



Mental Health and Disability Services Redesign 2011

PMIC Ancillary Subcommittee Webinar Notes

Friday, November 18, 2011

MINUTES

Facilitator: Beth Waldman, Bailit Health

Participants: Jennifer Vermeer, IME; Don Gookin, IME; Dennis Janssen, IME; Tim Harris, Milliman; George Estle, Tanager Place; Jeff Humeston, Tanager Place; Kristie Oliver, Coalition of Children and Family Services; Kermit Dahlen, Jackson Recovery; Tami, Four Oaks; Zack, Four Oaks; Kelley Pennington, Magellan; Dennis Peterson, Magellan; Amber Rand, CFI; Kristen Petty, Orchard Place; Brock Wolff, Orchard Place; Beth Gay, LSI

The PowerPoint Presentation that was used in this Webinar is available here:

http://www.dhs.state.ia.us/docs/Nov18_webinar_final_ppt_11-18-2011.pdf

Beth Waldman Remarks

- CMS has ruled that these services must be funded in a different way. All services provided to a child in a PMIC must be billed through the facility. The purpose of the group is to brainstorm ideas for the best possible solution.
- After the call, IME will take information and develop possible solutions that will be presented at the next meeting.
- This must happen regardless of whether PMICs are transitioned to the Iowa Plan.
- Slide #3 is the state legislative language from HF 649 that requires the department to develop a payment methodology in consultation with the PMICs that is budget neutral to the institutions and cost effective to the state.
- The goal is to limit financial risk to the PMIC and help PMICs gain access to Medicaid rates while maintaining budget neutrality and ensuring that all necessary services a child needs are provided per the EPSDT mandates. There will need to be reporting from the PMICs on compliance with EPSDT.
- Prescription drugs appear to be the most costly item of the ancillary services.

Comment: There is a concern about the accuracy of the ancillary data that was previously provided. It included claims for time when children were not in PMIC. The PMICs had to go through the data sets and match times of service with times of claims and not all have done that.

Response: They will need to re-run the data but they can still discuss methodology. Three PMICs have been analyzing their ancillary costs data.

Comment: Why is there data for only these three agencies? Were other agencies outside of the coalition given the opportunity to have this?

Response from IME: IME ran the 2010 data for everyone. Some coalition PMICs came to IME last year and asked for their own data. Lutheran Services, Children's Square and Four Oaks requested their data. All PMICs can request their data and do further analysis on it.

LSI and Children's Square data shows that there is approximately a 50% difference between full pharmacy charges compared to Medicaid reimbursement. There is a concern about the risk to PMICs of paying full pharmacy charges vs. what Medicaid will reimburse the PMIC for.

Response from Jennifer Vermeer: IME is not planning to re-price PMIC claims. We may enact rule or statute that would require pharmacies to contract at Medicaid rate with PMICs. Do PMICs have any contractual arrangements with medical professionals today?

Comment: Tanager has professional agreements but generally does not directly pay professionals.

Beth Waldman Remarks

- We have been researching what other states are doing because this is new for all states. No state has come to a complete solution on this. Milliman is working with the state of South Carolina which is planning to pay a comprehensive rate with risk borne by the facility. Information is also being requested from Massachusetts.
- Slide #7 features two payment options to consider.

- Option 1 is to add on to the PMIC rate, with law or rule change that requires providers to accept same payment rate from PMIC as Medicaid. This would also include an individual PMIC or the coalition/association negotiating a rate with pharmacies similar to how Medicaid negotiates rates.

Comment: How does pharmacy management work in PMIC? Is it unit dosing, pill bottles, similar to other long-term care facilities?

Response: Most facilities contract with a specific pharmacy provider. They receive medications on a weekly or monthly basis in pre-packaged blister or strip packs. The contract covers the delivery and dosing, the pharmacy provider bills Medicaid directly for the prescription cost. If they need non-psychiatric medications, it comes through the same process.

Response from Beth Waldman: If your PMIC had a relationship with an FQHC, you could partner with them to get 340B pricing which could be better than the Medicaid rate but this would require that the physician prescribing is connected to FQHC. Do any PMICs have relationships with FQHCs?

Response from Kermit Dahlen: Jackson Recovery has a relationship with FQHC but current regulations have not allowed what Beth refers to.

Response from Jennifer Vermeer: PMICs already have relationships with pharmacies. Is pricing the main issue?

