Eric Holcomb, Governor
State of Indiana

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

Medicaid Advisory Committee Minutes

November 30, 2022
In person and Zoom meeting

Members Present—taken by roll call
Ms. Maddie Augustus, Ms. Sirrilla Blackmon, Dr. Sarah Bosslet, Senator Jean Breaux, Rep. Ed Clere, Mr. Michael Colby, Ms. Terry Cole (Co-Chair), Ms. Danielle Coulter, Ms. Elizabeth Eichhorn, Ms. Katherine Feley, Ms. DeAnna Ferguson, Rep. Rita Fleming, Ms. Zoe Frantz, Mr. Herb Hunter, Ms. Julia Ketner, Mr. Rodney King, Mr. Luke McNamee, Mr. Dick Rhoad, Mr. Shane Springer, Ms. Katy Stafford-Cunningham, Ms. Jessaca Turner Stults, 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 10:04 a.m.

II. Approval of August 2022 Minutes

Ms. Cole invited a motion to approve the August 23, 2022 meeting minutes. Ms. Katy Stafford-Cunningham moved to approve. Ms. Julia Ketner seconded. The minutes were approved with no changes.

III. MAC Updates

Ms. Allison Taylor, MAC Co-Chair, reminded members this is the final meeting of 2022 and directed attention to the agenda listing the proposed meeting dates for 2023. The format for these meeting has not yet been determined. It was suggested to move the February meeting to the afternoon rather than morning due to the General Assembly schedule.

IV. Rules

Ms. Taylor introduced Ms. Amanda DeRoss, FSSA staff attorney, to present LSA 22-253-Program Integrity Rule.

Ms. DeRoss gave a brief overview of the rule and where the rule is in the promulgation process. This proposed rule [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. FSSA received approval from SBA on October 4, 2022 and received approval from IEDC on September 6, 2022. Notice of Public Hearing will be published with the Indianapolis Star and the Indiana Register on April 4, 2023. The public hearing for this rule will be held on April 23, 2023.

Ms. DeRoss invited questions.

Questions/Comments

Sen. Breaux: Why is IEDC part of this? Is this rule to allow more billing flexibility for CMHCs?
Ms. DeRoss: All rules have to be submitted to both State Budget Agency and Indiana Economic Development Commission.
Ms. Taylor: There are formal checkpoints for all rules.

V. Ethics reminder/refresher

Ms. Taylor introduced Jessica Keyes as the new FSSA General Counsel.

Ms. Keyes reminded MAC members of the communication they received regarding ethics training. She urged members to complete the ethics training and submit the attestation by December 13, 2022. Questions about the training and process should be sent to ethics.fssa@fssa.in.gov.

Ms. Taylor indicated this training is for non-legislative members of the MAC. Legislative members have a separate ethics training requirement, however Ms. Keyes noted that taking the executive branch ethics training is encouraged.

Questions/Comments

Senator Yoder: Since I sit on multiple boards and have taken the training, is there a way that you know I've taken it?
Ms. Keyes: We don't have a tracking method. The attestation link is the place you inform us that you took the training.
Rep. Clere: Legislators serving on a board/commission should take the legislative, not executive branch training.

VI. FSSA Updates

1. ***Management performance hub—Josh Martin, State of Indiana Chief Data Officer***

Ms. Taylor introduced Brian Arrowood, FSSA Chief Information Officer, who introduced Josh Martin, State of Indiana Chief Data Officer and MPH Director.

(slides 1-8) Indiana's Management Performance Hub (MPH) provides analytics solutions tailored to address complex management and policy questions enabling improved outcomes for Hoosiers. MPH empowers its partners to leverage data in innovative ways, facilitating data-driven decision making and data-informed policy making. The MPH and chief data officer role were created by statute IC 4-3-26. The MPH is positioned as the state of Indiana's hub for data-driven innovation and collaboration by understanding how challenges intersect, integrating

disparate datasets, leveraging technology and convening government agencies and community partners. MPH seeks to share data and insights, break down barriers and partner with others in innovation. The Indiana Data Hub can be accessed at hub.mph.IN.gov.

(slides 9-11) FSSA partnered with MPH to leverage Medicaid data for research. Medicaid Optimization unlocks the potential of Indiana Medicaid claims data, allowing researchers and providers to evaluate policy impacts across three primary categories: members, providers and claims. Various entities have used de-identified Medicaid claims data to analyze existing service areas and gaps, key drivers of emergency room use, and mental health costs.

