Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
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INDIANAPOLIS, IN 46204-2739

Medicaid Advisory Committee

Meeting Minutes
Wednesday, May 22, 2024
Indiana Government Center South and Zoom

Members and presenters in attendance:
Ms. Terry Cole (co-chair), Dr. Herb Hunter, Ms. Lynne Mong, Ms. Nonis Spinner, Ms. Michele Holtkamp, Ms. Kathy Dillinger, Dr. Sarah Boslett, Mr. Geovani Bonilla, Ms. Cora Steinmetz, Rep. Robin Shackleford, Mr. Shane Springer, Ms. Katy Stafford-Cunningham, Rep. Ed Clere, Rep. Mike Karickhoff, Mr. Rodney King, Mr. Luke McNamee, Ms. Kim Bremer, Ms. Holly Cunningham-Piggot, Sen. Fady Qaddoura, Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Sen. Ed Charboneau, Mr. Andy Zellers (Ms. Zoe Frantz), Rep. Brad Barrett, Ms. Katie Feeley, Sen. Shelli Yoder

I. Call to Order

Ms. Steinmetz called meeting to order at 1:02pm.

II. Approval of February 2024 minutes – Terry Cole, Co-Chair, Indiana Hospital Association

Ms. Cole invited the motion to approve the February 2023 meeting minutes. Mr. Hunter moved to approve. Ms. Terry Cole seconded the motion, and the minutes were approved with no changes.

III. Rules

Ms. Steinmetz introduced Ms. Amanda DeRoss, FSSA staff attorney, to present two rules. Ms. DeRoss gave a brief overview of the rules and where they are in the promulgation process.

1- Article 2 (LSA 23–819) amends 405 IAC 2 rule. Concerning updated definitions, guidance and clarification of terms that aligns IAC with federal code. Previously a second public hearing was held for this rule on April 29, 2024. Public comments are under review. Once approved, the rule will be adopted by the Secretary's office to be submitted to the Office of the Attorney General and the Governor's Office before being published in the Indiana Register.

2- Nursing Facility Rule (LSA 24–58) proposed rule amends, adds and repeals rules at 405 IAC 1 concerning fee for service (FFS) nursing facility reimbursement. A notice of the second public comment period and hearing will be posted on May 29th and a second hearing will be held on July 1st. Ms. DeRoss invited questions.

IV. FSSA Updates

1. Medicaid Director Updates – *Cora Steinmetz, Co-Chair, Medicaid Director*

Ms. Steinmetz provides updates on the improvements to the budget forecast. A follow up from the February meeting that discussed the previous December forecast. The Medicaid Forecast meeting provide a robust view of enrollment, expenditure and funding information for Medicaid across various programs and delivery systems both FFS and managed care.

The Medicaid Forecast meeting produced a monthly financial report just ten days prior to the MAC meeting. The monthly financial report was shared on the FSSA website. Information is shown on a various basis from the Medicaid budget or our appropriation amount as well as most recent forecast which in this case is December. A link to that will be shared in the meeting minutes. Included in the report is a "how to read" guide that explains the definitions. There is also an accompanying commentary that speaks to drivers of any variances in the lines of growth along with unexpected increases or decreases in the program. Ms. Steinmetz encouraged members of the committee to reach out for any further questions. A link to that will be shared in the meeting minutes.

https://www.in.gov/fssa/files/May-2024-Monthly-Financial-Reporting.pdf

In parallel, policy change review process is the corresponding prospective look at programmatic policy standpoint and operational systems standpoint to understand policy changes that may be in the state plan amendments. Changes to Indiana Administrative Code or other administrative level changes to waivers will will be communicated well in advance. Information will also be provided at the Medicaid Oversight Committee. Ms. Steinmetz invited questions.

2. Medicaid Return to Normal Updates and Cost Share Resumption – *Nonis Spinner, Director of Eligibility and Member Services and Michele Holtkamp, Director of FSSA Communications*

