

Medicaid Reform Council  
Minutes  
July 15, 2010

**Call to Order**

The meeting was convened by Chairperson Karloff at approximately 9:05 a.m. in Conference Room LLF of the Nebraska State Office Building in Lincoln, Nebraska.

**Open Meetings Law**

Copies are available.

**Roll Call**

Present – Jim Blue, Wanda Caffrey, Senator Kathy Campbell, Doris Karloff, Kathy Mallatt, Dr. Jessica Meeske, Jack Vetter

Absent – Gayle-ann Douglas, Alan Garey

DHHS Staff Present: Vivianne M. Chaumont

**Approve Minutes of March 18, 2010** – Ms. Mallatt moved to approve the minutes and Ms. Caffrey seconded. Minutes approved unanimously.

**Presentations** (handouts posted online)

- 1) Program for All-Inclusive Care for the Elderly (PACE) – Julie Docter, Program Specialist, distributed copies of information about the PACE Program and gave a brief presentation. Ms. Docter and Ms. Chaumont responded to the Council's questions.
- 2) Medical Home – Pat Taft, Program Specialist, distributed copies of information regarding the Medical Home Pilot and gave a brief presentation. A question and answer period ensued.
- 3) Transportation Broker – Courtney Miller, Program Specialist, distributed handouts explaining the Non-Emergency Transportation Brokerage Services Program as well as the Nebraska broker model and briefly went through the information. A question and answer period followed.
- 4) Coordination of Benefits RFP – Bob Kane, Medicaid Claims Unit Administrator, distributed handouts and explained the components within the RFP for the Coordination of Benefits (COB) and Third Party Liability (TPL) activities and the Health Insurance

## Program of All-Inclusive Care for the Elderly (PACE)

Medicaid Reform Council  
July 15, 2010  
Nebraska State Office Building, Lincoln  
Presented by Julie Docter, Program Specialist, NDHHS

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## What is PACE?

- Voluntary managed care program
- Medicare/Medicaid program
- Community option

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## Eligibility Criteria:

- Aged 55 years old or older
- Meet nursing facility level of care criteria
- Live in the designated service area of a PACE provider
- Able to live safely in the community when enrolling in PACE

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### Funding

- Capitated monthly Medicare and/or Medicaid payment to the PACE provider
- Monthly Medicaid payment must be less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled in PACE
- Private pay persons may also enroll

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### Services

- All care and services covered by Medicare and Medicaid, including prescription drugs, doctor care, transportation, home care, hospital visits, nursing home stays, etc.
- Other medically-necessary care and services not covered by Medicare and Medicaid but authorized by the PACE provider's interdisciplinary team, e.g., home modifications, air conditioning unit

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### PACE Center

- Serves as the focal point for coordination and provision of most PACE services
  - Similar to an Adult Day Health Care facility
  - Meets state and federal safety requirements
  - Includes an adult day program, medical clinic, activities, and occupational and physical therapy services

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### PACE in the Nation

- PACE model of care was created in the early 1970s
- The Balanced Budget Act of 1997 established the PACE model as a permanently recognized provider type under both Medicare and Medicaid
- 31 states have chosen to implement PACE, including Iowa, Missouri, Kansas, and Colorado

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### Status

- Request for Information (RFI) issued December, 2009
- One respondent with two proposed sites: one in Omaha and one in Lincoln approximately 18 months later
- Payment rate development
- Provider application
- Three-way contract between CMS, the State, and the provider
- Anticipated date for an operational site in Omaha: January, 2012

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## 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 from National Academy for State Health Policy to help in the design of the pilot
- Pilot will be evaluated for outcomes related to access, health outcomes, cost containment, patient and provider satisfaction
- Pilot practices will demonstrate core competencies and meet specific standards
- Practices will receive enhanced financial reimbursement and technical assistance to transform into medical home
- Pilot practices will be solicited through a Request for Interest selection process in non-managed care communities

### Tentative Key Dates:

August 2010	Practice Solicitation Begins
November 2010	Pilot practices selected
December 2010	Practice transformation support begins
January 2011	Pilot begins

# Non-Emergency Transportation (NET) Brokerage Services

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July 15, 2010  
Nebraska State Office Building, Lincoln  
Presented by Courtney Miller, Program Specialist, NDHHS

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## Purpose

- Program Efficiencies
- Cost Savings
- Better Data
- Quality Control

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## Nebraska Broker Model

- Fixed administrative fee per completed trip broker model.
- Two (2) year contract period with three (3) annual option years.

