Eric Holcomb, Governor
State of Indiana

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

Medicaid Advisory Committee Minutes

February 23, 2023
In person and Zoom meeting

Members Present
Ms. Maddie Augustus, Ms. Sirrilla Blackmon, Ms. Sirilla Blackmon, Dr. Sarah Bosslet, Senator Jean Breaux, Mr. Michael Colby, Ms. Terry Cole (Co-Chair), Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Ms. DeAnna Ferguson, Ms. Zoe Frantz, Mr. Herb Hunter, Ms. Julia Ketner, Mr. Rodney King, Mr. Luke McNamee, Mr. Gary Miller, Mr. Dick Rhoad, Mr. Shane Springer, Ms. Katy Stafford-Cunningham, Ms. Allison Taylor (Co-Chair) and Ms. Kimberly Williams. Ms. Carolyn Travis, Senator Jean Leising's legislative assistant, attended as her delegate.

I. Call to Order

Terry Cole, Indiana Hospital Association and MAC Co-Chair, called the meeting to order at 1:01 p.m.

II. Approval of November 2022 Minutes

Ms. Cole invited a motion to approve the November 30 23, 2022 meeting minutes. Mr. Herb Hunter moved to approve. Ms. Danielle Coulter seconded. The minutes were approved with no changes.

III. MAC Updates

Ms. Allison Taylor, MAC Co-Chair, asked MAC members to register their attendance and affiliation in the Zoom chat. She reviewed 2023 meeting dates and reminded members the July meeting is for the HIP/SUD/SMI waiver performance review and no regular business will be conducted.

IV. Rules

Ms. Taylor 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 public hearing was held on February 22, 2023. FSSA's Office of General Counsel and OMPP will review the public comments and make any necessary changes to the proposed rule. Following this process, the rule will be submitted to the Office of Attorney General for approval. 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 Notice of Intent to Adopt a Rule was published on January 4, 2023. Rulemaking documents were submitted to SBA, IEDC, and the legislative council for review and approval on January 6, 2023. FSSA received approval from

IEDC on January 9, 2023. Once FSSA receives approval from SBA, FSSA through OGC 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 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 Notice of Intent to Adopt a Rule was published on December 14, 2022. Rulemaking documents were submitted to SBA, IEDC, and the legislative council for review and approval on December 21, 2022. FSSA received approval from IEDC on December 22, 2022. Once FSSA receives approval from SBA, FSSA through OGC 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.

Q: Ms. Cole: Does this extend for two more years?
A: FSSA: The current rule will be bringing IAC into compliance through June 30, 2023. The IAC now cites IC 16-21-10-21 and IC 16-28-15-14. This will allow OMPP's IAC to be compliant when the 2-year timeframes are updated each biennium without having to go through the rule change process.

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) As a result of the recently passed federal spending bill, the continuous enrollment provisions that Indiana Medicaid has been following since March 2020 will end as of March 31, 2023. The requirements are no longer tied to the federal public health emergency, so any further extension of the PHE itself will not impact the timing of return to normal operations for Medicaid eligibility. This means that regular determinations of coverage will begin again and actions to adjust, reduce or eliminate coverage will be allowed beginning in April 2023.

(slide 3) Individuals who have continued to meet all eligibility requirements during the federal PHE will be subject to regular rules starting in April; this includes responding to ongoing verification requests when there is a change in circumstances (for example, an increase in income). Individuals who remained "open" solely due to federal PHE maintenance of eligibility rules will be reassessed when their scheduled annual redetermination is due. Individuals in this group cannot be closed or moved to a lesser-coverage category before their full redetermination process is completed.

(slide 4) Last December, FSSA began sending postcards to Medicaid members reminding individuals to update their contact information and to respond to all mail from FSSA. Initial warning letters will be mailed on February 26, 2023. On March 15, renewal correspondences will begin. And the first possible disenrollments could occur on April 30, 2023, with an effective date of May 1, 2023. This process and possible disenrollments will continue through May 1, 2024 when the return to normal operations will be complete for all members.

