

MEDICAID ADVISORY COMMITTEE MEETING

January 29, 2010

IGCS Room C – 1:00pm

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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	A	Susan M. Holbert	A	Michael Phelps	A
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	A	Todd Stallings	A

Opening Comments

Chairwoman Maureen Hoffmeyer opened the January 29, 2010, meeting of the Medicaid Advisory Committee (MAC) and thanked everyone for attending.

Review/Approval of Minutes from October 13, 2009 Regular MAC Meeting and December 8, 2009 Special MAC Meeting

The minutes from the October 13, 2009 and December 9, 2009 meetings were distributed for review, questions, or corrections. Ernest Klein noted that he was not present at the December 8, 2009 meeting and requested that the minutes be updated to reflect this. No other corrections, questions, or comments were presented.

A motion was made to approve the minutes of the October 13, 2009 meeting as written and approve the minutes of the December 8, 2009 meeting with the aforementioned amendment. The motion, being duly seconded, was unanimously approved.

LSA Document #10-XXX - Kevin Wild

Kevin Wild, Attorney with Family and Social Services Administration (FSSA), Office of General Counsel, discussed a rule to amend 405 IAC 1-14.6-24 to change the quality assessment fee for nursing facilities that became non-state government owned or operated after July 3, 2003 from \$2.50 to \$10.00. It also adds a reference for the new CCRC (continuing care retirement facility) criteria contained in the 2009 budget bill HEA1001 ss. This rule will affect approximately 19 facilities in Indiana that are non-state government owned with a net fiscal impact to the state of approximately \$3.4 million. A public hearing has not yet been scheduled but will probably be held in the spring.

OMPP Program Initiatives Update

Pat Casanova, Medicaid Director, Indiana Family and Social Services Administration provided an update on OMPP initiatives. Ms. Casanova noted that the contract reprocurement for the Hoosier Health and Healthy Indiana Plan has been initiated. The RFP/RFS has been issued and a prebid conference occurred during this week. FSSA hopes to award contracts by summer with implement of the new contracts on January 1, 2011. A good response to the RFP/RFS and prebid conference has been received. Contracts are being merged to try to keep and cover families' together rather than separating parental coverage under HIP from their children who may be covered under Hoosier Healthwise.

Matt Brooks raised a concern about the solvency issues that have developed during the course of the current contract with subcontractors. There have been issues with accountability with prime contractors and subcontractors. Mr. Brooks asked that FSSA consider this issue when issuing contracts for the new contract cycle. Ms. Casanova stated that they are learning from past experiences/contracts and will be conducting meetings to looking back at previous procurements and what was learned from those experiences.

Chairwoman Hoffmeyer also commented on the streamlining and invisibility to the provider. The current contracts require that any subcontractor services be invisible to the provider. With ophthalmology services under the current contracts this has not been true. Providers have been required to split claims and bill portions of a single encounter to different contractors/subcontractors. It has become very confusing to providers about which contractor or subcontractor is responsible for payment and which rules apply to a given encounter when multiple contractors/subcontracts are involved. There have also been occurrences of disputes between the

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prime contractor and subcontract with regard to which was responsible for payment. In some instances, the resolution took six or eight months to resolve. In the meantime the provider was not paid for services.

Legislative Initiatives

Ms. Casanova, Medicaid Director, Indiana Family and Social Services Administration provided an update on OMPP legislative initiatives. There is currently one bill that FSSA is moving. The bill makes some changes to the way providers in the DD system are able to be sanctioned if there is abuse or exploitation and also contains a few housekeeping items. Bills will be moving from one house to the next week. There are seven bills in the House that FSSA is watching. They include bills with health and Medicaid issues with the Medicaid Fraud Control Unit and FSSA is working with the Attorney General's Office on the bill. FSSA is also working with *Representative Crawford* to offer some changes to his health disparities bill, which has implications for the MCOs and a definite fiscal impact. HB 1325 is a long term care services bill which also has a fiscal impact so FSSA has been working with the legislators on this bill. In the Senate there are some of the same bills. A bill containing the removal of the FSSA expiration date seems to be moving through the process so FSSA should continue to remain in place. FSSA is also watching SB 148 which is limited to accreditation for DD providers. SB 163 involves some TANF issues so DFR is watching that bill. SB 292 is county hospitals operating health facilities which relates to the rule previously discussed by *Kevin Wild*. There are others that FSSA is following and they will be watching as they move through the Senate process.