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## Broker Services

- Standardized screening procedures
- Decreased fraud and abuse
- Focus on Public Transit
- Network coverage/coordination
- Quality Assurance Programs
- Data management

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## Status

- Intent to Award Issued
- Developing State Plan Amendment with CMS
- Developing regulations and a Fee Schedule
- Implementation Date: Nov. 2010

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## **Electronic Billing Initiative: Pending RFP Overview for Medicaid Reform Council**

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- ❖ 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 was made to the **Nebraska Health Care Association** (NHCA) in Kearney back in April (27<sup>th</sup>).
- ❖ As a result of this initial exposure, we have been asked to include a similar presentation at the **Nebraska Association of Homes and Services for Aging** (NAHSA) Fall Conference here in Lincoln in October (6<sup>th</sup>).
- ❖ In addition, some **System Change Requests** (SCRs) have been made in the **MMIS**

## **COB/TPL/HIPP RFP Overview for Medicaid Reform Council**

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- This Request for Proposal (RFP) includes a variety of both automated and manual Coordination of Benefits (COB) and Third Party Liability (TPL) activities for the Department's COB/TPL Unit and Nebraska's Health Insurance Payment Premium (HIPP) Program.
- Among the components/services required within the RFP, we have requested proposals for five primary areas:

### **1. Automated Data Matching to Identify Commercial Coverage**

### **2. Medical Support Enforcement**

### **3. Casualty Recovery**

### **4. The Health Insurance Premium Payment (HIPP) Program**

### **5. Recommend Other Enhancements to Nebraska's Third Party Functions:**

# Behavioral Pharmacy Management

The Behavioral Pharmacy Management program (BPM) is offered by Care Management Technologies (CMT), formerly known as Comprehensive NeuroScience, Inc., an independent vendor who contracts directly with state Medicaid departments or other payers. Lilly provides financial support for the initiative, while the operation and implementation of the program is done solely by the state and CMT.

The state and CMT work together to evaluate all mental health medication pharmacy claims and identify prescribing patterns that are inconsistent with national, evidence-based guidelines. Some of the inconsistent prescribing patterns seen in the Medicaid claims data reviewed are:

- Failure of patients to fill prescriptions in a timely manner
- Duplicative prescribing of medication by different doctors for the same patient
- Premature, rapid switching from one medication to another
- Prescribing multiple medications from the same therapeutic class
- Prescribing above or below recommended dosing levels

The Nebraska Medicaid BPM Committee is comprised of Medicaid employees and local Mental Health Professionals (2 Doctors, 3 Pharmacists, an APRN, a Medicaid Manager, and a Medicaid Project Coordinator). This committee is responsible for identifying the Quality Indicator that Nebraska will use to target prescribing practices that are outside national best practice standards.

As a result of this program prescribers who would like additional information have the option to request a peer consultation and work with our partners at the Nebraska Medical Association (NMA). The NMA has agreed to arrange meetings with Nebraska mental health professionals to discuss nationally recognized best practices regarding the prescribing of behavior health drugs. Medicaid also has the option to request peer consultations from the NMA for a prescriber if there are ongoing concerns due to failure to follow national guidelines.

The BPM, which has been implemented in over half of the states, sends educational materials to doctors who deviate from national prescribing guidelines, and also informs doctors when their patients fail to fill prescriptions in a timely fashion. Physicians who continue to experience the same issues over time are offered a peer consultation to discuss prescribing practices.

The first mailing focusing on the adult population was sent out July 1, 2010 and a second mailing focusing on the child population will be sent in the near future.

The goal of this program is to share the latest prescribing best practices for mental health drugs with prescribers and, in turn, shape their prescribing practices to more closely align with these practices.



# Aging and Disability Resource Center

## BACKGROUND

The Aging and Disability Resource Center Program (ADRC), a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), is designed to streamline access to long-term care services and supports for consumers of all ages, incomes and disabilities, and their families.

The ADRC initiative, launched in the fall of 2003, supports State efforts to develop “one-stop shop” programs at the community level that help people make informed decisions about their service and support options. States are using ADRC funds to integrate and/or better coordinate their existing systems of information, assistance, and access and are doing so by forming strong State and local partnerships.

ADRC programs provide options counseling to assist:

- Individuals and families needing either public or private resources;
- Individuals and families planning for their future long-term care needs;
- Professionals seeking assistance on behalf of their clients; and
- helping individuals with chronic conditions and/or disabilities who are being discharged to avoid unnecessary nursing home admissions as well as to avoid unnecessary readmission to the hospital.

ADRC programs also serve as the entry point to publicly administered long-term supports including those funded under Medicaid, the Older Americans Act, and State revenue programs.