(slides 12-13) In partnership with the Fairbanks School of Public Health, MPH created the first statewide random sample study of COVID-19 response in the nation, turning data from a variety of sources into valuable information.

(slides 14-16) The Indiana Equity Data Portal (IN.gov/equity/data-portal/) went live in the fall of 2021 and contains dashboards for health, public safety, social services, education and workforce development.

(slides 17-25) The Education Workforce Data System (EWD) helps policymakers, program administrators, educators, employers and other stakeholders make data-informed decisions to take actions that improve outcomes and facilitate research to improve policies and service provision. Partner agencies include: Indiana Department of Education, Indiana Commission for Higher Education, Indiana Department of Workforce Development, Governor's Workforce Cabinet and FSSA. The high school graduates employment outcomes dashboard and career and technical education employer connect tool present data to better understand the education-workforce pipelines in Indiana and to align the talent pipeline from CTE to employer workforce needs, respectively. And the Next Level teacher compensation commission dashboard provides graphic representation of Indiana's teacher salaries.

Mr. Martin invited members of the MAC and public to explore the various websites outlined in the slides.

Ms. Taylor invited questions.

Questions/Comments

Ms. Ketner: How is Indiana finding data on Medicaid members who might lose coverage when the PHE ends? Other states have done this with dashboards. Is OMPP partnering with MPH?
Mr. Arrowood: The next speaker will be talking about the PHE unwind and the efforts we're undertaking to ensure we're reaching people about coverage. We will be using all the data at our disposal to ensure we have updated information, including current address.

Sen. Breaux: Is the data representative of only Medicaid members or all Hoosiers? Do you do a demographic breakdown when you post to these dashboards? Are you looking at data through an equity lens?

Mr. Martin: The data comes from a number of environments, not just Medicaid population. The demographic data we had is how we developed the first version of the equity data portal. It may take some time to get the complete picture, but we are proud of what is currently available.

Ms. Stafford-Cunningham: How can our INARF employers use the technical career connect tool to address workforce shortage issues?
Mr. Martin: Please reach out to me directly to learn more. We are always looking for more partnership opportunities.

Ms. Frantz: It would be helpful to have access to care and outcomes to show data and share with legislators and stakeholders. She will follow up with Mr. Martin directly to learn about their capacity.

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

(slides 1-2) CMS renewed the federal public health emergency through Jan. 11, 2023 and did not provide a 60-day notice. So we expect it will be extended again. The next notification deadline is Feb. 11, 2023 for an April PHE end date. If the PHE ends in April, the first possible disenrollments could begin in May.

(slide 3) Starting the month after the PHE ends, we return to regular eligibility rules. This impacts approximately 75% of Indiana's Medicaid members. Individuals in this group who do not respond to requests for information or who are determined to no longer qualify for coverage can be disenrolled or moved to a lesser-coverage category.

(slides 4-5) Individuals whose eligibility remained open solely due to federal PHE maintenance of eligibility rules will be reassessed when their scheduled annual redetermination is due. This impacts approximately 25% of Indiana's Medicaid members (500,000 individuals). The state 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. It is important that these members take action to stay open.

(slides 6-8) FSSA is sending postcards reminding individuals to update their contact information and to respond to all mail from FSSA. FSSA is sending these in advance to allow for processing returned mail. CMS granted a special waiver allowing FSSA to use USPS mail forwarding and change of address provided by health plans, if they have confirmed the change with members. FSSA also has posters available at IndianaMedicaid.com for the community/providers to display. Health plans are communicating with phone calls and texts. And members can opt in to receive electronic notifications using their benefits portal at fssabenefits.in.gov/bp.

Members will receive an explanation/reminder letter 60 days before the redetermination letter is sent. The redetermination letter will be sent 45 days before the redetermination due date. If a member fails at redetermination, a final advance warning of closure notice

will be sent with appeal rights and instructions on how to appeal. Those who do not 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. This is a grace period.

