Medical Care Advisory Committee
Minutes Friday, May 2, 2008

Homer Site Visit
Teleconference 1-800-770-2121 (2478)

Members Present:

NP Deb Kiley, Chair
Dr. David Alexander
John Bringhurst
Tracy Charles-Smith
Marie Darlin
Gary Given, RPh
Megan LaCross
Karen Sidell

DHSS Staff

Jerry Fuller
Sally Bowers

Members Absent:

Amber Doyle
Mark Walker

Site Visit Homer Medical Clinic-staff in attendance:

William Bell, MD, Owner/Medical Director
Mary Lou Kelsey, Nurse Mid-Wife
Sonja Martin-Young, Nurse Practitioner
Patti Boily, Coding/Contracts/Compliance Mgr.
Janet McNary, Coding Specialist
Pat Boone, AR/Billing Manager
Paige Williams, Collections
Rebecca Lara, Clinic Manager

This clinic had submitted an email with a few points for discussion prior to the meeting:

- Faster processing for Denali Kid Care (DKC)
- CAMA patients-we need to know their CAMA diagnosis, especially if it is mental health
- Higher reimbursement for obstetrical care i.e. delivery, c-section
- Medicare\Medicaid cross over claims that are dropped to paper require too many changes on the CMS1500

Issues discussed:

1. A significant concern was voiced regarding delays being experienced enrolling kids in Denali KidCare (DKC) and getting pregnant women on Medicaid. Rather than the expedited process that Jerry indicated should be the case with pregnant women, they said it takes months to get these women on Medicaid. In some cases the woman has her baby before she is approved. The clinic has continued to provide the care; but the women are not able to get the prescriptions. The patients have to buy their prenatal vitamins. This impacts the willingness of the women to come in to get prenatal care as early or as often they should. It also impacts travel, especially for people who live across the bay. They either have to pay for the travel themselves or they do not come. When kids are not approved for DKC, they also are not able to get prescriptions. They mentioned a personal experience of staff person who has kids and it has taken her months to get her kids re-enrolled. When calls are made to DPA, they are placed on hold for extended periods of time and then end up being told the system is too busy; call back later. The past 2 years have been the worst. In one case, they were able to expedite it with a call to the Anchorage office, but this is not the process that can be done routinely. The clinic noted that they also have limited resources and cannot always advocate for the patients.

Action Item: Jerry Fuller will check with DPA to determine the reason for the significant delays and will have someone from DPA contact the clinic. (Rebecca Lara, office manager will serve as the contact.)

2. There was a discussion about the clinic's clientele. The clinic has seen about 13,500 patients active within the last 18 months; and see the lions share of Medicare & Medicaid patients. They are currently looking at the long term status of the clinic since they are private and do not get additional subsidy to deal with the low reimbursement for Medicare/Medicaid patients.

Action item: Staff at the clinic is reviewing their Medicare statistics. They will send detail of the number of Medicare recipients to Jerry Fuller.

3. Low Medicaid reimbursement for obstetrical care. For the work involved the reimbursement is very low. Could there be consideration for a rate increase?

4. A community health center has been opened in Homer. They are sponsored by the Seldovia Village Tribe. Even though they don't limit Medicare/Medicaid patients, they are limited by the number they can see due to their staff; one physician's assistant and a part time physician. The clinic has Health Resources and Services Administration (HRSA) funding.

   Kenai and the entire Peninsula have been defaulted as an underserved area. Medicare does not consider the area underserved so they cannot do a Health Professional Shortage Areas (HPSAs). The clinic gets no perks for seeing this population and Medicare does not pay the full cost of charges. There are a significant number of Tri-care patients in the area also because of the Coast Guard and military retirees. Tricare is on a 2 or 3 year demonstration program in Alaska. It reimburses at a 30% higher reimbursement than Medicare; it is about the same as Medicaid.

   It was noted that the Homer Medical Clinic has been in Homer since 1968 but they are concerned about their long term sustainability. A question was raised about the possibility of a forum with the medical community as a whole to discuss these issues; but they did not feel that was feasible.

   Local tribe members can only get their care at the community health center or the tribe does not pay for it. It was mentioned that Medicaid is paying for patients to come to Homer from Seldovia, although they have a physician who has been there for 20+ years. A question about medical necessity was noted.