A summary was presented on the unwinding of renewal activities within the last year. The team was able to cover any activities for twelve months with two months to process the data. First post-PHE renewals were due in April 2024. 1,785,104 renewals have been processed over the last twelve months. Each month an average of 148,759 members were due for renewal of those, average of 52% were renewed. 78% were auto renewed. This is also known as ex parte renewal meaning that there is enough up to date information in the system so no further action is required. An average of 32,101 members 22% were disenrolled for Medicaid each month. 3% were determined ineligible due to the information they provided; therefore, they were transferred to the Federal Marketplace for coverage. There is an extension for members to reenroll for Medicaid to November 2024. 18% were disenrolled due to procedural reasons (i.e. failure to respond). Of those who failed to respond, 21% have regained eligibility by submitting their missing verifications during the 90-day reconsideration period. The reconsideration period applies to HIP and Hoosier Healthwise also known as MAGI and the age, blind, disability Medicaid members which are non-MAGI. Of those disenrolled for procedure reasons, an average of 35% were known to have other insurance coverage. Indiana along with Tennessee has adopted the highest number of 1902(e)(14)(A) unwinding waivers among all states and territories. 15 waivers were adopted to increase successful renewals and decrease procedural terminations. New reporting to CMS for those pending at the end of their renewal month. 132,671 due for renewal of those 78,319 members renewed and retained Medicaid or CHIP. 4,132 members were determined ineligible for Medicaid or CHIP. 13,736 members were terminated for procedural reasons, 36,484 members were processed at the end of their renewal.

Ms. Spinner reviewed outreach efforts from April 2023-March2024. Her team aligned with Indiana 211 to send out 700,00 postcards and 49,357 outbound calls. 535,347 received a warning letter. 900,168 households received renewal packets. 323,997 received a text message. 169,628 outbound calls from DFR. 141,759 emails and 80,242 postcards were sent utilizing the BMV to compare addresses. Overall, there were five to seven different attempts to reach members about renewal.

Ms. Holtkamp reviewed outreach efforts to stakeholders. After some feedback from the stakeholders, the communications team aligned themselves with community partners such as the YMCA, pharmacies, food banks, etc. Cost-share Restart key days include February 2024, an updated insert was included in eligibility notices; April/May, a 60-day notification sent to members. June, the managed care entities (MCEs) send a notice alerting HIP members to watch for an invoice arriving in early July; July, invoices will be sent in the first half of July for HIP, CHIP and MEDWorks for the month of August. In July, copays will be active for HIP and CHIP.

Ms. Holtkamp simplified cost share restart into 3 questions, “Do I have to pay?”, “How much do I pay?”, “How do I pay?”. A QR code was created for members that follows to the website. Ms. Steinmetz invited questions. Sen. Yoder asked about how many months the unwind has taken. Ms. Spinner replied with thirteen to fourteen months. Sen. Qaddoura had a question about the numbers provided for CHIP, HIP and traditional Medicaid. Ms. Spinner replied that the waitlist was not available at the collection. Ms. Steinmetz responded that no one was receiving services on the waiver then added to the waitlist. The waitlist is for new entrants to the waiver.

Rep. Clere is pleased that OMPP has reduced disenrollments. Rep. Clere expressed concern with the unwinding but pleased that disenrollment has dipped below 10% after starting at 35%. He also asked a couple questions about outreach that has been identified to reach those affected by the unwinding. Indiana along with Tennessee adopted the highest number of and 1902(e)(14)(A) unwinding waivers so we adopted, fifteen waivers. Rep. Clere asked a second question about adding a 16th waiver to allow retroactivity to members in HIP 2.0. Ms. Spinner responded that the waivers offered applied to federal requirements not state requirements. Retroactivity affects those within the state of Indiana. Ms. Steinmetz included that individual flexibility were CMS level flexibilities in which CMS offered states to apply for those items. State level laws could not be waived by that entity so that is why it is not supported by the 1902(e)(14)(A) waiver. State law explicitly disallows retroactivity. Ms. Holtkamp answered the question regarding outreach, the layering of communication for those who were disenrolled. The communication team included four to five steps for those who lose coverage to regain other coverage. The QR code has been distributed through community partners. Ms. Spinner also included that Indiana Medicaid took a waiver for MCEs to reach out the members that were being affected by disenrollment. MCEs received a list of members that were due for renewal and a list of members disenrolled. MCEs reached out to members by personal phone call and mailings. Online, Ms. Stafford-Cunningham asked about what to attribute the additional 400,000 people that are currently enrolled versus pre-pandemic? Ms. Spinner answered with disenrolling 20,000 to 50,000 a month prior to this past January. One of the biggest changes was continuous eligibility for children up to age 19. Continuous eligibility means that from the time a member is approved and when renewal is due, in those 12 months, a case cannot be closed. There is a smaller change to enrollment due to those children who are keeping coverage.

Rep. Clere asked another question regarding communication for cost share restart. Ms. Spinner responded by referencing the slide deck. The first item (February 2024 and updated inserted included all eligibility notices.), a 60-day notification of cost was sent for FSSA, MCEs also sent postcards to HIP, CHIP and MEDWorks members that will take place in July. Rep. Clere also stated “historically, a large percentage of POWER account contributions have been made by a third party such as non-profit organizations, churches, etc.” He wanted to know what outreach activities have been done for those third parties. Ms. Spinner

responded that there has been one specific stakeholder meeting that was focused on the cost share restart, there will be another coming up in the next month. There is a QR code with all the different methods of payment. Anyone is welcome to attend the next stakeholder meeting. Rep. Clere would like the 60-day grace period to be reconsidered.

