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 17, 2020
Virtual meeting via AdobeConnect

Members Present

Dr. Leila Alter, Ms. Tabitha Arnett, Rep. Brad Barrett, Senator Jean Breaux, Mr. Matthew Brooks (Co-Chair), Dr. Melissa Butler, Rep. Chris Campbell, Mr. Michael Colby, Ms. Terry Cole, Ms. Elizabeth Eichhorn, Rep. Rita Fleming, Ms. Rachel Halleck, Mr. Herb Hunter, Mr. Rodney King, Ms. Barbara McNutt, Mr. Gary Miller, Mr. Michael O'Brien, Mr. Evan Reinhardt, Senator John Ruckelshaus, Rep. Robin Shackleford, Ms. Katy Stafford-Cunningham, Ms. Allison Taylor (Co-Chair), Mr. Drew Thomas and Ms. Kimberly Williams. Rhonda Bennett represented the Indiana State Medical Association in place of Grant Achenbach.

I. Call to Order/Opening Comments

Medicaid Director and MAC Co-Chair Allison Taylor called the meeting to order at 10:07 a.m. and welcomed members and guests. She advised attendees that today is the final MAC meeting of 2020 and there is a full agenda. 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.

II. Approval of February Minutes

Co-Chair Taylor invited approval of the August 2020 meeting minutes. Mr. Herb Hunter and Mr. Rodney King moved to approve and Ms. Tabitha Arnett seconded. The minutes were approved with no changes.

III. MAC Updates

Co-Chair Taylor directed MAC members to the agenda and proposed meeting dates for 2021. The Office will work with its legislative partners to ensure the February 26, 2021 date will work given the General Assembly's schedule. It is highly likely that the first quarter's meeting will be virtual the Office will notify members closer to the date.

Co-Chair Taylor advised MAC members to visit the provider services section of the Medicaid website for COVID-19 policy updates. It is the Office's intent to maintain the current waivers and flexibilities through the near term and does not expect to make changes as the public health emergency continues.

IV. Rules

Ms. Chelsea Princell, Staff Attorney for FSSA, presented an update on LSA 19-602 (Article 2 Cleanup Rule). This rule amends 405 IAC 2 to 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 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. 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. Following her presentation, Ms. Princell invited questions. Ms. Arnett asked whether there was a link or attachment regarding this rule. Ms. Princell responded that these can be found in the Rulemaking Notices and Updates section at the left side of the FSSA homepage.

V. FSSA Updates

Co-Chair Taylor introduced Michael Cook, Provider Services section director, to present again about Electronic Visit Verification (EVV).

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

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

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

EVV captures six data points: (1) type of service performed, (2) individual receiving the service, (3) date of service, (4) location of service delivery, (5) individual providing the service, and (6) the time the service begins and ends. Beginning January 1, 2021, all claims

submitted for services provided in the home must be accompanied by an EVV record or they will not be reimbursed.

Mr. Cook next reported on the overall readiness of providers. The original number of providers expected to be impacted by EVV when it was first announced several years ago was 1,600. Today, the Office estimates approximately 911 IHCP providers of personal care services will be impacted based on claims data from calendar year 2019. Of these 911, 383 providers are considered "confirmed capable" and have either 1) completed Sandata training and received log in credentials or 2) completed steps for using an alternative EVV vendor and are capable of submitting records. Of these 383, only 64 providers have successfully submitted EVV records. This number indicates we still have a lot of providers who are not ready.

Mr. Cook next explained the current visit verification data for the period April-September 2020. Although providers have been submitting claims through the EVV systems, the majority of those claims do not meet all required criteria for a verified visit. When a visit is considered incomplete, it is due to incorrect or missing data from the EVV record. When this occurs, providers must log into the system and have to clear the exception. Top five reasons for providers to clear the exception: unauthorized service, unknown employee, missing service codes, visits without out-calls (provider forgot to clock out) and unknown clients. Most providers are capturing visits through calls, application on smart phone/device, and manually through the Sandata website. Currently 80% of providers are using the Sandata solution and 20% using an alternative vendor. However, the Office expects the percentages to even out a bit.