OMPP New or Revised Medical Policy Issues

Natalie Angel, Office of Medicaid Policy and Planning, presented information regarding medical policy considerations. A handout was provided which contained an overview of the process and currently pending medical policy consideration requests which have been approved for implementation. This process is used for requests to change a policy related to policy, coverage, and reimbursement. There is a formal process where individuals or providers can submit requests to be evaluated.

Chairwoman Hoffmeyer asked *Ms. Angel* about the first pending item listed, PC20080106, was this request from 2008? *Ms. Angel* responded that yes, the item was submitted in 2008. *Chairwoman Hoffmeyer* also asked how many items were pending but did not have any implementation date and do not appear on this list. *Ms. Angel* responded that they do try to work through the items quickly and evaluate items on a monthly basis. They generally review five to six items a month. When an item is received it is generally addressed at the next month's policy meeting so there is not a backlog of items that have not been addressed.

Mr. Brooks asked *Ms. Angel* to explain who serves on the medical policy committee and to what extent the Medicaid Director has input on whether to move forward and how the line of communication works. *Ms. Angel* explained that there are approximately 12 people on the Medical Policy Board comprised of internal OMPP staff representing a cross-section of OMPP staff for every subject matter area. They have staff from policy consideration, some from the MCO area, and the medical director. That group takes the initial look at the request. If they choose not to move forward with an item that is where the process stops. If the Board chooses to move forward with an item it goes to the Executive Team which is made of up approximately six directors in each area including *Ms. Casanova*. *Mr. Brooks* questioned the need for some involvement of the Director on those items in which the Board does not recommend action to ensure that the Director knows these items have been submitted. *Ms. Angel* explained that there is a considerable volume and many are frivolous requests. However, on a quarterly basis the Executive Team does see a list of those items that were rejected. If they then want to take a look at one of those items there is an opportunity at that point. *Ms. Casanova* commented that *Ms. Angel* has done a great job of getting the whole process organized. At the time the state took over the Medical Policy from the contractor who had been handling this process when their contract ended they discovered an enormous black hole where things had been languishing for years. It has taken a few years to sort through all of that and get to this process. She commented that there are rule and statues that also govern what is allowable. They frequently get requests from vendors and such for coverage of new products, supplies, and drugs when they come to market. Some of those items cannot be taken any further until there is some national approval. Others contain a lot of rationale and basis but it is just not financially feasible at this time. These requests are not discarded. They have put together a library for all requests that have come in and it contains the date it was submitted and the decision so it can be reviewed at a later date if necessary/appropriate. The PET team presented four items to the directors just yesterday and made decisions on as a team and quarterly they review those that have not been acted on to determine if they should re-consider the request so items do not go into a black hole and those that are not acted on initially do not get discarded. This new process has been in place for about a year and a half so the effects of this new process should start to be seen.

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Ms. Angel also clarified that the submitter of the request does receive feedback about the status of the request and any next steps they may need to take for consideration of the request. *Chairwoman Hoffmeyer* asked *Ms. Angel* about the use of external subject matter experts. *Ms. Angel* stated that yes the individual who is assigned the lead for an issue may reach out to external subject matter experts to assist in the research or policy development. *Ms. Casanova* commented that they now also have the added benefit of the two physicians on staff, which were previously not in place.

Update from HP (EDS) and MCOs - Top Denial Reasons and Appeals Data

Mr. Arguello, COO, HP, (formerly EDS) provided a presentation and handout regarding the top denial reasons for physical health and behavioral health claims for Traditional Medicaid and Care Select. *Chairwoman Hoffmeyer* asked there was any ongoing analysis of these denials to determine trends or strategies to reduce these denials. *Mr. Arguello* stated that once a month they get together and do an analysis of these denials to determine if they are related to educational needs for providers or if there is some internal problem that needs attention. *Chairwoman Hoffmeyer* asked if the top reasons remained relatively consistent. *Mr. Arguello* indicated there were some slight changes but they do not change a lot.

