Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy and Planning
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Medicaid Advisory Committee Minutes

February 26, 2021
Virtual meeting via AdobeConnect

Members Present
Mr. Grant Achenbach, Dr. Leila Alter, Ms. Tabitha Arnett, Rep. Brad Barrett, Ms. Lacey Berkshire, Senator Jean Breaux, Mr. Matthew Brooks (Co-Chair), Dr. Melissa Butler, Rep. Chris Campbell, Senator Ed Charbonneau, Mr. Michael Colby, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Senator J. D. Ford, Dr. Heather Fretwell, Ms. Rachel Halleck, Rep. Mike Karickhoff, Mr. Rodney King, Ms. Barbara McNutt, Mr. Gary Miller, Ms. Allison Taylor (Co-Chair) and Ms. Kimberly Williams.

I. Call to Order/Opening Comments

Medicaid Director and Co-chair Allison Taylor called the meeting to order at 10:03 a.m. and welcomed members and guests. Co-chair Taylor asked all MAC members to register their attendance in the chat room and provided brief instructions about navigating the virtual platform and using the chat room to ask questions. Co-chair Brooks thanked the members of the Committee and audience members for their work during the pandemic.

II. Approval of November 2020 Minutes

Co-Chair Brooks invited approval of the November 2020 meeting minutes. Ms. Tabitha Arnett moved to approve. Mr. Mike Colby seconded. The minutes were approved with no changes.

III. MAC Updates

Co-Chair Taylor reviewed 2020 highlights and set the stage for 2021 initiatives. She expressed appreciation to MAC members as we continue to build an efficient and effective Medicaid program.

Medicaid is Indiana's largest health coverage program, covering more than 1.7 million Hoosiers. Medicaid's centering goal is to **collaborate to improve member and provider experience**. Four strategies support this goal. First, developing a sustainable program that ensures access, which was at the forefront during the global pandemic. Our focus on not cutting member services and not cutting provider reimbursement rates were central themes throughout 2020. Second, ensuring our policies and programs advance health outcomes through measurement, evaluation and analysis to improve. Third, increasing efficiency and reducing administrative burden. And fourth, investing in our team members.

The Office's strategic initiatives include continuing to develop and support our matrix organization. Due to the complex nature of the Medicaid program, it is imperative for the various sections within Medicaid to work together rather than be siloed. Our Project Management Office (PMO) is one product of this strategic initiative. Natalie Angel, Deputy Director of Operations, worked diligently in 2020 to develop the PMO. We have a cloud-

based tool to track and charter proposals. We have established a SMART workflow, developed handbooks and project templates and timelines for staff to use, and have offered staff training. We now have bench strength among staff members who have completed training and can serve as project managers.

Another strategic initiative is targeted managed care alignment in which we look at policies and experiences across our managed care health plans and find areas to reduce unnecessary administrative burden. We had several alignment projects in 2020 including MCE treatment of chiropractic care under HIP, we set standards for MCE treatment of emergency room claims, we aligned the expectation for SUD and behavioral health denial letters and undertook a year-long revision process with our SUD workgroup. We required alignment from our MCEs on all COVID-19 policies including provider enrollment, telehealth and prior authorization. We have included some alignment initiatives in our Hoosier Care Connect contracts that will be discussed later in this meeting. And we brought the Office of General Counsel and the Office of Hearings and Appeals together to create more member-friendly and aligned appeal language both for fee-for-service and for MCEs.

Finally, investing in team members is another important initiative for us. We are working to enhance the culture of our staff so we can better serve members. We developed a brown bag series and training program and 100% of our staff attended at least one training. Brown bag topics included: HEDIS and quality measures, privacy, waivers, and performance analytics. We had 15 classroom training sessions on 28 separate occasions that included extensive project management instruction, vendor management, contract monitoring, and other topics.

