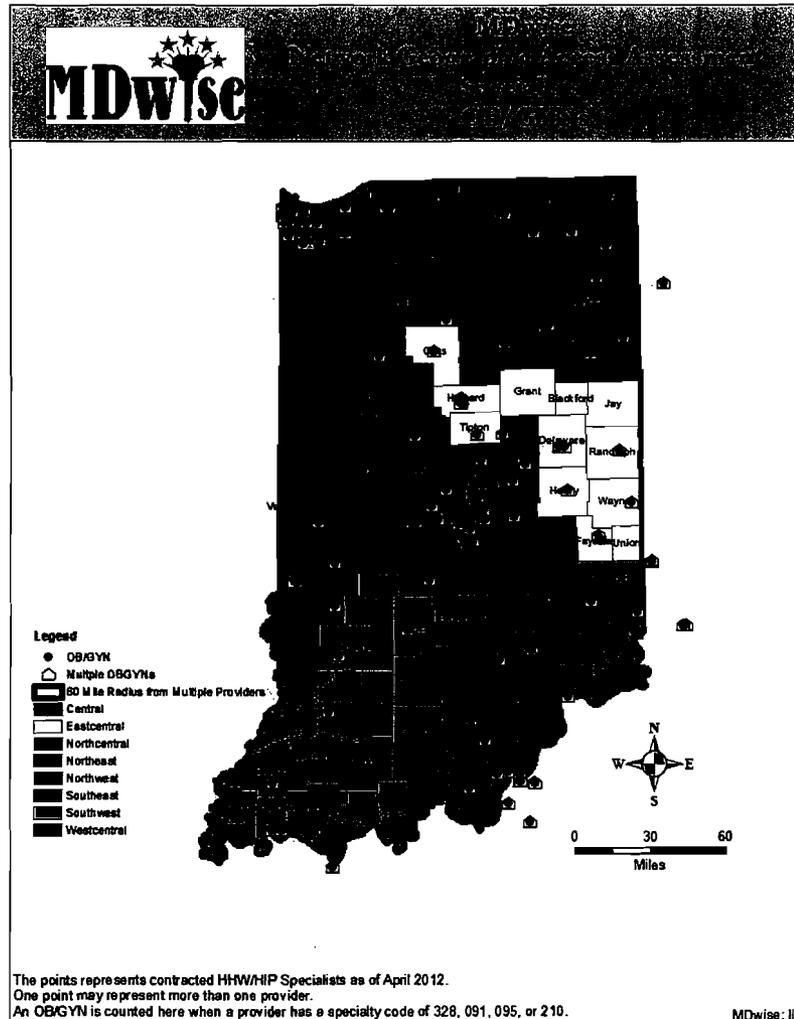
MDwise Specialists: Anesthesiologists



MDwise Specialists: Cardiologists



MDwise Specialists: OB/GYNs



HHW MCO Enrolled Providers By Region and Members per Provider

Region	PMPs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Northwest	236 1/176	81 1/513	24 1/1,731	16 1/2,596	46 1/903	16 1/2,596
North Central	96 1/176	71 1/238	24 1/704	7 1/2,415	43 1/393	13 1/1,300
Northeast	242 1/168	88 1/462	35 1/1,162	18 1/2,260	37 1/1,099	19 1/2,141
West Central	171 1/178	58 1/525	31 1/981	8 1/3,803	30 1/1,014	17 1/1,789
Central	314 1/273	248 1/346	110 1/780	56 1/1,533	155 1/554	72 1/1,192
East Central	173 1/190	107 1/307	35 1/939	15 1/2,192	40 1/822	17 1/1,934
Southwest	95 1/111	73 1/145	52 1/203	19 1/556	49 1/216	20 1/528
Southeast	127 1/152	87 1/222	44 1/440	29 1/667	34 1/569	24 1/806



HIP MCO Enrolled Providers and Members per Provider

Region	PMs	Cardiologist	Orthopedic Surgeon	Otologist or Otolaryngologist	Psychiatrist	Urologist
Statewide	976 1/111	712 1/15	343 1/30	165 1/63	434 1/24	194 1/54



Claims Payment Timeliness

HHW Physical Health: Jan – Dec 2011

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	98% (53,356/54,599)	99% (400,061/403,773)
% Electronic Claims Paid Within 21 Days	98% (393,638/401,523)	99% (1,409,390/1,423,346)
% Denied	2% (9,191/456,122)	2% (43,135/1,827,119)
Total Claims Received (includes clean & unclean, paper & electronic)	682,260	2,482,869



Claims Payment Timeliness

HHW Behavioral Health Jan - Dec 2011

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	95% (5,800/6,104)	98% (76,346/77,836)
% Electronic Claims Paid Within 21 Days	99% (34,080/34,455)	99% (118,859/119,490)
% Denied	2% (969/40,559)	6% (11,244/197,326)
Total Claims Received (includes clean & unclean, paper & electronic)	48,621	246,019



Claims Payment Timeliness

HIP Physical Health Plan – Dec 2011

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	97% (5,827/6,033)	97% (40,781/41,851)
% Electronic Claims Paid Within 21 Days	89% (25,182/28,354)	95% (61,176/64,603)
% Denied	6% (2,163/34,387)	8% (8,296/106,454)
Total Claims Received (includes clean & unclean, paper & electronic)	57,939	179,071



