Eric Holcomb, Governor
State of Indiana

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

Medicaid Advisory Committee Minutes

August 22, 2019
Indiana State Library – History Reference Room 211

Members Present
Mr. Grant Achenbach, Dr. Leila Alter, Ms. Tabitha Arnett, Rep. Brad Barrett, Senator Liz Brown, Rep. Chris Campbell, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Rep. Rita Fleming, Senator J.D. Ford, Mr. Herb Hunter, Rep. Mike Karickhoff, Mr. Rodney King, Rep. Cindy Kirchhofer, Ms. Barbara McNutt, Mr. Michael O'Brien, Mr. Mike Phelps, Mr. Evan Reinhardt, Senator John Ruckelshaus, Mr. Mark Scherer, Rep. Robin Shackleford, Senator Mark Stoops, Ms. Allison Taylor (Co-Chair), Mr. Drew Thomas, and Ms. Kimberly Williams.

I. Call to Order/Opening Comments

Medicaid Director and MAC Co-Chair Allison Taylor opened the meeting at 10:09 a.m. by welcoming members and guests. She advised the members that Co-Chair Matt Brooks was unable to attend due to illness and that Drew Thomas would assist in running the meeting. MAC members and speakers introduced themselves and Co-Chair Taylor reviewed the meeting agenda and remaining dates of 2019 MAC meetings. Co-Chair Taylor briefly explained the recently-passed legislation adding more members to the MAC and the goal of investing in good conversation and collaboration to make Indiana Medicaid a leader. She indicated the Office will revise the MAC member handbook and member list prior to the November meeting.

II. Approval of May Minutes

Co-Chair Taylor presented the minutes of the May 23, 2019, meeting for approval. Kimberly Williams requested the corrected spelling of *Ophthalmology*. After being moved and seconded (with correction), the minutes were approved.

III. Opening Remarks from Members

Co-Chair Taylor invited opening comments from members. There were none.

IV. Rules

Ms. Chelsea Princell, Staff Attorney for FSSA, presented one rule for discussion:

a. LSA 18-375: Radiology Rule
This proposed rule will amend 405 IAC 5-27-1 clarifying reimbursement limitations and utilization criteria for CT scans, nuclear medicine, upper GI studies, sonography, PET scans, interventional radiology, and MRIs. FSSA's OMPP received one written comment concerning the rule and FSSA's Office of General Counsel made clarifying changes to the rule. FSSA Secretary Walthall must approve and the rule will be

submitted to the Attorney General's Office. If the Attorney General approves of the rule, it will be submitted to the Governor for approval.

Ms. Princell invited questions from MAC members. There were none.

V. FSSA Updates

A. Emergency Department Coverage and Reimbursement to Providers [HEA 1548, Section 3. IC 12-15-33-9.5(a)(1)]

Co-Chair Taylor introduced Meredith Edwards, Director of OMPP's Quality and Outcomes Section. Ms. Edwards presented a PowerPoint presentation with details about Indiana's emergency department coverages and reimbursements. Within the Indiana Health Coverage programs (IHCP) Managed Care Entity (MCE) contracts, if the prudent layperson standard is not met (whereby an emergency condition exists if a prudent layperson with average knowledge of health and medicine could expect their symptoms to jeopardize their health, unborn child, bodily function, or organ), the MCE must, at a minimum, reimburse at the screening fee level and is not required to pay for other services provided. If the prudent layperson standard is met, the MCE is to pay the claim at the level billed.

Providers have expressed concerns that too many claims are being paid at the screening fee and that the medical record submission process to have a prudent layperson review is overly burdensome. To address these concerns, a Medicaid Workgroup for Emergency Services, led by Representative Kirchhofer, is collecting information and feedback from stakeholders and evaluating regulatory, legal, and financial implications of various solutions. The goal is to standardize MCE and Fee for Service processing of emergency claims as much as possible.

OMPP is working with stakeholders on selecting and fully developing a solution, implementation plan and timeline, and will report back to the MAC.

