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 25, 2022
Virtual meeting via Zoom

Members Present
Dr. Leila Alter, Ms. Tabitha Arnett, Ms. Maddie Augustus, Dr. Sarah Bosslet, Senator Jean Breaux, Ms. Julia Camara, Rep. Chris Campbell, Rep. Ed Clere, Mr. Michael Colby, Ms. Terry Cole (Co-Chair), Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Ms. Katherine Feley, Ms. Zoe Frantz, Rep. Mike Karickhoff, Senator Jean Leising, Mr. Luke McNamee, Ms. Barbara McNutt, Mr. Gary Miller, Mr. Evan Reinhardt, Ms. Katy Stafford-Cunningham, Ms. Allison Taylor (Co-Chair), Ms. Kimberly Williams, and Sen. Shelli Yoder.

I. Call to Order

Terry Cole, Indiana Hospital Association and MAC Co-Chair, called the meeting to order at 10:03 a.m.

II. Approval of February 2022 Minutes

Ms. Cole invited a motion to approve the February 24, 2022 meeting minutes. Mr. Luke McNamee moved to approve. Ms. Tabitha Arnett seconded. The minutes were approved with one change-adding Ms. Katherine Feley to the members present section.

III. MAC Updates

Ms. Allison Taylor, MAC Co-Chair, reviewed dates for upcoming MAC meetings and reiterated OMPP's vision, mission, and strategic priorities focus on collaborating to improve member and provider experience.

IV. Rules

Ms. Taylor introduced Ms. Angka Hinshaw, FSSA staff attorney who had no rules to present.

V. FSSA Updates

1. ***Telehealth Update – Lindsay Baywol, OMPP Coverage and Benefits Manager***

Ms. Taylor introduced Lindsay Baywol, OMPP Coverage and Benefits Manager, to provide a telehealth update, specifically the permanent telehealth policy in place for the remainder of 2022.

(Slide 3) Prior to the public health emergency, reimbursement for services delivered via telehealth were limited to only services designated by OMPP to be provided via telehealth via our Telemedicine code set. Telehealth was also limited by provider type in Indiana Code and we

did not allow for phone or audio only telehealth. We made many policy changes during the PHE. For example, with Executive Order 20-05 and 20-12, we were able to expand the types of providers and services delivered via telehealth. Also, services were no longer limited to our telemedicine code set, we were even able to provide some services via telehealth that were previously excluded and allow for phone/audio only telehealth.

(Slide 4) Prior to the PHE, if a person wanted to have a health care service delivered via telehealth, it had to be audio-visual telehealth only (e.g. a "skype" like application to access your doctor). There were on a handful of providers that were eligible to perform services via telehealth, per Indiana Code. Ultimately, there was a very low number of folks that actually sought out receiving health care services this way.

During the PHE, we had additional modalities, including telephone. As a result of the PHE flexibilities, many additional licensed providers were added as eligible to deliver services via telehealth. This was then codified in SEA 3 (2021) and also expanded upon in the most recent legislative session in SEA 284 (2022). For example, in February 2020, there were 802 claims for the month for a 30-40 minute office visit (procedure code 99214: Office of other outpatient visit for the evaluation and management of an established patient, 30-44 minutes). In April 2020, there were there were 27,938 claims using the same procedure code. This is an increase of 3000 percent. For all of 2020, there were: 2,034,493 claims for Telehealth Services paid by Indiana Medicaid. For all of 2021, there were: 1,737,200 claims for Telehealth services paid by Indiana Medicaid. This figure is slightly less than 2020, but still significantly more than what was normal prior to the PHE. This solidifies how telehealth continues to be used now and will be used even after the PHE.

(Slides 6-9) Ms. Baywol continued by explaining how telehealth policies will look after the PHE. First, Indiana will go back to the use of a telehealth code set like we used prior to the public health emergency. Our Final 2022 Telehealth and Virtual services code set was published on May 19, 2022 and specifies the services that Indiana Medicaid will continue to cover post-PHE. The services included within this code set were selected to align with the utilization of telehealth services during the PHE, but also to comply with the limitations set out in SEA 3 (2021). The telehealth code set is a "menu" of the health care services Indiana Medicaid will reimburse when delivered via telehealth. Every health care service delivered has an associated "code" that is used for reimbursement purposes. If the "code" is on the "telehealth code set" (or if the "service" is on the "menu") then Indiana Medicaid will reimburse for that service when delivered using this modality. For a complete list of these services, please see BT202239 for more details.

