

MEDICAID ADVISORY COMMITTEE MEETING

April 20, 2010

IGCS Room A – 9:00am

DRAFT

Committee Members: P – Present, A – Absent, *Proxy Present*

Michael Baker	A	Monica Foye	A	Senator Jim Merritt	A
Matthew Brooks	P	Maureen Griffin	P	Dr. Judith Monroe	A
Pat Casanova	P	Maureen Hoffmeyer	P	Donald Mulligan, Sr.	A
Mike Claphan	P	Susan M. Holbert Mark Sherer (Proxy)	P	Michael Phelps	P
Rep. William Crawford	A	Ernest C. Klein	P	Ed Popcheff	A
Gina Eckhart	P	John Kukla	A	Daniel Rexroth	P
Rep. Jeffrey K. Espich	A	Lawrence McCormack	P	Todd Stallings	P

Opening Comments

Chairwoman Maureen Hoffmeyer opened the April 20, 2010, at 9:10AM of the Medicaid Advisory Committee (MAC) and thanked everyone for attending.

Review/Approval of Draft Minutes from 1/29/10 Regular MAC Meeting and 3/16/10 Special MAC Meeting

The draft minutes from the regular January 29, 2010 meeting, and the special March 16, 2010 meeting were distributed for review, questions, or corrections.

Motion: A motion to approve the draft minutes of the January 29, 2010 and the March 16, 2010 meetings, was moved, seconded, and passed unanimously.

Notice of Rate Change – Joy Heim

Joy Heim, Attorney with Family and Social Services Administration (FSSA), Office of General Counsel, along with *Yvonne Burke*, Office of Medicaid Policy and Planning (OMPP), discussed an overview of the Emergency Rule to modify reimbursement for physician-administered drugs under the Medicaid state plan and state regulations at 405 IAC 1-11.5 by changing the reimbursement methodology for Medicaid services provided by enrolled providers of physician administered drugs, billed on the paper CMS-1500, electronic 837P, paper UB-04 and electronic 837I claim types. *Ms. Heim* stated that this emergency rule will become a permanent rule. The emergency rule will become effective May 1, 2010. *Chairperson Hoffmeyer* asked what would be the current AWP if there were multiple NDCs. *Ms. Burke* replied that if there are multiple NDC's that can be billed under one J-Code, that they take the lowest AWP that corresponds to a NDC that will match up with the J Code. *Ms. Burke* stated the physician reimbursement rate is the WAC plus 5%. This was calculated to provide a fair reimbursement. Currently, CMS reimburses at ASP plus 6 which is below what Indiana is currently recommending. Also, sister states in Region 5 reimburses at ASP plus 6. Indiana will continue to reimburse at a higher amount to ensure that Indiana Medicaid members have access to receive the physician-administered drugs. *Ms. Burke* said that this change will not affect the Vaccines for Children Program.

HP Enrollment Breakdown

Roger Arguello, of HP distributed a handout of their provider breakdown. *Mr. Arguello* said that they have a total of 5,162 end-dated (has not billed for last 12 months) providers, with 2,017 being rendering providers, and 3,145 billing, dual, and group providers. This handout also listed the number of providers by provider type. This information included 31,298 active rendering providers with 72 provider types and specialty. Of the active billing, dual, group providers by type and specialty are 123 provider types and 14,748 providers.

System Updates

Mr. Arguello will provide the system update at the next MAC meeting.

HP Top Claim Denial Reasons Breakdown

Mr. Arguello provided two handouts that included a more detailed breakdown of "HP's Top 10 Claim Denial Reasons" and of the "Behavioral Health Breakdown of the Top 10 Claim Denials". *Mr. Arguello* verbally reviewed these handouts to the committee.

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MHS Top Claim Denial Reasons Breakdown

Jackie Shearer of MHS, provided a handout, and talked of the “*M.A.C. Presentation April 2010*” of MHS breakdown of the top 10 claims denial reasons for behavioral health and the top 10 claims denial reasons for physical health.

MDwise Top Claim Denial Reasons Breakdown

Jean Caster of MDwise, reviewed their handout, “*MDwise Top 10 Claims Denial Reasons for Physical Health*” and “*MDwise Top 10 Claims Denial Reasons for Behavioral Health*”. *Chairperson Hoffmeyer* asked about the non-covered charges that are listed on the handout. *Ms. Caster* said that the non-covered charges were billed charges that are not covered by the Medicaid benefit.

Action Item: *Jean Caster* will follow-up on the non-covered charges and report back to the Committee.

Anthem Top Claim Denial Reasons Breakdown

Minga Williams of Anthem provided a handout, “*Claims Denial Reasons and Claims Dispute Data*”. *Ms. Williams* reviewed the portion of the handout that included the top 10 claims denial reasons for physical health and the claims disputes. *Tina Hurt of Magellan Health Services* reviewed the top 10 claims denial reasons for behavioral health.