Claims Payment Timeliness

HIP Behavioral Health Jan – Dec 2011

	Facility Claims (UB-04)	Professional Claims (CMS 1500)
% Paper Claims Paid Within 30 Days	94% (198/211)	95% (4,792/5,026)
% Electronic Claims Paid Within 21 Days	87% (871/996)	90% (2,854/3,174)
% Denied	16% (193/1,207)	9% (700/8,200)
Total Claims Received (includes clean & unclean, paper & electronic)	1,953	13,736



Top 10 Clean Claims Denial Reasons

HHW Physical Health: Jan – Dec 2011

Facility Claims (UB-04)

1. Payment adjusted because this care may be covered by another payer per coordination of benefits
2. Incorrect billing
3. Non-covered charges
4. Duplicate claim/service
5. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
6. Payment denied/reduced for absence of, or exceeded, precertification/authorization
7. Member was not eligible at the time the service was provided
8. Claim/Service lacks information which is needed for adjudication
9. Exceeds filing limit

Professional Claims (CMS 1500)

1. Duplicate claim/service
2. Incorrect billing
3. Payment adjusted because this care may be covered by another payer per coordination of benefits
4. Non-covered charges
5. The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
6. Claim/Service lacks information which is needed for adjudication
7. Payment denied/reduced for absence of, or exceeded, precertification/authorization
8. Member was not eligible at the time the service was provided
9. The provider was not eligible to render the service at the time the service was rendered
10. Benefit maximum for this time period or occurrence has been reached



Top 10 Clean Claims Denial Reasons

HHW Behavioral Health: Jan – Dec 2011

Facility Claims (UB-04)

1. Duplicate claim/service
2. Payment because this care may be covered by another payer per coordination of benefits
3. Payment denied/reduced for absence of, or exceeded, precertification/authorization
4. Incorrect billing
5. The benefit of this service is included in the payment/allowance for another service/procedure that has already been adjudicated
6. Member was not eligible at the time the service was provided
7. Exceeds filing limit
8. Claim/Service lacks information which is needed for adjudication

Professional Claims (CMS 1500)

1. Duplicate claim/service
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6. Payment denied/reduced for absence of, or exceeded, precertification/authorization
7. Claim/Service lacks information which is needed for adjudication
8. Exceeds filing limit
9. Member was not eligible at the time the service was provided
10. Benefit maximum for this time period or occurrence has been reached



Top 10 Clean Claims Denial Reasons

HIP Behavioral Health Plan – Dec 2011

Facility Claims (UB-04)

1. Payment denied/reduced for absence of, or exceeded, precertification/authorization
2. Duplicate claim/service
3. Incorrect billing
4. Exceeds filing limit
5. Claim/Service lacks information which is needed for adjudication

Professional Claims (CMS 1500)

1. Payment denied/reduced for absence of, or exceeded, precertification/authorization
2. Exceeds filing limit
3. Duplicate claim/service
4. Incorrect billing
5. Claim/Service lacks information which is needed for adjudication
6. Payment adjusted because this care may be covered by another payer per coordination of benefits
7. The provider was not eligible to render service at the time the service was rendered
8. Member has a restricted card and must use assigned providers for benefit coverage



Top 10 Clean Claims Denial Reasons

HIP Physical Health Plan – Dec 2011

Facility Claims (UB-04)

1. Exceeds filing limit
2. Claim/Service lacks information which is needed for adjudication
3. Duplicate claim/service
4. Incorrect billing
5. Payment denied/reduced for absence of, or exceeded, precertification/authorization
6. Non-covered charges
7. Payment adjusted because this care may be covered by another payer per coordination of benefits

Professional Claims (CMS 1500)

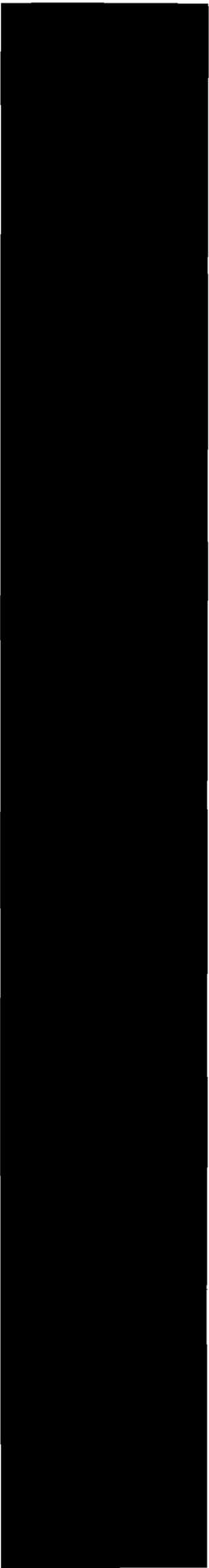
1. Exceeds filing limit
2. Duplicate claim/service
3. Payment denied/reduced for absence of, or exceeded, precertification/authorization
4. Non-covered charges
5. Payment adjusted because this care may be covered by another payer per coordination of benefits
6. Incorrect billing
7. Charges do not meet qualifications for emergent/urgent care
8. Member has a restricted card and must use assigned providers for benefit coverage
9. Claim/Service lacks information which is needed for adjudication
10. The provider was not eligible to render the service at the time the service was rendered





Indiana Health Coverage Programs Update to Select Joint Commission on Medicaid Oversight