3. Indiana Health Coverage Programs (IHCP)– *Kathleen Dillinger, Director of Quality Improvement*

Medicaid is required to confirm a quality strategy plan. Ms. Dillinger gave a background of the Medicaid Managed Care Quality Strategy Plan (QSP). There are steps to the QSP development plan, currently the QSP in the public comment period. Any comments will be reviewed and taken into consideration. There are 3 key changes to the QSP. First, Pathways for Aging implementation, adding specific goals and objectives. Second**,** quality of care revisions, including new directed healthcare performance. Third, improve quality management structure. OMPP includes three quality measure categories, Early Indicator Metrics, Process and Outcome Measure, finally, Pay for Outcome Measures. Ms. Dillinger provided an example of an early indicator such as a member not being able to get an appointment with their doctor. This has potential impacts to the member's healthcare, so the quality team looks into monitoring measures to notice that there has been a decrease to children and adults not completing their wellness visits. Working with MCEs, the quality team ensures that members can complete their wellness visits. Then monitoring to see if more wellness visits go up over time. In addition, OMPP had identified five measurable pillars of wellbeing based on state and nation data from surveys and interagency collaboration. The five pillars are behavioral health, maternal/child health, oral health**,** chronic conditions, care coordination. Public Comment will end on May 24th. Ms. Dillinger provided her email for any further feedback. Ms. Steinmetz invited questions.
Sen. Yoder asks a question about how the person-centered approach is expected but not required for high quality of services. Mr. Bonilla responded that there will be two care coordination strategies that will affect different Medicaid populations. Indiana PathWays for Aging and non-PathWays members. For the non-PathWays population there are a lot of requirements and there are a lot of quality measures that will be monitored. Care coordinators must be in the state of Indiana. They do not have to live in Indiana, they must provide services in the state of Indiana.

4. Indiana Pathways for Aging Updates - *Holly Cunningham-Piggot, Director of Care Programs, Kimberly Bremer, Director of Indiana Pathways for Aging and Hoosier Care Connect, Geovani Bonilla, Director of Clinical Operations*

Ms. Cunningham-Piggot reviewed enrollment activities beginning in May 2024, members receive a 60-day Pathways enrollment notice with plan benefits and contact information. June 2024, welcome packets including with member ID card will go out. July 1, 2024, PathWays coverage becomes effective (and changes from fee-for-service or Hoosier Care Connect.) Individuals have the choice to change MCE Assignments up to ninety days post go-live. On May 1st members were auto-assigned through a specific auto-assignment criteria. There will also be other times through the year that members can change MCEs by just cause.
Ms. Cunningham-Piggot covered the Readiness Review, a large-scale review of MCE Staffing, policies and procedures, process documents, subcontracts, care coordination, etc. Two hundred and seventy contracts have been reviewed, over 90% of MCEs are compliant. OMPP is ensuring complaint claim submissions so that all MCEs are asking for the same thing.

Senate Bill (SB) 132: OMPP and PathWays MCEs are conducting claims submission testing. Testing will align the different entities to make sure the three MCEs are aligned. Providers who participate in the claims testing have access to emergency financial assistance. Emergency financial assistance is a prepayment for

claims. Currently, in the middle of claims testing that began April 29th. 800 providers registered to test claims and 250 claims submitted through the test claim process. Providers are being notified if the claim is tested successfully. Sen Qaddoura asked a question regarding pending claims for providers. Ms. Cunningham-Piggot responded that pending claims are already serving this population. In July, it will change to the payer of the claim. Providers have been involved in the process through a provider workgroup meeting. MCEs must contract with providers for the first three years to deliberate where their members are receiving care within their network. Sen. Yoder had a question regarding the contradictory language for individuals and how they can change their coverage. Ms. Cunningham-Piggot responded that members can change their plan for the first 90 days after auto assignment. After 90 days, members can change up to 4 times a year for just cause. Care coordinators will help members assist with care from out of network providers. A member service call center has been set up that is outside the MCE. Ms. Steinmetz included that the plans are required to cover the same benefits that are currently on Medicaid fee-for-service plan today. The differences from the PathWays MCE plans and fee-for-service will be what is covered for supplemental benefits such as, gym membership, prepared meal delivery service, etc. Supplemental services provided by Medicare will not be affected. Maximus, the enrollment broker, is skilled in counseling constituents questions regarding supplemental benefits provided through Medicaid.