Comment: The issue is pricing plus there would also be more administrative costs to manage the actual payment for the drugs. It would have to be tracked client by client by each CPT code. There is a question on how much detail on ancillary services Medicaid will need to track these services. PMICs currently don't have the capacity to do this.

Response from Jennifer Vermeer: IME will need more information on the medical services provided to maintain compliance with EPSDT.

Comment: PMICs will also have to bill private insurance first then get the denial before paying the claim. It will be an additional delay and cost. PMICs said that approximately 70% of the kids have a third party insurance provider.

Comment: What is the size of the PMICs accounting operations today?

Comment: Currently, the range is less than one to one full time staff. PMICs think they would need two dedicated staff to manage the additional administrative work.

Comment: Is there anything in rule or law that says the private providers still have to bill the third party insurance first and then bill the PMIC only for what isn't covered? There is a concern that it puts the PMIC at financial risk if the other provider doesn't bill correctly and may open up audit issues.

Response from Jennifer Vermeer: MHI may have information on how they contract with providers. MHI staff was not available today but we will try to get this information to the group. Have the PMIC concerns been documented so that they can be addressed?

Response from Don Gookin: Many of these issues were shared with CMS and have been documented.

Comment: The reality is that PMICs will have to make upgrades to computer systems and add two additional staff to manage this.

Comment: PMICs want to look at claims data and then quantify what it will actually cost.

Beth Waldman Remarks

- From claims data, were PMICs able to see if the child had third party insurance? It appeared that they could not tell this from the data; therefore, it was not clear if the Medicaid payment was a partial or full payment for the service.
- Option 2 presented on Slide 7 is to pass through claims to IME.
- The process would be that the PMIC accepts the claim, sends it to IME, IME processes and send back to PMIC for payment. This may not work for pharmacy as they want paid in real-time, are currently using electronic payment and probably wouldn't want to do paper billing.

Comment: PMIC will become the managed care entity, payer as well as provider. They are not equipped to do this.

Comment: Will CMS allow this kind of pass through?

Response: Possibly if it is a real claim for services and not an administrative pass through.

Jennifer Vermeer Remarks:

- Compared payment for PMIC services with billing for nursing homes as nursing homes also have contracts with multiple providers.
- Costs are passed through the nursing home; it is included on the cost report and in their rate. Hospice services provided in the nursing home were mentioned. The nursing home is not billing for the service, the hospice is billing but then reimburses the nursing home for the room and board provided by the nursing home.
- There is a precedent for these kinds of arrangements in long term care nursing facilities so pharmacies are used to operating under these types of arrangements.
- How are ancillary services billed? It is possible that not all services are included in the nursing home.
- Kristie Oliver said in her experience pharmacies bill Medicaid directly for Medicaid patients in nursing homes. For Medicare they bill a flat per patient rate.

Beth Waldman Remarks

- We have discussed pharmacy options and it appears pass through is not as likely as building it into the rate.
- Slide 8: presents the payment option of developing a rate based on trended utilization of PMIC residents that accounts for outliers, and also accounts for bed holds when children are in an inpatient hospital. There is no cost reconciliation afterward.
- Question was asked regarding rate vs. cost settling. How will this work with Magellan as they don't cost settle?
- Jennifer Vermeer responded that Medical services will still have to go through IME as Magellan doesn't manage medical costs. IME could require Magellan to cost settle if necessary. IME is still working on trying to figure out how to make it cost neutral.
- Slide 9: presents the second option that is to do prospective payment of rate with reconciliation.
- What do members want?
- Response: Option 2, reconciliation of costs is needed.
- Reconciliation could be done for a few years then be changed if needed.

Comment:

If a child had brain surgery, is the PMIC responsible for the bill? Are they discharged? They do get 10 days payment from Medicaid right now if a child is hospitalized. Medical costs can be very expensive. Would that fall under the PMIC ancillary costs? How do we make sure children don't get disadvantaged? We don't want to discriminate against a child who has serious medical health issues.

Response from
Joan Discher: There is the possibility of having a separate risk pool for high risk outliers.

Response from
Jennifer Vermeer: There will have to be some mechanism for immediate outlier situations where PMICs won't have to wait a quarter for reconciliation. Slide 9 refers to this.

Comment: There should be reimbursement for additional administrative costs.