September 18, 2012



Indiana Health Coverage Programs

Volume Statistics, July 2008 through June 2012

	SFY 2009	SFY 2010	SFY 2011	SFY 2012
	Jul '08 - Jun '09	Jul '09 - Jun '10	Jul '10 - June '11	Jul '11 - June '12
Dollars Paid *	\$5,640,700,000	\$6,136,400,000	\$6,581,000,000	\$6,888,000,000
Claims				
Risk Based Managed Care	15,080,731	15,242,671	9,460,510	11,831,244
Fee-for Svc Paid Claims**	29,590,516	35,474,838	30,105,003	41,629,585
Fee-for Svc Denied Claims	13,978,353	15,684,009	13,438,222	18,678,570
% Paid	67.9	69.3	69.1	69.0
Adjudication Days ***	2.3	2.4	1.9	1.7
Providers****				
MCO & FFS Enrolled*****	52,456	46,669	48,046	47,184
Recipients at End of Period				
Enrolled (Medicaid)	965,853	1,028,746	1,043,664	1,049,135
Enrolled (HIP)	44,621	46,219	41,892	41,100
Total Enrolled	1,010,474	1,074,965	1,085,556	1,090,235

* SFY2009 through SFY2012 reflect dollars paid for Medicaid medical assistance.

** Increase in fee for service claims from SFY 2009 to SFY 2010 is result of HP processing MCO pharmacy claims, beginning January 2010.

*** Adjudication is the number of days from submission to payment determination. Payment occurs in the next available weekly payment run.

**** Figures include all provider types who were enrolled at any time during the state fiscal year.

***** Enrollment decrease from June '09 to June '10 is due to the October 09 implementation of automatic termination of providers who have not submitted claims for 18 months.



Indiana Health Coverage Programs

SFY 2012 Claim Statistics (July 2011 – June 2012)

Top 2 Hard Denial Reasons

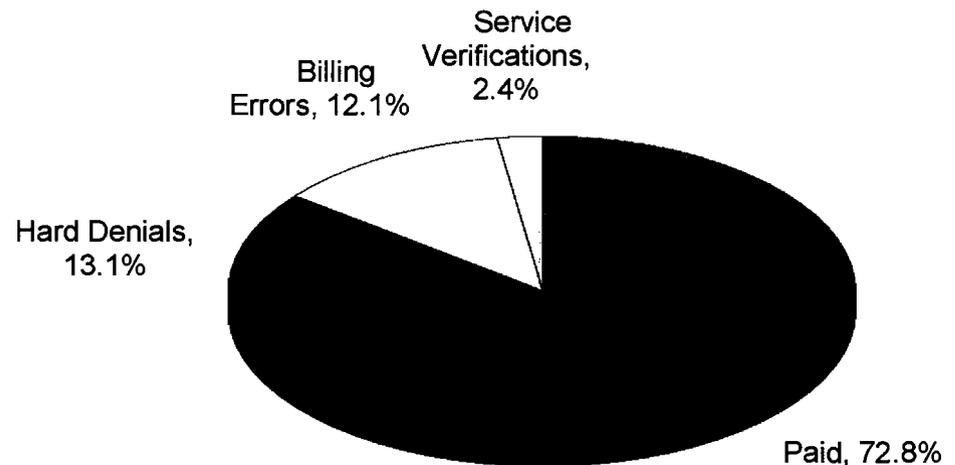
- Other insurance related denials
- Recipient eligibility related denials

Top 2 Billing Error Reasons

- Missing coinsurance and deductible
- Duplicate billing

Top 2 Service Verification Reasons

- Prospective Drug Utilization Review (ProDUR) related
- National Drug Code vs. days supply



Indiana Health Coverage Programs

Operational Statistics (July 2011 – June 2012)

Operational Areas

Claim Volume: July 2011 - June 2012

FFS Electronic	31,502,922
FFS Paper	2,306,296
Pharmacy	26,498,937
Risk Based Managed Care (RBMC)	<u>11,831,244</u>
Total Claims	72,139,399

Web Claim Volume (Included above) *	3,421,827
Percent Electronic Claims	96.8

Call Center: July 2011 - June 2012

Provider Calls	181,976
Recipient Calls	<u>159,698</u>
Total Calls	341,674

Automated Voice Response (Volume)	477,446
Percent Automated Calls	58.3%

New FFS Provider Enrollments:

July 2011 - June 2012	15,244
-----------------------	--------

Claim Inventories: June 2012 Month End

Claims Suspended for Manual Adjudication	33,254
Claims Received, Awaiting Data Entry	30,284
Claims Received, Awaiting Attachment	<u>1,854</u>
Total	65,392

