

Medicaid Advisory Committee Meeting January 12, 2009

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Committee Members: P- Present, A- Absent

Michael Baker	A	Maureen Griffin	A	Donald Mulligan, Sr.	A
Lula E. Baxter	A	Maureen Hoffmeyer	P	Michael Phelps	A
Matthew Brooks	A	Susan M. Holbert Sherry Hodge - Proxy	A	Ed Popcheff Jay Dziwlik - Proxy	A
Mike Claphan	P	Ernest C. Klein	A	Daniel Rexroth	A
Rep. William Crawford	A	John Kukla	A	Todd Stallings	A
Rep. Jeffrey K. Espich	A	Senator Jim Merritt	A	Jeff Wells	P
Monica Foye	P	Dr. Judith Monroe Ed Bloom - Proxy	P		

Opening Comments

Mike Claphan opened this meeting.

Approval of draft minutes from October 14, 2008 meeting

At a regular meeting of the MAC held on January 12, 2009, *Mr. Claphan* announced the *Committee* could not vote regarding the draft minutes of October 14th 2008 until a quorum was present.

LSA Document #08-602

Scott Linneweber, Staff Attorney with Family and Social Services Administration (FSSA), reviewed LSA Document #08-602 which describes the institutions that qualify for a capital component rate add-on, the calculation of a capital component rate add-on, and the funding exemptions that apply to the capital component rate add-on. Nursing facilities that satisfy each of the four conditions listed shall qualify for a capital component rate add-on. The four conditions are: (1) 25% or more of its residents as of December 31, 2006 were under the chronological age of 21 years; (2) According to the last health facility survey conducted by Indiana State Department of Health (ISDH) on or before December 31, 2006, the facility was not in compliance with 42 CFR 483.70(d)(1)(i); (3) The facility bedrooms accommodate no more than four residents; and (4) The facility bedrooms measure at least eighty square feet per resident in multiple resident bedrooms, and at least one hundred square feet in single resident rooms. Public hearing will be held on Jan 29, 2009 at 9:00AM at Indiana Government Center South Conference Center Room 6.

LSA Document #08-192

Mr. Linneweber, reviewed LSA Document #08-192 which amends 405 IAC 5-3 and 405 IAC 5-21 to apply prior authorization to community mental health rehabilitation services. Centers for Medicare and Medicaid Services (CMS) proposed regulations which have a significant impact on the financing and delivery of Medicaid Rehabilitation Option (MRO) services. Regulations include: (1) Intergovernmental transfer rule, (2) Medicaid rehabilitation rule, and (3) the targeted case management rule. These rules not only affect the funding structure of the MRO program, but also impact what services should be available, who is eligible to access the services, and how long the services are available. A MRO Prior Authorization (PA) workgroup meet monthly to discuss and draft changes to the MRO program as part of the delivery and finance transformation prior authorization to ensure that services are being delivered appropriately and that the state is in compliance with federal regulations. It is anticipated that these changes will produce minimal, if any, cost to agency. This program is expected to save the State \$170,000 to \$308,000. Public hearing will be scheduled upon completion of rules reviewed by the State Budget Agency. Dates for public hearings can be found in the Indiana Register, Indianapolis Star, and the FSSA website.

Rate Reduction

Dr. Jeff Wells reviewed the administrative process for the rate reduction. The rate reduction proposed intention is in recognition of the State of Indiana current financial situation with the most recent revenue forecast that was announced by Governor Daniels and the State Budget Agency. It is anticipated that there will be a \$750 million shortfall to close the 2009 fiscal year. The outlook for fiscal year 2010 is increasingly concerning from a budgetary perspective. The intent is to preserve all Medicaid services. To prepare for the potential need to assist financially from a provider

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reimbursement perspective, the state will start the administrative rule making process for a 5% provider hold back. Effective July 1, 2009, should the state be required to do this, providers across the board would be paid 95% of the current fee schedule depending on provider status. The expectation would be, should the financial situation improve over time that there will be the opportunity to hold back as opposed to a flat cut. Administration is hopeful to not have to pursue this action. *Dr. Wells* said that many other states have done or begun the process of moving forward with cutting provider rates substantially, removing services, keeping people off the program, etc. To avoid this, is to ensure that we are able to successfully navigate certain policies that can bring forth savings to the programs. An example of an important policy piece that will be in the process during the legislative session is the carving out of a pharmacy program. Hoosier Healthwise and Managed Care Organizations (MCOs) are responsible for managing the pharmacy benefit and reimbursement of claims. They are not eligible to receive the same level of state and federal supplemental rebates that the state does for the fee-for-service program for the aged, blind and disabled population. As an example, as we move forward to carve the pharmacy benefit away from the managed care organizations and put it within the states current fee-for-service drug benefit, the state will realize an annual savings of \$40,000. Information will be shared with the health plans. There will be no impact on the patient care and quality.

A question was asked regarding the co-pays, and if they would remain the same. *Ms. Heim* said that she believes that the co-pays would remain the same for children versus adults. The pharmacy team will be contacted to verify the answer.