Other 2020 highlights include securing a 10-year renewal of HIP, receiving HIP Bridge approval, enrollment of licensed behavioral health providers and updated the APRDRG grouper to improve hospital reimbursement equity. The Reimbursement team made some enhancements to allow some virtual audits, electronic supplemental payments, and centralized appeals in some instances.

During today’s meeting, we will hit on two of our biggest priority areas for 2021: (1) the successful re-implementation of Hoosier Care Connect, our Medicaid managed care product for aged, blind and disabled population and foster youth; and (2) the successful implementation of telehealth expansion. And our third significant priority for Medicaid and FSSA is LTSS reform and we will devote a large portion of the next MAC meeting on May 13 to this priority.

IV. Rules

Co-chair Taylor introduced Ms. Chelsea Princell, Staff Attorney for FSSA, and indicated Ms. Princell is leaving FSSA and today is her last day presenting rules for the MAC. Co-chairs Taylor and Brooks thanked Ms. Princell for her good work and Ms. Princell indicated her appreciation for the opportunity.

Ms. Princell presented an update on LSA 19-602 (Article 2 Rule) and LSA 21-32 (HIP Bridge Rule).

LSA 19-602 amends 405 IAC 2 to amend 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. It 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 for this rule on August 13, 2020 and received one oral comment and 6 written comments. With the help of Office of General Counsel, OMPP is currently reviewing the comment to determine whether any changes should be made to the proposed rule as a result and is working on responses. After making any necessary changes to the rule and receiving final approval from Dr. Sullivan, the rule will be submitted to the Office of the Attorney General for approval and adoption. Ms. Princell invited questions about this rule. There were none.

Ms. Princell then provided an update on LSA 21-32 (HIP Bridge Rule). The proposed rule amendment 405 IAC 10-13 adds HIP Workforce Bridge Account guidelines. The HIP Workforce Bridge Account will provide $1,000 for eligible members to use for qualified health care expenses during the 12-month period following disenrollment from HIP. This account is available to individuals who are no longer eligible for HIP due to an increase in income and who have completed enrollment in commercial insurance or will need to complete enrollment in commercial insurance to have continued coverage. The Notice of Intent to Adopt a Rule was published in the Indiana Register on February 3, 2021. The fiscal statements were then submitted to the State Budget Agency (SBA) and the Indiana Economic Development Corporation (IEDC) for review and approval on February 17, 2021. Once FSSA receives budget approval from SBA and IEDC, the proposed rule, economic impact statement, and Notice of public hearing will be published on the Indiana Register. Ms. Princell invited questions about this rule. There were none.

Ms. Princell concluded by indicating this is her final MAC meeting as her last day with FSSA is March 2. Madison Hartman, Staff Attorney for FSSA, will present rules moving forward.

V. FSSA Updates

Co-Chair Taylor introduced Ms. Meredith Edwards, Quality and Outcomes Section Director, to discuss the re-implementation of Hoosier Care Connect. This presentation provides a good overview of managed care operations, contracting, and procurement.

1. *Hoosier Care Connect re-implementation—Meredith Edwards, Quality and Outcomes Section Director*

Ms. Edwards introduced herself and indicated she is responsible for ensuring Medicaid health plans are compliant with state and federal laws and rules as well as the contracts they hold with the State of Indiana. She also ensures health plans meet the quality goals the state has established.

Currently 82% of Indiana's Medicaid members are enrolled in managed care programs—41% through Hoosier Healthwise (HHW) (720,261 members, children up to age 19 and certain pregnant women), 36% through Healthy Indiana Plan (HIP) (636,557 members ages 19-64) and 5% through Hoosier Care Connect (HCC) (96,901 members; blind, disabled, age 65+ but not on Medicare, foster youth who have chosen to be in managed care). Traditional Medicaid serves 18%.

Indiana's managed care entities (MCE) are health insurance companies that (1) have physical locations in Indiana, (2) serve the HHW, HIP and HCC programs, (3) are contracted for up to six years (four years plus two optional one-year renewals), and (4) are chosen through the Indiana Department of Administration's procurement process.