Publications: July 2011 - June 2012

Bulletins	51
Banners	44
Newsletters	12

Written Correspondence

11,268

Systems Availability: July 2011 - June 2012

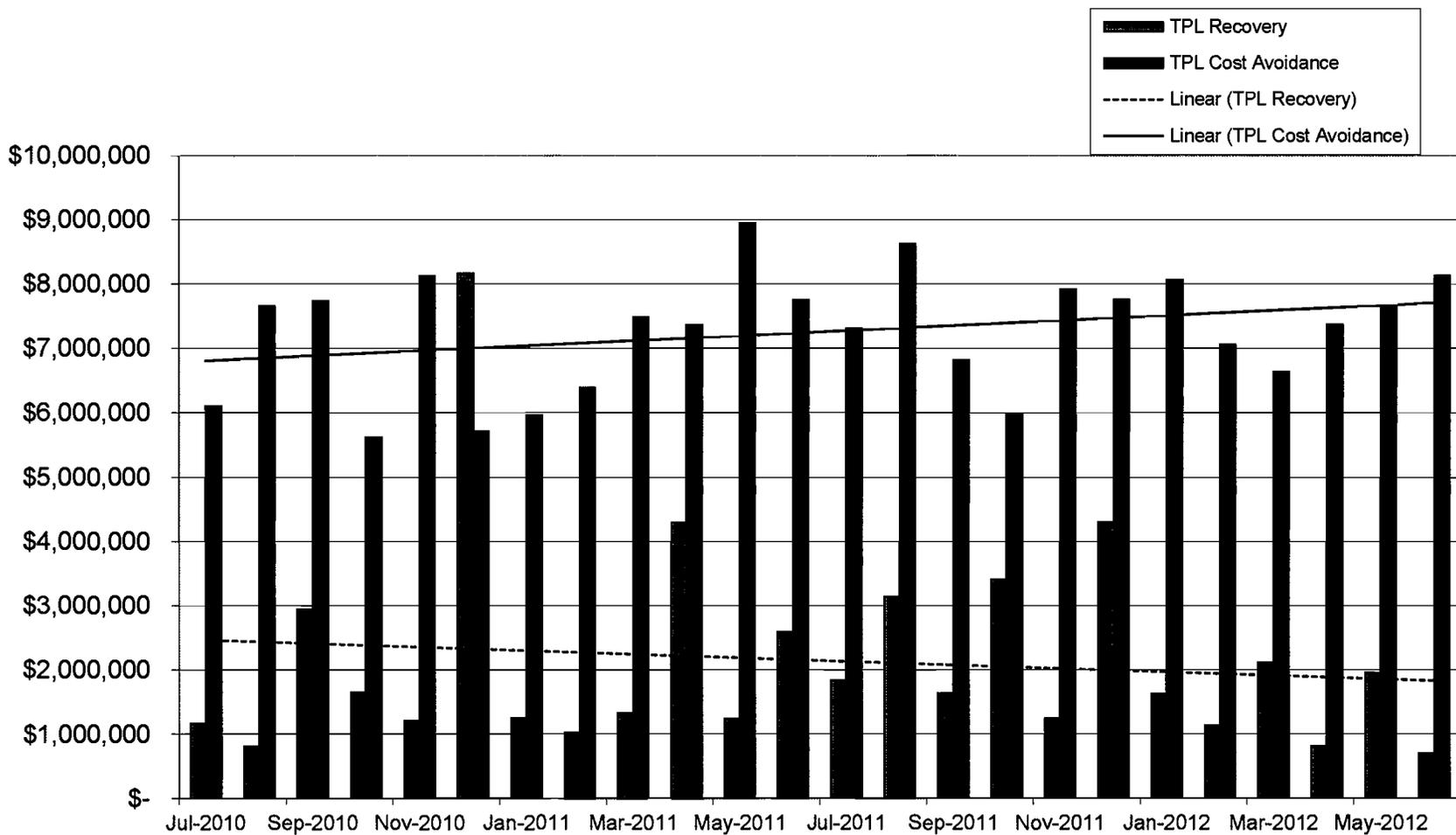
IndianaAIM (23 hours/day)	99.6%
Automated Voice Response (98%)	99.6%
OMNI - eligibility (23 hours/day)	99.6%
Response Time (Inquiry <= 3 sec)	0.0%
Response Time (Update <= 3 sec)	0.1%

(Numbers in parenthesis are contractual required minimums/maximums)



Indiana Health Coverage Programs

Third Party Liability Savings, July 2010 – June 2012)





Technology for better business outcomes

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The information contained herein is subject to change without notice.





Indiana Select Joint Commission on Medicaid Oversight

Family & Social Services Administration
September 18, 2012



Prepayment Review

Office of Medicaid Policy & Planning

Kristina Moorhead, Deputy Director



What is Prepayment Review?

Prepayment review is an OMPP provider monitoring program that ensures reimbursement for services is reasonable, medically necessary, and of optimum quality and quantity by reviewing claims and documentation prior to reimbursement.



How does prepayment review work?

- Providers in the prepayment review program must submit documentation with their claims for review by OMPP staff.
- OMPP staff review submitted claims and documentation to ensure that providers are following policies and procedures prior to paying the claim.
- OMPP and HP staff provide education and support to providers in the prepayment review program on policies and procedures of billable services.



Why is a provider placed in the prepayment review program?

- Providers are placed in the prepayment review program when provider billing practices create concerns that the provider may be receiving overpayments.
- Examples
 - Result of audit findings
 - Referral from a State or Federal agency



How long are providers in the prepayment review program?

- Providers are placed in the program for a minimum of six months.
- At the end of the six-month period, a compliance review is performed. If 75% accuracy in claim submission has not been achieved for three consecutive months, the provider may be subject to sanctions in accordance with *405 IAC 1-1-6*.
- If the provider remains in the program after six months, another compliance review is completed 12 months after the provider was placed in the program.



How are providers notified that they are in the prepayment review program?

- A notification letter and criteria letter are sent to provider by certified mail.
- The notification letter outlines the timelines of the program and the claim submission process.
- The criteria letter explains the prepayment review policies.
- Contact information for OMPP staff is included in the letter if providers have questions.



When is a provider removed from the prepayment review program?

- Once the provider achieves 100% accuracy for three consecutive months, they may be removed from the prepayment review program.
- What happens if a provider does not achieve 100% accuracy in order to be removed from the program?
 - Continue to be in the prepayment program.
 - Termination as a provider.
 - Provider creates a corrective action plan.