Ms. Edwards invited questions from MAC members.

Mr. Rodney King asked if this issue is the same for out of state hospital. OMPP answered yes, and affirmed that this does work the same for out-of-state claims. Mr. King continued his questioning and asked if OMPP could share one or two of the best solutions. OMPP answered that defining the scope of the issue must come before offering solutions to the MAC. Driving questions of the workgroup include: do we expand and how prescriptive do we want to be? The Office explained that there was no goal or action that would be prohibited. The workgroup finds varying results from the different plans and results, in order to come up with a solution.

Representative Fleming asked if providers are considering patient satisfaction in this issue. The Office answered "no" as providers are more concerned with finding whether or not this is an emergency diagnosis.

Senator Stoops asked if there was a spike in all MCEs. The Office answered "no" only two saw spikes in 2018. It differs year to year. Ms. Edwards stated that there is an allowance for an appeal, whereby the prudent layperson asks if this was emergent and more records are requested and submitted. Senator Stoops asked if OMPP was also seeing a difference in how that prudent layperson is deciding the value of claims. Ms. Edwards answered that it is difficult to see that decision because the burden of providing records is excessive. The hospital files on behalf of the individual. The Office would like to see the use of these records done less. Senator Stoops stated that it seems to add to the cost of the whole system. Ms. Edwards indicated that all MCEs must have a 24-hour nurse helpline to assist members in determining what their next steps are; but the number of members who call in is very small. Senator Stoops asked if pre-approval is part of the discussion MCEs have with members. Ms. Edwards replied "no" and that it would require additional work to get members to use the nurse helplines.

Senator Brown asked what kind of follow-up is conducted to educate members that the ER is not the best first option for medical care. The Office replied that each program has initiatives in place to educate over-users; it depends on the MCE. Some send a letter or make a phone call to member. Senator Brown brought the discussion back to out-of-state hospitals stating that she needed clarification on what pay rate is used if an Indiana Medicaid patient accesses an out-of-state hospital. The Office responded that the Indiana rate would be paid and this moves into the issue of HAF payments, which requires a more in-depth presentation. Co-Chair Taylor indicated that Senator Brown's question is appropriate and that ER use is being discussed within the workgroup.

Representative Fleming asked when a Medicaid patient goes to the ER and is seen by a Physician Assistant or Nurse Practitioner, but then is seen by a physician, who is reimbursed? The Office answered that they will get back to her with an answer to her question about the different provider types.

Representative Barrett asked whether it is the final diagnosis that dictates the payment. The Office responded that it takes several diagnoses to determine the possible solutions and the patient data must be considered. Representative Barrett then asked if a patient has chest pain and its determined to be something minimal, it seems like its rear-end based and not present symptom based. Co-Chair Taylor responded that the workgroup is looking into this, but that there is still work to be done.

Senator Ford inquired how many codes exist. The Office answered that each MCE has its own set of codes. Ms. Terry Cole responded that one MCE in particular has 600 pages of codes. The Office responded that this was per an Indiana Code.

Co-Chair Taylor concluded the conversation by indicating this is an issue on which OMPP and the health plans are re-partnering to streamline and align to remove red tape and confusion. This is a collaborative process to find solutions and OMPP will take this discussion back to the workgroup.

B. Reporting of Medicaid Denials Due to Retro-Eligibility Status [HEA 1548 Section 3. IC 12-15-33-9.5 (a)(8)]

Co-Chair Taylor introduced Michael Cook, Director of OMPP's Provider Services Section. Mr. Cook presented a PowerPoint about Retroactive Eligibility Review and Fast Track Eligibility Process. To address concerns from providers about unpaid reimbursement for inpatient hospital stays due to member retro-eligibility, OMPP created a workgroup with the Indiana Hospital Association and some hospital systems who were willing to share their claims information. The multi-step claims review process identified twelve "issue categories" affecting $27M in claims. Each MCE has its own process for retro-eligibility utilizing their appeals/disputes process, and there is still a need for a clear path forward.