The code set was developed using several methods. We first proposed the code set in December 2021, where we then allowed providers 30 days to make comments. After that comment period, we made further edits/reviewed other codes, and added several additional codes for telehealth coverage to this list. We reviewed claims that were submitted for telehealth services, using a telehealth dashboard we developed during the public health emergency. We reviewed with several other FSSA agencies and our MCEs for feedback. We reviewed CMS policies for telehealth. We also received a few policy considerations that were specifically for telehealth services that went through OMPP's formal policy consideration process.

For a provider to be reimbursed for telehealth services under IHCP, the provider must be enrolled with IHCP and be a licensed practitioner listed in IC 25-1-9.5-3.5. The service code must be a procedure code listed in the associated 2022 Telehealth code set to be eligible for reimbursement. Additionally, the claim must: (1) Have a place of service (POS) of either: 02—*Telehealth provided other than in patient's home*, or 10—*Telehealth provided in the patient's Home.* Per changes to IC 12-15-5-11, we cannot impose any location requirements concerning the originating/distant site in which a telehealth service is provided to a Medicaid recipient; (2) Have a modifier of either: 95-- *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system or* 93--*Synchronous telemedicine service rendered via telephone or other real time interactive audio-only telecommunications system.* As indicated in the new code set, only certain services are eligible for audio-only delivery and can be billed with this 93 modifier.

This new code set has greatly expanded what we previously allowed for reimbursement via telehealth prior to the PHE. There are many new behavioral health services now available via telehealth, including flexibilities allowing some MRO program services to be delivered via telehealth. Physical, occupational, and speech therapy options are now included in the code set. We also have some limited optometry, audiological, and pediatric evaluation codes now allowed via telehealth.

(Slide 10) We also have a new remote patient monitoring (RPM) policy. RPM is a telehealth modality listed under the definition of telehealth in IC 25-1-9.5-6 and involves the use of connected electronic tools to record personal health or medical data in one location, that is then reviewed by a provider at a different location. An example would be a heart monitor a person uses in their home, that transmits data to a doctor in another location for review. We published our new RPM policy on May 16, 2022 and can be found in bulletin number BT202238. Not all RPM services require prior authorization and, in general, we are reserving RPM services for members who have undergone major surgeries, organ transplants, or have uncontrolled chronic conditions.

(Slide 11) Due to provider feedback received from the proposed telehealth code set in December, we will also be including Intensive outpatient treatment as available via telehealth for the next 12 months. However, these services are considered a pilot initiative and all providers participating in this form of service delivery must comply in the submission of data to DMHA, if requested. There are also some specific requirements when providing these services, such as limitations on group size, check-ins with a peer or case manager, and a required video component to receive this service. All details are found in bulletin BT202239.

(Slides 12-14) Although this code set includes all changes made from SEA 3 (2021), further edits will be necessary due to SEA 284, passed in March of this year. This bill, effective July 1, 2022 includes definitive IC language that "Case management" is not considered a "health care service," and therefore does not need to be performed by a licensed practitioner listed in IC 25-1-9.5-3.5. FSSA was already following this definition of case management, but now it is permanently written in IC. So, any form of case management when delivered "virtually" is considered a "virtual service" and not "telehealth." The bill also added additional practitioners now able to perform telehealth services. OMPP will be publishing another clarification bulletin

specifying any changes that would result from SEA 284 that is currently not embodied in this code set. This code set was already in development prior to those changes, but we will make sure we make edits to the code set so that additional providers may be eligible for delivering services via telehealth.

Any questions related to telehealth services can be sent to Telehealth.OMPP@fssa.in.gov.

Ms. Baywol invited questions.

Questions/Comments

Q: Rep. Chris Campbell: Clinical fellows for speech therapists should also include audiologists.
A: Ms. Baywol: Slide 13 provided only a partial list of providers. Bulletin BT202239 provides more details.

Q: Senator Jean Breaux: Will presentations be available?
A: Ms. Taylor: Yes today's presentations will be available on the MAC website in a few days. We encourage MAC members and others to use the email box for questions.

2. ***Public Health Emergency update – Nonis Spinner, OMPP Director of Eligibility and Member Services and Jim Gavin, FSSA Director of Media Communications and Media***

Ms. Taylor introduced Nonis Spinner, OMPP Director of Eligibility and Member Services to present an update on the reestablishment of normal Medicaid eligibility processes when the PHE ends.