How many providers are in the prepayment review program?

- For SFY 2011, 65 providers were in the prepayment review program.
- For SFY2012, 91 providers were in the prepayment review program.
- Currently 95 providers are in the prepayment review program. This represents 0.2% of Indiana Medicaid providers.



Questions?



Division of Disability and Rehabilitative Services

Shane Spotts, Director

Indiana Medicaid Waiver Changes
Family Supports Waiver &
Community Integration and Habilitation
Waiver



Family Supports Waiver (FSW)

- The Family Supports Waiver is the new first point of entry into the Medicaid Waiver system in Indiana.
- The Family Supports Waiver provides waiver services to 5 times more people than either the DD or the Autism Waiver can serve.
- The amount of funding for individuals receiving the FSW increased from \$13,500 to \$16,250 each year.
- The FSW now offers Participant Assistance and Care Service



Community Integration and Habilitation Waiver

- DDRS replaced the Autism and DD Waivers with the new Community Integration and Habilitation (CIH) Waiver.
- The CIH Waiver is a needs-based waiver, which means that an individual must meet one of the emergency priority criteria to access this waiver.



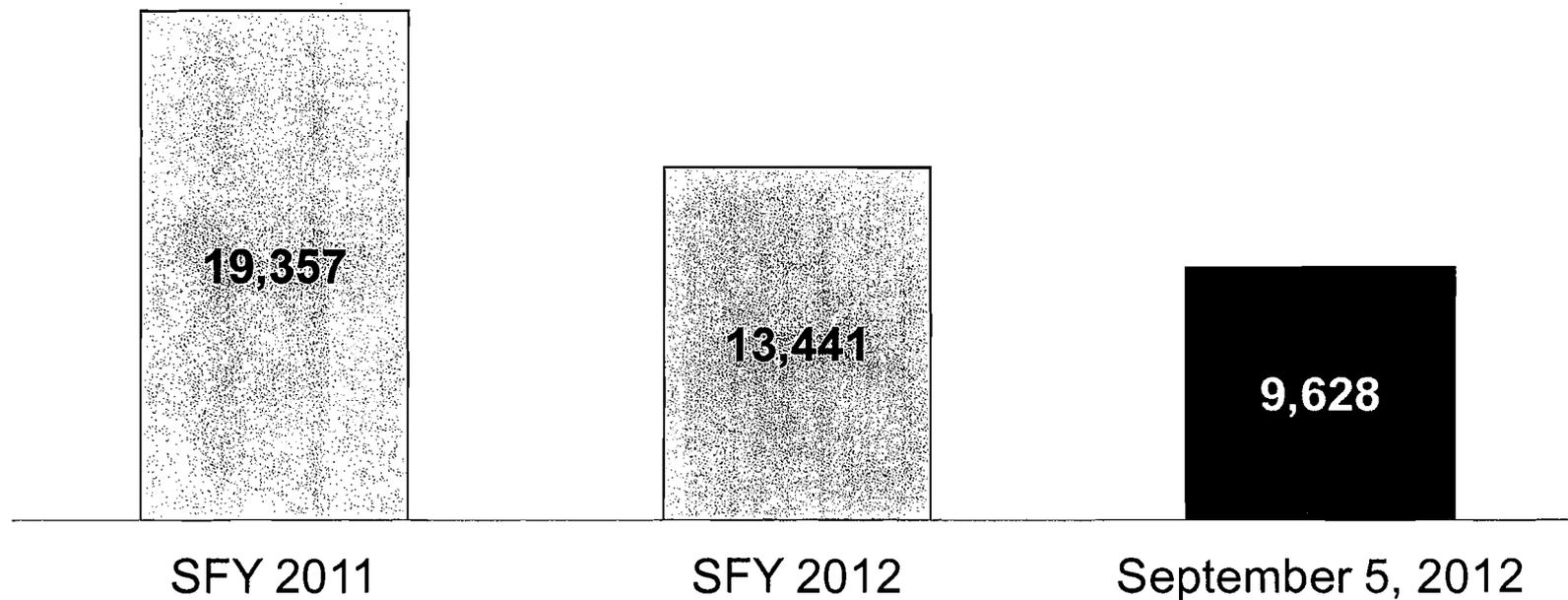
Waiver Waiting List Update

- Individuals on the DDRS Medicaid Waiver Waiting List were contacted about the following in an effort to ensure the list is as updated as possible:
 - Verification of contact information
 - Confirmation of consumers' desire to remain on the Waiting List
 - Information about group home vacancies



Waiver Waiting List Update

- Number of individuals on the Waiver waiting list
- Number of individuals on the FSW waiting list





Questions?