(slide 5-6) IndianaMedicaid.com contains information and resources addressing health coverage after the public health emergency. Click on "How a return to normal will impact some Indiana Medicaid members" on the Indiana.Medicaid.com home page. The website general information for members about how to update their contact information and how to sign up for electronic notices, a flyer with instructions about how to navigate the FSSA Benefits Portal, and special instructions for individuals experiencing homelessness. The website also contains other tools including flyers, posters, postcards, social media assets, key message points, an FAQ document and stakeholder information, including the January 2023 meeting slide deck and recording and listserv link. FSSA will continue to add communication tools and information to the site.

(slide 7)) Right now, providers and those who serve Medicaid members can watch for updates and participate in the next stakeholder meeting scheduled for March 7 at 11 a.m. Additionally, you can talk to members about how the return to normal operations could impact them, include content in newsletters and direct client/patient communications, print/request posters and postcards to display and distribute, and use FSSA's social media assets to help educate Hoosiers who may be at risk of losing coverage.

Questions/Comments

Q: Senator Breaux: Are you planning to have an unwinding plan, will it be on the website? You're supposed to send reports to CMS on how the unwinding is going, will you share those reports with how the unwinding is going? Will that data be routinely collected and available for review for MAC members?
A: Mr. Arrowood: We submitted our unwinding plan that we submitted to CMS on Feb 14. We are happy to share that if you'd like to see it. Externally, we do have plans to share the high-level data. CMS also plans to share this data in dashboard fashion.
A: Ms. Taylor: FSSA's legislative team emailed all legislators yesterday with language to use in newsletters.
Q: Senator Breaux: Could we have a summer study committee to look into how this unwinding affects constituents?
A: Ms. Taylor: We can take this back.

Q: Mr. Colby: Have you determined how many members may lose benefits?
A: Ms. Spinner: Up to 500,000 who only have eligibility because of these circumstances. We do not have estimates for throughout the year. Once we get into it, we will have a better idea but for now we are saying it is 500,000 at risk.

Q: Ms. Eichhorn: Some of our members are concerned about the unwinding process. At the last meeting, we talked about the fact that this will create extra work for the eligibility people. Do you have the staffing levels to go through the process?
A: Mr. Arrowood: We are in as good shape staffing-wise that we've been in the last 5-6 years. We have flexibility to do a little more with people on contracts. Our systems have been set for 2 ½ years and we have been preparing for this 12-month unwind.
Q: Ms. Eichhorn: At the last meeting, Rep. Clere was concerned about vulnerable populations losing coverage. Will they still be prioritized in redeterminations?

A: Ms. Taylor: The rules changed after our November meeting and became more concrete in December.
A: Ms. Spinner: We will start the process in March for vulnerable populations but won't be due until June so they will have more time. After that, aged/blind/disabled redeterminations will occur monthly. There is information on our website about how members experiencing homelessness can receive their mail/notices.
Q: Ms. Eichhorn: It's no longer the case that ABD folks are being put at the end of the redetermination process?
A: Ms. Taylor: Nothing has changed from our plan. These members have a longer runway, but they are not at the end of the redetermination process.
Q: Ms. Eichhorn: Will all of the ABD members verify their assets in April?
A: Ms. Spinner: No, it is spread out as members come due for their annual redetermination. But for the first ABD cohort that will be due for redetermination, the last day of their redetermination month would be in June. The soonest these members would lose coverage is July 1. The ABD population has a longer runway to begin with. There is more risk in concentrating everyone in one month, so we decided on this approach.

Q: Senator Breaux: Does everyone need to reapply?
A: Ms. Taylor: We are turning the redetermination cycle back on; so everyone will have to go through redetermination.
A: Ms. Spinner: Everyone will have an annual review. It isn't reapplying but more so a redetermination. Everyone will be protected until the end of their redetermination period. They will have 90-day grace period before having to reapply.
Q: senator Breaux: That's the redetermination communication part that we need to work on, correct?
A: Ms. Spinner: We have always redeterminations but there were 3 years where it had no teeth. It is why we are doing education on it. Every member will need to take some action.
Q: Senator Breaux: Isn't there an easier way to streamline this altogether? Can't you just look up where people are right now?
A: Ms. Spinner: The redeterminations are a federal requirement. If we have enough information to auto renew them (traditionally 50-75% of our membership qualifies for auto-renewal) then we renew them without requiring any action on their part. They receive an approval letter that tells them what information we used to renew them, with instructions to report any changes. We won't be able to do as many auto-renewals for those who remained open solely due to PHE rules because we already know something is missing in their case or they've confirmed they are over the income/asset limit.
A: Ms. Taylor: Indiana excels at the auto renewal process.