Members who are subject to cost-sharing (premiums, contributions, or copayments) will receive notice at least one month prior to the restart of cost-sharing. Contribution/premium restart explanation notice will come from FSSA, and information and due date will also be sent the month before the first payment is due from the member's MCE or healthplan (for HIP) or the premium vendor (CHIP or M.E.D. Works). Cost-sharing will not resume any sooner than the first of the calendar quarter after the PHE ends. (If the PHE ends in April 2023, the soonest cost-sharing will resume is July 2023.)

(slide 9) Individuals who are over the income limit for Medicaid will have their information transferred to the federal Marketplace (Healthcare.gov) and be given a special enrollment period to apply for coverage there. Those who are closed for failing to verify their income or other eligibility factors will be eligible to apply on the Marketplace at any time during 2023 as long as their income is under 150% of the federal poverty level. Hoosiers over age 65 could look into health coverage through the federal Medicare program (Medicare.gov) or by calling 800-MEDICARE. Indiana's State Health Insurance Program (SHIP) can also help with Medicare-related questions—Medicare.in.gov or 800-452-4800.

(slides 10-14) 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 contains other tools including flyers, posters, postcards, social media assets and key message points. More tools will be added in the coming months.

(slide 15) Right now, providers and those who serve Medicaid members can watch for updates about the end of the federal public health emergency, 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.

(slide 16) Current Indiana Medicaid members should confirm FSSA has their current information by (1) going to FSSABenefits.IN.gov, (2) scrolling to the blue "manage your benefits" section, (3) clicking on either "sign in to my account" or "create account." Members needing assistance can call 800-403-0864.

Questions/Comments

Representative Clere: A quarter of Indiana's Medicaid population is at risk and will be subject to normal redetermination based on their enrollment date.
Ms. Spinner: Yes, redetermination is based on their first application/anniversary date. It will not be shorter than 12 months and they will receive advance notice at 60 days and 45 days

before they're due. FSSA has been continuing redeterminations during the PHE, but those who did not pass went into the 25% bucket where we would follow up on them later.
Rep. Clere: Within the 25%, we have lost touch with people?
Ms. Spinner: Yes.
Rep. Clere: So they didn't pass. Let's use my August example. We've lost touch with someone and they are now in the 25% at-risk pool and their redetermination date would normally be in August; we emerge from the PHE in July, they would be expected to complete redetermination in August?
Ms. Spinner: Yes.
Rep. Clere: So, they would not have 12 months following the end of the PHE.
Ms. Spinner: It's 12 months from when their last redetermination was.
Rep. Clere: For a segment of this 25% who are at risk, the 12 months is effectively arbitrary because they haven't completed redetermination. So it's not like in August it would have been 12 months since they last completed redetermination during the PHE.
Ms. Spinner: It would be since the last time they were due for redetermination.
Rep. Clere: But it seems like some members in that 25% pool will be at a disadvantage based on where they started a long time ago before the PHE. It's luck of the draw after the PHE ends whether their redetermination date is in a month or in 11 months.
Ms. Spinner: I understand what you're saying.
Rep. Clere: Why wouldn't we reset everyone's redetermination to occur 12 months after the end of the PHE so everyone is on a level playing field?
Ms. Taylor: We do not wish one person to have a negative action that isn't true for their situation. For us as a statewide eligibility unit, processing over a 12-month period is the best and safest way to ensure we have a manageable workload. If we did everything in 12 months, that's a problem.
Mr. Arrowood: One of the earlier plans had three waves of redetermination. There is a funding component to this process. The biggest concern even with a 12-month plan is the workflow in DFR offices that will be higher than ever before and it is not feasible to do everything in one month at the end of the 12 months.
Ms. Taylor: To gold standard is taking that 12 months to "unwind" proportionally in addition to maintaining the regular DFR workload. These redeterminations are essentially new work on top of the existing workload. We believe doing 1/12 over time is the safest approach for members. Some will get less notice, but at the same time, we're going on three years and have been communicating and reaching out.
Mr. Arrowood: Each CMS extension has come with a different tenor and tone with what's going on with this population. We have a batch of postcards that will be mailed by February that will be a proactive step and head start. We know the PHE isn't ending before April. So will give a little more runway with those postcards as targeted outreach to members.