(Slides 1-12) During the PHE, Medicaid eligibility was maintained in the member's current or better state. Disenrollment has been limited to those moving out of state, member requested disenrollment, death of member and CHIP age-out. All copays and premiums have been suspended. Indiana has continued all normal Medicaid eligibility processes, including annual redeterminations, but did not disenroll members who failed eligibility. Indiana also allowed self-attestation on the application with post-enrollment verification.

CMS has stated it will provide state with a 60-day notice prior to the end of the federal PHE. Since we have not received notice, we expect another extension past July 15. State will have 12 months to return to normal operations. Indiana plans to distribute the work over the full 12-months after the federal PHE ends.

Once the federal PHE ends, individuals who have continued to meet all eligibility requirements during the federal PHE will be subject to regular rules starting the month after the PHE ends, including responding to ongoing verification requests when there is a change in their circumstances (e.g. an increase in income). This accounts for approximately 75% of Indiana Medicaid members. Individuals in this group who do not respond to requests for information or who are determined to no longer quality for coverage can be disenrolled or moved to a lesser-coverage category.

Individuals who remained open solely due to federal PHE maintenance of eligibility rules will be reassessed when their scheduled annual redetermination is due. This accounts for approximately 25% of total membership. Indiana will process roughly 1/12 of this group each month. Individuals in this group cannot be closed or moved to a lesser-coverage category before their full redetermination process is completed.

Following the end of the federal PHE, up to 500,000 individuals who remained open due to maintenance of efforts requirements during the federal PHE will need to take action to keep their Medicaid/HIP eligibility. Individuals will receive a prepopulated mailer requesting updated information. Members have at least 30 days to return the mailer with any required information and updates. Those who don't return the information can still come back into compliance in the 90 days after their due date and potentially regain eligibility without submitting a new application. Individuals who are determined ineligible will receive a final closure notice with appeal rights and instructions on how to file an appeal.

Individuals who are closed for failing to verify their income or other eligibility factors and those who are over the income limit for Medicaid can apply on the federal Marketplace (Healthcare.gov).

Medicaid members should take action now that could help them stay covered. If members have a new address or phone number should update it online now at FSSABenefits.IN.gov or by calling 800-403-0864.

(Slides 13-23) Ms. Spinner introduced Jim Gavin, FSSA Director of Communications and Media, who provided information about the key messages to Medicaid members and the various forms of communication that will be used during the state's return to normal operations. FSSA has been planning for about 18 months for the return to normal operations and communications to members will occur over the next 15-24 months.

KEY MESSAGES:

When the federal PHE ends:

1. Indiana Medicaid will return to normal operations and information about each member will be looked at once a year to determine if the member still qualifies for coverage.
2. The state is able to process many redeterminations automatically. But in some cases, the state will ask members for information about themselves and their family (i.e. current address, employment status and income, age, family size).
3. Anyone currently covered by one of Indiana's Medicaid health coverage programs should take action now to remain covered—verify current address, verify current income. Visit FSSABenefits.IN.gov, call 800-403-0864, watch your mail and respond with any information requested.
4. Indiana Medicaid will never discontinue a member's coverage without first giving the member the opportunity to provide the state new and updated information. The state will mail notices to members and it is important for members to respond to requests from the Division of Family Resources.

5. Members no longer eligible for coverage through Indiana Medicaid should see if they qualify for coverage through the federal Marketplace (Healthcare.gov or 800-318-2596). Hoosiers age 65+ should look into coverage from Medicare (Medicare.gov or 800-MEDICARE). Indiana's State Health Insurance Program (SHIP) can assist with questions about Medicare (Medicare.IN.gov or 800-452-4800).
6. Navigators and application organizations can also assist. https://www.in.gov/healthcarereform/indiana-navigators/find-a-navigator/.

FORMS OF COMMUNICATION

1. IN 211 has been making outbound calls to fee-for-service Medicaid members who could be at risk.
2. Managed care entities are also going to call their members and ask directly about any information needing to be updated
3. Indiana will use mobile messaging and emails (as allowable) to reach members. FSSA is asking for clarification from the FCC and hopes to have a decision soon.
4. Once the PHE end comes into clearer focus, FSSA will have postcards and posters available for distribution. These can be ordered at IndianaMedicaid.com.
5. The IndianaMedicaid.com website is live and contains a lot of information.