Q: Ms. Arnold: Is there a way for members who know they are no longer eligible for coverage to easily disenroll?
A: Ms. Spinner: Anyone who wants to voluntarily withdraw should send a letter expressing that to the Division of Family Resources.

Q: Senator Breaux: When will the newsletters and unwind information be available?
A: Ms. Taylor: Gus and Kayla sent information yesterday, so it should be in your inbox.

2. ***Managed Care alignment – Shannon Effler, OMPP Director of Care Programs and La-Risha Ratliff, OMPP Director of Managed Care***

(slide 2) Indiana Medicaid is committed to strengthening the monitoring and oversight of our managed care entities (MCEs) and reducing member and provider abrasion. Our goals are to (1) align major processes that are completed differently among the MCEs (i.e. prior authorization, recoupment, etc.), (2) decrease member and provider burden, (3) improve access to health care services, and (4) continue innovative internal management techniques that incorporate MCE key performance indicators.

(slide 3) This slide details a few of our alignment projects. (1) prior authorization management scheduled for April 2023, (2) single preferred drug list scheduled for July 2023, (3) aligning the fee for service and MCE requirements for provider corrective actions scheduled for April 2023, (4) HEDIS improvement, (5) MCE credentialing alignment, also known as "network participation,", (6) MCE processing of braille and alternative format requests, and (7) aligning fee for service and MCE requirements for home health prior authorization requirements.

(slide 4) OMPP's monitoring and oversight activities include (1) the creation of dashboards to monitor reporting and data, (2) hiring subject matter experts (SMEs), (3) quality oversight with FSSA's clinical staff, (4) monthly onsite audits, (5) document reviews and (6) monthly meetings between OMPP's compliance officers and the MCEs.

Questions/Comments

Q: Ms. Cole: Will the dashboards be made public or shared with MAC members?
A: Ms. Ratliff: Many reports are on our transparency portal. And we are working to have more transparency on the dashboards. If you have questions, please reach out.
Q: Ms. Frantz: Is this for all managed care and behavioral health?
A: Ms. Ratliff: Yes.

Q: Ms. Eichhorn: Is there any alignment effort around billing and claims requirements? Could you provide detail on the SMEs you have hired? What is their area of expertise?
A: Ms. Ratliff: We are making sure people being hired have the right background in this area. We can share our organizational chart with the MAC. In the next presentation, Dr. Messina will share details about OMPP's clinical operations team.
Q: Ms. Eichhorn: For billing and claims, it was brought to my attention that there are some inconsistencies between required claims forms and concurrent requests for continued stays. Most MCEs give ample notice, but one sometimes notifies a skilled nursing facility after the fact so you can't discharge safely.
A: Ms. Ratliff: Please send the billing and claims forms to Darcy Tower and she will be able to help get the information to the compliance team.

Q: Senator Breaux: What is HEDIS?
A: Dr. Messina: Healthcare Effectiveness Data and Information Set. It's a tool to measure health plan performance.

3. Prior Authorization-Utilization Management and OMPP Clinical Operations – Dr. Frank Messina, OMPP Director of Clinical Operations and Katrina Etter, OMPP UM Manager

(slide 2) Significant investments have been made in the OMPP clinical operations area to drive improvements including increasing MCE oversight and alignment, Pathways/mLTSS, single PDL and other improvement initiatives. OMPP's clinical operations section consists of a (1) coverage and benefits and clinical policy team responsible for ensuring medically necessary services are covered for our almost 2 million members across all delivery systems and health plans and are properly documented in policy; (2) a care management team which provides management and coordination to Fee For Service members, including those members with complex medical, behavioral, and social needs while also oversighting managed care entities in the performance of their care management responsibilities; and are leading care management coordination for Pathways; (3) a quality improvement team responsible for establishing quality metrics for all Medicaid programs working to improve health outcomes for members. Our MCEs are required to be accredited by the National Committee on Quality Assurance, including annual Health Plan Employer Data Information Set, commonly referred to as HEDIS, which scores and ranks health plans in a multitude of quality measures. (4) The pharmacy team manages the Medicaid pharmacy benefit including a single preferred drug list (PDL) and oversight of pharmacy benefits management performed by managed care. (5) The prior authorization and utilization management team which is the focus of the remainder of this presentation.

