Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
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DRAFT 2.15.22

Medicaid Advisory Committee Minutes

November 30, 2021
Virtual meeting via Zoom

Members Present

Dr. Leila Alter, Ms. Tabitha Arnett, Dr. Sarah Bosslet, Senator Jean Breaux, Rep. Chris Campbell, Senator Ed Charbonneau, Rep. Ed Clere, Mr. Michael Colby, Ms. Terry Cole, Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Ms. Katherine Feley, Rep. Rita Fleming, Dr. Heather Fretwell, Mr. Herb Hunter, Mr. Rodney King, Jason Kolkmeier, Senator Jean Leising, Mr. Gary Miller, Mr. Evan Reinhardt, Dr. Dan Rusyniak, Ms. Katy Stafford-Cunningham, Ms. Allison Taylor (Chair), Ms. Kimberly Williams, and Senator Shelli Yoder.

I. Call to Order/Opening Comments

Medicaid Director and MAC chair Allison Taylor called the meeting to order at 10:01 a.m. and welcomed members and guests. Ms. Taylor asked all MAC members to register their attendance and provided brief instructions about navigating the virtual platforms used today, Zoom for MAC members and presenters and YouTube for members of the public.

II. Approval of August 2021 Minutes

Ms. Taylor invited approval of the August 2021 meeting minutes. Dr. Leila Alter indicated her attendance had been omitted from the August minutes. Ms. Terry Cole moved to approve with the change. Mr. Mike Colby seconded. The minutes were approved with the requested change.

III. MAC Updates

Ms. Taylor welcomed new members of the Medicaid Advisory Committee and provided a brief review of members' roles and responsibilities. The MAC was established by state statute and serves in an advisory role for the Office of Medicaid Policy and Planning. It is comprised of elected officials, provider group representatives, and taxpayer and citizen representatives who share opportunities and challenges with the goal of helping the state run the best Medicaid program. The MAC's goal is to increase and enhance the level of Medicaid programming and members receive insight into programs and provide feedback on proposals and policies. The group meets quarterly and also hosts special forums on Medicaid waivers that are optional for MAC members to attend. All meeting information is available on the MAC website.

Ms. Terry Cole, representing the Indiana Hospital Association, expressed interest in serving as MAC co-chair with Ms. Taylor. Ms. Cole has been with the Association and a MAC member for six years. She has a background in finance and reimbursement and was CFO at MDwise for nine years prior to working with the Association. Ms. Kimberly Williams moved to approve Ms. Cole as co-chair. (a woman seconded—didn't show up in Zoom, though). The nomination was approved.

IV. Rules

Ms. Taylor introduced Mr. Adrian Bottomly, FSSA staff attorney who had no rules to present.

V. Ethics training

Ms. Taylor introduced Ms. Jessica Keyes, FSSA Deputy General Counsel and Ethics Officer who presented information about ethics training for MAC members.

New MAC members are required to complete ethics training within six weeks of appointment to a board or commission and all members are required to complete a refresher training every two years per 42 IAC 1-4-1. Ms. Keyes' presentation focused on ethical considerations for special state appointees, including conflicts of interest and OIG informal advisory opinions.

All MAC members will receive an email with instructions and information following the meeting. Ethics training must be completed by December 17, 2021.

VI. FSSA Updates

1. ***Network participation project update – Michael Cook, Section Director, OMPP Provider Services***

Ms. Taylor introduced Michael Cook, Section Director, OMPP Provider Services, to present an update about this project aimed at increasing efficiency and reducing administrative burden by simplifying provider credentialing.

Providers have expressed frustration with the credentialing process complaining it is too slow, lacks communication, and requires too much repetition across MCEs. The network participation process is comprised of three distinct processes: enrollment, credentialing and contracting. Enrollment allows the Medicaid programs to pay providers. Credentialing allows the MCEs to verify the qualifications of individual practitioners or organizations. Contracting is the agreed upon set of rules between a provider and an entity (health plan=contract; IHCP=provider agreement).

Today, when a provider/group wants to enroll with IHCP, the provider/group completes the IHCP provider application, submits a network participation request to the MCE, goes through credentialing followed by contracting with the MCE before being enrolled into the MCE's applicable systems. After going through these steps, the provider can render services to MCE members.

Several years ago, EnCred was anticipated to be a universal credentialing solution. However, this project was retired in June 2019.

Between January-April 2021, the Provider Services team conducted six listening sessions with provider groups and associations to discuss topics such as MCE 30-day timeline to determine

credentialing decisions, communication with health plans, enrollment forms, and effective date. Credentialing standards themselves are not the issue. While Medicaid has reporting requirements for MCEs, there was not the same level of visibility around enrollment and contracting. Additional reports have been requested to "tell the whole story" of a provider moving through the network participation process.

