# COMMISSION ON AGING

## Virtual Meeting March 18, 2021

## 10 a.m. to noon

Members Present: Dr. JoAnn Burke, Robert Bischoff, Michael Sullivan, Judith Schoon, Katie Ehlman, Jennifer Lantz, Debra Lambert, Kelli Tungate, Dan Mustard

Members Absent: Margaret Smith, Lauren Mullet, James Goen

Call to Order: Dr. Burke called the meeting to order at 10:00 a.m. JoAnn said that she is going to wait on the approval of the minutes until they have their introductions because they have new members. Dr. Burke did a role call and asked members to introduce themselves.

- **JoAnn Burke**, Commission Chair: Semi-retired professor of social work and gerontology at St. Mary's College. Founded the gerontology program that was at Notre Dame, and she is also an adjunct professor in nursing and she is now teaching a doctorate course in nursing on social determinants of health. She is currently doing a project using telehealth with older adults in nursing homes and affordable senior housing projects. They also have a project using mini horses and music to augment a memory care group. She has three doctoral students at the graduate of social work program at IUPUI interested in doing some research on that, and she has them working with the software developer. Dr. Burke expressed excitement about the work of the Commission on Aging. One of the things on her agenda as chair was to get representation from across the state, and she thinks that the Commission is accomplishing this goal.
- **Bob Bischoff** has been on the Commission for about 8 years. He is a former legislator from southeastern Indiana, state senator, state representative, public servant for 36 years from that geographical area.
- **Katie Ehlman** from Evansville Indiana (Southwest Indiana.) She has been a faculty member at USI for about 15 years, and before that was involved part-time, for about a total of 24 years now. She teaches gerontology, she is the Director for the Center for Health Aging and Wellness and Project Director for their Geriatric Workforce Enhancement Program funded through URSA.
- **Michael Sullivan** said he had a career in health care, Blue Cross, Methodist Hospital, Home Health Association, Alzheimer's Association and he retired 3 years ago. He has been a member of the Commission on Aging for several years.
- **Sue Grossbauer** lives in Valparaiso Indiana. Her background is in both health care and marketing. She is semi-retired and is still very busy. She is retired as CEO of a marketing company and is still working on particular projects especially in healthcare, like helping to communicate around issues like hospice, meals on wheels, dementia care, etc.
- **Debra Lambert** said she has been blessed to work with the senior community for nearly 30 years now. She started as an outpatient counselor in an outpatient program for seniors for a couple of years and behavior consultations for long term care. She ended up becoming a social worker in long term care and have been a licensed health facility administrator for the last 21

years. She's in Fort Wayne, Indiana. She works at Byron Health Center and they just moved into a new community in the middle of a pandemic, so last year has been a very interesting year for them. They were researching some of their history and interestingly enough Mr. Miller, the man who used to run this community back in the 50's, actually was the one who started the Commission on Aging. She just finds life delightful at times, how things come full circle when you don't even realize it, so that's as little fun fact about Byron Health Center and the Commission on Aging. It's great to meet all the new folks, and she can't wait for them to get back in person again, they've been 6 feet apart for far too long.

- **Kelli Tungate** Kelli said this is her first meeting as well and happy to be appointed a member at large. She is in Indianapolis and is Regional Vice President for a company called Caregiver Homes Senior Link and they provide Structured Family Caregiving under the Aged and Disabled Waiver as well as the TBI Waiver. She's been with Senior Link about 6-1/2 years, prior to that she spent about 20 years with CICOA Aging and In-Home Solutions in Indianapolis. During her tenure there she attended many CHOICE Board and many Commission Aging meetings, so she's excited to be joining this group.
- **Dan Mustard** is the Executive Director of Mill Race Center in Columbus, Indiana, a senior center in Bartholomew County. Dan is the Secretary of the Commission on Aging. Prior to his position at Mill Race Center, he served in disability services for many years. He is also one of the founders of the Senior Center Coalition of Indiana.
- **Megan Springer** is up in the Fort Wayne area, and this is her first year on the Commission and she is excited. She's been in home health for the last 17 years in various roles and she is also on the Fort Wayne Sub-Committee for Domestic Violence and Personal Safety.
- **Jennifer Lantz** is one of their newly appointed members by the Governor. Jennifer said this is her first Commission meeting she is from Whitestown Indiana, she is the Director of Development at IPMG which is a company that does case management for individuals with ID and DD. They do care management for those that are aging and disabled and they do wrap around facilitation for kids with significant emotional disorders.
- **James Goen** is a newly appointed member of the commission, but he was not able to connect this morning.
- **Laurie Mullet** is one of their members she lives in Westville Indiana and she is unable to be with them today because she had another commitment.
- **Judith Schoon** is one of their Commissioners who lives in Griffith, Indiana, but was unable to attend today's meeting.
- **Margaret Smith** was also unable to attend.

