Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W374, MS 07
INDIANAPOLIS, IN 46204-2739

Medicaid Advisory Committee Minutes

May 24, 2023
In person and Zoom meeting

Members Present
Ms. Maddie Augustus, Dr. Sarah Bosslet, Senator Jean Breaux, Rep. Chris Campbell, Rep. Ed Clere, Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Ms. DeAnna Ferguson, Ms. Zoe Frantz, Dr. Heather Fretwell, Mr. Herb Hunter, Ms. Julia Ketner, Senator Jean Leising, Mr. Luke McNamee, Mr. Gary Miller, Senator Fady Qaddoura, Mr. Dick Rhoad, Rep. Robin Shackleford, Mr. Shane Springer and Senator Shelli Yoder,

I. Call to Order

Lindsey Lux, OMPP Chief of Staff and Deputy Director, called the meeting to order at 1:01 p.m.

II. Approval of February 2023 Minutes

Ms. Lux invited a motion to approve the February 23, 2023, meeting minutes. Mr. Herb Hunter moved to approve. A second was received and the minutes were approved with no changes.

III. MAC Updates

Ms. Lux asked in person MAC members to introduce themselves and virtual members to register their attendance and affiliation in the Zoom chat.

IV. Rules

Ms. Lux introduced Ms. Amanda DeRoss, FSSA staff attorney, to present several rules.
Ms. DeRoss gave a brief overview of each rule and where it is in the promulgation process.

The Program Integrity Rule (LSA 22-253) will amend 405 IAC 1-1.4-2(a)(2) to include the carve out that services provided by a CMHC do not have to be documented at the time of service, but instead must be documented within thirty (30) days or before the service is billed to Medicaid, whichever comes first. The final rule was filed with the Indiana Register for publication on April 24, 2023, and became effective today, May 24, 2023. Ms. DeRoss invited questions. There were none.

The FQHC Rule (LSA 22-392) will amend 405 IAC 5-16-5 to revise the list of FQHC and RHC practitioners under the Medicaid PPS reimbursement methodology. The rule was submitted to the Office of the Attorney General on May 17, 2023, for review and approval. Once the Office of Attorney General reviews and approves the rule, the rule will be submitted to the Governor's Office for review. Ms. DeRoss invited questions. There were none.

The HAF Rule (LSA 22-369) amends 405 IAC 1-8-5 and 405 IAC 1-10.5-7 to extend the hospital assessment fee that is imposed on certain hospitals. The rule was submitted to the Office of the Attorney General on May 8, 2023, for review and approval. Once the Office of the Attorney General

reviews and approves the rule, the rule will be submitted to the Governor's Office for review. Ms. DeRoss invited questions. There were none.

The Postpartum Rule (LSA 23-366) amends 405 IAC 10-4-6(c) to extend the postpartum coverage under Medicaid from 60 days to 12 months. The Notice of Intent to Adopt a Rule was published on May 10, 2023. Rulemaking documents were submitted to SBA, IEDC, and the legislative council for review and approval on May 15, 2023. Once FSSA receives approval from SBA and IEDC, we will publish the proposed rule and Economic Impact Statement with the Indiana Register in order to obtain a date for the Notice of Public Hearing. Ms. DeRoss invited questions. There were none.

The Electronic Prescription Signatures Rule (LSA 23-367) amends 405 IAC 5-24-8 to clarify language to include electronic signatures. The Notice of Intend to Adopt a Rule was published on May 10, 2023. Rulemaking documents were submitted to SBA, IEDC, and the legislative council for review and approval on May 15, 2023. Once FSSA receives approval from SBA and IEDC, we will publish the proposed rule and Economic Impact Statement with the Indiana Register in order to obtain a date for the Notice of Public Hearing. Ms. DeRoss invited questions. There were none.

V. FSSA Updates

1. *Return to normal operations – Nonis Spinner, OMPP Director of Eligibility and Member Services and Brian Arrowood, FSSA Chief Information Officer*

(slide 2) Indiana's monthly Medicaid enrollment has grown to more than two million people since the beginning of the pandemic. One in three Hoosiers are Medicaid members. The impact of the eligibility actions will be felt by many Hoosiers, so strong partnerships are necessary to get the word out to these individuals.

(slide 3) As of April 2023, regular determinations of coverage have begun again and actions to adjust, reduce or eliminate coverage are being allowed. States have twelve months to initiate renewals for their Medicaid population and an additional two months to finish up renewal processing. Indiana will process roughly 1/12 of the state's total renewals each month. This plan allows us to manage the workload and ensure we are able to conduct outreach and follow up as each month's group comes due for their renewals and is processed.

