Michael R. Pence, Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Medicaid Advisory Committee
Meeting Minutes
February 26, 2016

Members Present
Chairperson Matthew Brooks, Director Joe Moser, Dr. Leila Alter, Herb Hunter, Edward Liechty, Barbara McNutt, Blayne Miley, Zachary Cattell, Ted Danielson, Jon Thompson, Jerry Key, Ryan Goodwin.

I. Opening Comments

Chairperson Matt Brooks opened the meeting of the Medicaid Advisory Committee (MAC). He welcomed the members.

II. Review of Minutes – November 12, 2015

The November 12, 2015 drafted minutes were approved with the addition of Senator Patricia Miller and the removal of Barbara McNutt from the committee members' present list.

III. MAC Updates

Chairperson Brooks welcomed the new MAC member, Ryan Goodwin, to the committee and shared Ryan's biography:

> "Ryan Goodwin serves as the President of the Morgan County Council, a position which he was elected to serve in 2010. Prior to serving on the County Council, Ryan served on the Mooresville Town Council from 2008-2010. Ryan is also the past president of the Mooresville Chamber of Commerce. Ryan holds an undergraduate degree in business from Liberty University, and works at Morgan Insurance Group as a commercial property and casualty insurance broker. Ryan lives in Mooresville with his wife, Daphne, a high school mathematics teacher, and their two young boys."

IV. Rules

a. *LSA 15-325 (HIP Link rule)*
This rule was approved and a public hearing was set for March 10, 2016. It will be effective on or before June 1, 2016.

b. *LSA 14-338 (tobacco cessation rule)*
The public hearing was held February 25, 2016. OMPP and FSSA Office of General Counsel are working together to finalize rule language based on public comments received. Chairperson Brooks asked about prior authorization and how that might change. Emily Hancock responded that is not the agency's intent to create barriers to members getting treatment. The approach in crafting the rule language has been to promote successful treatment outcomes while recognizing the need for multiple quit-attempts per year; consequently, there may be individual situations of erratic utilization of tobacco cessation products, which will require touching base with the prescriber to verify if the member is still actively engaged in tobacco dependence treatment before continuing

tobacco cessation products. Any prior authorization that may be implemented as permitted by state law would be in accordance with this policy intent.

c. *LSA 15-450 (dental cap rule)*
The fiscal documents were submitted to the Office of Management and Budget and State Budget agency on January 5, 2016. FSSA is awaiting approval of the fiscal documents.
d. *LSA 15-372 (hospital assessment fee rule)*
The fiscal documents were submitted to the Office of Management and Budget and State Budget agency on December 28th, 2015. FSSA is awaiting approval of the fiscal documents.
e. *LSA 15-449 (hospice rule)*
The fiscal documents were submitted to the Office of Management and Budget and State Budget agency on December 23rd, 2015. FSSA is awaiting approval of the fiscal documents.

V. Focused Presentation on Indiana Health Workforce Council

Director Moser, stated that Governor Pence established an Indiana Health Workforce Council to examine the healthcare workforce issues which Director Moser has been involved in creating. The council meeting is scheduled for February 29, 2016 at 12:30 in Conference Room A and will be open to the public. Director Moser stated he has invited the Indiana Health Workforce Council to do a presentation at the next MAC meeting on May 26, 2016. Council Chair Mike Barnes and the Council Director Hannah Maxey indicated that they would present.

VI. Federal Access Rule

Amanda Alvey, OMPP Policy and Program Development Director, presented on the Medicaid Access Rule. She discussed the timeline of the proposed rule, which was released originally May 6, 2011. The final rule was released with comment on November 2, 2015, and is effective date January 1, 2016. The access monitoring review plan required under the rule is due July 1, 2016. Amanda stated that this rule only applies to fee-for-service members and does not apply to 1115 demonstrations or home or community-based services waivers. The access monitoring review plan should include enrollee needs, availability of care and providers, utilization of services, and data sources for the reports. The review plan has to be updated every three years along with the review of required service categories. The remediation of access concerns are: modifying payment rates, reducing barriers to provider enrollment, additional transportation to services, improved care coordination, and changing provider licensing or scope of practice policies. She also said that the public notice for rate changes will be maintained on the state website and, regular provider bulletins. Ms. Alvey added that the next steps will be working with FSSA Data Management and Analysis to identify reporting needs, the Medicaid Medical Advisory Committee on data analysis, and leveraging current processes for ongoing input.