JoAnn said if her count is correct, they have 10 for a quorum. The members of the Commission have been reviewing the minutes, and they have made any corrections that were needed. Because there has not been a quorum, they were filed. JoAnn said she is going to do two things this morning; she is going to ask for a motion to approve the January minutes. and then ask for approval for all filed minutes. She asked if she could have a motion to approve the January minutes. Michael Sullivan made the motion, Deb Lambert seconded the motion, and the Commission approved the January minutes unanimously. Dr. Burke asked for a motion to approve their filed minutes. Michael made the motion, Deb seconded the motion and the Commission approved the filed minutes unanimously.

JoAnn said that they elected officers in January, and Judith and Katie discussed switching roles. Katie said thank you, and stated that she did not remember the official titles of the Vice Chairs but she agreed to change roles. JoAnn said that the Commission has three vice chairs and a secretary. The change will consist of Katie assuming the Vice Chair of Programs and Judith will be assuming Vice Chair of partnerships for this coming year. Dan Mustard made the motion to approve the change, and Jennifer Lantz seconded the motion. JoAnn asked for any discussion, and the Commission approved the motion unanimously.

JoAnn introduced the next portion of the meeting by saying that since she was on the CHOICE Board in the early 2000's and then on the Commission on Aging for about the last 5 years, she has never seen so much activity as she is seeing right now at FSSA in long term services and supports. There are many things going on in Indiana; changes that are long overdue in home and community based services and institutional care. Dr. Sullivan and Dr. Dan would like to make a presentation to the Commission, since they are quite involved and Erin Wright is working with them to schedule this.

Update from the Division of Aging: Dr. Burke thanked the Division for their efforts to be inclusive and to get stakeholder involvement, not just for Medicaid recipients, but also for private pay, geriatric workforce issues, and increased capacity for home and community based services.

Jesse Wyatt thanked Dr. Burke for the opportunity to speak today. To jump right in, he is going to give an abbreviated version of the presentation that Dr. Dan and Dr. Sullivan have delivered many times with some additional comments around some of the work that they have done recently. To set a baseline, there are several slides as to why the LTSS Reform is necessary, as many are aware of Indiana's poor performance in many statistical comparisons; chief among them is the AARP LTSS Scorecard. The 2020 rankings show that Indiana did improve slightly as far as our rank compared to other states, but we are clearly in the bottom percentiles, especially in many categories. Jesse stated that it is important to note that we still have a relatively low population in home and community based services, compared to those in nursing facilities, when you compare Indiana to other states. There are many reasons for that, and there is not just one silver bullet that is going to solve the problem, but it is a fact that many people want to stay at home and their inability to do that is troubling. Indiana spends more on nursing facilities as a percentage of the total pie of expenditures than they do on home and community based services, and it is more extreme than the population numbers.

Jesse said the average age in Indiana is increasing, as it is nationwide, meaning more and more people every year are going to need LTSS type services, whether it is in a nursing facility, or in a home or community setting. The state has to be prepared; because as volume increases they need to have a sustainable program and they need to have capacity to be able to assist individuals who want services. The chart shows the nationwide rebalancing from 2 years ago. Nationwide, the states actually spent a little more today on home and community based services versus institutional or nursing facility services. In Indiana, the percent is very different. Often it depends on the individuals, but on average, home and community based services are cheaper. Every Medicaid dollar has both a federal share and a state share. The ability of most folks to stay in their home saves the state dollars.

Jesse shared a chart from AARP showing what an effective long-term services and supports system looks like. Chief among them is affordability and access. They have to be able to support folks financially, they have to be able to access the right type of provider when they need it, and they have to have choice. For many individuals, nursing facility services is the right and most appropriate setting, but for

many people they may not be there yet or they have a different quality of life that they want to experience. The DOA has to make sure that choice of setting is available and individuals get a quality of life and a quality of care. They are very much intertwined for most people. This has been on ongoing theme and struggle that they often encounter in the Division of Aging. The Division doesn't know what's best for people, the individual and the family do. The individual should get to make that decision, not the DOA. Their role is to make sure they provide access and opportunity for older adults to experience the quality of life that they want and to ensure that the care they have chosen is the utmost quality.