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

Communication to providers has included: (1) 20+ articles on EVV in IHCP publications from May 2018 through October 2020; (2) quarterly provider association/stakeholder meetings (October 2018 through October 2020); (3) provider workshop sessions (July 2019, October 2019, October 2020); and (4) various webinars, videos and other electronic means. In September 2020, we conducted an EVV workshop during IHCP Live and an additional workshop will occur later this week. During the annual IHCP Works seminar in October 2020, we conducted an EVV workshop. Sandata has conducted additional training sessions, including one in November 2020. And since August 2020, the provider relations teams in OMPP, Division of Aging and DDRS have been making phone calls directly to providers.

The provider relations team works with FSSA Communications to administer a provider survey and received 536 responses. Sixty percent of respondents indicated they were aware of the EVV requirement. Nearly 60% of respondents indicated they were either not

prepared or unsure if they are prepared to implement EVV. Seventy percent of respondents indicated they had not or were unsure whether they had spoken to someone from FSSA about the EVV requirement. Less than 50% of respondents indicated they had spoken to a vendor (either Sandata or an alternative EVV vendor) about procuring the technology necessary for EVV implementation. In an open-ended question, the survey asked providers to identify the issues holding them back from EVV implementation. The overwhelming response was "lack of EVV awareness" followed by "training" and "technology." The public health emergency was also cited as a concern.

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

Following his presentation, Mr. Cook invited questions.

Questions asked in virtual chat room

Q: Ms. Stafford-Cunningham—What was the time period for the top five exceptions?
A: Mr. Cook—That data was from October 2020 and shows a month at a time.

Q: Ms. Stafford-Cunningham—Out biggest concern is obviously about payment disruption for people who did not heed our warnings.
A: Ms. Taylor—EVV has been a topic of discussion at the national level, including at the recent NAMD (National Association of Medicaid Directors) conference. All states are grappling with it and for our office this has required creative communication with providers. The Office will continue working with INARF and providers to make compliance as easy as possible because payment disruption is undesirable.

2. Central Credentialing Portal– Michael Cook, Provider Services section director

Ms. Taylor reminded MAC members that the Central Credentialing Portal was added into statute as a review item. The centering goal of the Office of Medicaid Policy and Planning is "to improve member and provider experience" and business process transformation is a strategic priority toward achieving this goal. Improving credentialing is significant and the Office recognizes this is an abrasion point for providers. The Office is committed to streamlining and aligning processes where we can.

Mr. Cook began by noting this information was presented during the recent IHCP Works listening session. Providers offered good feedback. And the information in this presentation is required by HEA 1548 Section 3. IC 12-15-33-9.5 (a)(6).

The terms "enrollment" and "credentialing" seem to be used interchangeably. However, there is a distinction. "Enrollment" is the process of enrolling to become an IHCP provider. This is a State process and is required before providers can participate with the MCEs. The provider completes and submits an IHCP application. Once approved, that provider can participate in the IHCP program.

"Credentialing" is the process when a provider enrolls with and is certified by an MCE to provide care to their members. This includes verification of education, training, experience, expertise and willingness to provide services. NCQA (National Committee for Quality Assurance) is the federal organizations that sets these processes and methods for validation. Credentialing is done by the MCEs themselves or by a company with which they contract. Once a provider is an approved IHCP provider (through the State process), they can then apply with the four plans (Anthem, CareSource, MDwise and MHS, and soon United Healthcare) separately and go through the plan's enrollment and credentialing process. The provider goes through the contracting process with the plan. Once approved, the provider can then serve members within that health plan.

Many providers have complained that it is burdensome to go through this process multiple times and also have separate decisions/responses from health plan to health plan. So that led FSSA to pursue a joint enrollment and credentialing solution called FSSA EnCred. We worked closely with our business partners for several years but suspended the project in June 2019. FSSA emphasized its commitment to improving the credentialing experience for our providers even if that meant not having a centralized, technology-based enrollment and credentialing system. FSSA remains committed to the goal of process improvements in general and identifying any areas we can fix with our health plans.