5. Provider recruitment for their clinic is also challenging because the 330 clinics can offer student loan forgiveness. Although they have looked at becoming a 330 clinic, they are not able to achieve the 330 status. Although they are looking for other options to increase their funding; so far none have been noted.

6. CAMA - The clinic is not able to get paid because they don't know the diagnosis for the mental health patients. There apparently is a list of qualifying diagnoses but no one seems to have the list. The only thing CAMA will cover is treatment for the particular diagnosis that has been entered into the system for that patient. The staff noted that the patient is assigned a specific code. The clinic does not have the specific code array and they are not able to find out what the diagnosis code is for billing. FHSC is not able to provide the information. It is very time consuming to track down the originator of the CAMA diagnosis. Most services for CAMA patients are written off. CAMA is very limited – patient has to have less than a $300 monthly income. Funds are dwindling.

7. Transportation - this can be a problem when the clinic has to arrange travel authorization but there is no reimbursement. This ends up being a problem when the patient sees another provider especially in Anchorage and the other provider will not make the travel arrangements.

8. Challenges of prior authorization for travel. FHSC has to follow the guidelines that state has set up. The clinic noted that they do deal with patients who try to take advantage of the system. Also, it was noted that currently the State is doing a review of Medicaid claims for paid emergency transports that were not associated with medical services.

9. Prior Authorizations for medications has been a real problem. This takes a significant amount of time. There is a preferred drug list on line list that indicates the medications that need prior authorization. It was mentioned that Prevacid is currently being denied unless the person has a diagnosis of an actual ulcer so they are not able to use it for gastric reflux issues. For many pregnant women it was like a "miracle drug". It apparently is not approved for GERD anymore.

Action Item: Jerry recommended that this information be brought to the attention of the pharmacy therapeutic Committee (P & T) that meets quarterly and makes recommendations for the drugs on the preferred drug list.

10. Potential abuse of DKC. Some families have their kids on DKC but their assets are quite high. Mention was made of a potential asset test for DKC; but this likely would not happen unless the State was dealing with more significant financial strains.

11. Reimbursement for NP and CNM at 85%. At the Homer hospital, the NMs deliver about 70 % of the babies. The 85% is still true at the Federal level. Blue Cross/Blue Shield do reimburse at 100%. Perhaps MCAC should consider this as a recommendation to the commissioner.

Jerry Fuller mentioned a demonstration pilot project in Anchorage that uses a survey "Ages and Stages in a Pediatricians Office" to do a more formalized evaluation of developmental progress or delay for kids. The focus is to pick up on developmental issues as early as possible and to initiate early treatment. This is different than EPSDT. Dr. Bell thought it might be valuable for the clinic.

Action Item: Jerry Fuller will make contact with the person who deals with the "Ages and Stages in a Pediatricians Office" survey and request they contact Rebecca.

Site Visit: South Peninsula Hospital – Staff in attendance:

Bob Letson, CEO
MaLisa Mudgett, CFO
Lori Meyer, Controller, Corporate Compliance Officer
JoAnn Medina, Patient Financial Services Manager

Tour of the hospital provided by Mr. Letson and Derotha Ferraro, Marketing Director

Although the staff reported they currently feel they have no significant issues with Medicaid, these are issues discussed:

1. The length of time it is taking to get patients enrolled, especially DKC. MCAC members noted that this issue has been mentioned by others and will be addressed by Jerry Fuller.
2. They have 1.5 FTE in the financial department who help with insurance, financial aid and Medicaid issues. Patients seeking services have to apply for Medicaid first. While they are waiting for the Medicaid denial, staff work with the patient to go through the eligibility process to determine if they qualify for Medicaid. They have a social worker who works in long term and others who assist with transportation issues, but no significant issues were noted.
3. Sometimes they do get psychiatric patients through the ER. They may have to hold them for 1-2 days. The patient often has to be monitored one-on-one. Jerry noted that Medicaid does pay for a wide array of hospital services; but limited substance abuse. The Community Mental Health Center will generally pick up those that do not have Medicaid. If the person is a danger to self or others, referral would need to be made to Alaska Psychiatric Institute (API) for possible transfer up there. Community mental health centers usually have grant monies available to serve those not eligible for Medicaid. Care for the chronically mentally ill is still an issue since Medicaid only treats seriously mentally ill; even the general fund money is focused on the severe cases. Substance abuse also is an issue since most of those services end up being paid through non-profit agency grants.
4. There was a brief discussion about the hospital rate setting, inpatient and long term care. Jerry noted that there is a change every year, but once every 4 years they do a "rebasing" when the facility sends in a new cost report; the staff in DHSS rate review analyze it. They come up with the new rate and an inflation factor is applied to that every year and re-evaluated every 4 years