ACTIONS TO TAKE NOW

1. Watch for updates about the end of the federal PHE.
2. Talk to clients, patients, and those you serve about how the return to normal operations could impact them.
3. Include content in your newsletters and any direct client/patient communication you do.
4. Print or request posters and postcards from the website to display and hand out.
5. Spread the word! Use the social media assets available at IndianaMedicaid.com to help educate Hoosiers who may be at risk of losing coverage.

Questions/Comments

Q: Sen. Breaux: Is Indiana's PHE end date consistent with the federal end and not sooner? I thought that Indiana's PHE had already ended. What does it mean to be reassessed when their scheduled annual redetermination is due? Are copays and premiums suspended?
A: Ms. Spinner: The state PHE has ended, but MOE is still allowed under the passed bill. For example, if someone got coverage in January, their annual redetermination would occur in December. People can take the actions outlined on slide 10 now. People are not paying copays and premiums now and we are not sure when they'll be turned back on. However, we will communicate with members.

Q: Rep. Clere: are we permitted to send electronic notifications even if someone has not opted in? Can we leverage the state's management performance hub?

A: Ms. Taylor: All of these questions are good. We can answer these following Jim Gavin's presentation.

Q: Amanda Hall: How is the state handling returned mailers? Also, how is the state planning to help people who are not able to access the portal to update their information (i.e. people without reliable internet).
A: Ms. Spinner: The portal is not the only way to report changes. Members can mail, fax, physically bring it to a local office, call. However, the portal is the fastest way.

Q: Ms. Eichhorn: IHCA would like to work with FSSA on a strategy to ensure skilled nursing facilities and assisted living waiver residents who continue to be eligible do not lose their coverage due to not receiving their notifications from FSSA and/or not understanding actions they need to take to keep coverage.
A: Mr. Gavin: FSSA is happy to partner and have more conversations with these groups. We have made information and tools available on the IndianaMedicaid.com website.

Q: Amanda Hall: Has the state considered giving people more than 13 days to respond with verification, especially when members' redetermination dates are soon after the end of the PHE?
A: Ms. Spinner: Once we send the mailer, individuals will have at least 30 days to respond. If they do not respond to the first, we send an additional mailer for which they have 13 days to respond. So, they receive 30+13 days, or roughly 45 days before a negative action is taken.

Q: Melanie Morris: Has consideration been given to mailing the post cards to Medicaid members?
A: Ms. Spinner: Yes, postcards will be mailed to all Medicaid members.

Q: Julia Camara: Our enrollment team would like a copy of the slides.
A: Ms. Taylor: The slides will be posted to the MAC website.

Q: Sen. Breaux: What are the reasons for disenrollment? Why are there fee-for-service members at risk?
A: Ms. Spinner: During the PHE, we could not disenroll people from Medicaid unless it was for one of the four reasons shown on slide 2. Once normal operations resume, you can be disenrolled if you are over the asset limit or income limit. People can still appeal. All fee-for-service members will need to be re-determined.

Q: Ms. Cole: When this does happen and people fall off Medicaid because they have not submitted their paperwork and a month later they arrive in the emergency room, do they still qualify for presumptive eligibility?
A: Ms. Spinner: Yes, they still qualify and can get coverage.

Q: Ms. Stafford-Cunningham: Who can we contact regarding patient liability questions for individuals in ICFs during the return to normal process?
A: Ms. Spinner: Contact the Division of Family Resources since they can see more details. For general questions, OMPP can help.
A: Mr. Gavin: For future updates, healthcare stakeholders can enter their email addresses in the chats and we will reach out.

Q: Sen. Breaux: What is the thinking behind when cost sharing and copays will resume? What is the criteria? The longer it takes us to decide, the longer people can have services without these barriers.
A: Ms. Taylor: We haven't gotten there yet and at this time we are trying to understand the general mechanics of how it will work.

Q: Nicky Harris: Due to inflation, will the wage requirements be increased for families or will it stay the same?
A: Ms. Spinner: We adjust income limits based on federal poverty level. We do this effective March 1 and will make updates when they become available.

Q: Rep. Clere: Making the suggestion again for using the state's management performance hub to help find Medicaid members. I would hate for the state to have contact information for a member and miss the opportunity to communicate with the member because we don't have that information within the Medicaid program. People interact with the state in lots of ways. It could be a driver's license renewal, a hunting or fishing license or any of dozens of other possible contacts.
A: Ms. Taylor: Maybe we could feature this during another MAC. Additionally, we are taking under advisement the possibility of moving the August MAC due to a conflict. We will keep MAC members updated.