Rep. Clere: Thank you for the thoughtfulness you have been putting in along the way. And I'm sensitive to the workflow. It's just that we know that within that 25%, there are the most at-risk individuals including those caught in the housing crisis. Many of these people

are probably housing insecure and have changed addresses multiple times during the PHE. And we may have lost touch with them. Is it correct that FSSA can't use updated address information unless it has been verified with the member? So if there is a person who is housing insecure and has changed addresses multiple times during the PHE, maybe they don't have an address right now, now we think we have an address for them which we got through our partnership with MPH, but if we cannot verify the address, we can't use it to contact them?

Ms. Spinner: With electronic data we receive, CMS requires that before we take action on it, we reach out to the member to confirm it themselves. We have secured two waivers to allow us to take electronic data we receive from their healthplan (if they've spoken with the member) or information from the national change of address database as authoritative. We can act on that information without having to reach out to the member. If we were to get another source of data, we are required to reach out to the member to ask "is this really your address?" We cannot use any other form unless it's from the member or their authorized representative.

Rep. Clere: So if we have an updated address available from the BMV, CMS says we cannot use that address unless we verify with the member?

Mr. Arrowood: Yes. We will use that address for targeted outreach. We also have a waiver to use text messaging. The 211 team will make outbound calls to the member to update their information. We could take the information from BMV and send a postcard or text message or have 211 call the member. We are following federal guidelines. Our DFR offices have to do a phone call as well.

Rep. Clere: What if we have an address from BMV but don't have a good phone number because this housing insecure person is using a prepaid cell phone and they've changed cell phone numbers multiple times in the last year?

Ms. Spinner and Ms. Beam: If we are unable to reach the person, we will send mail to the new address asking that the member confirm it is their current address. DFR will absolutely send something to the new address asking member to confirm the address.

Rep. Clere: That is somewhat reassuring. But circling back to my original concern for the 25% of the Medicaid population and their redetermination dates, it is arbitrary because it keys off when they first enrolled. Some will have a month while others have 11 months or more before they hit the redetermination requirement. Right?

Ms. Spinner: Right.

Rep. Clere: Is there a way to keep workflow considerations in mind, especially in the early months after we emerge from the PHE to put folks we are unsuccessful in communicating with into a probationary/cushion status and give them another 90 days of coverage to give them more time to respond? If, by the luck of the draw, someone has an almost immediate redetermination after we emerge from the PHE, then there may not be enough time for calls (if the number is bad), mail only being checked every few weeks at a homeless shelter if they are housing insecure, and they don't connect with us before their time is up.

Ms. Taylor: We need to balance the need while making sure we don't break the system. Whenever we redetermine someone, that sets us up in perpetuity for them to have that

annual redetermination date. Part of the reason behind the 12 month smoothing out is so that we can continue doing our jobs effectively and have the correct staffing levels year round so we don't have periods of crisis where we are behind/have backlogs and increased appeals. I understand your concerns about our "at-risk" population. We need to think about what can be doing now.
Rep. Clere: Can we respect the redetermination date and also provide latitude/cushion for those members who meet certain criteria (including being unable to find them) so that they aren't penalized if we find them after a reasonable amount of time after the original redetermination date (in the first couple of months after the end of the PHE). They need special treatment.

Sen. Breaux: What are the numbers we're talking about? Can a listing of all benefits that will be dropped/changed once the PHE ends? Can you provide us with a one-pager? Can we create a mailer/packets for legislators to provide to their constituents?
Ms. Spinner: 25% is 500,000 people; 75% is 1.6 million people. We are not implementing any changes now. We are waiting for the federal government to tell us that the PHE has ended.
Ms. Taylor: The online resources can be printed for free. Please connect with Gus Habig on the FSSA legislative team. We will return to normal eligibility processes after the PHE ends. There are some instances for cost-sharing that are included in state statute. So those will come back.
Mr. Arrowood: Go to IndianaMedicaid.com to access the PHE updates and toolkit resources. This is also included in the presentation.
Sen. Breaux: Is it just cost-sharing that will resume when the PHE ends or are there other things alongside that?
Ms. Spinner: Cost-sharing will resume, some individuals may have to verify their eligibility, some individuals may drop to a lesser coverage. So if they stayed on disability Medicaid during the PHE because we could not change them, they could move to something like HIP Basic once we review their eligibility. If someone was pregnant and they are past that 12 months post-partum, they could move from pregnancy full coverage to HIP Basic if that's what they're eligible for. So those "downgrades" that haven't been occurring during the PHE will go back to normal after the PHE ends and we'll put them in the appropriate category that fits their eligibility criteria.
Sen. Breaux: So cost-sharing and "downgrades" will resume following the end of the PHE.
Ms. Taylor: There may also be people who are no longer eligible for Medicaid. We will run them through the process. We expect to see people no longer eligible for Medicaid and we will do warm hand-offs to the Marketplace. We want everyone to be successful. Medicaid enrollment will come down, although we are uncertain by how much, over a 12-month period.
Ms. Spinner: For HIP members, there are no lockouts. So if there was an error, they can immediately re-apply and regain coverage. A CMS waiver removed the 6-month lockout period and it is no longer part of the program.