for update. In July 07 they had a rate change based on their cost report. There is an option to do the cost report year by year versus every 4 years.

5. Mr. Letson noted that they are in the process of becoming critical access hospital. They need to get the survey done but are awaiting the surveyor.

Open Community Forum – Guest Provider - Seldovia Village Tribe Health Center

Emiley Faris Outreach Specialist
Donna Fenske, ANP
Heather Tonga, PA
Jody Moore, PA
Sue Cushing, Behavioral Health Coordinator
Debbie Albugh, Case Coordinator

Issues Discussed:

1. Access to care
    - Persons between ages of 22-65 not eligible for medical assistance unless they meet very restricted qualifications. Although there are waivers, most in this age group do not fit a category.
    - Since this clinic is a FQHC, they do see patients that do not have income and do not qualify for other medical assistance.
    - Disability is a lengthy, complicated process that takes generally at least 3 attempts with denials that have to go through reconsideration and special hearings. It was recommended that perhaps better training on how to objectively evaluate for disabilities would help.
    - CAMA diagnoses cover some illnesses but interesting it does not cover coronary heart disease.
    - Denali KidCare access. Currently they are experiencing 6-8 weeks to qualify. Some parents will not bring kids until they have the card and this causes delay in treatment.
        - Emiley sends applications by certified mail which seems to make a difference.
        - When working with pregnant women, she contacts them every week or so.
    - Contract health care- they use local providers (if an emergency or under $1000); the hospital in some situations and others have to be sent to ANMC.
        - Guidelines are dictated by the tribe. One of the key qualifiers is the documentation in the record that indicates why the referral was made. There is no cost to the tribe if the patient goes to ANMC.
        - Medicaid patients often don't realize that they will have to pay if they do not have a documented referral.
        - Patients prefer to have their treatment in Homer and do not want to travel to Anchorage unless they have to.
        - FHSC does restrict travel to the nearest facility that offers the necessary treatment. They have to have a PA number.
2. Medicare and Medicaid reimbursement
    - As an FQHC, they have combined federal and state reimbursement issues. State reimbursement is driven through statute.
    - If the 330 or FQHC grant was increased could see more patients but this would take legislative action.
    - Recommended provider talk with legislators.
    - Concern was voiced over the difficulty in getting Medicare eligible patients into primary care; Medicaid is not as much of a problem.

- Some providers refuse to accept new Medicaid patients who are on narcotics. An insufficient number of providers may be contributing to this issue.

Open Community Forum – Guest Provider - South Peninsula Behavioral Health Services AKA The Center

Nina Allen, Director
Carla Meitler, CFO
Molly Stonorov, Director of Children's Services
Kathy Carssow, Director of Adult & Emergency Services
Susan Drathman, Director of Developmental Disabilities Program

This is a community mental health center that receives funding through Behavioral Health grants. They have a psychiatrist on staff. There are Developmentally Delayed (DD) foster homes but none for mental health. Revenue is about $350K from Medicaid, third party payers, State grants, small United Way grant, and self pay.

Issues Discussed:

1. Denali KidCare
    - Recommend the committee support increasing the eligibility qualification to 200% of the poverty level.
    - Turnaround time for getting kids re-enrolled. Families lapse out of services and the amount of time it takes to get them back on DKC is too long. The clinic has to cancel appointments because kids don't have coverage. Right now, they generally have about a 2 month wait period for the psychiatrist. When the kid has to cancel, then they may have to wait another 2 months. The typical length of time for DKC enrollment is 2 months; but the application can be in process 4-5 months. The agency has to bill retroactively and then they feel like they have to jump through a lot of hoops at FHSC. If it is beyond 90 days, they have to have a letter. It is incredibly labor intensive as far as the amount of time it takes to process. Sometimes they have to repay money because benefits are not in place and then bill again after the process has been completed.
    - Consider some way to allow case managers to be notified when a child's DKC will expire. Often, due to extremes in the family situation, they do not realize they received notice that their child's DKC is going to expire. Families have trouble keeping track of their daily needs and cannot deal with deadlines such as DKC. It was noted in the DD program, the care coordinator notifies the families when DKC will lapse. It would be helpful if this could happen in the mental health program also. If a family signed a release of information, could the case worker who currently helps that family, be alerted that the DKC will lapse. No system is in place to identify a specific case worker who is on their case to help them stay current.
    - Could there be access to a data base to check expiration date. They can call the Eligibility Verification System (EVS) to check to see if eligibility if current, but they cannot look forward to see when it expires. It would help to know if it is expired so they are not waiting till months later and then have to bill retroactively. It was noted that the DKC cards and stickers do have this information. They noted that perhaps they need to require the cards.
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Jerry Fuller noted that this will be a feature of the new web based MMIS system that will be up and running in June 2010.

2. Case management issues
    - Cathy mentioned new state regulations dealing with mental health.

Jerry clarified that they are integrating their old substance abuse and mental health into one package.

- Medicaid regulations dealing with mental health are very detailed in terms of what is required for a treatment plan, progress notes, assessments, etc. Originally written as an ideal without the

expectation of an audit that would hold the provider to every detail. All the community mental health agencies have been hit very hard in the Meyers and Stauffer audits. The detail currently required is very difficult. Behavioral Health (BH) has been trying to get them to work. At the federal level the feds are imposing new regulations that threaten the ability to do case management. It applies a much stricter medical model that doesn't really work for mental health. Basically the mental health providers essentially coordinate social services that help the person remain in the community i.e. making sure they are getting treatment; taking their medications; dealing with financial problems so they don't end up homeless. These services help keep them in the community and out of much more expensive institutions such as API or jail. Concern was voiced that if the proposed regs are passed, they will not be able to continue to provide these types of services. Skilled development and other social services will not be able to be billed. The House passed a moratorium on these regs for 1 year. Staff currently caring for these clients are called Skills Trainer, paid between $10-14/hr. Although they are skilled at their job, they are not good documenters. The services, reimbursed by Medicaid are described in a treatment plan developed by the case manager and signed off by a Masters level person who has done the assessment.

- It was noted that Senator Murkowski is on the health committee and it would be good to advise her of the problems being experienced in Alaska related to these issues.
- Their point was to stress the importance of how case management & social services keeps people in the community; out of hospitals; out of jail and maintaining a more normal lifestyle and stability in their lives.

3. AK AIMES – State reporting database
    - For over 4 yrs the agency has been told by BH that the database is Medicaid compliant; but it is not. Nina clarified that when they enter the data into AK AIMES, it does not have all the elements necessary in order to comply with the current Medicaid regulations for documentation. The system is used to collect the data for the feds but it does not force compliance; when you are filling out the screen you cannot be sure that all fields are checked that an auditor would be looking for.
    - They use it as their clinical data base because they could not afford to set up two data bases; but it has to be Medicaid compliant i.e. the diagnosis is not on the treatment review; subjectives don't show up on the actual notes.
    - The treatment plan has to be entered into AK AIMES. It is the only document they have for the assessment and progress notes.
    - BH is mandating that providers use it. In the agency's old data base, they had checks and balances and triggers that forced them to ensure things were done and people would not forget.
    - They currently do a lot of their own checks but are concerned about a Myers and Stauffer audit.
    - Recently, BH is admitting the data base is not adequate.
4. Issues related to regulations
    - Reimbursement for case management services; consider different rate structure.
        - Currently they have to build these into their other services.
        - There is a current rate freeze; rates have not gone up for 4 years.
        - Difficult to recruit & keep providers; cannot pay adequately or provide health benefits.
        - Can only bill for services they actually deliver. It is hard to have a work force in place. Can't pay people unless they are actually working i.e. the worker is a supportive employment provider, the client is sick and can't go to work, they cannot pay the worker for that day.
        - No longer allow what was called "compression". If an individual needed services over 100 days they could compress that cost into 80 days – would have been able to continue to provide services for that period. They no longer can bill this way.
    - Twenty-four hour respite needs to be done in a licensed facility. This makes it very difficult to offer respite care in the more rural areas. What it means is that the family has to take their loved one to an assisted living home or hospital in order to get respite. It cannot be given in a hotel, fish camp, MDA camp etc. They gave an example of a home that they had licensed as an assisted living home so they would have one bedroom for people that needed it. But to check

them in for an overnight respite, it is the same process as if the person was being admitted to an assisted living home where they were going to live the rest of their life.