MCEs are paid to take care of the health needs of members with a per member per month (capitation) fee. This is an amount of money which covers the MCE's administration costs (the activities they are required to perform as outlined in state and federal law and their contracts) and all health claims (all the services members receive). The MCEs are "at risk" in this arrangement and it is beneficial for them to steer members to the right kind of care through disease management, care management, member engagement, and utilization management or the plans will lose money and members will not receive the care they need.

We have established contractually mandated medical loss ratios to prevent MCEs from under spending on health care services and to limit what they spend on administrative costs. We require health plans to spend at least 85% of their capitation fees on health care costs, not administration, or that money must be returned to the state. In commercial insurance, the ratio is closer to 80%. But Medicaid pushes health plans to higher standard: HCC is 90%, HHW is 85% and HIP is 87%. [For example, if Medicaid gives a health plan $10 for an HCC member, we expect the plan to use $9 for health care services and $1 for administration.]

Additionally, we based the next year's capitation on the claims that were paid during the previous year. If plans do not meet the established ratios, they not only risk their next year's capitation, they will also be in trouble with FSSA and the Indiana Department of Administration, and not meet quality measures.

Medicaid establishes 6-8 key quality measures for each program (HCC, HHW, HIP) based on HEDIS measures (nationally-recognized standard for care) and based on utilization. Medicaid emphasizes wellness visits/preventive, prenatal care, dental visits, and follow-up care after hospitalization. Medicaid withholds a portion of the capitation (usually 2-3%) if the MCE does not achieve excellence in the quality scores. For example, in 2019, Medicaid withheld $56 million from one of our largest plans for not meeting quality metrics.

Medicaid aligns the quality measures with the state's health focus areas. Because Hoosier Care Connect's member population is older with more health needs and more likely to have a disability, so the quality measures reflect that. In 2021, Hoosier Care Connect's quality measures are: completion of health needs screener for new members; completion of comprehensive health assessment, follow up after hospitalization for mental illness (7 day follow up and 30 day follow up), annual dental visit for ages 2-20, and adult preventive care for ages 20+. *(2021 quality measures for Hoosier Healthwise and Healthy Indiana Plan are found on slides 10 and 11 of the presentation.)* The comprehensive health assessment quality measure is unique to HCC and is used to determine which members would benefit from care management services. Although all of the programs have care management components, it is more critical for HCC members because they tend to be sicker.

Care management is purposeful outreach designed to help members positively impact their health through the coordination of services, self-management support, and the involvement of the member's support system. Care management focuses on the needs of the individual through communication with the member, their primary care provider, other providers and the member's natural support system. The care manager, most often a nurse or LCSW, assists in creating a plan, goals, and interventions for the member to help them achieve healthcare success and improve their health. In HCC, Medicaid expects MCEs to enroll members who have two or more chronic conditions, individuals in their first 90 days after discharge, or members with high utilization in their care management program. An Agency for Healthcare Research and Quality evaluation found telephonic care management, which is what our MCEs offer, is effective at improving outcomes for patients with chronic pain, asthma, diabetes and congestive heart failure, which are very common in HCC members, as well as improving self-management behaviors, like proper use of medication.

In the last two years, the Quality team has begun comparing quality measures between managed care and traditional Medicaid using the CMS adult core measures, very similar to the HEDIS measures outlined previously. Although not all measures are appropriate for comparison between HCC and Traditional Medicaid, five are: (1) breast cancer screening ages 52-74; (2) follow up after emergency department visit for alcohol or drug dependence; (3) follow up after hospitalization visit for mental illness; (4) follow up after emergency

department visit for mental illness; and (5) individuals age 18+ with a recent hospitalization and not readmitted within 30 days. In all five categories, HCC outperformed Traditional Medicaid.

