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

August 27, 2020
Virtual meeting via AdobeConnect

Members Present

Mr. Grant Achenbach, Dr. Leila Alter, Ms. Tabitha Arnett, Rep. Brad Barrett, Senator Jean Breaux, Mr. Matthew Brooks (Co-Chair), Senator Liz Brown, Rep. Chris Campbell, Sen. Ed Charbonneau, Mr. Michael Colby, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Rep. Rita Fleming, Senator J.D. Ford, Dr. Heather Fretwell, Mr. Herb Hunter, Ms. Rachel Halleck, Mr. Herb Hunter, Rep. Cindy Kirchhofer, Ms. Barbara McNutt, Mr. Evan Reinhardt, Rep. Robin Shackleford, 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 10:00 a.m. and welcomed members and guests. He advised attendees that the MAC is a statutorily required meeting. Due to COVID-19 guidelines, today's meeting is being conducted virtually. Mr. Brooks asked all MAC members to register their attendance in the chat room and Co-Chair Allison Taylor provided brief instructions about navigating the virtual platform.

II. Approval of February Minutes

Co-Chair Brooks invited approval of the February 2020 meeting minutes. Mr. Herb Hunter moved to approve and Ms. Kathy Stafford-Cunningham seconded. The minutes were approved with no changes.

III. MAC Updates

Co-Chair Taylor thanked the members for their service on the committee. She invited them to review their information on the updated MAC member list and to notify Laura Dodson of any changes. She indicated the next MAC meeting will be November 17 and will likely be virtual again. The Office will notify members closer to the date.

IV. Rules

Ms. Chelsea Princell, Staff Attorney for FSSA, presented an update on LSA 19-602 (Article 2 Cleanup Rule). This rule amends 405 IAC 2 to change its current rules to impacting Medicaid eligibility. The amendment adds criteria for post-eligibility treatment of income for members receiving home and community based service waivers. It creates eligibility criteria for End Stage Renal Disease services for members that are not otherwise eligible under the Medicaid state plan. This rule implements new Medicaid financial eligibility requirements under Modified Adjusted Gross Income standards, updates the real property resource criteria for purposes of determining eligibility and updates the rule to conform to the most current supplemental security income (SSI) policies. It amends the rule to conform to state law at IC 12-15-3-8 regarding college savings accounts and clarifies policy regarding burial spaces and

funeral expenses. This rule establishes a Medicaid eligibility category for former foster care children and removes the expiration date of 405 IAC 2-8-1.1. Finally, this rule updates definitions and terminology and removes outdated references and amends the presumptive eligibility criteria and process. The public hearing was held on August 13, 2020 and received oral comment and written comment. OMPP, with the help of OGC, is currently reviewing the comment to determine whether any changes should be made to the proposed rule as a result. After making any necessary changes to the rule and gaining approval from Dr. Sullivan, the rule will be submitted to the Office of the Attorney General for approval. Ms. Princell invited questions. There were none.

V. FSSA Updates

Co-Chair Taylor indicated the topics being covered today—COVID-19 response, telemedicine and electronic visit verification (EVV)—are three important efforts at the top of the Office's "to do" list. She briefly reflected about the many changes that have occurred over the past six months and the resilience of the Office's team to reorient workflow to meet the changing needs of Medicaid members and providers and to begin thinking about how to solve the bigger problems that have been unearthed during the pandemic. The Office is committed to fully maximizing all Medicaid resources throughout the pandemic and during the recovery phase.

1. COVID-19 Response – Gabrielle Koenig, Government Affairs Director

Ms. Koenig presented information regarding the authorities the state leveraged during the public health emergency (PHE), the general policy response to COVID-19, and the impact of the PHE. At the time of the MAC meeting, the PHE was set to expire on October 22, 2019.

The state is using an 1135 waiver of the Social Security Act, a 1915(c) Appendix K waiver, an 1115 Emergency Demonstration waiver, and a disaster relief state plan amendment to provide flexibilities to respond to the changing demands of the PHE.