5. Need rates to hire, train and keep providers
    - Homer living expenses higher
    - Currently pay between 10-13 hour
    - All expenses are going up but they cannot give raise; very limited benefits
6. Development Delayed (DD) Waivers
    - Currently they have a categorical respite grant with 35 slots for respite and 12 individual slots for core services
    - Have about 30 waivers
    - The State is taking 50 people off the registry (wait list)/qtr
    - They were just informed that 3 of their grant clients would be getting waivers and coming off the list this month; there were 4 last month
    - They cannot bill for capacity; can only bill for services provided
    - They can't have extra staff trained and ready; become overwhelmed when they have to fill a position due to overcapacity
    - Even when someone is approved for a waiver, it takes at least 3 months to get a prior authorization to bill; sometimes need to wait 6 months
    - Very cumbersome process
7. Absence of any children's mental health services that fall under prevention
    - Have to wait until a child is severely emotionally disturbed that puts them at risk for hospitalization before they can provide services and get reimbursed.
    - Serve about 120 severely emotionally disturbed (SED) a month. About 30 of them would fall into that category.
    - They are not able to provide any parenting education unless the kids are present.
    - Also cannot work with groups of parents; has to be individual parent and child.
    - Group therapy is paid by Medicaid but only for the identified client.
    - Family therapy can be billed only for the individual family; cannot put families together so they can learn from each other.

Action item: Jerry Fuller will research the guidelines Medicaid uses for group therapy. Is this a state rule or other that prohibits billing for families to come together for group therapy?

8. Meyers and Stauffer Audits
    - Audits have really been an issue. They noted their audit that had exception, one missing note, (but all the back up documentation was there); a $240 mistake cost $9000 after extrapolation. They did appeal it and that ended up costing about $15K. They noted that these were basically simple human errors, certainly not intentional fraud; but this is putting people out of business. The amount of resources agencies are putting into making sure their documentation is correct is enormous. This money is being diverted from services. Currently they have about 3.5 to 4 FTEs devoted just to checking on documentation; billing matches AK AIMES; AK AIMES matches billing; notes are documented. The problem may be that the State is using a medical model for DD and mental health. They can't know what would happen if you did not get the services. The amount of resources going into ensuring adequate documentation is cost prohibitive.

Jerry noted that the current legislature has directed the state to remedy that so the next round of M & S audits are still on hold until they publish regulations to address extrapolation.

9. There also was a brief discussion about the survey currently being done by Myers and Stauffer dealing with the rates. Concern was voiced on the methodology being used. They are using information on the current rates that have been frozen for 4 years. This is not a good reflection on the actual cost. They have recently written a letter to Pat Sidmore regarding their concerns.

Open Community Forum – Guest Provider - Frontier Community Services – Staff present:

Ken Duff, Executive Director
Kara Bauer, Director for Senior and Disability Services Department, Soldotna
Tammy Meier, Assistant Director, Senior and Disability Services Department

Attached is a list of issues submitted by the provider in advance for the meeting.

This is a multi service agency; serves consumers from birth to death. Their sources of revenue include State grants, general fund, Medicaid reimbursement, self-pay, third party insurance (minimal).

