

Medical Assistance Advisory Committee
Wednesday, September 8, 2010

State Staff Attending: Jenifer Roberts-Johnson, Susan Buettner, Cindy Kadavy, Bob Kane, Anne Harvey, Pat Taft

- I. Roll Call - Dr. Scott Applegate, Heath Boddy, David Burd, Joni Cover, Ed Erickson, Tami Frank, Roxann Hamilton, Lynette Helling, Ron Jensen, Terri Melvin, Dr. Michelle Petersen, Brad Rasmussen, Dr. Ed Schneider
- II. Review of August 11, 2010 Meeting Minutes – approved as written.
- III. Department Issues – all handouts attached to minutes
 - A. Managed Care Promotional Materials – Ms. Roberts-Johnson reminded attendees this is the information given to us by the MCO's for review. Ms. Melvin asked if we need to differentiate on one of the Coventry handouts because all Lincoln hospitals are not participating. Ms. Roberts-Johnson said the network as whole will be in more areas than Lincoln. However, she also said she will mention that to Heather Leschinsky. Email Ms. Leschinsky at heather.leschinsky@nebraska.gov tonight if any other concerns.
 - B. Medical Home – (handout attached) Ms. Taft explained that the reimbursement and payment methodology adopted is at \$2 PMPM (per member per month) once the agreement is signed and Tier 1 minimum standards must be met for six months. Once those are met the PMPM increases to \$4. If the pilot site chooses to meet Tier 2 advanced standards it will receive an enhanced rate for some services. Eight practices have sent in applications. We will have finalists in two or three weeks and by November, we should know who the pilot practices are. Key dates listed are still on target. Dr. Schneider said as optometrists see patients they want to be assured there won't be a wall or screen to go through because of the medical home. Ms. Taft responded that it should be business as usual from the client's perspective. The client develops a relationship with the doctor. That's the premise of the medical home. Should the doctor for the medical home be aware if a client is being treated for glaucoma? The medical home is expected to develop relationships with other providers that the client would need. Dr. Applegate said patients are not required or prohibited from going to see any optometrist if they want. The optometrist should let the medical home doctor know he saw the client possibly with a follow-up note. Good communication will be needed on both sides, Dr. Peterson said. Mr. Burd asked if any federal funds are available for this. Ms. Roberts-Johnson responded that there is a demo project we will look at but the project may be up before it's available. Ms. Taft's email address is pat.taft@nebraska.gov and her phone number is 402-471-7787. The website is <http://www.dhhs.nr.gov/med/Pilot/index.htm>.



Nebraska Medicaid Patient-Centered Medical Home Pilot



Background:

- Nebraska Legislature passed the Medical Home Pilot Program Act directing DHHS to establish a Medicaid medical home pilot in one or two geographic areas by January 1, 2012
- Governor appointed a Medical Home Advisory Council including six primary care physicians and one hospital administrator
- Definition of patient-centered medical home: a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team. This team will provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and coordinate the patient's health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner
- Pilot practices will include General Practice, Internal Medicine, Family Practice, and/or Pediatrics
- Purpose is to improve health care access and health outcomes and contain Medicaid costs

DHHS Project Development:

- One-year technical assistance award received from National Academy for State Health Policy to help in the design of the pilot
- Outcomes for the evaluation of the pilot include access, health outcomes, cost containment, patient and provider satisfaction
- Minimum Standards within five core competencies will be met by the pilot practices with an option to meet a set of Advanced Standards
- Practices will receive financial reimbursement including per-member-per-month payment and opportunity for an enhanced FFS on Evaluation & Management and Preventive Visits procedure codes
- Support includes professional technical assistance to assist with practice transformation; patient registry; learning collaborative; and care coordination staffing.
- Interested practices submitted an Application of Interest and those are currently being reviewed

Tentative Key Dates:

November 2010	Pilot practices selected
December 2010	Practice transformation support begins
January 2011	Pilot begins
January 2013	Pilot concludes

Acute home health means Medicaid-reimbursed services that are:

- a. Provided for 60 calendar days or less; and
- b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or stabilized or until 60 calendar days after onset, whichever comes first.
 1. Newly diagnosed infections.
 2. New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.
 3. Care related to recent post-surgical recovery.
 4. Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.
 5. Exacerbation or severe instability of a chronic condition.
 6. New diagnosis of a long-term chronic condition, such as, but not limited to, diabetes that requires acute care services.
 7. Complications of pregnancy
 8. Physical, occupational and/or speech pathology and audiology services.

Long-term home health means Medicaid-reimbursed services that are:

- a. Provided for 61 calendar days or more; or
- b. Provided for less than 61 calendar days when services are provided solely for the care of existing chronic conditions.