To start on this new path, OMPP developed the Fast Track Eligibility Process, whereby Medicaid members (except for HIP plan members) can reserve their eligibility spot with coverage back to the first of the month in which payment was made for a $10 Fast Track fee. To date, 1,284 individuals have utilized the Fast Track notification form and 548 (42.6%) have completed the full eligibility notification form.

Mr. Cook then invited questions from MAC members.

Mr. King asked what year this data is from. The Office responded that this data was from April 1st, 2019 through this week, August 22, 2019. Ms. Cole stated that this was only for inpatient; not for outpatient.

Senator Ruckelshaus asked if there is an auditing process for possible fraud. The Office responded that fraud audits are outside of the scope of this process to re-determine retro-eligibility. However, OMPP does have a Program Integrity section that has an auditing process in place for possible fraud.

Senator Stoops asked what the purpose of the $10 charge of Fast Track was. Co-Chair Taylor responded that is a design of HIP and is an opportunity for individuals to make a small payment to get into the program quickly. Senator Stoops asked if that is basically the reinstatement fee. The Office answered that it is not a reinstatement fee; rather, it the individual's first contribution into the POWER Account to get into the program faster. Senator Stoops followed up by asking what happens if they cannot afford the $10. Director Taylor responded that this is a component of the HIP process and policy and indicated the legislative team would follow up with him. Ms. Cole stated that she thought CMS did not want retroactivity for HIP and that Fast Track was a compromise. Mr. King indicated $10 is a small fee and seems an economical way to get coverage. Senator Stoops stated he was thinking more of NEMT (non emergency transportation) rules with his question and that is another subject.

Senator Brown asked for clarification about the progress numbers on slide 12 for those utilizing the process. The Office answered that the number of individuals completing the full eligibility notification form are part of the number of individuals utilizing the Fast Track notification form. Senator Brown asked who is not completing the appeal, the provider

or the patient. The Office clarified that it is the provider, and that the MCE will then send the provider a notification to make sure they submit a prior authorization. The Office has yet to have a conversation with the MCEs, but can take a look.

Senator Brown questioned why the provider is submitting the appeal and the actual patient has no "skin in the game" in this process. Ms. Cole responded that a lot of information is required to complete the full application and there is a lot of back and forth with the patient. Since the care has been provided, the patient typically does not feel a great sense of urgency to complete the process.

Senator Brown asked who bears the debt if the patient is not Medicaid eligible. Ms. Cole replied that typically the hospital's charity fund will cover those instances. Senator Brown laid out a scenario in which she is a Medicaid patient, saying it would be in her best interest to assist the provider with following through this debt that will follow her. But if she is Medicaid eligible and there are unpaid claims, it is not her problem and the hospital cannot send her the bill. Ms. Cole responded saying that generally the bills fall into the hospital's charity policies. If the patient does not get aid, they will still not have the debt. Senator Brown confirmed her question that, in the end, there is no incentive for the hospital after the patient has left the hospital.

Co-Chair Taylor stated that the goal is to get individuals to value the healthcare system and complete the application. They are certainly incentivized and motivated. Senator Brown responded that she did not disagree, but that it just seems that the burden will be on the provider or the MCE to complete the process. Co-Chair Taylor said that would be a relevant topic for the group to discuss.

Representative Fleming inquired whether the Office had sorted the information according to certain patient characteristics. Mr. Cook responded that the Office had not gone to that detail. Representative Fleming stated that it would be beneficial to Fast Track OB/pregnancy patients. Mr. Thomas answered stating that a scenario that would fill backdated coverage is part of Hoosier Healthwise. Mr. Cook indicated the Fast Track has an early April rollout. The Office wrapped up the discussion by indicating this is a solution for now that required a detailed look at each individual claim. In the future the plan is to automate the process.