- Early intervention program to work with families with children birth to 3 years and then they are transitioned to head start.
- Fetal Alcohol Spectrum Disorders (FASD) educational diagnostic program (team consists of neuropsychologist, MD, speech therapist, FASD coordinator; parent navigator). At the clinic they diagnose an average about 50-55/year.
- DD services – Short Term Assistance and Referral (STAR) grant that help people fill out paper for DD eligibility, getting them on the "registry". Budget between $83-86K/yr and about $23-24K in crisis funds – set aside specifically for families that can't pay their heating bill or some other emergency.
- All four choice waivers i.e. mental retardation/developmentally delayed children with complex medical conditions; older Alaskans and adults with physical disabilities.
- Personal care attendant – consumer direct and agency based.
- Two behavioral health grants – independent case management and pilot project looking as supported employment for those with significant behavioral health issues
- Senior in-home grant that provides care coordination, respite and chore services for seniors that are not eligible for the waiver
- Developmental Disabilities grant to provide limited services for people who are not on the waiver
- SDS has been doing a commendable job in removing people's names from the registry.
- Prevention grant –11 agency collaborative on the Peninsula have come together for a behavioral health prevention grant. The hospital is the grantee and the agency subcontracts under that. Plan to do a thorough needs assessment for seniors on the Kenai Peninsula this coming year.

Issues Discussed:

1. It was noted that psychologist services can now be billed under Medicaid (testing & assessments).
2. No Medicaid money for diagnoses. The State has a process called the provider agreement that provides for an individual who goes through a diagnostic clinic, the agency gets reimbursed $3000 – this is general fund money from the State.
3. Assisted living, 24 hour respite can be provided in the person's own home. That means the provider has to move in for the period of time to stay in the patients home. If the family is leaving on vacation, they have to trust that provider in their home. It used to be that the child could go over to the respite provider's home but they cannot do that anymore.
4. Billing issue for 24 hour respite – midnight to midnight is the 24 hour time. In the audit it was determined that when the respite started at 3 pm and went over to the next day, it was not considered 24 hours. It should have billed 8 hr. on one day; 14 hours on the next day for daily respite. The agency billed 1 unit of daily respite and nothing on the second day but the auditor indicated that was wrong. The auditor found this as an exception. The agency has appealed and sent a letter with their explanation; but they have not heard a response. Anticipate that the auditors will read the explanation and determine that it actually makes sense. In reality if the agency had billed for the 8 hours and then daily respite, they would have made significantly more money; but they had taken into consideration the limitations and have been trying to be very conservative.

5. Recipients are allotted a limited number of hourly respite hours and then a limited number of 24 hour respite. By billing for the hourly respite in this manner, it really cuts into the allotment of hourly respite.
6. The PCA program used to be more of a social model. The purpose was to go in to help the person with basic needs i.e. getting out of bed, getting dressed, making a meal etc. It was a social model with 2 types – consumer directed, oriented to be consumer friendly (if the person is cognitively able to do it, the person selects the PCA, trains and schedules them) and agency based (for those who are not able to do the scheduling themselves). SDS has moved to the medical model that has had significant impacts. As the State has moved in to being the primary assessor (see attached comments from provider) SDS is using all nurses for the assessments including the PCAT that are geared for the medical model of delivery. It is a Medicaid reimbursable service, but the question is whether it is necessary to go that far into the medical model.
7. When serving consumers with developmental disabilities, significant multiple needs (mental health, substance abuse issues), the agency has to have multiple provider numbers. In terms of documentation, it is a real challenge to be sure that documentation for each diagnosis accurately reflects the treatment by the direct care provider. For each service provided by an individual provider, they have to bill a separate bill. The State also is moving to daily billing. Before, if services were performed over a lengthy period i.e. 14 days, they used to be able to bill for a span of dates; whereas now, they will have to bill for each day, that is14 bills. In their current infrastructure, at least 5 FTEs are doing quality assurance and actual billing.
8. It was pointed out that the State's guidelines are actually developed from the CMS guidelines.
9. Concern about the grant process. Chris Carson has taken over the responsibilities of Grants and Contracts with the goal to improve the process. Ken is on the committee working to develop a new process.
10. E-grants, contracts and audits have a tremendous turnover. The agency has a difficult time determining who is the responsible staff they should respond to for a particular grant.
11. Currently with the 8 grants, there are 6-8 people within "Grants and Contracts" to report to. Also, they have to coordinate their grant services with others within the separate divisions. From a provider standpoint, it is a very confusing process as they deal with an inordinate number of people within the same Department, although different Divisions.
12. Paper work getting lost. The agency was getting noticed they had not submitted their reports. Sometimes the paperwork was actually sitting on the desk of the person who handled the grant, but had left their position with the State. The agency then has to re-submit.
13. E-grants – the provider has difficulty accessing the data. Recently when they tried to submit their data, the administrators were not even in the system. Only a portion of the grant can be submitted electronically. Most of the time they have to submit their reports as hard copies, even if they do it electronically, to be sure it is received.
14. The audit process is a very expensive for providers.
    - Providers were definitely not prepared for the audits that have been mandated by the State and CMS. Perhaps with the new regulations, providers will be more informed as to what they need to do to prepare, what is being looked at.
    - Significant time and resources are necessary to prepare for audits.
    - Providers can be consumed with multiple audits by different agencies i.e. Myers and Stauffer, Health Care Services, Quality Assurance by SDS etc.
    - If a provider appeals the audit findings, they encounter significant attorney fees.
15. Previously when an RFP was being released, providers received notification. Over the past year or so, the notice is just on the public notice web site. Providers have to routinely check the web. They loose a significant amount of time to respond generally a short 30 days. The State would get better response if there was a notice sent to providers.
16. Training is also a very expensive administrative cost for the agency. Most of it is not mandatory, but in order to maintain quality workers, they provide it. Generally 5-7 days of a worker's time is devoted to training just to get them started. No reimbursement for that cost.
17. Staffing is difficult. Hard to find and keep staff. The super store is able to pay more with benefits. The agency can only afford a catastrophic insurance benefit package.