For the IHCP enrollment process, if a provider submits a "clean" application with no mistakes, they can expect a decision withing 10 business days if they submitted through the IHCP online portal and 15 business for a paper submission. If the application contains errors, that triggers a new 21-day clock for corrections. If the provider does not resubmit a corrected application during that 21-day period, the application is closed and the provider has to open a new application. For the MCE credentialing process, decisions must be made within 30 calendar days upon receipt of a completed application or upon receipt from a delegated credentialing body. If from a delegated credentialing body, providers must be loaded into the system within 15 calendar days.

Mr. Cook reviewed multiple slides containing recent credentialing data from the four MCEs from Q4 2019, Q1 2020 and Q2 2020. (Special note: Q2 2020 and onward show relaxed NCQA requirements due to the public health emergency.) The first line shows the number of total providers requiring credentialing (initial credentialing or recredentialing). The second line shows the total number of providers that initiated credentialing during the time period. The third line shows the total number of providers that completed credentialing. The next lines show Level 1 and Level 2 decision data. The vast majority of applications fall into Level 1 review (the application for credentialing was "clean" and not submitted to a committee for review). Some applications undergo a Level 2 committee review when there are questions or additional dialogue is needed from the provider. The third line shows the number of providers who were not credentialed. And the final line shows the average number of business days to complete the credentialing process (from the date the MCE received the application to the date the MCE made a final decision).

Indiana's 30-day timeframe for credentialing decisions is less than some states that can take 45-90 days.

In October 2020, FSSA OMPP conducted a listening session with providers during the IHCP Works annual conference. During the session, providers offered feedback regarding pain points and areas for improvement in the current credentialing system. There were four main feedback themes: 1) align participation date with each health plan with the IHCP enrollment date, 2) have standardized enrollment and credentialing forms across all health plans, (we do have a universal MCE credentialing form that is available on our website, but this is worth more discussion), 3) make the Medicaid credentialing experience more like the commercial insurance experience, and 4) provider participation in a formal credentialing workgroup.

Beginning in January 2021, the Office will be conducting provider association interviews/listening sessions to get specific information about provider experiences with the current credentialing process and to obtain suggestions for improvement. During the winter 2021, we will review each health plan's current credentialing process from start to finish and also review other states' approaches to credentialing with the goal of creating some specific and actionable recommendations for improvement that we will present to the MAC in Spring 2021.

Mr. Cook concluded his presentation and invited questions.

Co-Chair Brooks complimented Mr. Cook on his team's efforts, but pointed out that it appears that Medicaid is going back to "step 1" in talking about the issues and challenges with the MCEs around credentialing. The legislation mandated that we would have centralized credentialing. When the Medicaid enrollment process was brought in, that added complications. Is a date certain for implementation of the legislation in the works to ensure the concerns that have been raised by providers during the listening sessions? Co-Chair Taylor responded that the EnCred technology solution was not going to work. So now, Medicaid's focus is to work with providers and the health plans on a solution. The current economic climate presents a challenge. We are evaluating what other states are doing, including those that have gone to a centralized credentialing portal. We are committed to ensuring this process is provider-centric rather than technology-driven. Due to the public health emergency, the NCQA waived some of its stringent requirements which is providing Medicaid with flexibility to explore options.

Co-Chair Taylor invited representatives from the health plans to comment.

Mr. Jeff Chapman (CareSource) indicated that due to NCQA requirements, they must credential providers unless they have a delegated contract with someone else (similar to what CareSource does for the large hospital systems). If providers are contracting for multiple lines of business (Medicaid, Marketplace, Medicare, etc.), there is one credentialing period. If providers have updated everything in CAQH, not a lot of extra work is needed. CareSource does try to streamline the credentialing process as much as possible and keep the application consistent across lines of business. The process seems to be smooth right now, with few

delays. The important things are to ensure the Medicaid enrollment is completed, the contracts are executed with the individual MCE and the CAQH information is submitted as well.

Ms. Katie Zito (Anthem) commented that Anthem uses the same process as CareSource, with one application for credentialing across the lines of business (commercial, Marketplace, Medicare and Medicaid) and the timeline is pretty quick. Credentialing is one piece of becoming part of the in-network provider group. Loading the provider into their system and contracting can take longer. Anthem is open to streamlining the credentialing process to make it seamless across the program and to collaborating to improve efficiency.