(slide 4) In December 2022, FSSA began sending informational postcards to Medicaid members asking them to update their contact information. Initial warning letters were mailed in February 2023 to those FSSA hadn't heard from during the PHE and wanted to make sure they understood they would be receiving a renewal mailer and the actions they need to take in order to keep Medicaid coverage. Renewal correspondences began in mid-March 2023 for those with redeterminations in April. If someone didn't respond to that mailer, the first possible date they would lose coverage was May 1, 2023. This process will continue with a new cohort each month until May 1, 2024, when all of the work to return to normal will be finished.

(slide 5) This slide details a sample renewal notice timeline for individuals due for redetermination on April 30, 2023. In mid-March 2023, FSSA sent renewal correspondence detailing the action/s

members needed to take to renew their eligibility or face loss of coverage on May 1, 2023. If they were closed on May 1 because they didn't respond to the mailer, they didn't sign it or return the information FSSA requested, there is a 90-day reconsideration grace period for late renewals to come into compliance without having to reapply.

(slide 6) On March 17, 2023, FSSA sent redetermination packets to 157,688 members due for redetermination in April 2023. Of these, 65,092 members were successfully renewed, 40,752 of these were auto-renewed meaning the member did not have to supply any additional documentation. Additional reminder outreach was conducted via text messages to 39,057 individuals, 15,176 outbound calls and 16,624 emails. Members who auto renewed did not receive additional outreach.

(slide 7) This slide details Indiana's monthly renewals as of the end of April pulled from the Kaiser Family Foundation's analysis of state monthly unwinding reports to CMS. Those in dark blue show auto-renewals, light blue shows those who sent back their mailers. Those in orange were not renewed, however the vast majority of them have 90 days to submit information to come back into compliance. and those in grey did not complete the renewal process (39,611).

(slides 8-9) These slides show Indiana is one of only nine states meeting most, if not all, of nine key metrics to promote continued coverage during the unwinding process. 1. Will complete all renewals in 12-14 months. 2. Follows up with enrollees who need to take action to maintain coverage. 3. Renewal processing is mostly automated. 4. Fifty percent or more of renewals are conducted on an ex parte basis. This is where the member doesn't have to take any steps, they are automatically renewed. 5. Has taken steps to improve ex parte renewal rates. 6. Adopted Medicaid expansion. 7. Adopted 12-month postpartum coverage. When the survey used to create the map was conducted, Indiana met these seven of the eight criteria. We will soon be in compliance with the eighth thanks to this year's General Assembly's passage of 12-month continuous eligibility for all children up to age 19 in Medicaid and CHIP.

(slides 10-11) These slides show screenshots of the IN.gov/Medicaid website which features a special "how a return to normal will impact some Indiana Medicaid members" section. There are a variety of videos. The "jump to" section features a variety of resources related to redetermination.

(slides 12-13) These slides provide samples of the free outreach materials that can be ordered from FSSA to spread the word about redetermination.

(slide 14) This slide provides information about what stakeholders can do right now including attending the next stakeholder meeting on June 6 at 11 a.m., signing up for updates and general information (not detailed client issues) at PHEStakeholders@fssa.in.gov, including information in newsletters and other communications, displaying and distributing posters, postcards and/or flyers, using social media to help educate Hoosiers who may be at risk of losing coverage and encouraging Medicaid members to update their contact information, watch their mail and respond when FSSA reaches out.

Questions/Comments

Q: For someone who was due in April for redetermination, what was the first possible date they could lose coverage?
FSSA: May 1.

Q: How does the math add up for the outreach?
FSSA: There may be multiple people in households. For individuals who auto-renewed, no additional outreach occurred. For everyone with a phone number, we did additional phone calls/text follow ups. Unfortunately, we don't have good phone numbers for all of our members. There could also be multiple Medicaid members in a household and we wouldn't call them all.

Q: Will they roll off on May 1 if they haven't renewed?
FSSA: Yes.
Q: So they could be reinstated, but they would have to do the work within 90 days?
FSSA: If they have their mailer, they just need to return it. It extends the due date. They would lose coverage. But for everyone, except HIP because HIP doesn't allow for retroactive coverage based on the design of the program, we will fill in that coverage gap when they closed with Medicaid.

Q: If there are troubles with phone numbers, are there also issues with addresses?
FSSA: Correct contact information is critical. So our efforts have been centered around making sure that people know they need to update their information. We are sending mailers first class which can be forwarded by USPS.