Something that they have talked a lot about within the Division, with Director Renner's guidance and direction, is increasing support for family caregivers. They often think about the type of service delivered to the individual participant and ignore the informal supports that the person is receiving outside of the paid supports that they provide. In many cases, those informal supports are more important than anything the providers do, and being able to support those people has to be a focus going forward. Effective transitions are something that Dr. Counsel has talked to the Commission about in the past, when you talk about someone who needs nursing facility services going from the home to that setting they need to support that individual. They also need to support individuals who have chosen to leave the nursing facility and return to the home or a community based setting and today they do but they can do it much better, which is to them a very important goal going forward.

A high percentage of folks, when surveyed, say they want to remain in their home and age in place, but when you compare that to how many people in Indiana are afforded that opportunity, there is a distance between what people say they want and what they are able to delivery today. When he talked about sustainability, one fifth of their LTSS spending goes to community based services, but four fifths of the spending goes into nursing homes. However, to try to be as fair as possible, nursing facilities provide services to individuals who might have higher needs, but it is unlikely that it is four fifths. That is a high disparity. AARP has really become a go-to standard, and Indiana has not fared very well in those reports.

Jesse said that Indiana, within FSSA, and between the VA and OMPP, started a pilot program for expedited eligibility. There is a real time difference between the deliveries of home based services or nursing facility services. A nursing facility is often able to serve someone very quickly, but on a home and community based side it can take weeks or even months before they are able to get a provider into someone's home to start delivering care. He believes there are several reasons for that, one big one is the amount of time it takes to get financial eligibility completed for Medicaid. Once a person gets Medicaid it tends to move a little bit quicker, there is still a little bit of a delay on the functional side and the care planning side within the Division's network that they need to improve, but that is secondary to applying for Medicaid that sometimes can be extremely long. The expedited process is still a pilot. It is in several areas, but is not statewide yet. They are using the emergency appendix K in the A&D waiver for authority to do this, so there still has to be work done to try to make something similar permanent. In the few months that they have had it, the pilot has been successful; people who have been approved are getting Medicaid the same day, which has been quite amazing. There is still a lot of work to do though on that piece. They want to speed up the time it takes for someone to receive home and community based services and that certainly starts with Medicaid. Again, they have to try to find a way to make it permanent, and they have to work on the down sloping impact that having such quick Medicaid has.

They are also moving into a managed long-term care services supports model. There is a lot of work done around this today, and it is not a short process. It is a multi-year process, they are just at the beginning stages, and there is a lot of stakeholder engagement going around their move into MLTSS. They've started some regular meetings, they're completing a request for information to gain more insight on what MCE's want to deliver and they are working with many stakeholders to develop what that really looks like. They are also talking about financial components of MLTSS, and how those pieces are going to work together as they move towards a sustainable system that is meeting individuals' needs appropriately and their preferences appropriately. This process is taking up a lot of time and work currently. A little bit down the road, but very intertwined, is a move to some value based purchasing (VBP). The idea behind this is that we pay more for better quality, and this is something not to take lightly on the surface, and it seems like an outstanding idea, but there are many pitfalls with VBP. We do not want to incentivize the wrong behavior, and just as important, we do not want to provide disincentives for best practices.

JoAnn asked Jesse to explain value based purchasing. Jesse said that Indiana has had, for some time, a value based purchasing model with nursing facilities. Value based purchasing, instead of saying "If you do these activities we are going to pay you "x", VBP takes that and says "Provider, if you perform these activities at this percentage, or if you perform these activities in a slightly different way than our standard, then we will pay you more." Potentially, if you perform less or if you do not perform these activities at the rate or frequency or a level of performance that we want you to hit, then we may pay you less. There are many different nuances and a lot of different ways to implement it, but you could say "Hey we are going to pay "x "dollars to this provider group, while we are going to take 10% of that amount out up front and we are going to wait and see how you perform. All of this is hypothetical. In a home and community based model, let's say it's the number of days that the person remains at home, it's the number of days that on average the individuals remains in the home goes up then they will pay you that 10%, if it goes down then you won't get it. That is probably a very extreme and somewhat simplistic example, but the whole idea is that we pay for the performance of those activities we want to see, as opposed to just saying "Okay, you did the work so we will we pay you."