18. The agency praised SDS for their efforts in involving providers in the process of reviewing the regs and reimbursement.
19. There was a discussion of the prescribed minutes allowed for PCA services that are not person centered. Allowing 15 minutes to do a bath for someone who needs 20 minutes is not fair. Could it be looked at in blocks of time for grooming, bathing, dressing, walking the person? Should be a set amount of time but not necessarily in minutes.
    - What can be done to better measure time to enable the person to get what they need but still guard against abuse?
    - Peoples' lives do not work in 5-10-15 minute increments. Could it be looked at for a weekly service? Document the services for each day; don't exceed what you are allotted for the week. The assessment should be accurate for the amount of time they need for PCA for the week and allow the provider to bill increments; offer more personal choice.
20. Rigidity of the definitions in regulations i.e. "in-home support needs to be in the home". If the consumer is taken to the park on a nice day, the agency cannot bill for the time at the park.

The State staff per teleconference:

Chris Carson : The Department is exploring an RFP calendar that will identify when RFPs will be released. They do have to be careful since many grants are competitive and they cannot give some potential grantees advance notice over others. They have to be fair in that everyone has the same amount of time and information. Some are recurring grants that come out about the same time annually and providers can plan somewhat for those routine grants. There is a registry that people can go to the State web site and sign up to receive all public notices. It was noted that there has been some change in the past year and the agency has not been receiving all types of notices.

Action Item: Chris Carson will check with the Department of Administration to determine if there is an issue with the public notice registry.

The State is looking at streamlining the narrative process Department wide. With all the different programs, it will take time. Now looking at logic models to help define what the State collects; make reports more evidence based with actual goals and objectives. Currently looking at what is collected; why it is collected it, how often it is collected and what is actually required. Likely will take another 12-18 months before they develop a streamlined narrative report that will be used Department wide. Developing 3 committees (Ken Duff is on one). They are applying for funds from the Rasmussen Foundation, which is a partner on the project. The Mental Health Trust will likely be part of it and several other agencies as well as grantees. They have identified the strengths and weaknesses and now are on about a 2 ½ year grantee project to streamline the grant process; increase grantee relationships; and to look at the internal organization.

Linda Hulse: They are trying to keep E-grants up to date on line. Currently, only the CFR can be submitted electronically and the narrative has to be a hard copy. They are working on the process but it is a new system being refined.

Jerry Fuller noted issues dealing with the audits are likely to get worse. One focus of CMS is to halt fraud, waste and abuse through Program Integrity. Myers and Stauffer may have been a good test for the State and providers.

Open Community Forum – Guest Provider Ninilchik Community Clinic

Mark Restad, PA - Clinic Director

The clinic is operated by the Ninilchik Traditional Council (NTC) & is the primary health care between Anchor Point and Soldotna.