Q: There were 92,000+ members who were not renewed? What other communication methods are we using to reach them? How many have come back as no contact/no forwarding address? How many people have we not be able to reach at all because of mailer being returned, text message doesn't go through or we don't have a number? How many have come back from the post office with no forwarding address?
FSSA: FSSA has conducted several stakeholder meetings and used them as the vehicles to reach out. We also use our MCEs partners as well and have marketing efforts to reach out. We know how many did not return the mailer, but we do not know how many never received it or how many received it and decided not to return it. Unless it's someone who does not have a forwarding address with USPS, we do not receive immediate information about that. DFR does not track returned mail, so we do not know how many members received the redetermination packets and did not respond. We utilize SNAP and TANF data.

Q: What came of using other state agency information (DOR, BMV, DNR, etc) to find individuals for whom FSSA doesn't have an address?
FSSA: There are federal requirements for what address we can use to contact individuals. We are required to use the address we have on file. If we have a potential address for an individual, we have to reach out to them ahead of time to confirm they want to receive their Medicaid information at that address. We are not allowed to send out medical/HIPAA related due to addresses members have not provided to us.

Q: USPS can forward mail to an address a member may not have lived at in months, but you can't use address information a member provided to another state agency?
FSSA: We have a waiver in place with CMS accept information directly from our managed care partners and act on that immediately which we've never been able to do before. And we are also accepting the national change of address information from USPS through an electronic data match that we can take and also act on immediately.

Q: Regarding HIP retroactive coverage, don't we have the ability to waive that? Shouldn't we look into that?
FSSA: We did not see where that was a waiver available to us because of the public health emergency. It would have been a separate waiver we would have had to have asked for in our 1115. We can take this back and look into it as an option. It was not part of the package of PHE waivers available to us.

Q: Are the numbers we saw in April representative of 1/12 of the redeterminations or were more than 1/12 reviewed in April?
FSSA: Roughly 1/12 were reviewed.

Q: Are there other languages for the fliers besides Spanish and Burmese? Arabic and Haitian Creole have been requested by our members.
FSSA: At this time, these are the languages we have, as well as large print. If there are other languages we should consider, please email PHEstakeholders@fssa.in.gov.

Q: Is there a particular statute or law where we can go to read about the address policy?
FSSA: This will be provided in the meeting minutes (see below).
FSSA: Federal law, HIPAA, prevents us from mailing Medicaid mailers to addresses we did not get from the client or as permitted by the CMS waiver.

Q: For those who lost coverage for not signing a document, will that reasoning be included in a closure notice?
FSSA: Closure notices will have a reason code. There may not be one for "failure to sign mailer" but there is a code for "failure to complete the mailer."

Q: If FSSA can get addresses from other agencies, can the state send a mailer asking the member to update their information without including medical details?
FSSA: We will need to look into this.

Q: When you say "procedural reasons," does this mean they haven't returned their information to FSSA?
FSSA: Yes. They have not returned a completed mailer. We follow up with those individuals who did not complete their process via phone calls and emails.

Q: The people in orange who have rolled off, are you actively trying to reach them in that 90 days?
Q: Have they rolled off?

FSSA: They do not have coverage, but they have the ability to have the closure rescinded. We are doing phone calls, emails if we have an email address, and any in managed care are also getting outreach from their MCE.

Q: Is FSSA tracking the churn?
FSSA: We are still working on some of our dashboarding. But we will be able to see of those who were due in April, how many came back in month 1, in month 2 and in month 3.

Q: If they are terminated for procedural reasons, they have 90 days from the termination date to complete whatever is missing? But coverage will not be retroactive during that 90 days?
FSSA: Yes, it would depend on when they come back into compliance. HIP is different and it's very important that those HIP members respond as soon as possible because we can't fill in gap in coverage.

Q: For those who aren't in HIP 2.0, will they have retroactive coverage?
FSSA: Yes, once we receive their mailer and process it, we will open it. For example, if they closed on 5/1 and we get their mailer at the end of June, we would open them back to 5/1, so there's no gap.

Q: Regarding the HIP population, whom does it benefit to not provide retroactive coverage? Should we look at this even though it was established previously? Why didn't FSSA anticipate that we would have individuals terminated for procedural reasons and that they wouldn't be able to get retroactive coverage if they were in HIP 2.0? Can we do an 1115 waiver now?
FSSA: This was part of the HIP waiver when it was designed and approved. It wasn't part of the package of PHE waivers available to us. It is something that is part of the HIP program. We can look into it. However, 1115 waivers are an 18-month process. We understand that is not what you want to hear, but that is the reasoning behind it.

