

# MEDICAID ADVISORY COMMITTEE MEETING

March 16, 2010

IGCS Room A – 10:00am

DRAFT

Committee Members: P – Present, A – Absent, Proxy Present

Michael Baker	A	Monica Foye	A	Senator Jim Merritt	A
Matthew Brooks Galen Goode (Proxy)	P	Maureen Griffin	P	Dr. Judith Monroe	A
Pat Casanova	P	Maureen Hoffmeyer	P	Donald Mulligan, Sr.	A
Mike Claphan	P	Susan M. Holbert Mark Sherer (Proxy)	P	Michael Phelps	A
Rep. William Crawford	A	Ernest C. Klein	A	Ed Popcheff	P
Gina Eckhart	P	John Kukla	A	Daniel Rexroth	A
Rep. Jeffrey K. Espich	A	Lawrence McCormack	P	Todd Stallings	P

## Opening Comments

Chairwoman Maureen Hoffmeyer opened the March 16, 2010, special meeting of the Medicaid Advisory Committee (MAC) and thanked everyone for attending. Chairwoman Hoffmeyer said that the minutes from the previous meeting will not be discussed until the regular April meeting.

## Notice of Rate Change – Radiology Services – Joy Heim

Joy Heim, Attorney with Family and Social Services Administration (FSSA), Office of General Counsel, discussed an overview of the first five agenda items. The four Notices of Changes: the Non-State Owned ICFs/MR and CRFs/DD, Providers of Dental Services, and the Home Health Agencies are temporary emergency rule changes. Ms. Heim stated that the Notice of Rate Change for the Radiology Services is a permanent rule change. These will all be effective on April 1, 2010, and all of the outpatient radiology services reimbursement changes will expire on June 30, 2011 and the rates will return to what they would have been before the reduction. Ms. Heim said that the LSA Document #09-910 (P) is a permanent proposed rule which the Committee has seen as an emergency rule. Ms. Heim said she expected that there will be another emergency rule at the April meeting that will affect physician administered drugs which they are finalizing that rule. All rules are being promulgated to keep Medicaid expenditures within the Medicaid biennium budget. All reductions were decided on after careful consideration of both the provider side and the recipient side.

**Radiology Services Rule** - Emergency reimbursement methodology changes to modify reimbursement for the technical component of outpatient radiology services by basing the rates currently paid to outpatient radiology providers under the Medicaid state plan and state regulations at 405 IAC 1-8 on the physician fee schedule rates for the technical component of physician radiology services. Chairperson Hoffmeyer asked is the reduction is down to the physician fee schedule then additionally cut 5%? Pat Casanova, Medicaid Director of the Office of Medicaid Policy and Planning (OMPP) said yes, but is not being introduced as a cost saving measure. It is to bring methodology in line with Medicaid rates with similar services. Chairperson Hoffmeyer wanted to know the difference between facility payment on tech component and physician component. Kristine Ellerbruch, OMPP, said that depends on the rate, as some were 10 – 15 cents different, and some were a couple hundred dollars different. Ms. Ellerbruch said it comes from rates that were set over time as new procedure codes came out. Methodology changed at different times, therefore different rates. This isn't entirely a decrease but really a realignment of the rates, which about 20% of the rates are going up, with the remainder going down. There is cost savings, but on a procedure code by procedure code basis as to what the actual impact would be. These are all determined based on CPT codes.

**Non-State Owned ICFs/MR & CRFs/DD** - Temporary emergency changes to modify reimbursement formulas by reducing rates currently paid to ICFs/MR and CRFs/DD under the Medicaid state plan and state regulations at 405 IAC 1-12 by three percent (3%) below what would have otherwise been in effect. Todd Stallings asked if it was a target or goal that caused OMPP to go for 3% on this rate versus 5%. Ms. Casanova said that the methodology is different for the ICFs/MR & CRFs/DD and is in the rule. Pat Nolting, OMPP said there were a number of issues that were looked into, in part at the historical growth rate, providers who have rate rebates every other year and in the non-rebate years the rates are adjusted based upon legendary adjustments. The trend over time

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has been the rates have increased over the last 4-5 years in total by 11%. Overall cost coverage in the aggregate is more than 100% as such, when you reduce the rates by 3% in the aggregate, the small group providers are left with, and that overall cost coverage is 102%, and the larger ICFs/MR have a net cost coverage that stills exceeds 100%.