Long-term home health with acute episode means Medicaid-reimbursed services that are:

- a. Provided for care of long-term chronic conditions; and
- b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or stabilized or until 60 calendar days after onset, whichever comes first.
 1. Newly diagnosed Infections.
 2. New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, decubitus.
 3. Care related to recent post-surgical recovery.
 4. Post-hospital care provided as follow-up care for the condition that required hospitalization.
 5. Exacerbation of a chronic condition.
 6. New diagnosis of a long-term chronic condition, such as, but not limited to, diabetes that requires acute care services.
 7. Complications of pregnancy.
 8. Physical, occupational and/or speech pathology and audiology services.

Resolved or Stabilized means that a client's clinical and behavioral status and nursing care needs are determined to be non-fluctuating and consistent or fluctuating in an expected manner with planned interventions, including an expected deteriorating condition.

- ❖ We are currently researching options to eliminate the standard processing of paper claims that continue to be sent to Nebraska Medicaid. Last year (FY 2009) we received over **817,000** paper claims from roughly **3,800** Medicaid providers who continue to send only paper claims.
- ❖ Highlights of the project proposals are:

1. Create a Web Portal for Nebraska Medicaid

2. Purchase a Specialized Desktop Scanner

3. Other Initiatives:

- ❖ A presentation on Electronic Billing and the DHHS website pages was made to the **Nebraska Health Care Association** (NHCA) in Kearney back in April (27th).
- ❖ As a result of this initial exposure, we will be making a similar presentation at the **Nebraska Association of Homes and Services for Aging** (NAHSA) Fall Conference here in Lincoln in October (6th).
- ❖ In addition, some **System Change Requests** (SCRs) have been made in the **Medicaid Management Information System** (MMIS).

6-006 Payment for Interceptiv e and Comprehensive Orthodontic Treatment: Payment for authorized orthodontic treatment is made upon approval of the treatment plan and submittal of a dental claim.

The procedure code to be used when submitting for payment for orthodontic treatment is the "five"-digit procedure code that was prior authorized by the Department.

~~The "Date of Service" on the dental claim must be the "date of authorization" or "certification authorization date" on the prior authorization.~~

Orthodontists shall bill for orthodontic services after receiving an approved prior authorization and after placement of the initial appliances for the orthodontic procedure. Orthodontists shall always re-check Medicaid client eligibility before starting a service, even with an approved prior authorization. Since Medicaid eligibility may vary from month to month, Nebraska Medicaid cannot guarantee that the eligibility for a prior authorized patient will remain constant. If a client becomes ineligible for Medicaid benefits, the authorization becomes void.

The "Fee" on the dental claim must be the dollar amount authorized on the prior authorization.

6-006.01 Transfer of Interceptiv e and Comprehensive Orthodontic Cases: If the client transfers to another dentist, the authorized dentist must shall transfer the portion of the amount paid by Medicaid that applies to the treatment not completed to the new completing dentist.

6-006.02 Interceptiv e and Comprehensive Orthodontic Treatment Not Completed: If prior authorized orthodontic treatment is not completed, the providing dentist must shall refund the portion of the amount paid by Medicaid that applies to the treatment not completed to the Department.

6-007 Standards for Participation: Providers of dental services must be licensed by the Nebraska Department of Health and Human Services as a dentist or a dental hygienist and must practice within their scope of practice as defined in Neb. Rev. Stat. Sections 71-183 to 71-193.20 and 71-193.21 to 71-193.35, and effective December 1, 2008, Neb. Rev. Stat. Sections 38-1101 to 38-1151.

If services are provided outside Nebraska, the dentist or dental hygienist must be licensed in that state and must practice within their his/her scope of practice as defined by those state licensing laws.

6-008 Provider Agreement: Providers of dental services must shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Nebraska Department of Health and Human Services for approval to participate in NMAP Medicaid.