C: These numbers are disturbing.
FSSA: We are working very hard to get the information out. One thing we do recognize is that when it starts happening to people you know who are Medicaid, it becomes more "real" to members. We hope this will help improve response rates. Again, we are reaching out to all our community partners to get the message out and to make sure everyone understands what is happening.

Q: Are we tracking the consequences of those who fail to be redetermined in terms of the cost to the program overall? For example, how many members to the emergency room rather than a regular physician had they had coverage? There are costs to not having people in plans.
FSSA: We are very early in the process of collecting data. CMS is also collecting data and will share that with us regarding how many people sign up for coverage through the Marketplace and through employer-sponsored insurance. Again we are very early in the process and there are a lot of moving parts and pieces.

Q: When does continuous eligibility for children up to age 19 begin?
FSSA: Federally on January 1, 2024.

Q: Are you tracking demographics for those who are renewed (ages, geography, English as a second language, etc.? Do we have an age breakdown?
FSSA: We are working on dashboarding and organizing some of that information internally. We are also working on a public dashboard because we know stakeholders are very interested in seeing where the hotspots are and where they should be focusing their energies to be most effective. We do not have age-specific information yet.

Q: What is the plan for tracking people who have been disenrolled?
FSSA: CMS plans to provide information on Marketplace coverage in July with more details in September. We will be tracking employed and uninsured members, but we won't have granular data to follow individuals. Once they are gone from Medicaid, we lose visibility.

Q: Can you partner with the hospital association since these people are going to keep seeking healthcare and have to share their social security number? Will there be reports about this at future MAC meetings?
FSSA: We will be able to look into presumptive eligibility and would be able to see if they did have Medicaid. We can take this back. The enrollment data tracks PE, in different categories and aggregate numbers. Our monthly Medicaid report is posted online.

Q: I'd like to know how many people lose coverage through our redetermination process and then show up in Medicaid again. This tells an important story and can inform future policy-making about who is falling through the cracks.
FSSA: We can track some of this information. When you sign up for PE, you aren't required to give your social security number. So for those who do, that is a good data point that we can share.
C: This is important because if we have tens of thousands in this first cohort who lose coverage and then six months later show up on the radar again, that should be a flashing red light to inform policy.

Q: Regarding the Indiana monthly Medicaid enrollment chart on slide 2, is that real growth or is that COVID? Are we expecting a drop off? Do you have any estimates on that?
FSSA: This is real growth. We don't expect that every single individual will lose coverage. Until we are a few months in, we won't know trends. We do expect this number to fall off as we continue redeterminations. We are estimating about 400,000 to disenroll. We expect April 2023 to be the peak and the number to begin to drop off over the next twelve months. This is a forecast, though, and we need to look at the numbers closely.

Q: Do we know the ages of individuals in the Indiana monthly Medicaid enrollment chart?
FSSA: We don't have that information now. We will work on getting it on some public dashboards and sharing it once it is available.

Q: Going back to disenrollment, where is the 400,000 coming from versus the 650,000?
FSSA: This was at a point in time at the end of April. We hope a lot of those who missed the deadline will still return their information and we will not have as many disenrollments.

Q: Will this be a continued pattern? For example, letters are going out now to those who would typically need to reenroll in June. Those who need to reenroll in July would get a letter in June?
FSSA: Yes.

2. ***Indiana Pathways for Aging/MLTSS update – Shannon Effler, OMPP Director of Care Programs and Karen McKinney, Indiana Pathways for Aging and Hoosier Care Connect Director***

(slides 2-3) Shannon Effler introduced herself and Karen McKinney to MAC members and provided an overview of the presentation.

(slide 4) Indiana Pathways for Aging, abbreviated Pathways, is the state's new risk-based managed care long term services and supports program for enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability.

(slide 5) The overall objective of Indiana's long term services and supports reform is to ensure 75% of new LTSS members will live and receive services in a home and community-based setting. This involves faster eligibility, the move to Pathways in 2024, paying providers for outcomes not transactions, integrating LTSS data systems, supporting the growth, retention and training of the HCBS direct service workforce, creating a home health roadmap, and integrating HCBS waivers.

(slides 6-7) On March 1, 2023 following a competitive procurement process (IDOA RFP 23-72118), four MCEs were recommended for award—Anthem Blue Cross Blue Shield, Humana Healthy Horizons in Indiana, Molina Healthcare of Indiana, and United Healthcare Community Plan. Both Humana and Molina are new to the Indiana Health Coverage Program. All MCEs have Medicaid experience and LTSS program experience. Additionally, Anthem, Humana and United Healthcare also have Indiana D-SNP (dually eligible special needs plan) experience. They all have to pass readiness review before being contracted to provide services.