Division of Aging

Susan Waschevski, Deputy Director

Waiver Waiting List Update

Aged & Disabled Waiver

Traumatic Brain Injury Waiver

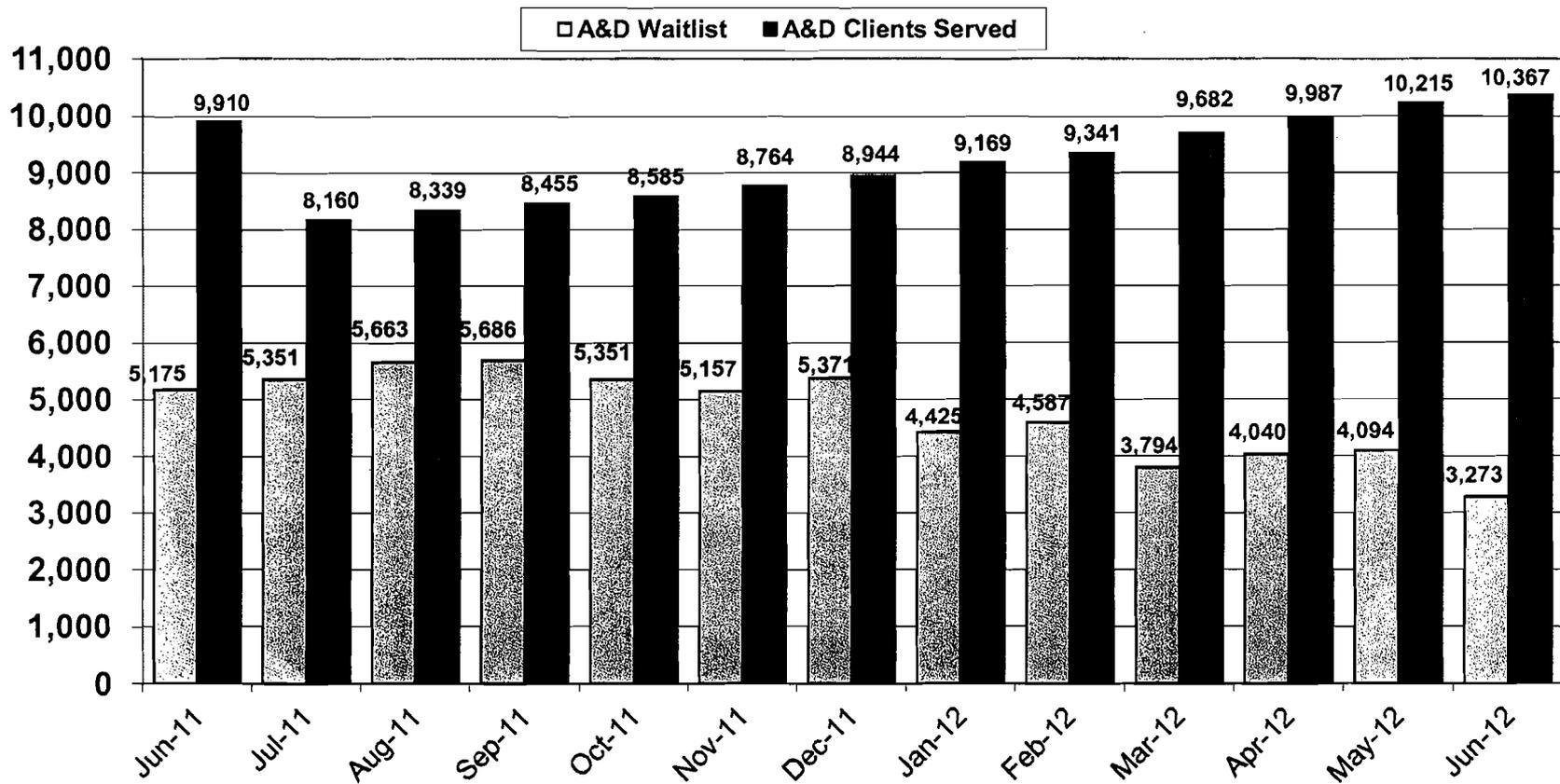


Aged & Disabled Waiver: Waiting List History

Measurement Time Period	Individuals on Waiting List
July 2010	3,368
July 2011	5,351
July 2012	2,679