HCC has been operating in Indiana's managed care environment since April 2015 and has some unique design features including greater focus on care management and disease management as well as state plan (Traditional Medicaid) benefits like dental and non-emergent transportation. Our health plans offer enhanced benefits targeted to this population such as unlimited transportation, food boxes, housing assistance, and rewards for receiving appropriate care. Additionally, HCC offers 90 days of continuity of care when members transition from one plan to another or from Traditional Medicaid to HCC. This means members can continue to see their doctors and have any prior authorizations honored by their new plan. In commercial insurance, it is usually 30 days. For example, if a member needs services and supports to help with activities of daily living for more than 30 days, they are moved into Traditional Medicaid. If the member then does not need those supports, they are moved back into HCC where they can access care management, disease management and the other tools the MCEs provide.

Ms. Edwards then presented information about the Hoosier Care Connect procurement process. HCC began on April 1, 2015 and we have been running it through managed care for six years. Prior to that time, members were on traditional Medicaid. Since managed care contracts run for six years, we began the procurement process in 2020 and put out a bid. The Indiana Department of Administration released a request for proposal and health plans submitted proposals. A team reviewed and scored the proposals and the IDOA awarded companies the work. Three health plans were selected: Anthem, MHS and UnitedHealthcare. Anthem and MHS served HCC previously and UnitedHealthcare is a new plan for Indiana Medicaid. The new HCC contracts will begin on April 1, 2021.

Indiana Medicaid's other contracts start and end dates are as follows: Healthy Indiana Plan—start date January 1, 2017, end date December 31, 2022. Hoosier Healthwise—start date January 1, 2017, end date December 31, 2022.

Ms. Edwards next discussed the process of onboarding UnitedHealthcare as a new Indiana Medicaid health plan to ensure a successful "go live" on April 1, 2021. OMPP and other FSSA divisions and state agencies have conducted more than 20 orientation meetings to teach UnitedHealthcare the specifics of Indiana Medicaid, as well as weekly project meetings to finalize operational and technical implementation aspects. OMPP conducted more than 30 hours of meetings to ensure successful technical connectivity and testing of UnitedHealthcare's systems due to the extensiveness of file transfers that will occur between the plan and the State. that needed to be established and tested. OMPP is also updating Indiana Medicaid's website to include UnitedHealthcare's information. Ms. Edwards referred to slide #22 showing a detailed timeline of all onboarding activities.

Ms. Edwards presented information about the Hoosier Care Connect readiness review, the extensive process required to ensure the health plans (Anthem, MHS and UnitedHealthcare) have all staffing, policies, processes, documents, subcontracts, system capabilities and provider networks in place and ready to "go live" on April 1, 2021. Because this is a new contract, Anthem and MHS are also undergoing the readiness review to ensure they are meeting the expectations of the new contract. Ms. Edwards referenced slide #25 detailing the readiness review requirements outlined in one paragraph of the new 183-page contract's scope of work and the activities each health plan must accomplish/demonstrate. To date, the OMPP team has reviewed more than 4,000 documents, policies, procedures and contracts to ensure compliance and readiness, and has participated in more than 24 hours of live readiness demonstrations. At least two FSSA subject matter experts (within OMPP as well as in other FSSA divisions) review every document and about 85% pass the initial review, with the remaining 15% requiring resubmission to ensure the health plan meets requirements. All health plans take this process very seriously and are on track to pass their readiness reviews.

Currently, Hoosier Care Connect members can always choose a plan on their enrollment application or within their first sixty days. Annually, members have the option to change plans on their enrollment anniversary or for a just cause reason. Most often we see just cause changes when members wish to continue seeing providers who have left the network. Our enrollment broker, an independent third-party call center, calls HCC members within their first 60 days to help members decide which health plan to select.