Issues Discussed:

1. Information technology – the public domain that is obtainable to tribes or small clinics such as this have been set up to interface with Medicaid software. Although they have made efforts to file on line, it was difficult and they went back to filing HCFA 1500 forms.
2. Web based billing – is one of the biggest issues. FHSC did not have the support staff to connect with them during the transition from HCFA 1500 to electronic. Incumbent on Medicaid or FHSC to make their software interface with what other agencies are producing.
    - Jerry noted the new web based MMIS system has the potential to resolve some of these issues.
    - The importance of making sure compatibility with the users was noted.
    - The clinic uses Medisoft software. RPMS does not seem to be manageable for small clinics.
3. Specialized Medical needs. Medicaid mandates the person goes to the nearest medical facility for treatment. Generally that would make sense. The exception is in cases when a person was routinely seen by a specialist in Anchorage and has an established relationship. When they move to the Peninsula, it does not make sense to be forced to see a new practitioner. ANMC has centralized specialty care. It would make sense that whoever is fielding the calls would understand both systems. We should be able to ensure that both systems are working together in a seamless effort to provide quality care to the patients. In the clinic, there is one person designated to deal with the travel. Sometimes their limited staff sacrifices clinic time to deal with travel and other non-reimbursable services.
    - Medicaid has rules to conserve money including travel. Although there is improvement in the travel process, it would be great if this could be addressed to be more efficient.
    - The goal should be to get systems to work together to coordinate services and provide seamless care for the patient.

4. Discussion about FHSC. Concerns voiced that staff are not helpful, rude and uncooperative.

Action Item: Jerry Fuller to check further into issues with the inadequacies of FHSC; the uncooperative attitude of their staff; who does their training and monitors their activities.

5. Denali KidCare – delays is processing applications. Not enough resources to process applications. The receptionist helps with applications but this takes so much time.
6. Currently have a certified coder/biller
7. Medication formulary is working OK. No real problem with the narcotic prescriptions or prior authorization. Prescriptions are filled by ANMC and mailed by certified mail to the patient.
8. Tribal 638 clinic gets paid at the encounter rate.

Open Community Forum – Guest Provider – Kachemak Bay Family Planning Clinic

Catriona Lowe – Clinic Manager for 5 years. She does case management for the Breast and Cervical Health Check Program; also does billing. The clinic has 9 people on staff including two practitioners (Certified Nurse Midwife and Advanced Nurse Practitioner) who do routine exams; Implanon inserts etc. They also have a health educator and outreach coordinator.

Catriona had sent in an email with a list of issues for discussion (attached). Sally noted that she had talked with Cindy Christensen, HCS regarding billing for Implanon. Cindy checked the MMIS system and determined the system was blocking those claims. The system was updated and the claims will be processed.

Issues Discussed:

1. Provider enrollment. The forms are on line but not able to fill in on line. Catriona was told by FHCS this will not change until the new system 2010. The question is why this cannot be done now. Would it be possible to at least fill it out to save a copy and print.

Jerry again noted the new MMIS system will be on line in 2010 and it will bring many changes.

2. Issue noted about the NPI number and the phone number that a person calls for the FHSC help line that has an outdated message.
    - NPI numbers are still being managed in dual system because many providers still have not got their number.
    - A remittance advice (RA) and bulletin will go out to providers as soon as they are ready to convert.
3. Catriona suggested that a summary of Medicaid provided services and payments be sent out to recipients at least on an annual basis. She mentioned that she does point out to her patients the charges and what has been paid by Medicaid. She does not use the word "free" but the fact that there was no charge. She noted this is particularly important for young persons coming off Denali KidCare to make them aware of the cost of health care and birth control.
    - Members agreed that this is an interesting consideration
    - Jerry noted that perhaps the providers themselves could offer the patients information about what they charge for the services and what Medicaid paid.
    - Gary noted that ANMC recently started educating providers on the costs of medications. They send an email each week with a disease state, the cost of the drug and the reimbursement. The second step is the patient. Since the patients get their medications for free, they do not understand the value.
    - If patients had a better understanding of the costs of the medications, they would be more considerate of what they are doing – some misplace them and just order a new prescription.

Action Item: Jerry and Sally will research further to determine options available to make this advice available to Medicaid recipients.

Action Item: Sally will send information on the Medical Care Advisory Committee for Catriona's consideration to apply as a consumer member of MCAC.