The project deliverables included (1) the development of a quarterly performance report to address the issue of timeliness (OMPP received its first report in October 2021); (2) a formal desk review, providing a full end-to-end demonstration of the network participation process; and (3) a live sample audit of enrolled providers. Based upon the findings of formal desk review, select audit, and overall project components, Medicaid assigned a color-coded grade to each health plan to identify minor, moderate, or major concerns. No health plan had a flawless system, but MCE scores differed. Variations in required documents, welcome letter storage and delivery, and a mechanism to track provider requests were identified.

The project's next deliverables due by January 1, 2022: (1) all MCEs will provide a step-by-step process for how providers submit a network participation request, including which forms need to be completed and posting common issues/mistakes providers make during the process on the MCE website; (2) welcome letter standardization across health plans; (3) standardized network effective date for all network participation requests will be the first of the month following a request; (4) all MCEs must have a central repository solution for all network participation correspondence and OMPP reserves the right to audit all correspondence; (5) MCEs must assign a unique identifier for each request to aid in tracking; and (6) all MCEs must participate in an annual process improvement project to identify key inefficiencies with any manual component of their process.

Mr. Cook invited questions.

Questions/Comments

Q: Dr. Bosslet - How does the process differ for major hospital systems and small private practices?
A: Mr. Cook - Medicaid does not have that detail level currently.
Q; Dr. Bosslet - How do providers know if their paperwork was submitted correctly? A. Mr. Cook - Medicaid requires MCEs to respond within 5 business days if information or forms are missing.
Q: Dr. Bosslet - Is there a vision or expectation for how credentialing is communicated from the designated team to the provider office?
A: Mr. Cook - The individual listed as the point of contact for credentialing will be the person informed of the final notification.

Q: Mr. King - What was the MCEs' initial feedback after this project?
A: Mr. Cook - MCEs demonstrated a high level of engagement and asked lots of questions during the project. The MCEs are largely supportive of process improvement.

Q: Dr. Alter – it would be helpful for the web page that houses the IHCP quick reference guide contact information to include a link to credentialing information for each MCE website. One of the top questions I receive from a new provider is "How do I start the process?" A link would be helpful for colleagues.

A: Mr. Cook – We will take this suggestion back for consideration.

2. ***Long-Term Services and Supports reform update – Kim Opsahl, Director, Division of Disability and Rehabilitative Services and LTSS Executive Sponsor***

Ms. Taylor introduced Kim Opsahl to provide an update on the LTSS reform project.

Through 2030, the proportion of Hoosiers over 65 will grow from 13% to 20%. The LTSS reform project addresses how to manage this growth while being mindful of the issues of choice (75% of Hoosiers prefer to age at home), cost (developing long-term sustainability rather than savings), and quality (Hoosiers deserve the best care).

There are five key results to reform LTSS: (1) ensure Hoosiers have access to home- and community-based services within 72 hours; (2) move LTSS into a managed model; (3) link provider payments to member outcomes (value-based purchasing), (4) create an integrated LTSS data system linking individuals, providers, facilities and the state; and a new fifth KR – recruitment, retention and training of direct service workforce.

Indiana has had demonstrated success in delivery system innovation and using managed care to achieve member outcomes. Key highlights of Indiana's plan include: integration with community and improving consumer access to home and community-based services, care coordination and single point of contact for members, and plan incentives aligned with improved health and quality of life outcomes. To accomplish this work along with our other managed care programs, Indiana Medicaid will expand its staffing footprint by hiring 25 new full-time positions.

Since January 2021, the mLTSS team has worked on designing the new program in preparation for the request for proposal design and release in early 2022 and a program launch in 2024. Key result progress includes piloting an expedited eligibility process to facilitate timely access to HCBS services; completion of an initial quality analysis and development of initial quality goals; exploring minimum data set for event notification; and recruiting a direct service workforce advisory committee. As of today, more than 180 stakeholder meetings occurred in 2021 to inform the process. FSSA maintains a policy decision log with questions and feedback from stakeholder meetings as well as other LTSS documents https://www.in.gov/fssa/long-term-services-and-supports-reform/important-information-and-documents/

3. Public Health Emergency update – Allison Taylor, Medicaid Director, and Nonis Spinner, OMPP Director of Eligibility

Ms. Taylor introduced Nonis Spinner, OMPP Director of Eligibility to provide an update to the public health emergency.

The PHE has been extended to January 16, 2022. During the PHE, Medicaid eligibility is maintained in current or better category and disenrollment is limited to those who have moved out of Indiana, by member request, death or CHIP age-out. All copays and premiums

remain suspended. Redeterminations are active and all disenrollment will be held to the end of the federal PHE. Self-attestation on the application with post-enrollment verification remains in place.