Response from
Jennifer Vermeer: What if there was some kind of accounting organization that would manage this for all of the PMICs? They could all pay for it so they wouldn't have to duplicate systems.

Comments: Jackson Recovery is not interested. We would prefer to maintain control of our administrative functions.

Comment: Would it be a clearing house? Would it take over the administrative burden? The PMIC would still have to provide the data and follow up so it would not remove the increased workload. There is a concern that it would be another layer of administration.

Response from
Jennifer Vermeer: We will be having another conversation with CMS to receive technical assistance on this.

Response from
Beth Waldman: We have not found another state that is actually doing the ancillary billing as proposed but are still looking at other states.

Comment: Ohio did away with residential programs that were not PRTF.

Comment: The IMD issue is more about residential treatment facilities that are not PRTFs.

Comment: Kansas resolved their problem of ancillary costs but gave up federal match. They are still suing CMS regarding this.

Response from
Jennifer Vermeer: IME hasn't been able to find a state that has come into compliance. CMS has implied that Iowa is behind, but it may not be so. Other states are not submitting state plan amendments about PRTF yet.

Response from
Beth Waldman: It should be added to the implementation step to go back to CMS for clarification.

Comment: Can Iowa be granted another year of delay due to the mental health redesign?

Response from
Jennifer Vermeer: We can ask CMS. She stated that IME may also have providers on the call with CMS to explain the concerns.

Response from
Beth Waldman: Montana may have a rate and we will get more information. Milliman is assisting South Carolina in this process but don't have a rate developed yet. Tim from Milliman confirmed that they are just starting the process.

Kristie (Oliver), can you reach out to the PRTF organization in South Carolina?

Response from
Kristie Oliver: I have and South Carolina is trying to get a certificate of need for PRTF. I will follow up for more information.

Comments: If we can estimate costs on the front end, add in additional administrative costs and ancillary costs, then it is doable. There would need to be legislation passed, administrative costs and staff costs accounted for, accurate claims information for ancillary costs, the ability to reconcile at the end of the year or periodically, a pool for the outliers, and also a requirement that pharmacies accept the Medicaid rate from PMICs.

Comment: Joy Midman at the National Association of Children's Behavioral Health has a lot of information about PRTF.

Comment: How would a clearinghouse keep them out of the administration all together? Can someone explore the clearinghouse concept?

Response: Medicaid will clean up the data and set up a call with CMS. Does Orchard Place have administrative costs estimates? Response was that they don't have a cost yet.

Response from Jennifer Vermeer: When we started this a year ago, Don asked the PMICs to send them an estimate of administrative costs. CFI sent theirs. Don said he didn't receive estimates from the other organizations. PMICs stated this was due to incorrect claims data. It will be different agency to agency, as some are starting with more sophisticated systems and others not. It would be facility specific for costs.

Beth Waldman Remarks

- As the PMICs talk about administrative costs, they should also consider start up costs of contracting with providers. Are they going to work together to contract with pharmacy providers?
- How will EPSDT issues be monitored? Is there a way for IME to monitor which services link to EPSDT?
- Jennifer Vermeer said that if we can get the rule passed to require the pharmacy to give PMICs the Medicaid rate, this would be helpful. PMICs would also request that the rule require pharmacies to contract with the PMIC. Will doctors be willing to contract with the PMIC? Some may not be willing.

Comment: We try to keep children with their own doctors. Will the PMIC have to contract with each doctor? Can the Attorney General's office provide consultation on contracts?

Response from Jennifer Vermeer: The AG's office can review for technical assistance on the contracting process.

Comment: The code already says private insurance is to reimburse for PMIC but it is not enforced, so PMICs get caught between the private insurance and Medicaid.

Comment: What else needs to be done to move the process forward?

Comment: Are there any funds in state government that could be used to support the start up of the process such as small business grants or CDBG? Jennifer is not aware of any.

Comment: Is there any one-time funding available as part of the mental health redesign process? No answer available yet.

Beth Waldman Final Remarks

- We will have another call in a few weeks with this group but we may not have answers at that point.
- We are thinking about the interim report to the legislature due Dec. 9 and what will be available at that time.
- For the next meeting, we will try to have MHI staff available and look at MHI contracts.
- The next meeting of the full PMIC Transition Committee is December 7 from 12:30 to 3:30 pm at Magellan.

For more information:

Handouts and meeting information for each workgroup will be made available at:
<http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.