Brian Arrowood (MDwise) responded that MDwise was an "outlier" on the Q4 2019 slide showing the number of days to complete credentialing as 70. MDwise is in compliance now. Contracting involves another sequence of events and is a big deal for the MCEs. MDwise supports efforts to streamline the processes to improve efficiency.

Tasha Wilder of MHS experienced technical issues and provided her email address (twilder@mhsindiana.com) for anyone wishing to ask questions.

Co-Chair Taylor reaffirmed OMPP is committed to providing actionable items for credentialing and keeping the MAC updated on progress. She invited MAC members to reach out to her, OMPP, or the plans with specific questions.

Questions asked in virtual chat room

Q: Ms. Leila Alter--As member of the EnCred provider workgroup and understanding the issues with that implementation, I agree with OMPP's approach going forward.
A: Co-Chair Taylor—Thanks, Leila, appreciate your contributions.

3. IHCP Policy Changes and Implementation – Hannah Burney, Senior Manager, Coverage and Benefits Section

Co-chair Taylor introduced this presentation by indicating it is another statutorily required item (HEA 1548 Section 3. IC 12-15-33-9.5 (a)(7) to address policy changes to the Medicaid program with an implementation period for providers or MCEs of more than 30 days. We will present the full picture of this process because it aligns with OMPP's centering goal of improving member and provider experience. Co-Chair Taylor introduced Hannah Burney, Senior Manager of the Coverage and Benefits Section.

The Clinical Operations team, led by Dr. Maria Finnell, oversees the Coverage and Benefits team which is responsible for researching and implementing medical policy changes for Indiana Medicaid. The presentation will touch on 1) the reasons for IHCP policy updates and changes, 2) the OMPP policy consideration (PC) process, and 3) the implementation process and requirements.

Developing new policies is essential for maintaining successful programs and the needs of Medicaid members. Policy changes can come from a variety of sources including emerging trends or concerns, policy consideration requests, and legislative or regulatory changes.

OMPP has a very robust process for reviewing and responding to requests for changes to our Medicaid policies. Although there is not a requirement for us to maintain a process like this, we value the partnership and do our best to keep the flow of communication and recommendations from our stakeholders open. A policy consideration (PC) request is a request for changes to IHCP policy or programs which can include: 1) adding coverage for a specific service, 2) removing a covered service, 3) revising a provider code set, or 4) revising a current medical policy. Any changes to the process can be found at the policy consideration website: https://www.in.gov/medicaid/providers/734.htm

PC requests can be submitted by internal and external stakeholders including providers, members, OMPP staff, MCEs, manufacturers or other state agencies and contractors. The OMPP Coverage and Benefits team is the first to review PC requests and consists of three policy developers and a prior authorization/utilization management contract manager. This team is responsible for researching the PC requests, but they do so much more than that. For example, the team has recently been involved with our COVID-19 policy response, and collaborating with IDOH on efforts to combat infant mortality rates and increase the use of community health workers, monitoring our 1115 SUD and SMI waivers, and managing our fee for service utilization contract. The PC review process also involves direct clinical input from Dr. Dan Rusyniak (FSSA Chief Medical Officer), Dr. Ann Zerr (Medicaid's Medical Director), Dr. Maria Finnell (Medicaid's Director of Clinical Operations) and Dr. James Shin (Medicaid's Pharmacy Director). Additional clinical experts from FSSA's Division of Mental Health and Addiction and Division of Aging, the Department of Homeland Security and the Indiana Department of Health provide input as needed, as do external sources (academics, independent evaluators, Medicaid providers and associations, other state agencies and MCE medical directors).

The steps for PC request review process is:

Step 1—Receive Request form
The PC request form is filled out and sent to the Policyconsideration@fssa.IN.gov mailbox; response is sent to the requestor confirming receipt, and the Coverage and Benefits Manager and Medical Directors determine next steps. The office receives an average of five PC requests per month in addition to general policy questions and inquiries. The PC email inbox receives 5-8 emails per day and in 2019 the team received over 200 PC requests and IQs. The PC request form contains the requester's contact information, the type of request, description of the issue, desired outcome, related procedure or revenue codes and supporting information.