Rep. Clere: If a member is disenrolled and re-enrolls, the re-enrollment would not be retroactive to the date of disenrollment. So there could be a gap in coverage.
Ms. Spinner: Correct. If they believe there was an error made in the eligibility determination, they should appeal and they could get continued benefits until there is a final determination.
Rep. Clere: We should be especially concerned about the 25% since they are very vulnerable. Does CMS limit our cushion for those who are in the early redetermination period?
Ms. Taylor: We will talk through the idea of cushion. When the PHE ends, we are "on the clock" to conduct the redeterminations because it is a mechanical/automatic process. We want to limit risk which is why we have the resources available now to communicate with members. We'll have to look into whether CMS limits our cushion. Our waiver authorities have ended.
Ms. Spinner: We have a full 12 months, with a month to start and a month to end. So, it's 14 months effectively. But we have just 12 months to do the work. If we have individuals who are still on after that point, we can be penalized on audits. And the additional FMAP runs out the quarter in which the PHE ends. So the funding to support our extra membership goes away before the membership is completely resolved.
Rep. Clere: So we have 12 months of flexibility from CMS in terms of not being penalized for keeping people on the rolls.
Ms. Taylor: FSSA's operations team has been planning for the unwind for more than two years. The amount of work coming will be tremendous.
Rep. Clere: There has to be a way to keep track of people who are being disenrolled in that 25%.
Ms. Cole: Is there additional data on those 500,000 people to parse them out and start working on that group now?
Mr. Arrowood: We have done that. The most vulnerable (Aged/Blind/Disabled as an example) have been pushed to the end of the 12-month redetermination period regardless of their regular redetermination date.
Rep. Clere: So we are on the same page.
Mr. Arrowood. Yes.
Rep. Clere: Again we have the housing insecurity issue. Those are the people I'm particularly worried about because these 500,000 people are about 7% of our state's population. So it's not a small number of people. And we know how many people in Indiana have faced housing insecurity over the past 12 months.
Ms. Taylor: During the February MAC, we can give an update talk more about prioritization with a little more detail.
Rep. Clere: Nothing I've said is meant as a criticism. I appreciate how thoughtful you've all been.
Ms. Spinner: The 25% will be addressed through redetermination and that comes with a 90-day grace period. They won't retain their coverage during that period, but all they have to

do is contact us, sign their form and provide their paystub/documentation and they start right back up again. For those individuals who are not on HIP, they will have retroactive coverage which will help them avoid having a gap.
Rep. Clere: Obviously people with chronic conditions, substance use, mental health issues that are being addressed through their coverage and then we have a gap in coverage and they lose the connection with something that's already tenuous in terms of treatment of a chronic issue.
Ms. Taylor: Our MCE partners will be helpful in that, too. The last thing they want to do is lose connection with a member. We will keep talking about how we can partner. There are a lot of opportunities to be intentional.

Mr. Colby: When a provider checks eligibility, is it possible for them to receive a message that the member is at risk? So when the member comes in for services, they can be informed.
Ms. Taylor: We'll take this back to confirm.
Ds. Alter: Providers can put posters and postcards in their offices.
Ms. Taylor: Providers can give members a postcard and encourage them to get into the portal to update their information. A lot of organizations want to help get the word out, and we appreciate that. We provided our website in the chat to access the very detailed postings on our PHE unwind plan. And outside of the MAC, will have additional stakeholder engagement opportunities to build coalitions around getting the message out and what needs to happen.

3. ***HCBS spend plan update – Dr. Maria Finnell, FSSA Chief Medical Officer***

Ms. Taylor introduced Dr. Maria Finnell to present an update about the HCBS spend plan.