Under the 1135 waiver, certain Medicaid and Children's Health Insurance Program (CHIP) requirements can be temporarily waived or modified to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the emergency area and during the emergency time periods. Additionally, it ensures that providers who provide such services in good faith can be reimbursed and exempted from sanctions. The Office requested this waiver in mid-March, and CMS approved the request shortly after.

The Office worked very closely with FSSA's Division of Aging and Division of Disability and Rehabilitative Services on the 1915(c) Appendix K waiver. The Appendix K allowed the state to modify or remove some of the restrictions outlined in our Home- and Community-Based Services (HCBS) waivers in order to maintain access to care for members and ensuring the federal match even with these changes on our limitations. The Office requested and received federal approval in April.

The 1115 Emergency Demonstration waiver is a more recent piece of the Office's COVID-19 response, and we are negotiating with the federal government now. The intention is to implement a streamlined HCBS/Medicaid eligibility process that will identify individuals likely to meet regular HCBS/Medicaid eligibility criteria and allow providers to initiate HCBS services for those individuals while they continue to engage in the full eligibility process. The expedited process will reduce unnecessary hospital and nursing facility stays due to a lack of care options during the PHE and allow people to remain in their homes by increasing access to HCBS supports before a person is in a nursing facility. The demonstration will operate as a pilot program, and we have identified a limited number of specific high need areas that will be targeted.

The disaster relief state plan amendment provides flexibilities, as well as continuing federal funding whenever our COVID-19 policies differed from those outlined in our state plan filed with the federal government. Some of the flexibilities included: expanded telemedicine capabilities and pharmacy benefits, suspension of cost-sharing for members, delayed eligibility redeterminations, extended timely filing period for managed care entities, modifications to prior authorization components in some categories, pausing termination of benefits for members, and adding coverage for numerous COVID-19 specific codes.

To help providers better identify COVID-19 modifications, the Office released more than 40 COVID-19 specific bulletins, produced numerous FAQ documents, and conducted 5 COVID-19 specific webinars in a 5-week span. The Provider Services Team continues to conduct at least one webinar each month and release materials to help providers navigate.

The Families First Coronavirus Response Act (FFRCA) provides a temporary funding increase of 6.2% in federal matching funds for the length of the PHE for states that: (1) do not dis-enroll a member unless that member moves out of state, asks to be dis-enrolled, or dies; (2) does not move a member to a category with a lesser amount of coverage; (3) does not impose a higher level of cost sharing than was in place in January 2020; and (4) does not impose cost sharing for COVID-19 testing or treatment. This applies to any member enrolled as of March 18, 2020.

Although there has been an increase of a little less than 200,000 members from July 2019 to July 2020, this increase can be attributed to a lack of closures rather than new applications.

At the conclusion of her presentation, Ms. Koenig invited questions.

Co-Chair Brooks asked for clarification regarding closures rather than new Medicaid applications. Co-Chair Taylor responded that this phenomenon is not unique to Indiana and has been seen nationally. She is unsure whether this will continue to be the case as the PHE continues. Co-Chair Brooks requested and Co-Chair Taylor agreed that providing enrollment data at a future MAC meeting could be appropriate.

Questions asked in virtual chat room

Q: Sen. Breaux—How are nursing home residents affected by these waivers?
A: Ms. Taylor—The waivers afforded providers, including nursing facilities, with flexibilities to navigate the health emergency. We can provide a little more detail during discussion.
A: Ms. Natalie Angel (Deputy Director of Operations)—The goal of this waiver was to provide flexibility and ease restrictions and administrative burden when moving people between hospitals and nursing facilities in light of the PHE. For example, if a hospital were to become overwhelmed with COVID cases, the hospital could easily transition patients to a different location, like a nursing facility, and ease administrative burden when a nursing facility transferred patients to hospitals. Fortunately, Indiana's hospitals have not been overrun and we have not had to implement this. But the flexibility is there, just in case.