With the new contract period beginning on April 1, 2021, as well as a new health plan option, Indiana Medicaid has extended the timeframe for HCC members to change plans freely and multiple times, if needed, from March 1, 2021 - August 31, 2021 and will mail information to current HCC members concerning the extended selection period. Additionally, OMPP is releasing a bulletin to providers and community organizations about the plan selection period. New HCC members will receive proactive outreach from the enrollment broker. If someone picks UnitedHealthcare, their coverage starts on April 1. Ms. Edwards referred to the letter being mailed to current HCC members (slide #30). OMPP will track the number of members moving between health plans. Once the special plan selection period closes on August 31, members will only be able to change plans during their enrollment anniversary or for a just cause reason.

After the new contract is implemented, OMPP continues to oversee the managed care entities to ensure compliance and quality. During this "post implementation" phase, OMPP conducts random checks, onsite visits and audits, document and contract reviews, and evaluating the member and provider concerns that OMPP receives, especially trends so that OMPP can address them quickly and early and ensure the managed care entities are doing what they're supposed to be doing.

Ms. Edwards invited questions.

Questions asked in virtual chat room

Q: Mr. Colby—Do all Medicaid approved providers participate in Hoosier Care Connect?
A: Ms. Edwards—Our managed care entities are allowed to create networks of providers that meet the needs of the members they are serving. There is the large pool of all Medicaid enrolled providers and our managed care entities can contract with a subset of that pool. They are allowed to pick their network and credential it. However, they do need to meet network adequacy standards, and that is a large part of our readiness review and something our team checks on regularly to ensure there are enough providers to meet the needs of members. Our providers are required to be NCQA certified and that requires that they create a network and credential every provider in the network. If a provider does not pass credentialing, the MCE cannot have that provider in the network. So that's one reason they create that subset.

2. ***Electronic Visit Verification (EVV) implementation update – Michael Cook, Provider Services section director***

Mr. Cook reminded attendees that 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. It is effective January 1, 2021 for personal care services providers, and January 1, 2023 for home health services providers. The personal care services implementation was pushed back a year because Indiana received a Good Faith Effort exemption from CMS.

Mr. Cook referenced slide #4 detailing the EVV solution providers are using. As of February 24, 2021: 257 providers are using Sandata Technologies, the state-sponsored EVV solution; 427 providers are using an alternative EVV solution that meets the requirements of the 21st Century Cures Act; 68 providers may have started using one solution and then switched to the other (providers cannot use both solutions at the same time); and 277 providers have not selected one of the solutions. The Provider Services team is focused on this group to make sure they are ready and actively using an EVV solution.

Mr. Cook provided an explanation of slide #5 showing the total number of EVV visits and the total number of verified EVV visits between July 2020 and December 2020. Month to month, we are seeing growth in the number of records the state is seeing.

Mr. Cook explained slide #6 showing the three ways EVV records can be submitted: mobile application, by telephone, or manually through a computer. There is an upward trend in the number of visits being reported through a mobile application, with a slight decline from November to December. OMPP prefers to see mobile application and telephonic verifications to continue to increase and manual verifications to be minimal.

Mr. Cook explained slide #7 indicating the number of records submitted through Sandata are on the decline while there is an increase in the number of records submitted with alternative EVV solutions. This trend began in September 2020 when FSSA modified its

approach to vendor-specific testing which allowed more alternative vendors to be up and running quicker to submit their records to the state.

There have been some system issues over the past couple of months. Sandata informed FSSA of a problem with the Sandata Aggregator, the system used to collect all of the alternative vendor records. We were not capturing the records in the Sandata Aggregator correctly due to a modifier and service code issue that prevented us from identifying the specific service that the record was associated with. Sandata corrected the issue with updated technical specifications on February 8, 2021, and we have been working with vendors to make the required adjustments to their systems to ensure they meet the updated specifications. Vendors who have made the needed adjustments are able to submit records correctly. Additionally, Sandata did not receive information for a small group of approximately 40 providers due to an enrollment issue. OMPP has corrected the issue and those providers are now able to submit records through Sandata.