(slide 8) This slide depicts the managed care implementation timeline Indiana Medicaid is following. From March-June 2023, FSSA is engaging the MCEs in onboarding, technical assistance and readiness review planning. From July 2023-June 2024, MCEs will undergo readiness review including nine months of testing with system vendors, to determine whether they are ready for the July 2024 go live. Then from July 2024-December 2024, MCEs will undergo post-implementation monitoring.

(slide 9) Stakeholder engagement has been and continues to be essential to Indiana's LTSS reform efforts. Since the end of 2020, more than 600 meetings have been conducted to inform the design, development and implementation of Pathways, to promote buy-in and support for the effort, and to ensure organizations are prepared to have a successful transition to Pathways. FSSA is pleased to share that 92% of stakeholder considerations were fully or partially incorporated into the LTSS design.

(slide 10) In partnership with Advancing States, FSSA hosted in-person and virtual HCBS provider and MCE roundtables across Indiana in late April and early May. These roundtables allowed HCBS providers to meet with MCEs and learn about topics like enrollment and claims processing. More than 650 individuals participated and FSSA will continue provider engagement. Information for providers is available at www.informindiana.com.

(slide 11) From March-June 2023, FSSA is proactively onboarding the four Pathways MCEs prior to initiating readiness review. MCEs will onboard with more than 20 FSSA agencies and business areas going over roles, responsibilities, and expectations. Additionally FSSA has provided each MCE with extensive Pathways documentation including scope of work, policy manual, service and care coordination manual, reporting manual, and assessments. FSSA business areas are providing MCEs with technical assistance or consulting, as needed.

(slides 12-16) Readiness review begins in July 2023 and is a systematic large-scale review of the MCE's staffing, policies, processes, documents, subcontracts, system capabilities, and provider network to ensure the health plan is prepared in advance of the July 2024 go live. This process answers the question "can the health plan deliver the Pathways program well?" To build out the readiness review requirements, OMPP conducted hundreds of external stakeholder meetings and leveraged internal FSSA staff feedback. To ensure consistency, MCE documents and readiness materials will be desk reviewed by at least two FSSA subject matter experts and at least 40 hours of live onsite readiness demonstrations will occur through the course of readiness review. OMPP has conducted readiness reviews for the last four contract implementations and continues to make enhancements to ensure the most effective process.

Questions/Comments

Q: Did the state get any stakeholder feedback during the RFP process?
FSSA: The state followed the standard RFP process. This is a confidential process that does not include stakeholder input on the selection of MCEs.

Q: Will FSSA share the feedback received from the HCBS MCE roundtables?
FSSA: We will present on Pathways at our next MAC meeting.

Q: Could you provide insight on what you look for when you selected candidates to be MCEs and on the procurement process? Have you had an opportunity to compare their quality in other similar states? Have you ever had someone go through that process, gotten this far into it, and just not complete it? Could you turn the process around and determine if they have capacity at the beginning rather than the end of the process?
FSSA: We have not experienced that in managed care. The Indiana Department of Administration manages procurement and we have to follow their rules. We describe exactly what we want to see

from a bidder, they respond, and we evaluate that response. We can provide a link to the public RFP with more specifics but can't speak to the specifics of how we evaluate them. Generally, we look at their business model, what they put in the scope of work, and their quality metrics. Procurement teams get access to everything those bidders submit and there are references we can use. We are not in the marketplace researching.

Q: Can we as elected officials attend the HCBS roundtables before the rollout in July next year?
FSSA: This round has concluded and we don't currently have plans to hold more. But that's not to say that we won't hold more in the future. If we can open it up to others, we'll let you know.

C: FSSA has gone above and beyond to include stakeholders.
FSSA: Thank you.

Q: When will you schedule the stakeholder meetings during which we will review the various readiness review topics? We have an internal group of members we have assembled to review and provide feedback and will schedule our internal meetings around the FSSA stakeholder meetings.
FSSA: These are scheduled during the monthly Pathways co-design meetings. It's once a month at the end of the month.

3. Rate Matrix update – Kathleen Leonard, OMPP Director of Reimbursement and Actuarial Services

(slide 2) This slide, also presented during the February 2023 MAC meeting, details the initial "catch up" phases of the rate matrix for the 30% of Medicaid providers who do not have a schedule of regular rate reviews. HCBS, NEMT, dental services and physician services are shown as proposed by FSSA and included in the Governor's budget that was passed during the 2023 session. A more complete rate matrix document is available at the FSSA website.