- C. Home Health – (handout attached - was distributed at August meeting also) Acute home health would be provided for a short time while long-term home health care would be provided for those with chronic conditions. Ms. Kadavy stated this would recognize the disparate needs of our clients. The draft has also been sent to the Nebraska Health Care Association for their review.
- D. Physical Therapy Authorizations for Kids – Ms. Roberts-Johnson said Dr. Garvin is working to get data together as to what would be reasonable. It will be on the agenda again when she receives all the data. Ms. Melvin gave Ms. Roberts-Johnson information to give Dr. Garvin.
- E. Electronic Billing – (handout attached) Mr. Kane reported we are paying 90-92% of claims electronically and are looking for alternatives to eliminate manual data entry. Electronic claims are processed faster and paid faster and reduce the chance for error. One potential solution for providers who continue to send paper claims is a web portal. Another potential solution is to purchase a desktop scanner and feed UV claims into the scanner where it would be turned into an electronic transaction. The scanner would create a 36-hour turnaround time and is relatively inexpensive as is the web portal. We will create an RFP and see what feedback we receive from vendors. Let Bob know your thoughts about this at bob.kane@nebraska.gov. Mr. Burd asked that we put together a group of providers to get input on how to set up the web portal and include part of the 3800 providers not sending claims electronically.
- F. Enrolling Physician Assistants – Ms. Roberts-Johnson explained PAs are currently listed under their physicians and paid under the physician number and are difficult to track. There will be a validation process where any PA who is a current provider will get documentation to update their information. We will get information from practices that have PAs. NPI numbers will be requested also. Information will be stored in MMIS. If you have questions about the process send them to margaret.booth@nebraska.gov. More information will be coming out in the next month or so.
- G. Consultation Codes – Ms. Roberts-Johnson said Nebraska is following Medicare's lead in how they pay for consultations. It will be a mirror of what Medicare pays and will not pay for any consultations Medicare doesn't pay for. A Provider Bulletin will be out later this month on the issue. Any questions or comments can be sent to margaret.booth@nebraska.gov.
- H. National Correct Coding Initiative – Ms. Harvey explained that the Patient Protection and Affordable Health Care Act requires us to use as of October 1, 2010. Our Information Technology office is working on what we need and can do to make the edits, published on their website, that CMS updates every quarter. They will add edits for things Medicaid covers but Medicare does not. CMS issued the guidance on September 1, 2010 in the form of a 16-page

State Medicaid Director (SMD) letter that essentially directs that states do what Medicare is doing and do it by October 1, 2010. Mr. Burd asked if we have the ability to file for an extension. That depends on how the SMD letter is interpreted, what questions we want to ask, and who we need to ask at CMS. We may have until April but we are not sure. There are lots of questions about NCCI and what it means. Dr. Peterson asked what it will mean to providers. Ms. Harvey responded that this is when a provider's claim comes in and we look at it to see if they did two services on the same day. Some can not be on the same day. There will be a Provider Bulletin issued on NCCI. We are probably looking at a third party vendor because MMIS would not be able to handle this. Ms. Cover asked when a new MMIS system will be in place. Ms. Roberts-Johnson explained that the health reform bill requires us to do certain things we weren't doing before so we are looking at that. In the next year or so we should know where we stand. Questions or comments can be sent to anne.harvey@nebraska.gov.

- I. RAC Audits – Ms. Harvey explained that recovery audit contracts have to be expanded to Medicaid as an extra auditing body for CMS to check for under and over payments. There are still a lot of questions on the process. RACs are not allowed to investigate fraud as the state's audits are. The timeline is the end of this year. We will need to coordinate all the audits so not more than one is looking at a provider at a time. After much discussion and a lot of questions, Ms. Harvey said information will be provided as we receive it.
 - J. National Drug Codes (NDC) Edits (Ideas for Provider Training) – Ms. Roberts Johnson said providers need to include the correct NDC code on their claims because they are not valid if the code is not included. The Provider Bulletin that went out stated if the NDC is not on the drug claim it will be denied. Margaret Booth will do training for providers with someone from the Unit for those who still have questions. Let Ms. Booth know if there is interest for training. Mr. Burd asked if the NDC is being requested so the state can receive rebates. Ms. Roberts-Johnson will check with Ms. Booth.
- IV. Regulations Review – Billing for Orthodontic Treatment (handout attached) – Ms. Roberts-Johnson explained that the change being made is that the billing must occur at the time service is given. If there are still comments, they need to be emailed to Margaret Booth at margaret.booth@nebraska.gov.
- V. Member Issues – Mr. Rasmussen asked that the issue of pharmaceutical and DME recovery program be on the next agenda. It was also requested that the final disposition on issues discussed here be shared with members. The final breast pump draft from the MAAC, as well as the provider bulletins discussed in August, will be presented at the DME Workgroup meeting tomorrow. Ms. Cover asked if there are any final decisions made and she asked if they could know what the DME workgroup discusses so she can provide information to their members. Mr. Erickson said information is going out through MAMES and she asked him to share some of that

information with her. Ms. Frank requested, and members agreed, that this committee see the final breast pump DME policy before it is sent out to everyone.

- VI. Other Issues – Our next meeting is Wednesday, October 13, 2010, at 5:30pm in Classroom 1 at the Lincoln Medical Education Partnership, 4600 Valley Road, Lincoln, Nebraska.

Dr. Schneider requested names of presenters be added to the agenda next to the issue they're presenting on as well as their name and contact information on the handout. Ms. Roberts-Johnson assured him that will be done.

Dr. Schneider asked for a chart that compares the two managed care organizations. Ms. Roberts-Johnson will send him the matrix the broker has that covers that.

- VII. Adjournment – The meeting adjourned at 7:10pm.