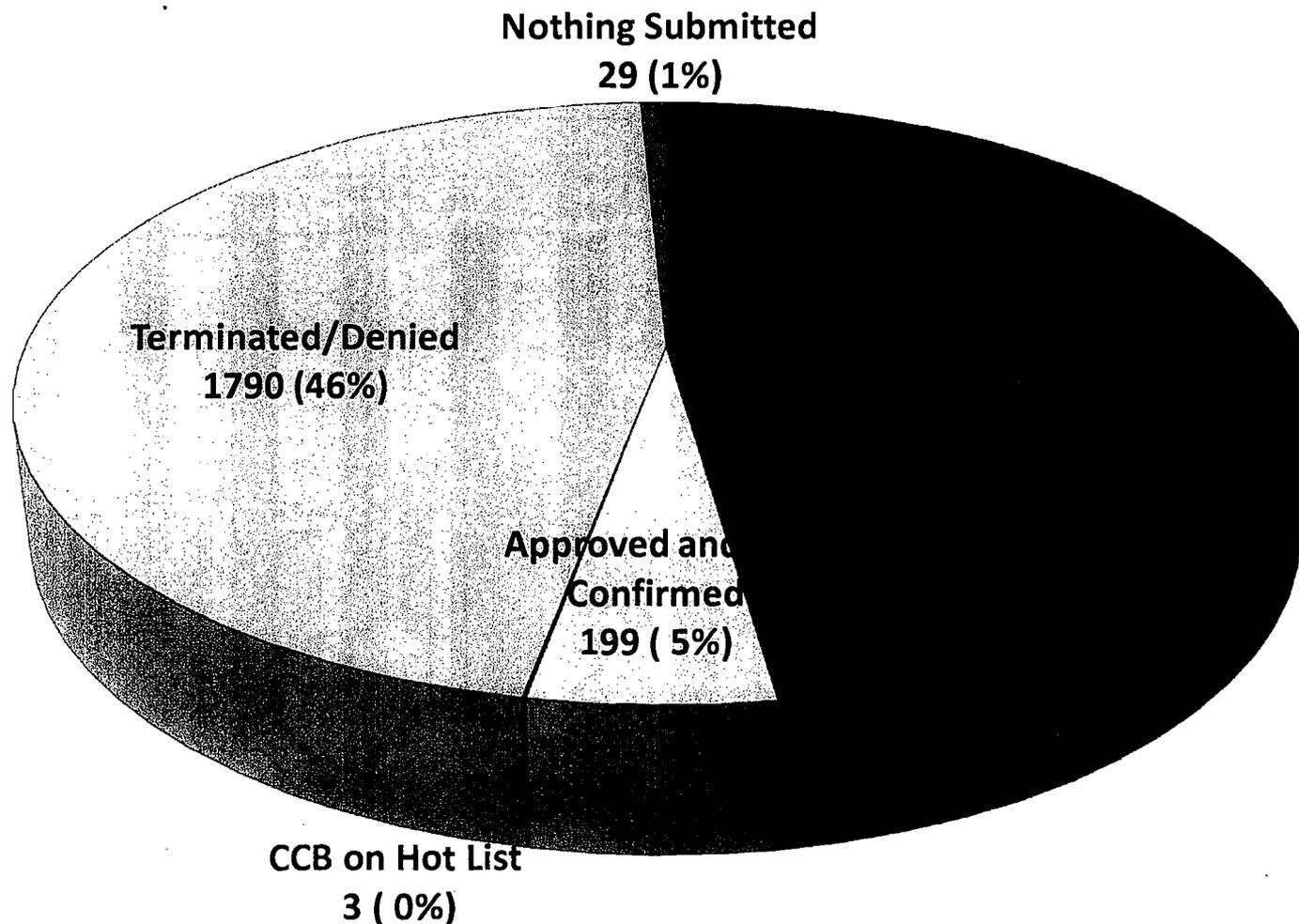


Aged & Disabled Waiver Client Wait List vs. Clients Served





Status of All A&D Waivers Released in SFY 2012



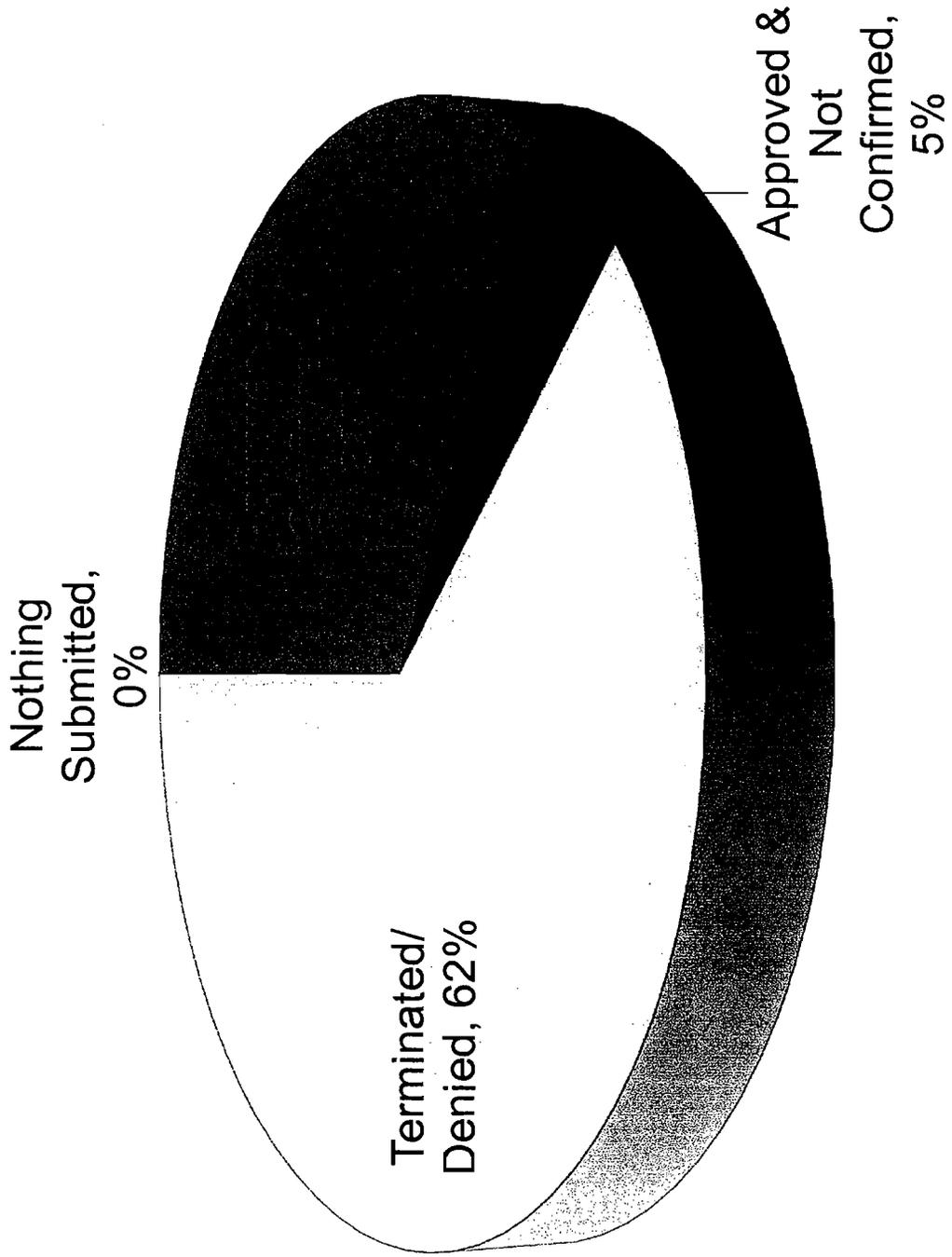


Traumatic Brain Injury Waiver Waiting List History

Measurement Time Period	Individuals on Waiting List
July 2010	129
July 2011	138
July 2012	109