(slide 3) Home and Community Based Services, including home health, will see rate increases. These are key to the Pathways work we are doing. Physician/professional services fee schedule will be aligned to 100% of Medicare rates. Strategic investments were approved for NEMT and dental services. And rate indexing which will provide rate adjustments (about 2% per year) between periodic rate reviews was also approved.

(slides 4-5) These slides provide a budget update for home and community based services. The investment for Division of Aging and DDRS for waiver services totals $746,600-$823,600 in state and federal dollars, and represent an aggregate 42.4% rate increase for Division of Aging and an aggregate 23.2% rate increase for DDRS. Additional state and federal funding of $79-$101 million was approved for home health services, which represents a rate increase of 32%. This funding is critical to supporting the Indiana Pathways for Aging program.

(slides 6-7) These slides outline the federally-mandated HIP equalization project that must be implemented on 1/1/2024 for Indiana to remain compliant. Although we began this project with a

"meet in the middle" approach, anticipating physician rates to be 80-83% of Medicare, all physician/professional services will be paid at 100% of Medicare (like HIP) thanks to this year's General Assembly. This is very important for access.

(slide 8) We are sharing the proposed rates with HCBS providers in late May/early June. We will submit waiver amendments to CMS in June/July with a target retroactive effective date of 7/1/23. We will submit rate methodology for physician/professional services to CMS for minimum fee schedule to be effective 1/1/24 for FFS and managed care programs. We will submit a rate increase for NEMT to CMS with a 7/1/23 effective date. And we are working with the Indiana Dental Association to determine how strategic investment in dental services will be incorporated into dental rate rebasing/HIP rate equalization for a 1/1/24 effective date.

Questions/Comments

Q: All programs will be aligned with the Medicare reimbursement rate?
FSSA: Yes, the physician/professional fee schedule is going to aligned with Medicare's reimbursement rate.

Q: But hospital are not included?
FSSA: Hospitals are already paid at 100% of Medicare via HAF.

Q: When was the last time the HAF changed? Why have I heard that these haven't been changed since the 1980s?
FSSA: Those are refreshed every year. We take a look at the average from all hospital admissions paid by Medicare. You might be thinking of the state base rate, which includes the supplemental program, which is just paid by the state. It was changed closer to 2011 rather than the 1980s. We can check on that.

Q: Regarding the reimbursement rate for dentists, we've heard some areas will see a decrease. Is that correct?
FSSA: The investment for dentists is a smaller amount—an aggregate 10% increase. NEMT is a 20% increase. Behavioral health is moving up to 100%. Our intent is to work with the IDA. First we need to rebase the rates because they are randomly aligned—some are high, others are low. We would like to strategically invest where it is needed. Some dental service rates will go up and others may go down. Currently we have some procedures paid above 100% of billed charges (that's too high for Medicaid) and others paid below 20% of billed charges. (Commercial is typically 70% of billed charges.) The goal is to align these.

Q: We have a dental crisis in Indiana. Providers don't want to take on Medicaid patients due to low rates. I'm hearing that FSSA's implementation regarding dental services could lead to a net loss in provider participation, is that correct? Some providers already "on the bubble" could receive even less?

FSSA: We need to work with the IDA to get a better sense of the providers "on the bubble" and how we can best utilize and balance out the money that has been allocated.

Q: Can't we do a restructuring and strategic investment in July 2023 instead of waiting until 2024 so it takes effect with the equalization project? I don't see a reason to wait.
FSSA: Our intent was to rebalance to meet federal compliance requirements and do it all at once rather than increasing now and decreasing later. The reason to wait is because we have a lot of work ahead to determine how rates will impact providers. We want to be methodical. We have to submit rates to CMS and won't receive a response until fall, then apply rates retroactively. Some other provider increases will be going into effect on 7/1/23. We are happy to have ongoing conversations regarding dental rates.

C: There is a disconnect between what many of us thought we passed and what it looks like regarding implementing.
C: IDA had a meeting with FSSA last week and we came away frustrated. HIP physicians will see an increase, but HIP dentists will not. Equalization is not good for dentists. Those that see HIP patients will see a decrease in their rates. IDA wants to see all dentists be at HIP rates.
Q: Have dentists ever been at 100%?
IDA: The HIP program paid out 130% of Medicaid.
Q: So that's what coming down?
IDA: Yes. We anticipate seeing an increase in the traditional Medicaid program, but at the expense of HIP. Even with the equalization and the strategic investments, HIP rates will be less than they are today. Our hope was that FSSA would bring all of the rates to HIP just like with physicians. But for whatever reason, dentistry will see HIP decrease to offset an increase in the other programs.
Q: When you say 130% of Medicaid, in reference to what dental reimbursement was, you are talking about 130% of the traditional fee for service Medicaid rate, which was an unreasonably low rate, correct?
IDA: Yes.