When the federal PHE ends, Indiana will have twelve months to return to normal operations. Medicaid expects updated guidance about how long enhanced FMAP continues. CMS indicates they will provide states a 60-day notice prior to the end of the PHE, although states have requested 90-100 days. This is all subject to change by legislation and/or updated CMS guidance.

When the federal PHE ends, Indiana's current plan is to process disenrollments (close benefits) or downgrades (change to less comprehensive benefits) in three groups. Group 1: HIP, CHIP and MEDWorks (estimated at 129,000 Hoosiers and effective five months post-PHE end). Group 2: other modified adjusted gross income groups (estimated at 98,000 Hoosiers and effective six months post-PHE end). Group 3: groups with resource/assets requirements (estimated at 50,000 Hoosiers and effective seven months post-PHE end).

Additionally, Indiana will return to normal cost-sharing. Five months post-PHE end, invoices for premiums and POWER account payments to be restarted. Six months post-PHE end, initial payments required to start benefits and copays restart. COVID-19 testing, vaccines and treatment are expected to remain without cost-sharing going forward.

Every person who has remained eligible only due to the federal PHE requirements will receive at least five advance notices (postcards, information notice, mailer) before any negative action will be taken. Medicaid wants every person who is eligible to retain their coverage.

Questions/Comments

Q: Ms. Tabitha Arnett and Hoosier Action - Are you planning any notices not through mail? Many people have moved during the past two years. Text, phone, and email notifications would really help ensure everyone knows. If someone is not using the portal, how will you address returned mail?
Q: Representative Clere - Can we utilize text and email since we have that information in our system?
A: Ms. Spinner - MCEs will participate in outreach efforts via text messages and phone updates for members who have opted in. FFS members will get notices from DFR via standard paper mail methods and email for those that have a benefits portal account. Three of the disenrollment letters will be sent prior to the end of the PHE, and FSSA is going to review returned mail to explore another point of contact for these members.
A: Ms. Taylor and Ms. Spinner - OMPP is seeking provider partners. Providers should tell patients to let DFR know if their income has changed, to keep their contact information updated with DFR, and to make sure they read the notices and take action by the deadline.
A: Ms. Spinner – Regarding returned mail, three of the notices will be going out before the PHE ends. Our hope is that returned mail will be returned to us quickly to give us time to follow up. The MCEs will provide outreach to make sure we find everyone.

Q: Representative Clere – Are there are implications to telehealth post-PHE, specifically with the development of a Telehealth Code Set?
A: Ms. Taylor - Telehealth is operating under the statutory authority granted in July, so it is not specifically tied to the PHE. OMPP's code set will provide support for those navigating telehealth in their practice. A December call with Dr. Rusyniak will provide an update on that progress. Once the code set is drafted, there will be time to discuss before this is "turned on" in the claims processing system. Giving notice and providing runway to implement are our goals.

Q: Mr. King - Did the legislature meet yesterday to discuss the end of the state PHE?
A: Representative Clere – No, the legislature did not meet yesterday.
A: Senator Leising – There were no official meetings of the legislature.

Q: Senator Breaux – When does the federal PHE end? Will Indiana follow this?
Q: Mr. King – Don't the federal legislators have to end the PHE before Indiana? Or can Indiana end the PHE before the federal end?
A: Senator Leising – For Indiana to end prior to the federal PHE, legislative provisions must be in place.
A: Ms. Taylor – Roughly fourteen states have ended their state PHE. The State is considering statutory requirements and thorough review for a smooth transition for Medicaid, particularly eligibility. The PHE is slated to end January 16, 2022.
A: Senator Breaux—I would like to offer legislation and volunteer time and support to aligning state and federal PHE, including appropriate statutory requirements.

Q: Mr. King - How have administrative costs for FSSA changed without Power Account contributions and with federal grant money received?
Q: Representative Clere – What were the administrative savings from the suspension of Power Accounts and co-pays during the PHE? This is a great time for a robust look at administrative savings, as it provides useful data on health outcomes and the financial participation from members. This is useful data to guide policy making moving forward.
A: Ms. Spinner – The average Power Account is $12/member/year. So that would not be a significant loss for the state.
A: Ms. Taylor – Good comment, Representative Clere.

VII. Comments

Ms. Taylor invited final questions from the MAC and public. There were none.

VIII. Closing Comments

The next regular quarterly meeting of the MAC is Thursday, February 24, 2022, from 1:30-3:30 p.m. and more information about that meeting will be provided to MAC members closer to that date.

With no further business to conduct, the meeting adjourned at 12:15 p.m.