Comment: Tracey with Hoosier Action: More stakeholder meetings and more options for public engagement would be great, especially if there is also an effort to include Medicaid members to share their perspective. The last stakeholder meeting was really great and I recommend everyone join the list if they yet. One concern with saying "return to normal" is that for people who enrolled in Medicaid during the pandemic, they've never really been subject to "normal" Medicaid. Love Rep. Clere's suggestion about the management performance data hub.

Comment: Melanie Morris: I recently met with Louisiana state officials who reported they are utilizing a similar state data hub to ensure members do not lose eligibility due to lack of communication.

3. HCBS Stabilization Grant update – Kathy Leonard, OMPP Director of Reimbursement and Actuarial Services

Ms. Taylor introduced Kathy Leonard, OMPP Director of Reimbursement and Actuarial Services, to provide an update about the federal HCBS stabilization grants.

The HCBS stabilization grants were designed to provide immediate stabilization to Indiana's workforce and community-based provider network and account for 20% of Indiana's HCBS spend plan budget. Indiana awarded $173M to 1,156 HCBS providers, with a median grant amount of $57, 000, and about another $1M will be released in June due to late, incorrect or incomplete attestations. In order to receive a grant, providers had to be in an eligible category and attest to pass 75% of their grant directly to their workforce. This means in Indiana, $129M was to be passed directly to workers.

Approximately 60% of Indiana's HCBS providers responded to the grant opportunity. Of the 1,156 providers who received grants, 51% were aged and disabled waiver providers, followed by FSW and CIH waiver providers (20.3%), home health agencies (14.9%), CMHCs (5.4%), TBI waiver providers (2%), outpatient mental health clinics (0.5%) and PACE providers (0.3%).

FSSA's website contains an HCBS landing page with links to additional funding opportunities.

Questions/Comments

Q: Katy Stafford-Cunningham: Were any providers deemed ineligible, hence why there wasn't 100%?
A: Ms. Leonard: Some providers gave attestations for ineligible services. They did not perform HCBS services and were not given a grant.

Ms. Taylor concluded by complimenting Kathy and the OMPP reimbursement team as well as OMPP's provider relations team for their efforts on this project.

4. Healthy Indiana Plan/Hoosier Healthwise readiness update – Meredith Edwards, OMPP Director of Care Programs

Ms. Taylor introduced Meredith Edwards, Director of Care Programs to present an update on the HIP/Hoosier Healthwise readiness review.

FSSA administers the Hoosier Healthwise and Health Indiana Plan (HIP) programs providing risk-based managed care services for 1.6 million Indiana Medicaid members. The OMPP team is working to successfully implement and conduct readiness review on new contracts for the four incumbent MCEs—Anthem, CareSource, Managed Health Services (MHS) and MDwise—

awarded through the last IDOA procurement. Contracts will be effective January 1, 2023 and go for four years with two one-year extensions.

Through the readiness review process, we want to ensure our MCEs are aligned with FSSA's goals to improve the quality of care and health outcomes for members. Additionally, we want to ensure the MCEs are aligned with each other. This comprehensive and extensive readiness review of all contract requirements ensures the health plan is prepared in advance of the new contract "go live."

Readiness reviews occurs over a one-year period of time, with three to four subject areas review each month. We started on January 20, 2022, with the RFP award announcement. From April through November, the MCEs will submit thousands of documents, policies, procedures and contracts to show compliance and readiness. Typically 85% of these documents pass the first time and 15% require revision. At least two FSSA subject matter experts review every document. Each MCE will also conduct approximately 21-24 hours of live readiness demonstrations to determine if they are compliant with the requirements. OMPP is utilizing the standard compliance verification format used for the last three contract implementations, with enhancements.

In mid-December, we will make a final determination (go-no-go decision) about whether each MCE has passed the readiness review process. Go live occurs on January 1, 2023 and post-implementation monitoring will occur from January 2, 2023-March 31, 2023.

Questions/Comments

Q: Sen. Breaux: Since we retained the incumbents, what information did we use to determine they could be retained.
A: Ms. Edwards: the Indiana Department of Administration has a procurement process. Each healthcare plan interested in the contract can apply. The HIP/HHW proposal was more than 1,000 pages long. OMPP reviews and we have other agencies review proposals. We do a full evaluation of what the MCEs are doing, how they're working in Indiana and in other states. That determines which plans are selected. Right now, the MCEs are operating under their current contract. But, if they don't pass readiness review, we don't sign off on the new contract and they fall off. We explain this to MCEs during the kickoff meeting.