Step 2—Research
Once it is determined that the request will be reviewed, it is assigned to a Policy Developer who reviews the request and begins research using the Research Summary Form to capture

information for future reference (commercial insurance policies, state and federal regulations, IHCP policy, Medicare policy, other states' Medicaid programs and studies/professional standards). Once research begins, it is possible a PC request may turn into a larger project like a Medicaid State Plan Amendment or changes to our Indiana Administrative Code. Typically, this research phase can take between 2-6 weeks, but depends on the complexity of the request.

Step 3—Policy Advisory Team
Once research is completed, the summary is reviewed by the Policy Advisory Team comprised of a multi-disciplinary team representing nearly all sections within OMPP. This team is responsible for reviewing the request, discussing with team members and/or the Policy Developer and providing feedback. All recommendations are considered advisory in nature. This process can take between 1-2 weeks.

Step 4—Final Review
Once the Policy Advisory Team completes its review, the PC is moved into Final Review phase and includes team discussions on the Coverage and Benefits team and with the OMPP Medical Directors. The policy developer will present the request overview, research compiled, and the Policy Advisory Team feedback. This information may also be presented to OMPP leadership which is common when the proposed change is expected to have a significant fiscal impact or a major change to Medicaid policy. The final review process can take between 1-2 weeks.

Step 5—Implementation
If a request is approved, implementation will begin and can take from several months to more than a year. When implementing, we must consider how intensive the work to update system and processes will be for our providers, OMPP, health plans and other vendors. We are required to provide at least 30 days' notice to providers if the change will be impactful to their care delivery or reimbursement. This is the minimum and we try to provide additional information and notice when we can. If needed, some PC requests may require the submission of an IAC rule change and/or State Plan Amendment, both of which can take from 12-24 months. We also have a post-implementation analysis period (6-12 months after implementation) to review claims data and stakeholder feedback. Based on the findings, some policies may require revision.

Ms. Burney provided multiple examples of recent policy changes. 1) Due to the public health emergency, policy changes to prior authorization requirements went into effect with only a few days' notice as provider requirements were being reduced. When pre-COVID policies are restored, providers will be given at least 30 days' notice. 2) In response to the state's opioid epidemic, provider bulletin BT202063 announced that separate reimbursement would be available for EMS providers when administering Naloxone/Narcan. The policy was announced on May 19, 2020 and was implemented on July 1, 2020. 3) The Podiatry billing policy change was announced in provider bulletin BT202099 on September 1, 2020, and was implemented on October 1, 2020, in response to an approved PC request. 4) In response to state legislation from the 2019 session (HEA 1175), provider bulletin BT202032 announced midlevel practitioners would be eligible under PPS for FQHCs and RHCs. The change was announced on

August 11, 2020 and implemented on October 1, 2020. This change required a Medicaid State Plan Amendment and resulted in a longer timeline for implementation.

Over the past two years, OMPP has been pursuing business transformation with Salesforce to improve some of our manual processes. Currently, the Coverage and Benefits team is using the internal platform for policy research and review. In January 2021, OMPP will launch the external online submission portal which will provide real-time status on requests, allow users to search for existing requests, and provide auto notification to requestors as requests move from one step to the next. OMPP made this change to increase transparency for external stakeholders, replace manual processes to reduce human error, provide more timely responses, and improve the overall submission process.

Ms. Burney invited questions. There were none.

4. Provider Communication – Michael Cook, Provider Services Section Director

Mr. Cook described the formal provider communication process and the avenues OMPP uses to announce changes and segues with the previous presentation's legislative basis in HEA 1548 Section 3. IC 12-15-33-9.5 (a)(7).

OMPP is mandated by IC 12-15-13-6 to provide notice to our provider community. In short, any change included in a notice or bulletin issued by OMPP, an OMPP contractor or an MCE under OMPP may not become effective until thirty (30) days after the date the notice or bulletin is communicated to the parties affected by the notice or bulletin.

Mr. Cook recognized Julia Camara, Provider Relations Communications Coordinator, for her efforts.