LSA Document #08-664

Joy Heim, of FSSA Legal Department talked about LSA Document #08-664. This document amends 405 IAC 5-3-9 to provide for prior authorization of a nursing facility admission after services have begun in certain situations. It also amends 405 IAC 5-3-10 to add nursing facilities to the list of providers who may submit prior authorization requests. Amends 405 IAC 5-3-13 to add nursing facility admissions and continued stays to the list of Medicaid services requiring prior authorization. It includes amending 405 IAC 5-31-1 to specify that prior authorization of a nursing facility admission or continued stay is required for Medicaid reimbursement. It will add 405 IAC 5-31-8.1 to define continued stay and to establish the prior authorization process for admission to a nursing facility or a continued stay. This document repeals 405 IAC 1-1-7 and 405 IAC 1-4.1. FSSA foresees that this requirement will reduce avoidable nursing facility admissions, potentially provide improved quality of life for those individuals not truly needing a nursing facility level of care and it should result in a cost savings to Medicaid, by a decrease of Medicaid spending. An example of an average nursing facility stay costs approximately \$40,800 a year. For every 100 persons that can be diverted into a home or community based service \$4.08 million can be saved in the budget. This estimate does not include the home and community based services costs. A Notice of Intent has been filed. Public hearing will be published.

Proposed Changes in Methods and Standards of Medicaid Reimbursement for State-Owned Psychiatric Hospitals

Ms. Heim said the Office of Medicaid Policy and Planning (OMPP) proposed to modify the existing reimbursement methodology of 405 IAC 1-17 to include state owned psychiatric hospitals. The state owned psychiatric hospitals will be exempted from the reimbursement methodology set out at 405 IAC 1-10.5. This change is expected to result in an estimated total annual state savings of \$2.1M (the federal share of the \$3.4M annual uncompensated Medicaid expenditures the state incurs in providing services to state psychiatric hospital Medicaid patients). A notice of proposed rate changed has been filed.

Notice of Intent

Mason Pike, Attorney for Office of General Counsel for FSSA, said a notice of intent was filed that amends 405 IAC 5-3-13 for the purpose of including Environmental Lead Investigation and Lead Case Management as services that require prior authorization. This amends 405 IAC 5-3-2 for the purpose of including Environmental Lead Investigation and Lead Case Management as services available with prior authorization by telephone. This intent will add 405 IAC 5-39 for purposes of including blood lead poisoning follow-up services as services covered by Medicaid; including definitions, eligibility requirements, description of covered services, and criteria for reimbursement. The amendment is anticipated to increase today's expenditures because these services were not previously covered by Medicaid. OMPP has reviewed the proposed rule to determine the economic impact of the rule on small businesses and based on information available at the time of rule promulgation, the proposed rule does not impose requirements or costs on small businesses. The primary benefit of this rule is the early identification of at risk Medicaid eligible children with elevated blood lead levels. The notice for public hearing has been drafted.

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Paperless Communications Plans

Dr. Wells discussed the amount of paper being exchanged among providers. The state would like to look at moving to electronic and paperless communications with providers. *Dr. Wells* asked that providers share feedback within the next few months of their thoughts and experiences with paperless communications. *Dr. Wells* said that it was his hope to have an electronic process for RA's, banners, bulletins, claim submissions, clinical documentation, etc. in the very near future. The electronic process would provide better access of information. *Dr. Wells* stated the state could save in excess of \$1 million a year.

Care Select Enrollment Update

Dr. Wells provided an update on the Care Select program which began November 2007. Initially, there were approximately 65,000-70,000 individuals members statewide who were eligible because of their age, blind or disabled status category. The last remaining group of individuals that were eligible, but had not yet been enrolled, were ward and foster children/adolescents. This group will be auto-assigned as they had not yet chosen a plan. Several notices were sent out and calls were made with no responses or had incorrect mailing addresses. This remaining group of members' transition will be completed in February with Care Select. *Dr. Wells* stated that 75% of the Care Select program members did respond by selecting a doctor and plan.

Open Enrollment Update

The state has received feedback from providers and health plans of frustration with switching of plans within the Medicaid program. Other states' solution is to move to an annual open enrollment period. For example, if an individual selects Plan A for 12 months, there will be a period within the first three months that the individual could change their doctor or plan. After the three months period, a member could only change their plan with due cause. The member can still chose their primary care doctor. A phase roll out will start in central Indiana. The first annual enrollment period will begin March 1st for the central region. The second period of the phase roll out will begin June 1st which will be most of the northern part of the state, and beginning September 1st the eastern and southern part of the state will start their roll out.

To view document, visit: <http://www.indianamedicaid.com/ihcp/Bulletins/BT200841.pdf>

Questions/Other Issues

None

Mike Claphan adjourned the meeting.

Please Note: The next Medicaid Advisory Committee meeting will be held on Tuesday, May 5, 2009, from 2:00pm – 4:00pm in the IGCS Conference Center Room 22.