C: When we say physicians will be reimbursed at 100% of Medicare, that is an accepted benchmark that physicians have been able to build a business model on and accept HIP 2.0 patients. So it's really apples and oranges. It's 130% of an unreasonably low rate that does not attract provider participation is causing the dental crisis in Indiana.
IDA: That is a fair characterization. IDA invested time and effort providing testimony on the budget bill and the need for greater investment in Medicaid. We've seen a drop in provider participation in the program. We'll continue to work with Kathy and FSSA. But we are very frustrated and disappointed by this.
FSSA: FSSA's budget included strategic investments for home health, NEMT and dental. FSSA did not make a recommendation to increase physician rates; rather FSSA's was revenue neutral. The change to take physician rates to 100% of Medicare was a legislative change. Perhaps there was a thought that raising that to 100% of Medicare would also increase the dental rates. People may

think there is a dental Medicare rate and that would move up. There are opportunities to improve coordination moving forward.
C: It was critical to get physician reimbursement rates as close as possible to Medicare rates to attract physician participation ensuring access for members. We need to get dental to the place where we can attract and retain more providers.
FSSA: Yes, we have more work to do.

Q: FSSA had made recommendations in the budget for significant investments in dental, but not physicians. Now there could be an exodus of dentists. Can't we bump up the discussion of this issue before July and move the process along faster? If FSSA acknowledges there is an issue and we've seen the impact this could have, why aren't we more urgent in our response than waiting until January?
FSSA: We can take this back. In order to do any increases, we need to do a SPA and there are steps we have to take. We may not be in a position to do something before July, but we can see if we can do it sooner than 1/1/24.

C: Oral health is the gateway to overall health. We must address this to avoid large costs later.
FSSA: Equalization improves rates for children. Under HIP for adults, we could have decreases.

C: Thank you for the hard work and investment in HCBS.

C: There are no dentists in the Batesville area who see Medicaid patients. It is a dental desert.
IDA: Under this proposed funding, it's only going to get worse for the HIP population.

Q: What is the date for Medicaid reimbursement to be increased to physicians?
FSSA: The physician increase will be 1/1/24. This is a minimum fee schedule so the health plans are required to pay that amount. The fee schedule will be adjusted annually.

Q: Doesn't FSSA have to abide by the July 1 date in the budget? Physician providers don't want to take Medicaid patients.
FSSA: The July 1 date was for the waiver and other services, but for physicians it is January. We can validate that, but it is the timing we are looking at.
C: That was not my understanding nor the understanding of some of my fellow senators. I think you're going to get pushback on that because we tried to vote for a bill that we thought was going to address some of the provider reimbursement issues across the state, not just the dental issue. Physician providers are not wanting to take Medicaid patients which is a big issue. I've been interested in OBGYN issues. I would like to see FSSA respond to what was passed in the legislation.
FSSA: We will take that back. The HIP equalization plan has been a two-year process so we'll have to see if there is an opportunity to bump up the date. We will take this back to make sure we're setting the right expectations with constituents.
C: Thank you.

Q: Why was total dental investment cut in the matrix at the end of session when the total Medicaid matrix increased significantly? Why not bring all to at least HIP? Why didn't rebase happen before now?
FSSA: The recommended investments were put together in the fall and those specific ones were identified and approved. These were specified up front.

IDA: In the rate matrix that was introduced or proposed when the budget bill was in the House, the total provider investment was much smaller than what was ultimately appropriated by the General Assembly following the April forecast. Where did all the extra dollars go from the rate matrix?
FSSA: The additional money went to the home health and waiver providers. In the fall, there was a preliminary estimate on what rate increases would be needed. As we got into the spring, some of those numbers were updated. Also, in the fall initially the Governor's budget covered some of these rates at 80% and then ultimately the amount approved was 100%. That is what changed between what you saw in strategic investments in the December forecast and the one shown in April.

Q: Are there any other healthcare providers who will see their HIP reimbursements decrease other than dentists?
FSSA: Some of the other ancillary providers, for example nursing facilities that had an add on for HIP-that is going away, home health had an add-on for HIP and that is also going away. Hospice will get less of a HIP add on as well. So it's not just dental. But these others have lower HIP membership.

Q: When does the State submit the SPA for reimbursement rates to CMS?
FSSA: We submit SPAs at various times. The first batch will be June/July and the rest will be throughout the year. We have to submit HIP rate equalization methodology by June and all rates filed with them by October.