(slide 3) This slide shows the OMPP clinical operations organizational chart. Medicaid made a significant investment in our clinical operations team, with the creation of 9 new positions in early 2022. Additional clinical support allows the State to increase and improve clinical and quality oversight of the managed care organizations and improve the member and provider experience.

(slide 4) Improvements include expanded staffing with more licensed professionals with various backgrounds and experiences who bring a more in-depth provider and member perspective in informing OMPP's policies and procedures. Additional improvements include single medical necessity criteria hierarchy without MCE "modification," single unified preferred drug list, Indiana Pathways for Aging PA-UM innovations and industry-leading new PA-UM vendor for fee for service.

(slide 5) OMPP's goals for utilization management are: maximizing member and provider satisfaction, minimizing member and provider burden, ensuring members achieve positive health outcomes through access to high quality care and services, and aligning utilization management review practices across MCEs and traditional or so-called fee for service Medicaid.

(slide 6) An important part of UM is assuring provided services are medically reasonable and necessary to address member needs. NCQA standards and best medical practice requires, as much as possible, that objective, current and evidence-based criteria be used as guidelines in determining medical necessity. Indiana Medicaid bulletin BT2022117 released in December 2022 outlined one hierarchy for providers and members to reference for medical necessity criteria. MCEs may no longer modify the national guidelines used and not be more restrictive than FFS criteria.

(slide 7) This slide outlines the prior authorization requirements OMPP must follow. We must first follow what is specified for UM and PA in federal and state statute. There are also specific sections of the Indiana Administrative Code related to PA and UM. Indiana Medicaid also posts requirements in its online provider module and PA provider module. Finally, to assure providers and members have the most updated info, bulletins and banners are pushed out when there are substantial changes to the modules-modules specifically direct providers and members to the bulletins and banners site to assure they are reviewing the most updated info.

(slide 8) This next slide shows graphically the hierarchy pyramid. Federal law is at the top, followed by Indiana Code, Indiana's state plan, Indiana Administrative Code, IHCP policy, clinical guidelines, professional society guidelines, professional references/subject matter expert opinions, and finally best standard of care.

(slide 9) Our efforts to maximize satisfaction and minimize burden include aligning PA-UM policies across MCEs and FFS and making changes to IAC to remove outdated or inconsistent criteria. Examples of the latter include overhauling dental policies and reimbursement matrix and our clinical policy manager going over the IAC and our modules to initiate updates as needed. Additional efforts include improving transition periods for members to ensure continuity of coverage, transfer of existing PA across health plans and PA always following the member.

(slide 10) Additionally, standardizing reporting requirements across MCEs and FFS Medicaid enables us to track timelines and ensure accuracy, completeness and compliance to MCE contract requirements.

(slide 11) On July 1, 2023, a new FFS PA-UM vendor, Kepro, will assume prior authorization processing for FFS members. They have 35 years of experience, are URAC (formerly Utilization Review Accreditation Commission) accredited and have received very high approval ratings from providers and members. We have contacted other states about Kepro's performance and they were very complimentary.

(slide 12) We have developed a transition plan that will not be disruptive to members or providers. After the transition, we will develop new "auto-approval" rules to allow providers to obtain "real-time" approval for certain services that meet identified criteria without needing to have an analyst evaluate. And we will use an online portal to provide immediate feedback to providers on how to modify or correct their submissions in order to have a "clean" PA. This builds in efficiencies by

reducing administratively-based claim denials after the service has been rendered. Kepro has impressive, industry-leading uptake/use of their portal.

(slide 13) On July 1, 2023, there will be one Indiana Medicaid preferred drug list (PDL) to ensure unified prior authorization criteria for FFS and all MCEs for drugs. Most preferred drugs on the list do not need PA, however non-preferred drugs, most drugs carved out of managed care and physician administered drugs will still require PA. OMPP's pharmacy team has been working for months to ensure this transition is well-communicated and seamless/invisible to members and providers.

(slide 14) For the Indiana Pathways for Aging (mLTSS program), PA-UM enhancements will simplify the PA process for those needing home and community-based services. The service plan developed by the member with their care team will be the authorization request and no additional steps are needed for the provider. There will be care management monitoring and care plan audits will be conducted for patient-centeredness and appropriateness.