## AOA & CMS VISION FOR RESOURCE CENTERS

AoA and CMS envision ADRCs as highly visible and trusted places available in every community across the country where individuals can get information on the full range of long-term support options. ADRC programs have taken important steps towards meeting this vision and have helped states move towards person-centered and integrated long term care systems that promote independence and dignity. To help and support these efforts, in 2006, Congress reauthorized the Older Americans Act with the inclusion of language supporting the development of ADRC efforts in every State.

The overall goal of the ADRC program is to empower individuals to effectively navigate their health and other long-term support options. Long-term support refers to a wide range of in-home, community-based, and institutional services and programs designed to help individuals’ access services.

ADRCs serve as integrated points of entry into the long-term care service system and are designed to address the frustrations many consumers and their families experience when they need to obtain information and access to supports and services. In many communities, long-term support services are administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services can be difficult. A single, coordinated system of information and access for all persons seeking long-term support minimizes confusion, enhances individual choice, and supports informed decision-making. It also improves the ability of State and local governments



FOR MORE INFORMATION ABOUT AOA

U.S. Department of Health and Human Services, Administration on Aging, Washington DC 20201  
PHONE 202.619.0724 / FAX 202.357.3523 / EMAIL [aoainfo@aoa.gov](mailto:aoainfo@aoa.gov) / WEB [www.aoa.gov](http://www.aoa.gov)

# FACTS

to manage resources and monitor program quality through centralized data collection and evaluation.

## ADRC GRANTEES

ADRCs will have a critical role in supporting health and long-term care reform by improving the ability of state and local governments to effectively manage the system, monitoring program quality and measuring responsiveness of state and local systems of care. With the 2009 awards, ADRCs will expand and operate in at least one community in 54 States and Territories. There are currently over 200 ADRC sites across the nation. Since the inception of this initiative, ADRCs have had over 4.8 million contacts, which include consumers, caregivers, providers and professionals. Nearly 30 states have appropriated state funding or passed legislation to support ADRC programs,

staff and functions. Currently, 13 states offer their ADRC services statewide.

## ADDITIONAL INFORMATION

For additional information on the ADRC initiative, please visit the ADRC Technical Assistance Exchange Web site at <http://www.adrc-tae.org>. The Web site includes contact information for AoA and CMS ADRC project officers, summary information on each of the grantees, and a variety of resources related to this initiative.

You can also find additional ADRC information on the AoA Web site at <http://www.aoa.gov> or the CMS Web site at <http://www.cms.hhs.gov/newfreedominitiative>



FOR MORE INFORMATION ABOUT AOA

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PHONE 202.619.0724 / FAX 202.357.3523 / EMAIL [aoainfo@aoa.gov](mailto:aoainfo@aoa.gov) / WEB [www.aoa.gov](http://www.aoa.gov)

Payment Premium (HIPP) Program. Mr. Kane and Ms. Chaumont answered questions from Council members.

5) Electronic Billing Incentives – Bob Kane distributed handouts about the Electronic Billing Incentives pending RFP and reviewed the information. Both he and Ms. Chaumont responded to Council members' questions. Dr. Meeske will ask the Medicaid Committee of the NDA that their Board adopt the policy that within one year all dentists have to use the 2006 form and submit their claims electronically.

Ms. Chaumont stated staff would prepare a proposal regarding a schedule for requiring providers to submit claims electronically.

6) Behavioral Pharmacy Management (BPM) Initiative – Candace Hupp, Project Coordinator, distributed handouts summarizing the initiative and reviewed the information. Ms. Hupp and Ms. Chaumont answered the questions Council members had.

7) Aging & Disability Resource Center (ADRC) – Sarah Briggs, Administrator of the State Unit on Aging and State & Grant Funded Programs Unit, distributed copies of a US DHHS Administration on Aging document that detailed the background and vision for the resource centers. She discussed the information as it relates to Nebraska's model. A question and answer period followed. More information can be found at their website - Google answers4families and it will take you directly to the AoA's website.

Mr. Blue asked Ms. Chaumont if there is anything she could share about the state's Medicaid budget. She responded that we will submit the budget in September. Mr. Blue asked that members be kept informed. The budget and the Medicaid Reform Council annual report will be on the next meeting's agenda.

Dr. Meeske wanted the minutes to reflect that Nebraska gave a .5% increase for providers last fiscal year and the upcoming fiscal year where the large majority of states kept rates flat or cut rates.

#### **Public Comment**

No public comments.

#### **Adjourn**

Meeting adjourned at noon.

Minutes prepared by Department of Health and Human Services staff. Minutes are intended to provide only a general summary of Council proceedings.