**Providers of Dental Services** - Temporary emergency changes to modify reimbursement formulas by reducing rates currently paid to dental providers that bill using current dental terminology (CDT) codes under the Medicaid state plan and state regulations at 405 IAC 1-11.5 by five percent (5%) below what would have otherwise been in effect. *Ed Popcheff* asked for clarification of *Ms. Heim's* comments on the earlier overview of the considerations of the recipients and providers regarding dental services. *Ms. Casanova* said that when FSSA reviewed the rate changes they had specific targets to meet. They have done a review of what rates are in Indiana and what the rates are of the same services in the states surrounding Indiana. *Ms. Casanova* believes overall that Indiana is still paying more than the surrounding states for dental services in the Indiana Medicaid Program.

**Home Health Agencies** - Temporary emergency changes to modify reimbursement formulas by reducing rates currently paid to home health agencies under the Medicaid state plan and state regulations at 405 IAC 1-4.2 by five percent (5%) below what would have otherwise been in effect. *Todd Stallings* wanted clarification of the reduced rate. *Mr. Stallings* asked if 5% is from the current rate, and effective July 1, 2010, if it would be 5% off the newly calculated rate. *Ms. Heim* confirmed this rate.

*Maureen Griffin* asked about the federal match. *Ms. Casanova* said that Indiana has to meet the federal match in order to pull down the federal match. The match for the federal funds comes from the divisions' budget, not the Medicaid budget. If the match does not come from the divisions, it still has to be paid, and that comes from the Medicaid budget. *Gina Eckart* said what the division directors have to watch out for is that they have populations that they are responsible for that are not covered by Medicaid. So they need to be very wary that the budgets do not all go to the Medicaid match, as they would have no funding left for those left that are not covered by Medicaid.

**LSA Document #09-910(P)** - Temporarily amends 405 IAC 1-8 and 405 IAC 1-10.5 to change hospital reimbursement formulas by reducing rates currently paid to all hospitals for outpatient and inpatient hospital services by five percent (5%). Proposed ruled was published March 10, 2010, and there will be a public hearing March 31, 2010, 3:30pm IGCS Conference Center Room 2.

## **LSA Document #10-45 – Bobbi Nardi**

*Bobbi Nardi*, Attorney with Family and Social Services Administration (FSSA), Office of General Counsel, said LSA Document #10-45 adds 405 IAC 5-21.5 concerning Medicaid rehabilitation option (MRO) services, which replace community mental health rehabilitation services; defines MRO services and terms related to MRO services; sets out reimbursement criteria for MRO services; specifies the types of services that constitute MRO services; specifies eligibility criteria , program standards and provider types; and provides prior authorization requirements for MRO services. Repeals 405 IAC 5-21, concerning community mental health rehabilitation services. Goal of rule is to provide mental health services in the community, so that hospitalizations can be avoided and unnecessary. The repeal of the existing rule and preparation of the new rule was prompted primarily from a series of audits by CMS. A result was that OMPP was required to reimburse CMS in excess of \$22 million dollars. These were for overpayments in the Community Mental Health Rehabilitation Options Program. Some issues for the overpayments were from documentation, such as being billed as a different service, or not signed off by the appropriate qualified provider. CMS also required the state to implement internal controls to ensure that oversights are identified from the internal audits which were included on written reports to CMS. As a result from the audit, OMPP determined that a major revision of the existing rule was needed. The main goals of amending this rule are: (1) to clarify the broad general language that is currently in effect, and to give more detail as to what is being required of providers in order for reimbursement to occur, (2) to ensure that services are furnished by qualified providers and that we are specific as to who is a qualified provider for a specific service, (3) to ensure that services are provided to Medicaid eligible individuals, and (4) ensure that patients have a goal oriented individualized care plan. A question was asked if there was a plan for educational audits for practitioners. *Ms. Casanova* said the State does not have teams to be able to do educational audits, and at the same time trying to meet their requirement for the regular audits. *Ms. Casanova* said they do have, and are working on improving how they enroll new providers and make sure they understand what the rules are regarding whatever kind of provider they are, how to bill, what the process is, and what services they are billing and how to do that, to help keep them from those kind