C. School-Based Services [SEA 392 Section 1. IC 12-15-33-9.5(b)(1) & (2)(A)(B)]

Co-Chair Taylor introduced Gabrielle Koenig, OMPP's Government Affairs Manager, and Kelly Flynn, Director of OMPP's Policy and Program Development Section. Co-Chair Taylor and Ms. Koenig presented a PowerPoint about Senate Enrolled Act 392: School-Based Services Feasibility Study. The issue is to determine whether Indiana should apply for a Medicaid state plan amendment to (1) provide Medicaid reimbursement for health care services and school-based services provided to specified individuals by a school-based health center, and (2) provide potential directed payments to school-based health centers, including alternate fee schedule payments and supplemental Medicaid reimbursement payments.

On August 12, 2019, OMPP conducted a special MAC subcommittee meeting on this topic. The draft report summarizing the subcommittee meeting (provided to MAC members) must be reviewed and recommendations reported to FSSA's legislative team by November 1. Today's meeting is the only MAC meeting before the November 1 deadline and OMPP requests the MAC's feedback before the end of the day.

Kathleen Leonard, OMPP's Director of Reimbursement and Actuary, provided a brief, high-level overview of how reimbursements and supplemental payments work in Indiana nursing homes and indicated there is much complexity in establishing a supplemental payment program for schools.

Rep. Karickhoff asked for clarification on the number of schools corporations from the Indiana Department of Education. Director Taylor confirmed that the number was incorrect due to a typo.

Co-Chair Taylor indicated that OMPP wanted to know where Indiana falls in the ranks of schools-based services compared to other states, specifically CMS Region 5 states. Generally, Indiana is very similar to many states listed. Indiana reimburses according to the IEP plan, in a fee for service model, and schools can choose to engage if they have the capacity. OMPP is partnering with DOE to determine why other school corporations are not engaging in this reimbursement and how to make the process more accessible.

Rep. Karickhoff confirmed the meeting summary is very accurate, and indicated the MAC's legislators should determine the issues that lie within their home districts. He also thanked Mike Grubbs, Barnes and Thornburg, for his work on bringing this topic into the 2019 legislative session. Rep. Karickhoff continued stating that every school is supposed to enroll in order to receive federal funds, but they are not required to file claims and there is no penalty for choosing to not file claims. He has not spoken to the superintendent in his district, citing the number of students who utilize IEP services in Kokomo's large school corporation. Rep. Karickhoff mentioned that in 2016 the General Assembly changed Indiana Code to mandate schools enroll, but they do not have to file claims. He questioned what is keeping schools from accessing the money and asked that FSSA's agencies use their power to roll out the program more efficiently. He continued that he will look into the corporations in his district and understand how they have been doing it in the last 5-6 years. Co-Chair Taylor agreed stating that part of this report is assessing where the breakdown is between schools and DOE, and creating better awareness.

Mr. King asked if there is information detailing which schools are filing claims and which are not. The Office responded that DOE has a document on their website that documents claims and participation. Rep. Karickhoff stated that large schools are participating at a much higher rate than smaller schools.

Rep. Shackleford asked if there are more IEP claims. Co-Chair Taylor deferred the question for the future discussion with DOE.

Rep. Campbell stated that one of the bills she testified against this past session concerned speech pathologists/therapists and indicated these providers cannot bill for services without permits. This would be a big reimbursement item. But in order for schools to be providers, especially with smaller schools, they are needing these permits.

Senator Stoops asked if there is any data to show how much administrative costs and time are required per claim. He continued stating that smaller schools might not be equipped to submit claims. He also commented on how it would be unfortunate for the General Assembly to mandate that schools participate without knowing how much it actually costs and whether schools have the capacity to provide services. The Office responded that there is a specific process by which schools can claim administrative costs and OMPP funds that administrative cost. Senator Stoops stated that most schools would need to hire someone and find the money to pay them to facilitate the claims process. That would likely be cost prohibitive for smaller, rural schools.

