Eric Holcomb, Governor
State of Indiana

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

Medicaid Advisory Committee Minutes

February 27, 2020
Indiana Government Center South - Conference Center Room B

Members Present
Mr. Grant Achenbach, Dr. Leila Alter, Mr. Matthew Brooks (Co-Chair), Dr. Melissa Butler, Rep. Chris Campbell, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Ms. Rachel Halleck, Mr. Shane Hatchett, Mr. Herb Hunter, Mr. Rodney King, Ms. Barbara McNutt, Mr. Gary Miller, Mr. Michael O'Brien, Mr. Evan Reinhardt, Mr. Mark Scherer, Ms. Katy Stafford-Cunningham, Ms. Allison Taylor (Co-Chair), Mr. Drew Thomas and Ms. Kimberly Williams.

I. Call to Order/Opening Comments

MAC Co-Chair Matthew Brooks called the meeting to order at 3:08 p.m. and welcomed members and guests. He advised attendees that the MAC is a statutorily required meeting and relayed that due to the legislative session, this was going to be a difficult meeting for legislators to attend.

II. Approval of August Minutes

Co-Chair Allison Taylor explained that the committee is trying to limit excessive paper production and that is why the prior meeting minutes were not printed. Mr. Evan Reinhardt moved to approve of the minutes, Ms. Barbara McNutt seconded. The minutes were approved.

III. Medicaid Director's Update

Co-Chair Taylor thanked the members for their service on the committee. She noted the new year bringing in the new MAC season and informed the committee of the reorganization of the Office of Medicaid Policy and Planning (OMPP) structure. She made members aware of the updates and improvements the Office has made. Through the reorganization, the executive team evaluated OMPP's mission and vision. Co-Chair Taylor relayed that from a mission perspective, they have spent a lot of time thinking about what is most important to the Office.

Co-Chair Taylor mentioned remarkable collaborations of Medicaid programs with sister departments. As the Co-Chair and Director, she tries to get OMPP staff to see experiences of members in order to connect to the work. From a strategic perspective, the leadership team has identified OMPP's centering goal to be: ***Collaborate to improve member and provider experience.***

She explained OMPP's leadership team identified four strategies to move the Office to the next level—promoting long-term sustainability of the program that ensures access; advancing health outcomes; increasing efficiency and reducing administrative burden; and

investing in team members. Co-Chair Brooks thanked Co-Chair Taylor for the efforts to reduce administrative burden, as this initiative was included in legislation years ago with the goal of directing accrued savings realized by the State back into direct patient care.

Co-Chair Taylor explained OMPP is focused on building a team to serve members. The newly formed Strategy Team is charged with strategic thinking, problem–solving, project management, and leading interdisciplinary teams. Deputy Director Natalie Angel oversees all Indiana Health Coverage Programs (IHCP). Nonis Spinner oversees member services. Ms. Lindsey Lux is the new Chief of Staff and manages staff development/training and vendor management. Dr. Maria Finnell oversees all clinical operations. Ms. Kathy Leonard oversees reimbursement and actuarial services.

Co-Chair Taylor introduced the refreshed Hoosier Health Wise (HHW) logo and indicated health plans would receive an email with the logo to update their websites.

Co-Chair Taylor discussed the Community Health Worker (CHW) program, indicating Indiana is the first state in the country to reimburse for CHWs. Indiana's CHWs are required to be enrolled under IHCP providers rather than as a standalone provider, and focus on social determinants of health. They can extend the State's efforts in areas including Substance Use Disorder (SUD) and infant mortality. OMPP will examine how to leverage and explore tiered reimbursement since each CHW's work can be different.

Following her presentation, Co-Chair Taylor introduced Ms. Rachel Halleck, Deputy Director of the Department of Mental Health and Addiction (DMHA) to discuss the partnership between OMPP and DMHA in the areas of SUD and Severe Mental Illness (SMI).

Ms. Halleck explained that OMPP and DMHA submitted and have been approved for an SMI waiver effective January 1, 2020. The waiver includes the full continuum of services and expands limitations around the IMD exclusion and opportunities to expand the population. For people with SUD, OMPP and DMHA still have work to do in the mental health space. DMHA is also looking to do this through the SMI waiver. For SUD, there has been a significant increase in the number of people served. Over a two-year period, $28 million has been used for Medication Assisted Treatment (MAT) for the Medicaid population which has kept people safe and functioning better. There has also been an increase in the number of residential addiction treatment beds from 259 beds in 2015 to 1,059 beds today. Ms. Halleck recognized and thanked the providers and stakeholders who participated to make these improvements.

Using best practices from the Substance Abuse and Mental Health Services Administration (SAMHSA), DMHA has drafted standardized levels of care guidelines for addiction treatment and is making modifications to ensure OMPP and DMHA are balancing best practice with practicality. Ms. Halleck presented a new study on a peer recovery coaching pilot program in emergency rooms across the State. The pilot paired an SUD "survivor" with an individual currently struggling with SUD. Peer services have a significant level of efficacy. During the pilot, 59% of 1,071 participants had peer-to-peer interaction in addition to outpatient treatment. DMHA is working with OMPP to see about a pilot program. Ms. Halleck also noted

DMHA has increased the number of prescribers of buprenorphine, a treatment for those at high risk of overdose and overdose death.