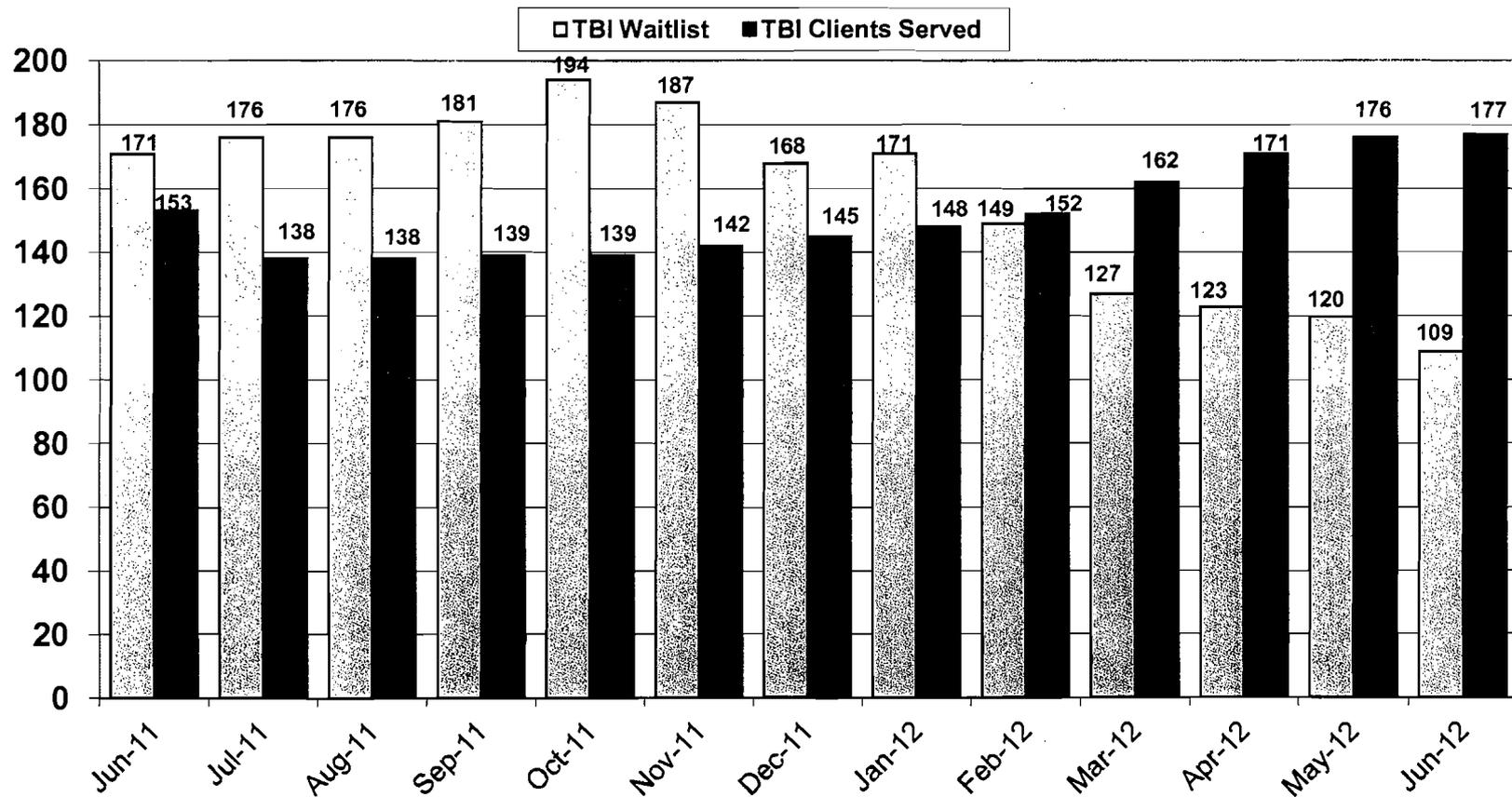


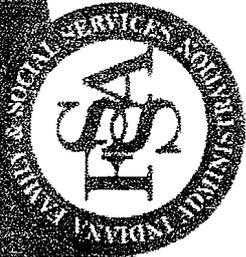
TBI Waiver FY 12 Slots Released





TBI Waiver Client Wait List vs. Clients Served





Questions?



Healthy Indiana Plan Update
Division of Family Resources
Adrienne Shields, Deputy Director



Healthy Indiana Plan (HIP) Update

- Trust fund balance: \$279M
- Enrollment update (as of 7/31/12):
 - Current enrollment: 42,356 individuals
 - Total clients served: 100,862 unique individuals
 - Wait list: 39,538 individuals
- July 2011 announcement – target wait list for childless adults
 - 38,300 letters mailed to waitlist clients
 - First on wait list
 - Invitation to submit information to prove still eligible for program
 - 4,576 individuals deemed eligible
- No wait list for parental adults