Co-Chair Taylor reassured the members that follow-up questions from today will be reflected in the report and asked MAC members to affirm they were comfortable with the report. She indicated she would check with NAMD (National Association of Medicaid Directors) for information and feedback about school-based services. She noted Mr. Grubbs' testimony in the report concerning an NAMD briefing on Massachusetts school-based services in which the funding mechanism was IGT and/or supplemental payment. She stated that the Office has not heard that any states are using supplemental payments, and indicated that Massachusetts IEP programs do not use a supplemental retro-payments process. Co-Chair Taylor stated that OMPP regularly collaborates with Massachusetts and will inquire further about their school-based services programs. The Office is working on simplifying reimbursement documents to help Indiana schools leverage this reimbursement opportunity. Co-Chair Taylor asked MAC members, specifically the legislators, to have conversations with school superintendents in their districts. The Office will partner with DOE and take appropriate action on items that are reflected in the report. Ms. Eichhorn asked if the article that Mr. Grubbs referred to was found and Co-Chair Taylor confirmed that it had not been found.

Mr. Thomas indicated all 48 FQHC locations are places of service. There are two entrances, one for schools and another as a public entrance. As a school-based service, FQHC just happens to be inside a school. He said based on the report, there is no language that changes the structure of FQHCs and what they provide in the school. He asked if this was correct and whether there would be no changes to their methodology and payment. The Office indicated that OMPP must look at the specifics of the program to better distinguish which entity is being reimbursed, the provider or the center.

Co-Chair Taylor invited closing comments and feedback on the report. Rep. Karickhoff motioned for a vote, Senator Brown seconded. Co-Chair Taylor asked MAC members who favored submitting the report as is. The responses: all yays, no nays.

VI. Public Comment

Co-Chair Taylor invited public comment.

Senator Andy Zay began his testimony regarding SEA 392 by mentioning that schools were the theme going out of 2019 Session and the General Assembly spent a lot of time talking about mental health. He discussed how the school-based services bill (SB 437) encompassed all three of those sentiments. A commission report came out from Indiana Supreme Court Justice Rush on the wellbeing in our schools. He stated that Medicaid is complex and that he is certainly not as knowledgeable on the complexity of Medicaid, but that as of 2017, Indiana received $10.7 million dollars in IEP for schools. He stated that the issue is about putting these dollars in our schools because they are providing these services whether or not they are billing Medicaid. He questioned whether schools would be able to free up money for other school costs. Again, what stuck out to him was the opportunity for Indiana to fund an unfunded mandate. Collaboration with the Indiana Department of Education (DOE) and OMPP is strongly recommended. He thanked Senator Stoops for his commitment to schools. Senator Zay ended by stating that Indiana has to provide administrative mechanisms for schools, especially smaller ones, to access these services and funding. He appreciated the recommendations and will continue to work with OMPP to further formulate for the benefit of Indiana's children.

Mr. Mike Grubbs, representing Barnes and Thornburg, echoed Senator Zay's sentiments and stated that the priority is making sure Indiana's children are receiving the IEP services they require and that the 111 school systems that are not billing for Medicaid, start billing. He indicated that the State does not need to get federal approval, and that there is an interesting statute where schools must enroll in Medicaid, but don't have to bill claims. The Legislature needs to consider how this makes sense. Mr. Grubbs stated that he just met with DOE on Tuesday and found out that there is a company in Zionsville called ClaimAid that handles billing for school systems for a 10% fee. He informed the members that ClaimAid provides other services such as time studies, and works with small and large school corporations. He continued by stating that large schools in the state have service corporations. Mr. Grubbs stated that he spent time researching other states and found that each state has a different reimbursement method. Indiana reimburses on a fee schedule, and is covered by a cost report. Speech therapists are in short supply, and high demand. Yet many of them are unwilling to receive Medicaid rates, leaving school districts to pay privately for their services. He is uncertain whether Indiana has to change the Medicaid State plan, since Indiana already covers IEP. Co-Chair Taylor confirmed that OMPP will check and thanked Mr. Grubbs for his in-depth knowledge of this subject and the work he has done for schools. Co-Chair Taylor stated that if members are comfortable, the MAC can let the current report stand.

VII. Conclusion

With no further business to conduct, Co-Chair Taylor adjourned the meeting at 12:10 p.m.