Mr. Arguello explained that some of the exact duplicate denials are related to situations in which a member sees two providers in the same date. One of the claims is then reviewed to determine if it is, in fact, a duplicate and is held while it is being reviewed. *Chairwoman Hoffmeyer* asked him to clarify that these top reason include claims in suspense as well as those that have completed final adjudication. *Mr. Arguello* stated that these numbers did include both. *Mr. Brooks* asked if there were any statistics for denials that were incorrect denials related to internal problems with HP's adjudication of the claim. *Mr. Arguello* indicated that he thought there was but would have to check. Additionally, information was requested to further break-down these denials to evaluate the suspended claims showing these errors and their final adjudication status. *Mr. Arguello* stated they would provide a more thorough and detailed breakdown for the next meeting. Obtaining this information will allow each of the MAC representatives to take this information back to their memberships to provide education to help reduce provider errors and denial rates.

Mr. Arguello also provided data regarding provider appeals filed. Only 37 fee for service appeals were filed in 2009. *Mr. Arguello* explained that customer service receives many calls regarding the status of claims or requesting information about claims. These are tracked and provide additional data but are not categorized as appeals. They receive between 25,000-30,000 phone calls every month. *Chairwoman Hoffmeyer* asked if the 37 appeals represented FSSA appeals or Administrative Review appeal requests. *Mr. Arguello* stated that this includes both levels.

Ms. Shearer, Provider Relations, MHS, provided a handout and presentation regarding top denial reasons for physical and behavioral health. During her presentation *Ms. Shearer* clarified that the top denial reason for facility claims for behavioral health was related to a problem with a revenue code. They have received clarification on this issue which corrected the problem. As a result, this denial code should not continue to be a top denial reason. *Chairwoman Hoffmeyer* stated a concern that timely filing and primary insurance show up as top denial reasons for both UB and CMS-1500 claims and these were not top denials on the HP list. *Ms. Shearer* stated that these two issues are fairly consistent with all three MCOs. She further explained that providers historically have accessed the HP eligibility system to obtain eligibility information for members and information about other insurance carriers. That should not be the final source of information about MCO members. Each MCO data mines other insurance resources and has these resources within the eligibility files they maintain for the member. MHS wants their providers to obtain eligibility information from MHS because their data is more current. The data is available on the provider portal of the MHS website and they have started listing that information on the explanation of payment (EOP). With respect to the filing limit issue, they have several providers on re-occurring cycles. Payment turn-around is 8-11 days. They are also working with providers on the appropriate manner to resubmit a corrected claim. Some claims are refiled but not identified as a corrected claim. *Maureen Griffin* asked whether the filing limit clock starts over when claims are resubmitted when it related to an original claim was timely filed. *Ms. Shearer* stated that when a provider submits a corrected claim they have 60 days from the date of the primary EOP to file the correction. *Ms. Shearer* was also asked to clarify situations in which the member has other insurance and the claim is filed on the 119 day of the 120 day filing limit. *Ms. Shearer* stated they will allow a one year filing limit and an additional 60 days from the date of the primary EOP to file the claim with MHS. *Chairwoman Hoffmeyer* asked *Ms. Shearer* to explain how a provider can identify under which system they should verify eligibility. The patient presents with the Indiana Health Card which does not contain information about the MCO affiliation. The provider would have to use the HP system to establish initial eligibility but then re-verify with MHS to obtain additional information

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about other insurance resources, etc. *Ms. Shearer* indicated that the provider should be confirming the other insurance with the member at the time of the visit and would use the HP system to determine in which MCO system in member is enrolled and then when billing if there is question about other insurance they should contact MHS directly to confirm the other insurance data. The MHS data will be more accurate than the other insurance data that HP has in their system. *Chairwoman Hoffmeyer* asked if MHS provides TPL data updates to HP to make sure the data is always current. *Ms. Shearer* said that MHS does currently provide data back to HP.

Ms. Shearer reviewed the rest of the denial codes and stated that the data is reviewed, tracked, and trended. It often comes down to provider education.

Dr. Southern, an audience member stated that during a previous meeting with MCOs it was agreed that HP would include the member's phone number on the eligibility screen so physicians could contact the patient via phone. This data has not yet been added. This issue will be added as an agenda item for the April meeting.

Mr. Brooks asked that MHS similarly break down the denial codes with further explanation to identify which were provider errors, which may have been system errors, which claims may be suspense claims but subsequently worked through to payment.