OMPP continues to do extensive outreach and communication to the provider community regarding EVV. We have a dedicated resource with our partners at Gainwell Technologies to help us with problem-solving customer care issues in addition to the call center that is available to providers. FSSA continues to participate in dedicated meetings with provider association leadership on EVV implementation and shares updates as we have them. We are also continuing to conduct monthly webinars about EVV for providers. These opportunities allow us to receive feedback from providers so we can make continuous improvements and are planned through April and will likely continue through the rest of the year.

Mr. Cook invited questions and provided a quick update about the spring listening sessions for providers to offer feedback about their credentialing experience and present their concerns about the credentialing process. We are also looking at the health plans' credentialing, enrollment and contracting processes. For the next MAC meeting, we will present what we have learned about the credentialing and enrollment process as well as some recommendations on how to move forward from here.

Mr. Brooks complimented Mr. Cook on his team's communication efforts with providers and provider associations.

Questions asked in virtual chat room

Q: Ms. Eichhorn—Could you loop in IHCA for credentialing feedback? We had concerns about the EnCred project and would like to make sure those issues are addressed in future credentialing plans.
A: Ms. Taylor—We see your message and have noted it.

3. *Telehealth and the COVID-19 public health emergency update: Claim utilization and results –Lindsay Baywol, Policy Developer, Coverage and Benefits Section*

Ms. Baywol indicated today's presentation is a follow-up to the presentation she gave at the August MAC meeting.

Prior to the public health emergency (PHE) declaration, reimbursements for services delivered via telehealth were limited to only services designated by OMPP to be provided by telehealth via the Telemedicine Services Code Set. Additionally, telehealth was limited by provider type in Indiana Code (405 IAC 5-38-4) and we did not allow for phone or audio-only telehealth.

During the PHE, OMPP made many policy changes. For example, with Executive Order 20-0 and 20-12, we were able to expand the provider types and services delivered via telehealth. Services were no longer limited to the Telemedicine Services Code Set. We were even able to provide some services via telehealth that were previously excluded and allow for phone/audio only telehealth.

In the last presentation, we only had data for the first half of 2020. At this time, we are now able to review claims and telehealth utilization for calendar year 2020 as a whole. This data includes telehealth usage between 2019 and 2020, but there are some caveats to this information in relation to how Medicaid collected telehealth claims. (1) The first billing guidance released by OMPP for telehealth was developed in August of 2019, in which we developed and published the telemedicine code set that was mentioned previously. Before this, there was not a uniform way in which our providers were required to submit claims for services delivered via telehealth. So with how this data was then pulled, there may be some undercounting of telehealth claims for 2019, simply because there was not a uniform way in which these claims were required to be submitted. (2) Second is related to our expansions that were made during the PHE. For example, we were able to expand telehealth modalities and allow for audio-only telehealth. We decided to not cover audio-only specific codes, and instead allowed any service to be delivered via audio-only unless it was specifically listed as an excluded service that required video. Because of this though, we can't evaluate specifically how often people utilized telephone-only or audio-only telehealth services. (3) We also had flexibility with how these expanded telehealth services could be billed and reimbursed. We encouraged (but did not require) providers to bill for these new telehealth services with the "GT" modifier, to provide greater billing flexibility, as requested specifically by our CMHCs. However, because this modifier was only "encouraged" and not "required" at the start of the PHE, we could be missing some of the telehealth claims in our data, before the GT modifier became mandatory the fall of 2020. (4) Lastly, we were able to collect demographic information from 2020 to assess which of our members are utilizing telehealth, so that information will be provided in this presentation as well.

Ms. Baywol referred to slide #5 (Summary Statistics) and overall statistics for the second data report. The slide details all telehealth claims collected in calendar year 2019 and all claims collected in 2020 (that have been billed for thus far). We see that there is a substantial increase between the two years both in total number of claims—63,844 (2019) compared to 2,673,241 (2020)—as well as total paid reimbursement--$4,871,436 (2019) compared to $151,189,713 (2020). We also wanted to add that this number for 2019 is lower in comparison to what was originally presented to the group in the fall, and again this because we did not have solidified billing guidance for telehealth services until August 2019.