(slide 1) FSSA is maximizing the one-time opportunity provided by Section 9817 of the American Rescue Plan Act (ARPA) to invest an estimated $817 million into the HCBS landscape through March 2025. In June 2021, we engaged over 660 stakeholders to ensure that the services delivered are in line with community needs.

(slide 2) The state's HCBS spend plan consists of two phases. Phase 1 focused on stabilization of Indiana's workforce and provider networks. In spring 2022, FSSA issued $176 million in direct funding to providers. Phase 2 focuses on longer-term targeted initiatives with the goal of building out a sustainable environment to support long-term care reform efforts. This phase has four priorities: workforce, enhancing HCBS, building provider capacity and caregiver training and support.

(slide 3) On this timeline, you can see we are about half-way through the funding period. All funds must be spent by the end of the first quarter 2025.

(slide 4) A majority of Indiana's planned investments serve more than one target population, as well as directly impact HCBS providers and the workforce through 2025 and beyond. *Populations served*: crisis supports (13.7%), older adults (10.9%), individuals with IDD (8.8%), high-need youth and families (2.7%), caregivers (2.0%) and multiple populations (61.9%). *Provider and workforce impact*: HCBS provider and workforce (78%), policy administration support (12.1%), HCBS data investment (8.0%) and stakeholder engagement (1.6%).

(slide 5) FSSA prioritized immediate stabilization efforts to the critical workforce in the first phase of Indiana's HCBS spend plan, disbursing $176 million to 1,195 HCBS providers throughout the state in the spring of 2022. The majority of funds ($132 million) went to frontline staff in the form of bonuses, benefits, training and recruitment.

(slide 6) During phase 2, FSSA is investing $638 million in numerous initiatives within four priority areas to drive systemic change--$195 million to support the provider workforce, $166 million to build provider capacity to meet the growing HCBS needs of the Medicaid population, $236 million to ensure all individuals have easy and equitable access to HCBS, and $41 million to support families and caregivers of individuals receiving HCBS.

(slide 7) There are three grant mechanisms in phase 2. (1) MLTSS provider readiness grants of $20,000 will be distributed in December 2022 to support providers transitioning to the managed care system in 2024. (2) HME/DME stabilization grants amounting to 8.1% of their qualifying HME/DME claims total will be distributed in January 2023 to stabilize and support HME/DME providers. (3) Direct Service Worker investment grants totaling $130 million will be distributed in January 2023 to providers to support direct service workers as part of the publicly-available DSW state plan.

(slide 8) FSSA recently launched three grant opportunities totaling $13.6 million to improve non-emergency medical transportation access. $3.8 million was awarded to 12 applicants ($180,000 each) to purchase 21 bariatric ambulances. $6.5 million total is being distributed to 90 applicants for the purchase of 115 wheelchair vans and 41 wheelchair lifts. And applications for the purchase of up to 30 Type II Sprinter ambulances ($3.3 million total, $110,000 each) closed on November 28.

Questions/Comments

Sen. Breaux: Thank you for the easy-to-follow presentation. Are the direct service worker grants in addition to the increased funding to direct service professionals that we put through the legislature? Did we use this grant money to provide that increase?
Ms. Taylor: FSSA is very excited to be comprehensive about these HCBS opportunities. This grant funding does not supplant what the legislature has done. It is the additional FMAP

funding from ARPA and is not tied to SBA. The rate methodology work will be done separately. All of HCBS spend plan information is online and we are working on clean up that landing page listing the opportunities.

VII. Comments

Ms. Taylor invited questions from the MAC and public and reminded attendees this is the final MAC of 2022. As plans for the PHE unwind become more concrete, we will continue communicating. Today's presentations must go through ADA compliance before being posted to the MAC website. This can take several days. The MAC recording from FSSA's YouTube channel will be available after the meeting.

Questions/Comments

Hoosier Action: Thank you for going over PHE unwind and encourages legislators to put blurbs about the unwind in their newsletters. Fantastic news that lockouts are permanently ended.

VIII. Next meeting

Ms. Taylor indicated the team would look at changing the time for the February 23 meeting to occur in the afternoon rather than morning due to General Assembly business.

With no further business to conduct, the meeting adjourned at 11:51 a.m.