OMPP publishes information in banners, bulletins, news announcements and webinars. Banner pages provide policy clarification and specific information to IHCP providers primarily targeting billing and claims processing. Banners are issued weekly on Tuesdays. Bulletins send information about policy changes, including reimbursement and programmatic changes. Bulletins are issued as needed, generally on Tuesdays or Thursdays. News announcements provide immediate, brief notifications on the Medicaid provider website to advertise upcoming events or immediate news items that providers need to be aware of. We have been using this method for waiver application deadlines and for advertising the COVID-19 provider relief effort.

The provider notice approval process begins with an initial draft document provided by OMPP or Gainwell Technologies. OMPP's subject matter experts and publications review team edit the draft for accuracy and clarity. The final draft must be approved by the subject matter expert and an Executive Team member before it is published to the IHCP website.

We also communicate with the provider community through provider association meetings, the IHCP Live webinar series, the IHCP Roadshow and annual seminar, and through email and

telephone campaigns. OMPP has used the IHCP Live webinar series extensively during the public health emergency. In a regular year, OMPP conducts several IHCP Roadshows around the state and invites providers to Indianapolis for the annual seminar. As needed, OMPP will initiate email and telephone campaigns to providers. Recent examples include the EVV (electronic visit verification) and COVID-19 provider relief fund calls and emails.
Mr. Cook then presented four slides with a high-level overview of the many communication methods Indiana's MCEs use and indicated the plan representatives are available during this meeting to answer any questions that arise. Examples of communication methods include bulletins, webinars, newsletters, postcards/fliers/letters, and provider portal alerts.

Mr. Cook concluded his presentation and invited questions.

Co-Chair Brooks complimented Mr. Cook and his staff for their efforts to communicate with the provider community.

Co-Chair Taylor commented that the 30-day notice applies equally across the board and acknowledged there have been a few times when OMPP has fallen short in issuing notices for large-scale rollouts. But OMPP has learned from those experiences and strives to give providers enough information and advance notice of changes.

Mr. Jeff Chapman (CareSource) commented that CareSource is committed to using every medium they can find. He makes every effort to go over every state banner and bulletin during his joint meetings with health systems to ensure providers understand the information and interpret it in the same way. In 2021, CareSource will roll out a more robust communication program and Jeff hopes providers will say they are receiving too much information rather than too little. He welcomes suggestions about what communication methods work best for stakeholders.

Ms. Katie Zito (Anthem) expressed appreciation to MAC members representing provider associations who have assisted when Anthem has needed to communicate large-scale and complex changes with their provider members. She welcomes the opportunity to collaborate with provider associations in the future to ensure positive results for providers affected by changes. Anthem strives to provide more than 30 days' notice is working toward 45 days' notice whenever possible. Anthem's provider relations team is available for questions, can conduct 1:1 meetings with individual providers, and is available for association meetings and webinars. She concluded by saying Anthem is open to feedback about their provider communication efforts.

Co-Chair Brooks (representing the mental healthcare provider community) complimented the MCEs for their communication efforts.

Questions asked in virtual chat room

Q: Ms. Leila Alter—The MCEs could offer an email service where links to provider notices are sent to providers. I greatly appreciate the current IHCP emails with the IHCP Banner/Bulletins.
A: Mr. Jeff Chapman—CareSource is working on an email tool to notify providers about new announcements. This should start early next year.
A: Co-Chair Taylor—We will take this suggestion back as an action item to discuss with all of the health plans. Listserves are very helpful to distribute information to our providers.

VI. Closing Comments

Co-Chair Taylor requested feedback about the MAC meetings and indicated Adobe is a good platform for sharing content and educational materials.

She reminded MAC members that the next regular meeting is tentatively scheduled for Friday, February 26, 2021, from 10 a.m. – 12:00 p.m. depending on the General Assembly schedule. MAC members will be notified as soon as 2021 dates are finalized.

Co-Chair Brooks agreed that the content of the MAC meetings has improved and the process of notifying MAC members about meetings via email rather than by calendar invitation works well. He invited MAC members to contact Co-Chair Taylor and himself with suggested agenda items or if they have items to discuss.

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 11:52 a.m.