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of difficulties. *Ms. Casanova* said they will try to do, whenever they have the ability to do that. The State does not have a structured program of sending people out for educational audits, because they do not have enough resources. Another way to reach providers is through trade associations and meeting with them on a regular basis, and through information the providers receive from bulletins and banners. *Chairwoman Hoffmeyer* asked if the \$22 million dollars was recouped from the individual providers or is it money that the state paid back. *Gina Eckart* replied that as of now, the state paid it back and what makes it complicated to recoup in a timely fashion. CMS came in and again reviewed the nineteen out of the then thirty centers, and the extrapolation process they used the totality of the billings of the state which crossed over to centers that actually had not received an audit, so when you decide who pays back what and you have varying sizes of your organizations, so it becomes difficult to figure out. *Chairwoman Hoffmeyer* asked if any communication is provided to alert providers of results of audits. *Ms. Griffin* asked if CMS provides educational audits to the State. *Ms. Casanova* said there is a clear division between program areas and auditing and regulatory. *Ms. Casanova* said she will bring these questions to a meeting of the National Association of State Medicaid Directors of which she is an executive committee member. *Ms. Casanova* said that the state can provide the results when completed from the CMS exit conferences.

## **LSA Document #10-121 – Mason Pike**

*Mason Pike*, Attorney with Family and Social Services Administration (FSSA), Office of General Counsel, said LSA Document #10-121 amends 405 IAC 5-3-13 for the purpose of including tobacco dependence products and counseling sessions as services that require prior authorization. Amends 405 IAC 5-37-1 for the purpose of defining tobacco and tobacco dependence. Amends 405 IAC 5-37-2 and 405 IAC 5-37-3 for the purpose of requiring prior authorization and establishing new reimbursement criteria. Adds 405 IAC 5-37-4 by shifting existing regulatory language to create a new section and amends for the purpose of adding practitioners who can provide tobacco dependence counseling. *Mr. Pike* said that OMPP does not expect to see expenditures to increase moving forward. In conclusion, the fiscal economic business impact rules are currently being drafted, and a public hearing has not been scheduled.

## **LSA Document #09-928 – Mason Pike**

*Mr. Pike*, said #09-928, amends 405 IAC 5-9-1 and 405 IAC 5-25-2 to correct conflicting IAC language regarding the number of allowable office visits per calendar year. The proposed rule change would conform all IAC references to the number of allowable office visits to 30 per calendar year, per recipient, per provider without prior authorization. OMPP anticipates that the proposed rule change will not have a fiscal impact. Prior authorization will be given for more frequent visits if medically necessary. The fiscal and economic small business impacts have been submitted to be approved by the agencies. A public hearing has not been scheduled.

## **LSA Document #09-482 – Mason Pike**

*Mr. Pike*, said #09-482 adds 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. Blood lead poisoning follow up services is comprised of environmental blood investigation, and blood case management. Concurrently, with this change, OMPP has reviewed and accepted the state rates established by Myers & Stauffer for these specific services. The primary benefit of this rule is early identification of adolescent Medicaid eligible children with elevated blood lead levels. The early identification or remediation process can be made clear therefore preventing further damage by continuous exposure to lead. Other benefits include a gradual increase in percentage of children receiving screening for blood lead poisoning with the potential for all children being screened for blood lead levels. The fiscal and economic small business impacts are currently being drafted and a public hearing has not been scheduled.

*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.**