Q: Ms. Eichhorn—What is the timeline for the 1115 waiver? Could you expand on "limited target population" for aging and disability? What qualifies members for this pilot? How are you identifying members for the pilot? If the pilot is successful, is there a possibility of making this expedited process permanent? Are there any assisted living providers in the pilot?
A: Ms. Angel—We hope to start operations in October and then end is dependent on the conclusion of the PHE. We can run about two months past the end of the PHE. The pilot's goal is to create an expedited eligibility process for those age 65 and older who do not currently have Medicaid, but who really need home and community based services (HCBS). This will allow for an expedited eligibility processing for both Medicaid and HCBS waiver eligibility so that services would start within 10 days. This is a small pilot program (a few hundred people). But, if successful, we hope to grow the pilot program. We are identifying pilot provider sites and will be offering training. Those pilot provider sites are identifying members to participate. There is one assisted living provider in the pilot.

Q: Sen. Brown—The requirement was to cover all COVID-19 related costs. How many Medicaid patients had COVID costs outside of testing? This is an important data point if we want to know, for future public health spending, how many patients in this sector were affected.
A: Ms. Koenig and Ms. Taylor—The Office reported they did not have that information at this time.

Q: Rep. Fleming—Are there waivers or other assistance to family members who decide to keep their elderly family members at home for fear of greater risk of COVID-19 exposure to their loved ones?
A: Ms. Angel—In a limited way, the pilot project does address this for families wishing to keep their loved ones, who require higher levels of care, at home. But there is not a more expansive policy.

Q: Amanda—Is the waiver publicly available?
Drafter's note: The Office and CMS determined post-MAC meeting that a waiver was not required, thus the pilot is being operated under existing Medicaid authority.

Ms. Taylor commented that Indiana reached out to coastal states to learn how to do disaster spas. This was the first time at a nation-wide level that states pursued disaster authority. We learned a lot and special thanks to the OMPP team for keeping providers informed at the rate of change. The provider community was very engaged and helpful in providing real-time information from their channels.

Q: Sen. Breaux—All the Medicaid components that been suspended, such as cost sharing, do those provisions come to an end in October?
A: Ms. Koenig—Yes, the cost-sharing provision would come to an end at the end of the PHE.

Q: Rep. Brad Barrett—Will the telehealth expansions expire at the end of the PHE in October?
A: Ms. Taylor—We may have some flexibilities on some telehealth authorities, but do not have particulars at this time.

2. Telehealth – Lindsay Baywol, Policy Developer

Ms. Baywol presented the Office's previous telehealth policy, data results on current increases in telehealth usage as a result of Covid-19, and the move forward plan for revising the telehealth strategy.

According to Indiana Code and Indiana Administrative Code, telemedicine services are defined as the use of videoconferencing equipment to allow a medical provider to render an exam or other service to a patient at a distant location. Example: Facetiming your doctor in real-time. Telehealth is the remote monitoring of clinical data through equipment in a member's home to be used by a home health agency. Prior to the PHE, there were limitations for providers and services. But the PHE and executive order relaxed the limitations so telehealth services could expand.

As we have been considering changes to telehealth policy, we examined claims data using the pre-PHE code set between 2019 and 2020 and found a large increase in telehealth service claims. In 2019, the most commonly billed telehealth service was treatment of speech, language and voice concerns. In 2020, behavioral health services were the most billed, indicating the high demand for these services during the PHE. In both 2019 and 2020, mental health providers submitted the majority of claims. But in 2020, there was also a large increase in claims submitted by physicians and clinics.

To further understand providers' perspectives regarding telehealth, we asked providers to respond to a survey in early June and received more than 1300 responses. The key takeaway from the survey: 93% of providers would be interested in conducting video telehealth visits after the PHE ends if provided the equipment and technical assistance.

Providers identified the following barriers to telehealth: (1) technology issues including no access to devices, bad internet connection, limited minutes/data on devices, and limited

understanding of how best to use technology; (2) effectiveness/quality of telehealth vs. in-person care; (3) communication issues including hearing impaired people unable to read lips or use ASL (need interpreter), English not a first language (need interpreter); (4) client/family preference in using technology; and (5) maintaining privacy/confidentiality.
Providers also identified positives of telehealth including: (1) increased family/client engagement; (2) no need for transportation to and from appointments; (3) convenience—no waiting rooms for patients and improved scheduling options for providers.