Advantage Care Select – Certification Codes

Katie Fabbro, Care Select Manager, OMPP, reviewed the certification code process. This information is available in the Provider Bulletin BT2723 which can be found at the Indianamedicaid.com provider website. The cert code policy is something they have used prior to the Care Select with the Medicaid Select program so they continued with the implementation of the Care Select. They are trying to build one medical home in relationship with a member with a primary medical provider (PMP) by using a certification code. A primary medical provider is given a different digit code every quarter through HP and is mailed directly to the provider. The provider is then asked to release that certification code anytime a member needs a referral to a specialty service. A certification code is not needed for self-referral services or other ancillary services such as transportation, home health, radiology, etc. *Ms. Fabbro* said that *Chris Kern* from MDwise and *Kelvin Orr* from Advantage were present to discuss the certification code policy. *Mr. Kern* said that both CMO’s follow rules and regulations that have been set forth by OMPP. Both CMO’s extensively educate their contract providers on their responsibilities regarding certification codes. They both have quick reference guides and are located in the provider manuals. *Mr. Kern* said that there are instances where both CMO’s are given the authority by OMPP to release the PMP cert code. Some of those circumstances include death of the PMP, and could include providers who have left the state and have not informed either the CMO or IHCP that they were leaving their practice or leaving the state of Indiana. It does occur very often and are reviewed case by case. *Mr. Kern* discussed the auto-assign process. If a patient has been auto-assigned to a PMP, but that member has called in to choose another PMP, then the CMO has the ability to release the certification code of that auto-assign PMP in order for that member to continue service with the PMP of choice, while that new connect of that member takes place. They also have instances of where large populations come into the program. *Mr. Orr* said the cert code changes every quarter and if the PMP has problems with getting that cert code, sometimes the CMO’s step in to release that cert code. It was mentioned that from time to time they hear that the cert code letters not being received by PMP’s. *Mr. Orr* said that these letters are regenerated by HP and are mailed to providers at the pay to address. It was stated that rendering providers that belong to a large group, are likely receiving their cert codes at the pay to address.

OMPP Initiatives

Pat Casanova, Director of Medicaid, talked about the OMPP Initiatives. *Ms. Casanova* said that they were having many meetings to discuss how to manage the OMPP budget over the next biennium. Currently, they are reviewing all of the state and federally funded programs. *Ms. Casanova* also said they are looking ahead to year 2014, and the changes that they will be required to make, and how to do that prior to 2014. It is estimated that there will be ½ million people who will be Medicaid eligible on January 1, 2014, who are not currently Indiana Medicaid eligible. *Ms. Casanova* said there a lot of questions regarding the health reform legislation. She said they are looking at what they have to do as an agency, and what they are in the process of doing. While looking at health care reform they are looking at what those changes are, what are the mandatory changes, what are the optional changes, looking at the mandatory and optional requirements, when are the changes due and effective, while continually looking at opportunities going forward on how to provide services to all constituent groups including expansion groups. OMPP is also looking at ongoing initiatives, MMIS procurement, HIT dollars that come in to Indiana, the requirements under Medicaid for health information technology services

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as well as those outside of Medicaid and how those roles go together. They are also looking at the next budget cycle and what the budget agency is asking from them for the next biennium, and how they will be able to meet that, while still being able to provide services and resources required to doing that. *Ms. Casanova* said that the MAC members may be asked to participate in workgroups. FSSA is holding meetings at an agency level to put together a framework of a plan going forward. The Governor's office will be taking part of the agenda, with FSSA taking the larger portion. *Ms. Casanova* referenced the "Exchange" of how people come in and out of the "Exchange". *Ms. Casanova* said her vision is that they will probably not have the issues they have now with people falling on and off of eligibility because of spend-down. People are going to fall in and out of the "Exchange". So this will be a whole other set of issues. *Ms. Casanova* said that there have been earlier discussions of the issues of not having real-time data, and the new MMIS procurement will help with some of that, but unfortunately it is not coming soon enough to help prior to year 2014.

Update on Status of Policy Items

Natalie Angel, OMPP, distributed a handout, "OMPP Policy Change Update". There are three items listed on the handout that are currently in implementation phase. These three items are: Revenue Code 510, Global Delivery Code Change, and Physician Provided Fluoride Varnish. There is one item listed on the handout as a change in implementation plan which is the Tobacco Cessation.

A motion was made, seconded, and unanimously approved to adjourn the meeting.

The next Medicaid Advisory Committee Meeting is scheduled for Tuesday, July 20, 2010, 1:00pm – 3:00pm in the Indiana Government Center South Building, Conference Center Room C.