Maureen Griffin expressed a concern about the filing limits and asked if each of the MCOs had different filing limits as HP claims were subject to a one year filing limit. This may lead to further confusion for providers keeping track of the various different filing limits. Currently, MCOs may set their filing limits. *Maureen Griffin* would like this issue brought up with *Ms. Casanova* at the next meeting (as she had to leave early and was not in attendance at this point of the meeting) because it would be helpful to have consistency across all plans.

Ms. Shearer when on to review the MHS disputes. There are two levels of disputes, informal and formal. The information process often starts with calls to the call center. They receive between 6,000-7,000 calls per month. Approximately 90 percent of these calls are related to claim status. Less than 1 percent of all claims received go through this process.

Chairwoman Hoffmeyer questioned the low percentage of claims overturned on appeal. *Ms. Shearer* stated that indicates that denials are correct. Often with an appeal they receive additional information that was not received with the initial claim that allows it to process for payment.

Jean Castor, MDwise, provided a handout and presentation of the top denials generated by the MDwise plans. The top denials for MDwise were similar to those of MHS. Other insurance coverage data was noted as an issue. HP is working with HMS to provide insurance data which is also being provided to MDwise. However, the file transfer does not indicate what file data was provided by HMS versus another source and the HMS data is more accurate. Each of the MCOs are also using HMS to provide other insurance data for members.

Chairwoman Hoffmeyer asked Jean to clarify her previous statement that each of the MCOs are using HMS to provide other insurance coverage data yet each entities system contains different information. *Ms. Castor* indicated that it depends on how the MCO contract is set up. MDwise uses the HMS data in a retrospective capacity meaning they pay claims and if they later find out other insurance resources exist, they recoup from the provider and require them to bill the other insurance company. They do also send their data to HP.

Chairwoman Hoffmeyer asked for clarification regarding use of centralized data. *Kim Williams*, an audience member, commented that a piece of legislation was passed three sessions ago that required a centralized third party vendor. *Mr. Brooks* commented that he thought there may be some federal limitation to having a single vendor. This question will be added to the agenda for the April meeting.

MDwise was asked to similarly break down the denial codes with further explanation to identify which were provider errors, which may have been system errors, which claims may be suspense claims but subsequently worked through to payment.

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Maureen Griffin asked MDwise to comment on their filing limit. *Ms. Castor* stated that 180 for in network providers and 365 days for out of network providers.

Jamie Bruce, MDwise, discussed the appeals information for MDwise. She reviewed the most common reasons for the appeal and stated that in many cases, they are able to obtain information not previously provided during the appeal process.

Minga Williams, Anthem, was scheduled to present the Anthem denial information. She was not present at the meeting. A handout was provided.

Anthem will be asked to provide a representative to review the information and also similarly break down the denial codes with further explanation to identify which were provider errors, which may have been system errors, which claims may be suspense claims but subsequently worked through to payment.

Enrollment Purge

Mr. Arguello, COO, HP, provided information about the recent Medicaid provider enrollment purge. *Mr. Arguello* informed the group this was really a purge but a notification to providers that had not had any activity if the system for 12 months. 8,000 providers were notified and given 45 days to respond. Of those, 300 responded and 7,700 were end-dated. They continue reviewing the files at a rate of 200-300 per month. Following this initial end-dating, there are approximately 44,000 active Medicaid providers.

Mr. Brooks asked if any issues had been identified with the 7,700 providers who were end-dated, were there any outstanding claims or incorrect end-dates. *Mr. Arguello* indicated that with the initial round of notifications providers were actually given 60 days to respond and no issues had yet been identified.

Chairwoman Hoffmeyer requested a break down by provider type of the active 44,000.

Questions/Other Issues

Dr. Southern, an audience member, indicated that an issue related to certification codes from two meetings ago remained outstanding. In some areas a large percentage of physicians work for a hospital network. Their staff does have the certification codes and are giving it out. The CMOs will be asked to come and provide some data about the referrals and any initiatives to address inappropriate certification code utilization.

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

The next Medicaid Advisory Committee Meeting is scheduled for Tuesday, April 20, 2010, 9:00 am – 11:00 am in the Indiana Government Center South Building, Conference Center Room A.