We formed an internal telehealth workgroup and conducted the first meeting in July. The overall goal of the group is to improve Indiana's telehealth services by answering these questions: (1) What services can be provided through telehealth? (2) Which providers can utilize telehealth? (3) What coverage can be offered via telephone/audio-only? (4) How do we update our "Telemedicine" and "Telehealth" terminology? We will schedule an internal meeting for FSSA divisions so we can compile their feedback and also identify the Indiana code changes needed to update our telehealth policies. We will also request feedback from other stakeholders (MCEs, providers and members) as we consider long-term changes.

At the conclusion of her presentation, Ms. Baywol invited questions.

Mr. Brooks affirmed the findings of the telehealth survey.

Questions asked in virtual chat room

Q: Rep. Barrett—Has the telehealth expansion been budget neutral? Has there been a shift from in-office visits to telemedicine visits?
A: Ms. Baywol—We have not visited the fiscal impacts yet. We will circle back about this issue in the future.

Q: Mr. Steve McCaffrey—Have you tracked the use of telehealth for behavioral health therapy to insure comprehensive services in addition to telehealth like medication adherence and other services?
A: Ms. Baywol—We have not yet been able to evaluate the quality of medicine provided through telehealth.
A: Ms. Taylor—This is a good question to be considered by our SUD (substance use disorder) workgroup because of the clinical focus.
A: Mr. Brooks—We need to be able to show outcome data.

Q: Sen. Charbonneau—What is the timeline for coming up with recommendations for changes to the telemedicine statutes moving forward?
A: Ms. Taylor--We are in the active research/learning phase to better understand the current statutes. So there is no timeline at this point.

Q: Ms. Arnett—Have we seen an increase in the percentage of errors (misdiagnosis) with the increase/volume of telemedicine?

A: Ms. Taylor—We do not have data about this yet, but it is a good point. Good to consider within the state as well as nationally.

Q: Sen. Charbonneau—Are you aware of any problems that have been incurred using telehealth?
A: Ms. Baywol—We are not aware of any problems other than the barriers discussed during the presentation.
A: Ms. Taylor—We want to be thoughtful and always keep the Medicaid member first.

Ms. Baywol concluded her presentation by indicating FSSA's Division of Mental Health and Addiction has heard from providers that patients are attending their appointments more than they were before telehealth became an option. Additionally, some addiction treatment providers have said their patients are being more honest with them about how they are dealing with their take-home doses of medications.

3. Electronic Visit Verification (EVV) – Michael Cook, Provider Services section

Ms. Taylor set the stage by commenting that this EVV program update is important for MAC members to know and understand. This is national requirement generated by federal legislation and we've been working on it for several years. In partnership with industry, Indiana received a good faith effort extension to implement, but that extension is coming to an end and the requirement for compliance will go into effect on January 1, 2021. It is important to get the message out to all providers that this is required and will impact reimbursement if not followed.

Mr. Brooks commented that the goals of the program are understandable, but there is a cost in the form of administrative burden.

Mr. Cook began the presentation by indicating EVV is required by the 21st Century Cures Act and Section 1903(l) of the Social Security Act and requires providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered. Impacted services include respite, unskilled respite, attendant and homemaker services, services for ADLs and IADLs. It is effective January 1, 2021 for personal care services providers, and January 1, 2023 for home health services providers. The goal is to improve the overall quality of services by reducing fraud, waste and abuse and ensuring services are billed according to services authorized and performed.

EVV captures six data points: (1) type of service performed, (2) individual receiving the service, (3) date of service, (4) location of service delivery, (5) individual providing the service, and (6) the time the service begins and ends. Beginning January 1, 2021, all claims submitted for services provided in the home must be accompanied by an EVV record or they will not be reimbursed.

The Indiana Health Coverage Programs (IHCP) uses the open vendor model for data capture. Providers can use Sandata, the state-sponsored EVV solution, or they can use an alternative EVV solution that satisfies the requirements from the 21st Century Cures Act.

