

Medical Assistance Advisory Committee  
Wednesday, August 14, 2013

State Staff Attending: Vivianne Chaumont, Jeanne Larsen, Ruth Vineyard, Catherine Gekas Steeby, Lori Harder

Members Attending – Dr. Scott Applegate, David Burd, Joni Cover, Dr. Deb Esser, Lynette Helling, Ron Jensen, Terri Melvin, Jina Ragland, Ed Schneider, Natalie Torrez, Ricky Ann Trobaugh, Dr. Dale Zaruba

Members Absent – Dr. Joe Acierno, Mary Barry-Magsamen, Heath Boddy, Ed Erickson, John Milligan

Members Absent (Unexcused) – Brad Rasmussen

Carol Paige, NHCA, attended the meeting for Heath Boddy.

- I. **Review of June 12, 2013 Meeting Minutes** – approved as written.
- II. **Department Updates**
  - A. **Policy Changes** – Ms. Gekas Steeby reported the Medicaid eligibility regulations are now consolidated from three manuals into three chapters and include changes from the ACA. The public hearing is August 29 at 10am in Conference Room LLA of the State Office Building. The substantive changes have to do with family groups, children, and pregnant women. The new methodology for determining eligibility will be based on MAGI (modified adjusted gross income) and there will not be disregards. The regulations add a new group of former foster care children, age 19-26, who will be eligible to stay on Medicaid as long as they remain in state, regardless of income and if they are on Medicaid when they age out of foster care. This is a federal requirement. If a child loses eligibility solely because of loss of a disregard, federal law requires us to cover them under CHIP for one year.
  - B. **MCO Marketing Materials** – There were no concerns with the materials.
  - C. **180 Days for Claims Submissions** – Ms. Larsen reminded all that the 180 day timely filing requirement goes into effect September 1, 2013. Refer to Provider Bulletin 13-50, which was released on July 15, 2013.

D. **CMS 1500 Claim Form-New Version** – Ms. Larsen provided a sample of the new CMS 1500 form and change log as a FYI. Medicaid is currently reviewing, and will provide update at a later date on impact to billing instructions. Per their July 2013 state survey, CMS anticipates implementing the revised CMS 1500 claim form (version 02/12) as follows:

- January 6, 2014: Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).
- January 6 through March 31, 2014: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).
- April 1, 2014: Medicare receives and processes paper claims submitted only on the revised CMS 1500 claim form (version 02/12).

E. **Payment Error Rate Measurement (PERM)** – Ms. Larsen advised that Nebraska Medicaid is currently going through a PERM review.

CMS conducts PERM reviews to assess the occurrence of improper payments in Medicaid and CHIP in accordance with the Improper Payments Information Act (IPIA) of 2002 and the Improper Payments Elimination and Recovery Act (IPERA) of 2010. Each state participates in PERM once every three Federal Fiscal Years. This review is conducted to ensure that state Medicaid agencies are only paying for services that are medically necessary and in accordance with their rules and regulations. To do this, a random sample of claims paid over the FFY is selected to be reviewed for payment accuracy.

CMS has retained A+ Government Solutions to conduct data processing and medical record reviews. Their data processing reviewers will make sure that we are paying claims appropriately in our system and that our edits comply with our regulations. The medical record reviews will be to verify that the service paid for was the service provided, and was medically necessary. The medical record requests will be for a specific claim or claim line, not for a client's entire history of care with a provider. For example, if a client has been residing in a nursing facility for the last six months, the facility bills on a monthly basis, and one of the claims was sampled, the facility only needs to provide documentation to support the one month that was on the claim, not the entire six months that the client has been in the facility.

Providers will have 75 days from the date of the request to return the requested documentation, and will receive reminders at 30, 45 and 60 days after the request. If additional documentation is needed, a separate request will be sent and the provider will have 14 days to provide that documentation.

Any questions regarding the reviews can be directed to Betsie Steenson at [DHHS.MedicaidPERM@nebraska.gov](mailto:DHHS.MedicaidPERM@nebraska.gov) or at 402-471-9353.

- F. **Requiring Providers to Subscribe to Website** – Ms. Larsen advised that MLTC is proposing to auto-enroll providers on the Nebraska Medicaid website. In talking to providers on issues (billing, submission instructions, etc.), they often indicate being unaware that a procedure or policy is in place, that changes have been made, etc. Many providers are not receiving bulletins either since they are not signed up for alerts (Recent Web Updates alerts). To ensure they are receiving news, we will sign them up for updates as part of their provider enrollment. Feedback from MAAC members was supportive of this.
- G. **Update on the Transition of Medicaid Eligibility from CFS to MLTC** – Ms. Harder reminded members the effective date of the Medicaid eligibility transfer was July 1. The Lincoln and Lexington Customer Service Centers are now under MLTC. We continue to do the same work using the same phone number. The separation will be October 1 with computer and phone systems. Ms. Harder explained we are working with CFS to improve the phone problems under ACCESSNebraska. We are in the process of training new staff. We are advertising for part time social service workers to work the Saturday 4-7 and 10-2 time periods. The age requirement is 18 or 19. We are addressing the call wait times. Ms. Harder asked that members let us know any ideas on that. We have reduced the huge backlog of work by half in six weeks. We have heard from staff and the public and are looking at implementation plans for some individuals in alternative living programs (spousal impoverishment or assisted living) to have their own caseworker. Feel free to call Ms. Harder. A client's one application will go through the entire program and both divisions will focus on it and share the information back and forth. We are looking at a new computer eligibility system that will be real time eligibility.

Ms. Chaumont shared Nebraska's MMIS implementation schedule regarding the PCP bump (fee for service). Dr. Esser will find out if Coventry started paying August 1 or if will be September 1, when Arbor will begin paying, and let physicians know.

Ms. Chaumont explained that in the behavioral health regulations we tried to give the basic outline for the services we pay for. Some say an individual needs to be a medical doctor, but we let providers and facilities practice within the scope of their licensure.

- III. **Regulations Review** – Regulations go from a public hearing with any comments to the Attorney General’s office and then the Governor’s office for review. Both offices have to sign off on them before they become effective.

There were no concerns with the changes in the regulations listed below.

*Consolidated Medicaid Eligibility and Affordable Care Act Regulation  
Behavioral Health Managed Care  
Children’s Mental Health & Substance Use Treatment-Outpatient Services  
Authorization and Payment for Home Health Services  
Transfer-on-Death Deed Revocation under LB 536, Sec. 21 (2012)*

- IV. **Member Issues** – Ed Schneider asked about the EHR incentive program. Ms. Chaumont said it will not be done for optometrists.
- V. **Other Issues** – The September 11, 2013 is cancelled. The next meeting will be October 9, 2013, at 5:30pm in Classroom 1 at the Lincoln Medical Education Partnership, 4600 Valley Road, Lincoln, Nebraska.
- VI. **Adjournment** – adjourned at 6:45pm.