Ms. Baywol referenced slide #6 (Telehealth Utilization) as a visual representation of the data. There was an increase in telehealth claims between March and April 2020, which is representative of the public health emergency and also our telehealth expansions. From August 2020 onward, we have seen a decrease in the number of claims and this may not actually be a result of lower utilization, but instead because of billed claims lag. We will monitor this trend and provide more updates on this data as it comes in.

Ms Baywol referenced slide #7 (Claim Types) which shows the break-down of all 2020 telehealth claims (totaling 2,673,241) and the types of telehealth procedures. About 54% (1,452,606) were claims for services previously not allowed under our policy and were part of the policy expansions made during the PHE. About 44% (1,166,926) of those claims were for the procedure codes that we covered on the telemedicine code set. And 2% (53,709) were for Medicare crossover claims for our dual eligible population.

Slide #8 (Services) details the most utilized telehealth services for 2020. These tables only include results for services that were already covered prior to the PHE. These codes are not related to telehealth expansions that occurred during the PHE. We see that office/outpatient visits still are the most often utilized of these codes, with psychotherapy codes a close second.

Slide #9 (Demographic Data) compares the 5 most common provider types billing for telehealth claims. For both codes that were listed on our telemedicine code set (shown in red) and codes that were a result of PHE expansions (shown in blue) that Behavioral Health providers were utilizing telehealth delivery the most. This just provides more context as to why we want these providers to be able to continue to utilize telehealth, especially since how Indiana Code is currently written, many of these providers (e.g. Licensed clinical addiction counselors, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, etc.) will not be able to continue to utilize telehealth unless Indiana Code is amended.

Slide #10 (Demographic Data) shows a breakdown of the race and ethnicity of Medicaid members utilizing telehealth services sorted by number of claims. Among Medicaid members, the majority of claims (67.3% or 1,802,600 claims) represent members who identify as Caucasian, which is higher than the percentage of Medicaid members who identify as Caucasian (61.3%). A percentage of claims (18% or 482,652 claims) did not specify race or ethnicity. There is evidence that our members who identify as Black, Hispanic, or Asian are utilizing telehealth at lower rates than the percentage of Medicaid members that identify as these races. (Although we know the percentage of Medicaid members that identify as these races, we do not know the pre-public health emergency utilization of Medicaid services by race.) While we see that more Caucasian people are utilizing telehealth services than the percentage of Medicaid members that actually identify as Caucasian, it could be that Caucasian members are *overall* utilizing Medicaid services at a higher rate than our Black or Hispanic members, and that this is not specific to telehealth services. We hope to do further analysis on this demographic information, so we can definitively identify that these decreases in utilization are related to telehealth, and not overall Medicaid utilization. However, as we can see from this example, we do have evidence that our members who identify as Black, Hispanic, or Asian are utilizing telehealth services at lower rates than their Caucasian counterparts, when comparing this to our overall Medicaid enrollment data. Our programs may need to provide additional supports to achieve equality. For example, improved access to internet or smart devices.

Co-chair Taylor commented that this snapshot of data is significant and OMPP is watching nationally to make sure that our Medicaid policies do not further the divide to access to care. OMPP will analyze our services, policies, procedures and programs and look forward to digging in to ensure equity and access across the board.

Slide #11 is a graphical representation of slide #10. The graph on the left depicts the demographics of our telehealth claims, and graph on the right is the demographics of our Medicaid members. The blue slice (Caucasian) is the largest percentage of telehealth claims and is larger than the demographics of our Medicaid members. The green slice (Black) and the purple slice (Hispanic) are smaller in telehealth claims in comparison to the demographics of our Medicaid members. The red slice (no race/ethnicity data available) indicates there is less demographic information available for our telehealth claims compared to the information available for our Medicaid enrolled members.