C: Just a comment to ensure pediatric well child codes that don't have a Medicare code equivalent will be included in rate equalization equations.
FSSA: Yes, we are looking at adjusting any rate that doesn't have a Medicare equivalent to make them comparable.

Q: Is it possible to make the dental reimbursement rates retroactive to 7/1/2023 even though implementation is 1/1/2024?
FSSA: We will take back and see.

C: The child program rate increases are on far obsolete rates.
C: As Rep. Clere said, the child program rate increases are on far obsolete rates.

Q: Will these slides be posted online?
FSSA: Yes.

Q: Is it time for the mental health behavioral rates?
FSSA: Behavior health rates that are paid through the physician/professional services fee schedule will be increased with the others. There are some other behavioral health services that are outside the HIP rate equalization and they would be looked at for the next biennium. We don't have specific dates on when we'd work on those.

VI. Comments

Ms. Lux invited additional questions/comments.

Denise Franklin/Claimaid: We are seeing issues that could be contributing to the number of disenrollments. There is a spike in authorized representative forms being able to be viewable by those at the call centers, which is hampering those advocates trying to help people keep their coverage. Has this been identified and is it being addressed? Additionally, we are seeing some issues with notices going out. For example, we had an advocate who assisted a patient with a new application who received a denial letter for failure to complete their redetermination form. We are concerned about the accuracy of some of the notices being sent. Finally, when we're reaching out to regional managers via email, frequently it's not the regional manager nor the state eligibility manager who receives. Rather it's being kicked down to eligibility consultants who have little in the way of being able to help. Are these issues FSSA is aware of? Are they being addressed?
FSSA: For public comments, we will address at our next meeting.

Q: Regarding disenrollment, at some point there is a 13-day requirement. If they were in orange, they receive a notice saying they have 13 days, right, to provide the missing information and if they don't do it within that period then the 90 days starts?
FSSA: When they get a redetermination mailer, they have a due date 30 days out, but we really wait about 45 days before we take any negative action. So it's not a 13-day due date. But when they get their notice, if they send something in before the effective date of the closure which would be 13 days in the future, then they can come back into compliance. But the 90 days supercede that even if they get that notice, they still get the 90 days if the reason they were closed was because they didn't turn something in.
Q: I think we'll see a very different experience in two populations. You have the fee for service population and the HIP 2.0 population. Is that the correct way to describe the two populations?
FSSA: It's HIP and everything else, like Hoosier Healthwise and Hoosier Care Connect.
Q: HIP is different because it doesn't have the retroactive coverage provision. So the 13 days is a lot harsher in effect for the HIP 2.0 participant, correct?
FSSA: Yes, it's more important for them to get things returned more timely.
Q: Thirteen days isn't very much time if they have to look for documents, contact a previous employer to get a paystub, W2 or something, that may not be feasible within the 13 day window. And they would lose coverage.
FSSA: They did get the mailer 45 days before then which outlines everything they need to turn in. The 13 days is added on to the 45 days they've already had.
Q: Could they have been responsive to the 45 day mailer and sent something that wasn't adequate?

FSSA: If someone responds to the mailer and they haven't provided enough information, DFR will send out another request. Is that what you're referring to?
Q: Maybe. If we can't do something in the near term about the 90 days because that would require potentially an 18 month amendment process, can we do something about the 13 days for the HIP population?
FSSA: We'll take that back.

Q: Can we?
FSSA: I am not certain. We will have to take that back and look at it to see if there are other alternatives we can do here.
Q: What would be the level of decision-making that would be needed to make this happen? Can it be done internally within FSSA or how would that decision be made?
FSSA: This is the first I have heard of it, so we will need to do some more analysis about what it would need.

Q: Are there any other policy changes or anything else we're thinking about that may mitigate these disenrollment numbers?
FSSA: As we go through this process we will learn and will find things we can do better. We are open to considering anything that will help.
C: We don't want to learn at other people's expense.

C: IPHCA and Health Centers are furthering our exploration of opportunities around value-based care for the Medicaid population/health center patients and look forward to engaging with Medicaid and the MAC as we progress in our discussions.

VII. Next meeting

There will be a special MAC meeting on July 26, 2023 for the annual HIP, SUD and SMI waiver update and no regular MAC business will be conducted. Ms. Lux indicated today's planned presentation from the managed care entities will be done at the August 23 regular quarterly meeting. The final meeting of 2023 will be November 29.

With no further business to conduct, the meeting adjourned at 3:01 p.m.