Ms. Halleck reported that DMHA asked SAMHSA for assistance and suggestions to mitigate the gap in services for incarcerated individuals. Historically, federal dollars from mental health block grants have never been used to treat incarcerated individuals, but SAMHSA agreed to allow DMHA to use these funds for services, including mental health, inside the jail setting. The change is expected to significantly improve the quality of health for this population nationally. DMHA is making some revisions to the block grant language and will report out at a later date.

Co-Chair Brooks asked Ms. Halleck for clarification. Ms. Halleck indicated the change is not in the amount of grant funding, but in the more efficient use of it. Co-Chair Brooks asked if other programs would be negatively impacted by the change. Although Ms. Halleck noted this is a fair concern, she stated DMHA does not intend to "blindside" and will thoughtfully and intentionally look at programming that might be impacted by these funds. Co-Chairs Taylor and Brooks agreed that is not a bad problem to have.

Mr. Gary Miller asked whether incarcerated individuals are eligible for Medicaid services. Ms. Halleck clarified that federal regulation prohibits incarcerated individuals from receiving Medicaid services and indicated the jail/prison is responsible for the person's care. Mr. Miller asked if that was because the prisons are getting funds elsewhere. Ms. Halleck explained that medical care is outsourced, and there is still some grey area around work-release or incarceration-based services. She believed that recently, work-release services were able to receive funds. Mr. Brooks clarified that for inpatient stays, if the county has signed an agreement with FSSA, that county's jails or prisons can provide inpatient covered services. Mr. Brooks added the block grant raises the care to include outpatient services and most counties in Indiana are under similar agreements and can be covered under Medicaid.

Co-Chair Taylor concluded programmatic updates with a discussion about the Healthy Indiana Plan (HIP). OMPP submitted a request to CMS for a ten-year extension of the HIP waiver, including the SUD and SMI extension and HIP Workforce Bridge. The Workforce Bridge component covers the payment gap when members transition to their next insurance coverage. She also indicated that because OMPP is moving forward with HIP, the Office would not be pursuing CMS's Healthy Adult Opportunities initiative. Additionally, the ENCRED project that included a credentialing "reboot" is being put on hold to allow for further examination of ways to reduce administrative burden. OMPP plans to host a stakeholder meeting by the end of March to work on a credentialing "move forward plan." Co-Chair Taylor indicated OMPP would provide a post-session legislative update at the next MAC meeting.

IV. MAC Updates

Co-Chair Taylor reviewed the remaining meeting dates for 2020.

V. Rules

Ms. Chelsea Princell, Staff Attorney for FSSA, presented an update on LSA 19-602 (Article 2 Cleanup Rule). The rule expands provider qualifications to make presumptive eligibility (PE) to Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs), and local health departments. The rule also aligns the Prior Authorization (PA) process under the Fee-For-Service (FFS) program to provide more efficient access to PE adult members. The rule change will align with current policy and makes changes to definitions. The Office of General Counsel (OGC) is awaiting approval from the State Budget Agency (SBA) to continue with the rulemaking. Notification of the public hearing will be published. Ms. Princell invited questions. Receiving none, she continued with a presentation on the rule promulgation process.

Ms. Princell presented on the steps specific to the Family and Social Services Administration (FSSA) rule promulgation process. (The presentation will be available on the MAC website.) Co-Chair Brooks thanked Ms. Princell and indicated the importance of understanding the process.

VI. FSSA Updates

a. Prompt Payment to Providers for Claims Within 30, 90, 180, and over 365 days [HEA 1548 Section 3. IC 12-15-33-9.5 (a)(4)(A-D)]—Michael Cook, Provider Services Section Director

Co-Chair Taylor welcomed Mr. Michael Cook, Provider Services Section Director, to present about prompt payment to providers and also invited Managed Care Entity (MCE) representatives in attendance to the table.

Mr. Cook recognized OMPP's Quality & Outcomes team for assistance in preparing the presentation, which will be available on the MAC website. Mr. Cook discussed how the Indiana Health Coverage Programs (IHCP) processes hundreds of thousands of claims in a given quarter. Claims can be rejected or denied for a variety of reasons including missing information, third-party liability, no prior authorization, and timely filing limit. The vast majority of claims are adjudicated in a timely fashion. OMPP's Quality and Outcomes team is responsible for MCE oversight, including claims and payment activities, and compliance. OMPP strives for continuous improvement for providers.

Co-Chair Brooks asked Mr. Cook if member enrollment is stagnant or declining based on the presentation and believes this is an area the MAC should think about. Mr. Cook responded that Anthem's system will sometimes process some claims as denials when other MCEs will reject them. Anthem's system also supplies the provider with reasons why the claim was rejected and what they can do to resubmit the claim. Mr. Cook indicated a possible system glitch in MDwise's numbers. Co-Chair Brooks asked that Mr. Cook's team report back to the MAC when the MDwise issue is resolved.