(slide 15) To conclude, OMPP is making improvements to the prior authorization and utilization management processes. These include expanded staffing with more licensed professionals with various backgrounds and experiences who bring a more in-depth provider and member perspective in informing OMPP's policies and procedures. Additional improvements include single medical necessity criteria hierarchy without MCE "modification," single unified preferred drug list, Indiana Pathways for Aging PA-UM innovations and industry-leading new PA-UM vendor for fee for service.

Questions/Comments

Q: Senator Breaux: IAC are the rules you put in place based on what we put in the legislator? Can you change those without changing the legislation that initially led to the rule?
A: Ms. Taylor: The legislature sets the tone and we create administrative rules to implement the legislative effort. We can change the administrative rule, but we have to be consistent with state statutes. They cannot conflict with one another. I believe state statute is superior to rules. These changes are intended to make the processes easier and keeps members safe with less duplication/burden for providers. Utilization management is also about patient safety, giving them what they need and not more.

Q: Ms. Eichhorn: Who handles PA for FFS now? What is the effective date for Kepro to take over?
A: Ms. Etter: Gainwell is the current vendor for FFS. Kepro will take over July 1, 2023.
A: Ms. Taylor: Many other states are doing this and we are getting them involved to help us make a smooth transition. We did a public procurement for this and Kepro as the choice. We'll partner with providers and stakeholders.

Q: Mr. Hunter: When will the preferred drug list be available?
A: Dr. Messina: The pharmacy team is working with MCEs and going class by class.

Q: What sort of provider training will be available and when will it begin?
A: Dr. Messina: It's communication rather than training. Kepro will host some virtual and live sessions. We're looking at May 2023.

Q: Ms. Frantz: Will Gainwell be involved at all with any of the MCEs?
A: Ms. Etter: Kepro is specifically for FFS. Gainwell will no longer do that but will continue to do claims processing.

Q: Senator Breaux: Will the single drug list combine all of your current drug lists?
A: Dr. Messina: There is work on a preferred and non-preferred list. Some drugs will drop off.
A: Ms. Taylor: Senator Brown's made testimony about Step programs during session. This single PDL is meant to take that away so there is one list to help reduce PA for pharmacy benefits.
Q: Senator Breaux: Will clients still have access to drugs that drop off? They'll just have to get prior authorization?
A: Dr. Messina: Potentially. There is a transition plan. Members will have a 90-day overlap to work with their provider to get on a PDL drug or go through the PA process.

Q: Ms. Alter: Where will Kepro's link be located?
A: Ms. Etter: It will be available on the IHCP website and we are developing a landing page so providers only have to go to one place.

Q: Mr. Colby: Does each MCE have their own PBM?
A: Dr. Messina: They do. They will still need to follow the preferred drug list.

Q: Senator Breaux: Kepro will only handle fee for service?
A: Dr. Messina: Yes.
Q: Senator Breaux: The PAs are just for the FFS members or anyone?
A: Dr. Messina: Kepro will only handle FFS. Each MCE will handle its own members.
Q: Senator Breaux: Is there one central location for PAs once you implement your PDLs?
A: Ms. Taylor: There won't be a single portal. We are trying to align as much as possible. We can follow up with you to go through the slides.

Q: Ms. Cole: I appreciated this presentation. The process will likely reduce friction and it will be good to stay in communication about it.

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

(slide 2) There will be a lot of discussion over the next few months about the concept of the rate matrix. This slide provides a visual representation of the differentials we've seen in forecasting and budgeting methods among the different provider types. Mandated rate increases account for 70% of Medicaid spend and the frequency the rates for each provider type included in this group are

reviewed is different. Discretionary (ad hoc) increases account for 30% of Medicaid spend have no set schedule and are contingent upon funding availability. So these providers (non-HIP physicians, waiver services, home health, NEMT and dental) have no set frequency for rate increases and must have advocates in order to realize increases. Some of these provider types are still being reimbursed at pre-COVID rates. We want to "catch up" the rates for the providers who have ad hoc increases. We want to have a structure for all provider rate increases.

(slide 3) The high level rate matrix concept visually represented on this slide provides a structure for provider rate increases in three ways. First, rate reviews for similar services would be performed at the same time. Second, each service will have a rate review performed every four years. Although CMS recommends every five years, we chose four because of Indiana's biennium budget cycle. Finally, between rate reviews, rates will be indexed to increase either using Medicare rates or inflation as the index.