Ms. Baywol concluded her presentation and indicated OMPP hopes to do further claims data analysis and will provide updates on this data as requested. Also, OMPP is supportive of the current telehealth legislation proposed and going through the general assembly, as it aligns with our need for telehealth policy expansion. We are optimistic for the future of telehealth, and how changes to the policy will benefit our Medicaid members.

Co-Chair Taylor thanked Ms. Baywol and indicated we would revisit the data and trends as additional claims are submitted and analyzed.

Questions/Comments in virtual chat room

C: Dr. Daniel Spitzberg—I have been on national meetings on telehealth and the numbers are skyrocketing, especially in behavioral health.
C: Sen. Jean Breaux—Yes, we many need to provide additional supports. Great snapshot.

Q: Sen. Breaux—Why is there no data available for those self-reporting?
A: Lindsay Baywol—We are using claims data and do not have that information today. We will take this question back to our team. However, Meredith Edwards, Quality and Outcomes Section Director, says we only use demographic data available from applications and not from the claims data. So that's a correction.

Q: Kavya Jagannath—Is there a research team in place that deals with equity issues, especially as it pertains to race?
A: Co-chair Taylor—We have clinicians and policy developers of different backgrounds who work together on this. We are trying to really enhance our equity lens. So the idea of having a team specifically dedicated to this is something I think we should consider. OMPP will be partnering more and more with FSSA's new Chief Health Equity and ADA Officer, Dr. Breanca Merritt, and we will continue to hit that theme to ensure we are deliberate and methodical with the health equity lens for our Medicaid members. We are always looking for best practices.

VI. Public Comments

Co-Chair Brooks thanked everyone for their patience with any technology issues they experienced today and opened the meeting for comment, first from MAC members and then from the public.

Questions/Comments in virtual chat room

Q: Mary Beth Roska—Is there any update on Gateway to Work?
A: Co-chair Taylor—There are no updates on Gateway to Work and it is on hold indefinitely pending the outcome of litigation.

Q: Suzanne Clifford—Are you seeing any increases in overdoses or suicides by Medicaid recipients?

A: Co-chair Brooks—As we have seen on the news, there are national increases in suicides and overdoses. Although we do not have data to present today, we do know that in Indiana 1 in 5 people are Medicaid members, and Medicaid members do have higher rates of overdose and suicide.
A: Co-chair Taylor—OMPP has been pulling data jointly with the Division of Mental Health and Addiction and we should be able to break it down by payor source and anticipate Indiana data may reflect the national trend.
A: Co-Chair Brooks—Perhaps at a future MAC meeting, we could look at how the pandemic has impacted overall healthcare and various health conditions as we consider what may need to be overcome during the post-pandemic and recovery periods.

C: Rep. Chris Campbell—I would be interested to know how well Medicaid covers mental health vs. other state-funded mental health services, and how the shortfalls in budget may also impact these issues.
A: Co-Chair Taylor—We will plan to have Jay Chaudhary of DMHA present at a future MAC meeting. And we can discuss the Medicaid coverage levels for mental health.

C: Suzanne Clifford—Yes, the DMHA budget is a big concern!
A: Co-Chair Brooks—We acknowledge that there are concerns here.

VII. Closing Comments

Co-chair Brooks reminded MAC members that the next regular meeting is scheduled for Thursday, May 13, 2021, from 10 a.m. – 12:00 p.m. and will likely be in a virtual format once again. He reminded MAC members that meeting announcements are sent as an email and not a calendar invitation. The meeting agenda contains a link to the meeting.

Co-chair Taylor indicated OMPP will debrief with the technology team concerning today's issues and develop best practices to make improvements before the next meeting. She encouraged MAC members to run a test prior to the meeting using the same device they will use during the meeting.

Today's presentations will be posted to the MAC website in a few days and we will prepare robust minutes to share before the next meeting.

With no further business to conduct, the meeting adjourned at 11:34 a.m.