Mr. Bonilla presented on how PathWays will support members. Medicaid, Medicare and waiver services can be complex for individual members to navigate through. The support process starts with the Enrollment Broker, Maximus. Mr. Bonilla provided an example of a patient that is in the hospital July 1st, and they are discharged on MCE but were on fee-for-service update admission into the hospital. They may have some changes in their supplemental benefits and doctor visits. If the member has Medicare and Medicaid, Maximus works to identify the primary payer and who has the best coverage based on the care needed for a member. Service coordination supports the member's waivers needs. Care coordination and care management assist with individual needs such as attending appointments, managing a complex medical condition and acute needs are met. Service coordination for an individual falls on the Area Agencies on Aging (AAA)s, if AAA is leaving, service coordination relies on the MCE to identify the care needed. Transition of Care, MCEs have received data to ensure a smooth transition of care. Anything authorized prior to July 1st must be authorized by the MCE without medical review. MCEs have a stratification process using data to assist in determining the need for in complex case management. Stratification example followed, from Nursing Facility Level of Care to a member on Dual Eligible Special Needs Plan(D-SNP) with diagnosis of dementia, then a health needs assessment is performed. Finally, there are 6 months of claims data acquired for the diagnosis. The stratification process assists the member to find the right MCE service plan for a complex diagnosis. MCEs will be reviewing 30 service plans at a minimum monthly.

Ms. Bremer presented a transition plan engagement for members and providers. All three MCEs will be contacting members through the welcome packet sent out in June as well as personalized phone calls to each member to confirm language preferences, introduce the care team and how to reach them. Outreach to each provider will be communicated regarding the new authorizations starting July 1st. Community outreach started in March that took place throughout the state for eighteen different events. There are also monthly provider workgroups and stakeholder meetings. Through the Indiana Health Coverage Program (IHCP) roadshows, there has been half day presentations with all three MCEs to discuss PathWays. Other upcoming engagements were also shared.

Visit the Indiana PathWays Website for more information.

5. Comments & Questions

Rep. Clere asked about the breakdown in communications with CCHI, at this point how many AAAs have entered a contract with MCEs? Ms. Cunningham-Piggot answered that ten MCE contracts have been signed. Ms. Steinmetz included that some AAAs wanted to become service providers but were not able to because of a conflict of interest from a federal viewpoint.

Rep. Clere asked if Anthem requires an Non-Disclosure Agreement (NDA)? Ms. Steinmetz included that the NDA is part of Anthem's master services agreement. They are using Anthem's proprietary IT system. The data is Medicaid's data, Medicaid has access to it.

Rep. Clere asked about readiness review while still in the chaos of Service Coordination? Ms. Cunningham-Piggot answered MCEs must submit reports to OMPP, there is auditing monitoring in place, and they must present their service plans to OMPP for questions and answers.

Sen. Qaddoura asked about the number of slots on the waitlist. Ms. Steinmetz replied that slots open up every year due to various factors (aging, death, etc.)

Sen. Qaddoura asked about a person that medically qualifies for services regardless of your healthcare but will not get services due to budget concerns. He would like to know if this is a general assembly issue. Ms. Steimetz replied that the waiver is separate from an individual's state plan services (Medicaid). The state is dedicated to the goal that more individuals can get home and community based services(HCBS), if appropriate. Unfortunately, this area is where waiting lists are common – thirty-four states have them in place relative to these types of situations. Sen. Qaddoura also asked a question about HCBS for adults 18 and over. Ms. Steimetz stated that it depends on the need of the child or the individual receiving the services. The transition is based upon on who is providing the care.

Rep. Campbell asked if their continuity between coverage for Medicaid? Mr. Bonilla stated that the services are medical, and you are transitioning to Pathways, the MCE must honor those services from a continuity of care perspective. Under the Medicaid state plan, all the MCEs must provide the same core services but are allowed to offer supplemental ones as well.

Rep. Campbell asked if people sixty-five and over will have a choice to enroll in PathWays. Mr. Bonilla answered that it is true that it isn't really a choice. Once an individual that has Medicaid becomes eligible for Medicare, Medicare becomes their primary insurance. To receive Medicaid care coordination, they would have to enroll with one of the three MCEs, but they may choose to stay Medicare FFS.

Rep. Campbell asked why we are changing over to PathWays. Ms. Steinmetz replied that the transition to managed care allows for opportunities to do more meaningful care management and have partners assisting us in this work.

6. Next Meeting August 21st, 2024 10am-12pm

Meeting Adjourned at 3:35pm