In the next few weeks/months, we'll be communicating with provider groups about the rate matrix. Next steps will depend on what is approved for the next biennium budget.

Questions/Comments

Q: Senator Breaux: What suggestions have you put into the budget? Which of these provisions?
A: Ms. Leonard: This is the structure we're recommending for the future. We've proposed in year 1 of the budget to "catch up" the rates for waiver services and home health and two services with older rates--dental and NEMT--that have not had a rate increase in some time. There is different legislation that might impact these.
Q: Senator Breaux: Are you proposing anything to put into the budget? During the interim are you going to introduce the rates to be indexed?
A: Ms. Leonard: We have rate reviews going on for HCBS services, dental and NEMT. We have budgeted for those rates to be increased in the first fiscal year to "catch up" and indexed in the 2nd year. We've been working with the State Budget Agency and these are included in the Governor's budget. We are advocating for these to continue in future years.
Q: Senator Breaux: For those you have selected for indexing, is that what you would like to see moving forward?
A: Ms. Leonard: No, we are proposing all of them. Some rate increases now to "catch up" and indexing until the next rate increase four years out. This is the framework we are proposing.
A: Ms. Taylor: We presented the rate matrix concept in our Medicaid forecast presentation to the Ways and Means committee on January 18. The plan can be found on IGA's website. During future MAC meetings, we can share with the group about the progress of the plan.

Q: Nicholas Krumwied: Will the rate change that follows Medicare adopt Medicare at the current year rate and hold that rate for a few years? Or will the rate adjust to the current year Medicare rate?
A: Ms. Leonard: Instead of setting the rate to this year's Medicare rate and freeze it, we would like to float it. Each year as Medicare increases, the rate increases as well. Some services, like dental, don't

have Medicare rates, so we will have to pick a number or index it to another cost of living adjustment. We want the rates to move forward each year until their next review.

Q: Ms. Frantz: For my members who tend to have diverse payment structures, they'll still have different rates depending on how that service is delivered? For example, hospital-based rates will be different from HCBS-based rates?
A: Ms. Leonard: We want similar services to have similar (aligned) rates. If services are different, then the rate would be different.
Q: Ms. Frantz: As we're transforming our system to value-based approach, keeping in mind there will still be a FFS and clinic-based model is helpful.
A: Ms. Leonard: Value-based purchasing would be on top of base rates. We do not want to have different pay for the same services.

Q: Mr. Springer: I like the rate matrix concept. What about the timeline? How are you navigating the need for bigger investments in programs like dental with the mandate to equalize rates amongst Medicaid programs?
A: Ms. Leonard: We are working with the budget team on this and we do have strategic investments that could be available as early as July 1. Then the HIP rate equalization is required to be effective January 1, 2024. We are trying to avoid raising rates every six months to lessen the disruption to providers and are looking into whether we can package things at the same time.
Q: Mr. Springer: The dental association thanks FSSA and would like to keep the lines of communication open about this.
A: Ms. Leonard: FSSA appreciates this offer so we can look at the impact of changes appropriately.

Q: Senator Breaux: This presentation is not part of the rate equalization?
A: Ms. Leonard: No, it is not. This is a different one.
Q: Senator Breaux: If you float the Medicare rates for physicians, don't you have to float them for everyone?
A: Ms. Leonard: We don't have a final number yet. But as an example, if we set physician rates at 82% of Medicare, it would impact all of our programs. Next year, we'd look at new Medicare rates and set to 82% of that. Then in four years, we'd review to see whether 82% is the correct percentage.

VI. Comments

Ms. Taylor invited additional questions/comments.

Q: Ms. Frantz: One of the things my members are still waiting on is the CPT code breakdown. When will that be available?
A: Ms. Leonard: We are looking into anything related to behavioral health and substance use disorder now and will have more to share once our research is finished.

A: Ms. Taylor: Organizational charts are posted on the FSSA website or we can send to MAC members.

VII. Next meeting

Ms. Taylor indicated the next quarterly meeting is May 24 and advised MAC members to watch for banners and bulletins about the various projects OMPP is working on.

With no further business to conduct, the meeting adjourned at 2:49 p.m.