Mr. Rodney King asked for the reasons why a claim could keep getting denied. Mr. Cook referenced slide #7 describing common reasons for rejections/denials.

Mr. Cook mentioned the monthly onsite meetings between OMPP and the MCEs for the purpose of reviewing policies and procedures and asking questions. Additionally MCEs report claim and authorization metrics to OMPP on a quarterly basis. The MCEs who fail to meet OMPP metrics are assessed liquidated damages. Whenever MCEs use a new system, OMPP conducts a readiness review. Moreover, OMPP is committed to providing ongoing MCE and provider education to ensure continuous improvement.

Co-Chairs Brooks and Taylor thanked Mr. Cook for the presentation and invited questions from MAC members.

Representative Chris Campbell asked for clarification for two acronyms, OMPP and MCE. Co-Chair Taylor responded that OMPP is Office of Medicaid Policy and Planning and MCE is Managed Care Entity.

Mr. Miller asked whether providers are required to file an electronic version of the 1500; Mr. Cook responded no. Mr. Miller asked how much flexibility individual plans have to determine their own rules and regulations in requiring prior authorization (PA). Mr. Cook responded that OMPP allows all MCEs to use their own utilization management procedures. Ms. Meredith Edwards, Quality & Outcomes Section Director, added that the MCEs are permitted to be innovative in certain ways with OMPP oversight and approval. For example, in the area of utilization management procedures, OMPP's clinical team reviews changes prior to approval by OMPP. Additionally, OMPP requires health plans to alert providers 45 days prior to any material changes. Mr. Miller asked if there is a formal public hearing for the denial appeal process. Ms. Edwards responded that there is not a formal public hearing process, but OMPP does take provider feedback.

Co-Chair Brooks thanked the presenters and invited additional questions. Mr. King asked about the footnote on slide 14 of the presentation regarding liquidated damages for MCE failure to adjudicate 98% of all claims in a quarter. Ms. Edwards explained that OMPP assesses liquidated damages frequently. In 2019, OMPP assessed three failures in meeting claims processing timelines ($5,700 penalty) in three of four quarters. The OMPP contracts also allow for general damages when MCEs are not performing to OMPP standards.

Co-Chair Brooks invited Mr. Cook to present about the provider appeals process.

b. Provider Appeals Process for Administrative and Medically Necessary Medicaid Denials and the Resolution of Appeals, Including Rates of Reversal [HEA 1548 Section 3. IC 12-15-33-9.5 (a)(5)]—)]—Michael Cook, Provider Services Section Co-Chair

Mr. Cook presented on provider grievances and appeals and the PowerPoint presentation will be available on the MAC website. Providers can receive denials or have disagreements in two areas: improper claims payment (including reimbursement) and adverse benefit determinations. The MCEs have their own processes, procedures and timelines for disputes

and adverse benefit determinations. Providers have multiple steps to pursue to resolve both claims issues as well as denials around medical necessity.

Mr. Miller suggested it would be helpful if all timeframes were aligned across the MCEs. Mr. Cook expressed appreciation for the suggestion to streamline the process.

Ms. Barbara McNutt asked what happens if the MCE does not get the claim appeal resolved within the required time frame. Ms. Edwards responded that OMPP has sanctions for appeal time frames as well. Providers can work with their MCE, or they can work with the OMPP Provider Relations team to escalate and resolve an issue.

Mr. Miller asked if the MCEs have a process by which multiple claims can be processed together as one blanket appeal. Ms. Edwards deferred the question to the MCEs. Ms. Katie Zito, Anthem, explained their online dispute system, Availity, is used in all lines of business, across multiple payors, is not specific to Anthem and allows a provider to file one appeal and link all claims to that appeal. Ms. Patty Hebenstreit, MDwise, explained they have a system similar to Anthem's and the process works the same. All MCEs reported that providers can appeal multiple claims in one blanket appeal.

Co-Chair Brooks asked if providers must appeal every claim when there is a system error, or if the MCE will reprocess the claims. MDwise responded that they will mass-reprocess claims when a system issue is found, but this process is not possible for older claims since the claims were paid through their older systems. Mr. Jeffrey Chapman, CareSource, explained they use a system to track of appeals and reprocess all claims related to an appeal or system issue. MHS echoed similar information as CareSource.

Co-Chair Brooks invited final questions. Hearing none, he thanked everyone.

Co-Chair Taylor added that on the Medicaid side of appeals, providers or members can contact Michael Cook and the OMPP Provider Relations team directly if they run into an issue. OMPP can assist with triaging MCE issues; but MCEs are the best place to start.

VII. Public Comment

There were no public comments.

Mr. Miller requested an update on the Gateway to Work federal lawsuit. Co-Chair Taylor responded that the lawsuit is still pending, and OMPP is waiting for the ruling following the Arkansas appellate decision.

VIII. Next Meeting and Conclusion

Co-Chair Brooks reminded MAC members of the May 14, 2020 meeting to be conducted in this same room from 10:00 a.m. – 12 Noon.

With no further business to conduct, Co-Chair Brooks adjourned the meeting at 4:37 p.m.