VII. Core MMIS Update

Shane Hatchett, Deputy Medicaid Director, stated that OMPP and HPE (Hewlett Packard Enterprise) are in the process of updating the claims processing system, which is 25 years old. Mr. Hatchett stated that HPE has processed approximately 260,000 claims and the results so far have been positive. The state will continue to test the new system and when it meets certain performance standards, then FSSA will approve implementation. Providers will be given 30 days' notice before the blackout period begins. Current projections indicate the system should be ready to go live sometime in the fourth quarter of 2016.

Mr. Hatchett added that as of today, the OMPP team has uploaded 60 provider modules to the Medicaid webpage and feel this is more provider friendly. Dr. Leila Alter reviewed the modules and noted that the modules are a fantastic resource.

VIII. FSSA Updates

Director Moser stated that the Affordable Care Act requires states to revalidate Medicaid provider enrollments, including those enrolled prior to January 1, 2012 who have not since revalidated. The provider would have to submit their revalidation packet prior to the indicated deadline in order to remain an Indiana Health Coverage Programs provider. Indiana Medicaid is now required to enforce this federal mandate, which will affect approximately 6,000 providers. The state and HPE notified providers that they are required to have their revalidations submitted by March 26, 2016 to remain enrolled. Approximately 1,500 providers have revalidated to-date. When revalidating, the provider must now submit the enrollment fee of $554.00, which is set by the federal government. It also was mentioned that Medicare revalidations are not the same as Medicaid revalidations. If a provider revalidated for Medicare as a provider, the provider is still required to revalidate for Medicaid.

Chairperson Brooks commented on this federal mandate and asked if the provider has to bill at least one service per a certain time period to stay an active provider. Director Moser noted that in most cases providers will have to bill at least one claim during the last 18 months or they will be disenrolled from the program. Director Moser added some providers are exempted from this requirement.

Zach Cattell asked if March 26, 2016 was the federal deadline to complete the revalidation or if this would be providers first opportunity with a later deadline. Director Moser stated that this is the federal deadline for the revalidations to be submitted and that the providers were notified last fall. He also mentioned that they could have extended the deadline until September 1, 2016, but with the Core MMIS transition, Medicaid opted to proceed as planned.

Mr. Cattell also inquired about the provider types of 4,500 providers that had to revalidate and Director Moser stated that all types of providers had to revalidate.

Barbara McNutt stated that she would share the electronic bulletin and send it out to all of the providers about the March 26, 2016 deadline to help remind them.

The HIP Anniversary just passed and Director Moser stated that they needed one year of data and information to be able to see if the program is yielding. He also stated that they will aggregate the information and submit it to the federal government in their annual report. Director Moser stated that Natalie Angel, OMPP HIP Director, will be presenting on the first year results at a future MAC meeting.

Director Moser did say that there is an average of a 40% reduction in emergency room utilization because the Medicaid members were required to pay a copay if they went to the emergency room when it was not an emergency. This reduction in improper emergency room visits is much higher in HIP 2.0 than in HIP 1.0. The results are a true savings to the state and less overcrowding in the emergency room for non-emergent care.

Chairperson Brooks asked how we determine health outcomes for a new set of people without claims data or benchmarks for when the program started. Director Moser stated that it is difficult but that they can always compare results to other states that have insured this population for a more accurate analysis.

IX. Public Comments

There were no public comments.

X. 2016 MAC Meetings

The next meeting is May 26, 2016 in Indiana Government Center South Conference Room C.