The Office has worked with providers to educate them and get them ready for implementation. FSSA produced a two-page, step-by-step guide to EVV on the Indiana Medicaid website. Several years ago, the Office created an Electronic Visit Verification webpage, accessible through the Indiana Medicaid website, with FAQs, policies, and contact information. There is also a separate EVV training section located under the Provider Education tab, specifically for Sandata users.

Communication to providers has included: (1) 18 articles on EVV in IHCP publications from May 2018 through July 2020; (2) quarterly provider association/stakeholder meetings; (3) provider workshop sessions; and (4) various webinars, videos and other electronic means. We also created an EVV inbox for questions. In the last several months, we have conducted additional IHCP Live webinars. We have been making phone calls to providers directly. We have made ourselves available to participate in provider meetings to answer any questions that may come up.

Based on provider feedback we have received, we have modified some policies. For example, we no longer require a Medicaid member signature or voice recording as part of the EVV record. We have changed to a vendor-specific alternative EVV vendor approval process. Alternative EVV vendor users can now opt out of Sandata communications that were being sent to all users. And we have removed the Residential Habilitation (Daily) code set.

EVV impacts more than 900 enrolled locations and many providers are NOT ready. As of July 2020, 151 agencies have completed Sandata training. For those agencies using alternative EVV vendors, 47 have production credentials and are ready to submit EVV records; 31 have completed testing, but not moved to production; and 127 have requested testing.

On January 1, 2021, providers will see claims payment disruption for claims submitted without an EVV record. So providers must act now to be ready.

Following his presentation, Michael invited questions.

Questions asked in virtual chat room

Q: Ms. Stafford-Cunningham—What percentage of providers do you believe will be able to comply with the requirements by 1/1/21? And how do you anticipate that claim denials of those who cannot comply will impact the system capacity?
A: Ms. Taylor—We think that everyone will have the tools and time to plan and get ready/able, as we've been working on this for many, many months. Will all be ready to comply? No. We have some providers who are still not engaging and/or are not on a path to compliance.

Q: Mr. Michael Colby—What role, if any, does DXC have in assisting with EVV roll out? Are they assisting with provider education on EVV?

A: Mr. Cook—DXC has the contract with Sandata. Sandata has a system that stores EVV records that will interface with DXC's system, CORE MMIS. The systems will look for records and all information needed to process incoming claims. DXC has been a good partner for this effort overall. DXC is also assisting with provider education. Last fall, we set up 20-25 in-person Sandata trainings for providers that DXC conducted. And DXC has also been conducting virtual trainings. DXC also has a call center that assists providers with their technical questions about the Sandata system.

VI. Public Comments/Additional Questions

Mr. Brooks indicated today's presentations will be available on the MAC website.

Q: Ms. Stafford-Cunningham and Sen. Breaux—At a future MAC meeting, can we add an agenda item to go through the fiscal impact of COVID, how the State utilized the increased FMAP, and how Medicaid dollars were used?
A: Ms. Taylor—Yes, we can plan to when that information is available.

Q: Dr. Fretwell—Are there discussion ongoing for expansion of coverage for chronic care management codes in an at large environment? We are working to implement a collaborative care model within an FQHC environment; Medicare will reimburse those codes and we wondered if Medicaid may follow suit at some point.
A: Ms. Taylor—OMPP's clinical operations and policy team would be best to address the question. And we can take this question back and follow up with more information. We are always open to receiving more information.
A: Mr. Brooks—OMPP is analyzing codes in a telehealth environment.

Q: Dr. Leila Alter—I've been contacted by pediatric dental providers that are having difficulty obtaining hospital operating room availability pre-COVID.
A: Ms. Taylor—We will take this information back for our awareness and we can check with our team.
A: Mr. Brooks—Maybe Terry Cole has something from the hospital association. It looks like Terry and Leila will connect.

VII. Next Meeting and Conclusion

Co-Chair Taylor reminded MAC members about the next regular meeting on November 17, 2020, and indicated the effort to return to providing report outs of the statutorily required topics. She also invited feedback regarding the virtual format. We will ensure our slides are larger.

With no further business to conduct, Co-Chair Brooks adjourned the meeting at 11:50 a.m.