Q: Dr. Alter: What were the changes to network adequacy requirements?
A: Ms. Edwards: I will follow up on that.

Follow up:
In addition to the already standard distance requirements, several ratio requirements were added to the MCE Contracts. Those additions are:

- Contract with a minimum of 90% of IHCP enrolled acute care hospitals located in the State of Indiana.

- Contract with a minimum of 90% of IHCP enrolled Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) located in the State of Indiana.
- Contract with a minimum of 90% of IHCP enrolled Community Mental Health Centers (CMHC) located in the State of Indiana.
- Meet or exceed the following provider-to-member ratios:
  - 1:1,000 for PMPs (includes all physician and advanced practice nurses enrolled as a PMP with the Contractor)
  - 1:1,000 for Behavioral Health Providers (excluding physicians, CMHCs, and inpatient)
  - 1:2,000 for OB/GYNs
  - 1:2,000 for Dentists
  - 1:5,000 for Anesthesiology, Cardiology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, General Surgery, Pulmonology, Rheumatology, Psychiatry, Urology, Infectious Disease, Otolaryngology, Oncology, Dermatology, and Physiatry/Rehabilitative

Q: Dr. Bosslet: It is often difficult to get meaningful data from the MCEs in terms of patient panels assigned to a physician or group, quality gaps, those due for care, etc. Is this part of the readiness review process?
A: Ms. Edwards: Yes. We will be evaluating the portals, which is where we find those care gaps, to see if they are easy to use. We will be asking them about where care managers find those care gaps.

Q. Sen. Breaux: Are the welcome packets in different languages?
A: Ms. Edwards: Yes. MCEs are required to supply information in the language of the member's choice. MCEs provide translation for calls and have native speakers in their call centers, too. In late 2021, about 7% of members are Spanish speakers, so Spanish language translation is important. Braille is as well.

Following Ms. Edwards' presentation, Ms. Taylor provided an update regarding Healthy Indiana Plan reimbursement. Indiana recently entered a 10-year HIP renewal period. HIP reimburses at Medicare rate. CMS has instructed us to stop differing the payment rates between our programs. We have negotiated a runway to equalize rates so no one program gets a different rate than the other programs and have until January 1, 2024 to equalize rates. OMPP is waiting on additional details and logistics from CMS.

We will work in partnership with stakeholders and the public and there will be no imminent changes now or in 2023.

Q: Sen. Breaux: I was not aware of the equalization and understand it is a long runway. Does that mean rates will be increased?
A: Ms. Taylor: We cannot really say at this point. CMS says we need to equalize rates. However we will keep aggregate reimbursement the same.

Q: Sen. Breaux: Does this discussion need to occur with MCEs? Won't this impact their contract?
A: Ms. Edwards: We have informed the MCEs that we have to do this. They understand the runway. OMPP will be doing another readiness review once the contracts to into place in 2023.

Q: Sen. Breaux: Moving forward, I wish to be included in future conversations.
A: Ms. Taylor: Yes. This will be a MAC discussion item when we have more details and logistics.
A: Ms. Leonard: This does not impact hospitals or pharmacies; only physicians and ancillary services.

VI. Comments

Ms. Taylor invited questions from the MAC and members of the public.

Q: Sen. Breaux: I'd like to speak with Ms. Taylor about an information request.
A: Ms. Taylor: We can follow up.

Q: Sen. Breaux: Did we renew the SET contract for four years?
A: Ms. Taylor: We will have our NEMT team follow up with you. The NEMT Commission meets this summer.

Comment: Sonder Health: Thank you for streaming live over YouTube and taking questions from the chat. Great meeting today with very beneficial information.

VII. Closing Comments

Ms. Taylor indicated today's presentations will be on the MAC website in a few days.

There will be a special MAC meeting on Wednesday, July 27, from 10 a.m. – 12 p.m. ET to provide the annual update for Healthy Indiana Plan, Substance Use Disorder and Serious Mental Illness waivers. No regular MAC business will be conducted.

The next regular quarterly meeting of the MAC is Tuesday, August 23, 2022, from 10 a.m. – 12 p.m. ET. More information about that meeting will be provided to MAC members closer to that date.

The final meeting of 2022 is scheduled for November 30.

With no further business to conduct, the meeting adjourned at 12:00 p.m.