The fourth point is data. Data within FSSA has a long way to go. Some of it they do very well, and some of it they don't. Being able to have an integrated data system not only within FSSA, but for individuals, providers, facilities across the state is way past due. This is an important piece to reform their MTLSS going forward. Dr. Sullivan and Dr. Rusyniak will be presenting to the Commission, although the day has yet to be determined. He just wants to provide a brief overview of the direction they are going and some of the important reasons why.

Jesse said he also wants to give an update on some of the recent stakeholder engagement that they have been doing. This past week, they held a couple of meetings with various stakeholders around eligibility and level of care, and the intake process inclusive of both nursing facilities and home and community based services and case management. There have been some questions regarding the intake/eligibility and level of care process. There was good conversation, and there will likely be continuing conversation because he doesn't think there were enough stones turned over, so to speak. They had a wide range of folks participate and provide their insight and feedback, and they had a very good discussion that included Dr. Burke, on case management and how we can improve case management going forward.

Case management is one of the main reasons for the move to MLTSS. He is not sure how many folks realize FSSA doesn't pay for case management outside of the waivers for LTSS. Someone who's receiving state plan services like home health or nursing facilities, other than what the providers deliver (and providers do provide their own case management) but there's no independent case management being provided by FSSA. They do have case management for waiver services, and Triple A's waiver care managers make referrals to state plan providers and they do help the person navigate that process, but they don't have any ability to influence and they don't have good data on where those state plan services are being delivered or what's been approved or what hasn't. There is very poor independent case management for non-waiver type services today, and an individual on Medicare often has more than one health card, because they have more than one plan, and often has to navigate all of that by themselves. Waiver care manager from the Triple A's do their best, but he thinks the state has failed to give them the tools they need to really provide the type of care coordination needed to help navigate an individual through this system.

They had a case management conversation last week with a number of case managers and a few different providers and you never know where these discussions will go. The focus is on how they can improve going forward. To reiterate, the move to MLTSS is a multi-year process and it is not happening tomorrow. It is very important and it takes time. There were very good conversations and excellent feedback from the participants at this last meeting. I hope that this will give some insight to the Commission into some of the kinds of activities that FSSA is currently working on, and what the Division is working on and why they are doing it. Jesse asked if there was any feedback, concerns or questions around these topics.

Jennifer said she thinks the discussion was helpful in identifying some of the areas that they will need to address as they move forward into looking at managed care. Deb said, "Thank you for being humble." She has had the pleasure of working with him in many different ways and they are doing a phenomenal job. She thinks the collaboration between FSSA, the State Dept. of Health, in her 23-year career, has never been better, and she is giving him and Sarah a "shoutout." She has two quick questions; something that has been a real concern is staffing. Is there someone doing a parallel track to try to help solve the staffing issue? Her second question there has been plenty of other states who have gone to managed Medicaid and her only concern is when you pay a managed company you are now taking money away from direct care services to pay a management company. Now you've got less money available in the pool and we know statistically there is going to be more people needing that money. So are we looking at other states to find best practices and pitfalls for some of these managed Medicaid services so that we absolutely bring the best people onboard and we get the biggest bang for our managed care bucks?

Jesse thanked Deb for the kind comments. He would give Sarah all the credit for the health department; she has a long relationship with the health department and the Division's collaboration with them. He thinks it's a great relationship between the two. The second question regarding staffing, we think this is an excellent point, and they have had some discussion very recently about staffing workforce concerns across the board. He is very familiar that often times they have someone who needs a select set of services and for some reason they are not able to find a provider to serve that individual. It is especially hard in rural areas and it can be difficult for individuals with very high needs. These are two areas of home based services that often have issues. Adult day is another area of concern. They have several adult day centers in Marion county and central Indiana, but when you get outside of central Indiana,

there is a real shortage of adult day providers. Internally within FSSA, this is a conversation where it's certainly a very important item, as the population increases they have to have workers who deliver care and if we don't, the best laid design is not going to matter. He is in 100% agreement that they have to work to insure they have the workforce to meet the demand.

In looking at pitfalls and comparing to other states with MCEs the simple answer is yes. FSSA is looking at several other states who have gone through a managed long term care services and supports model and states who have done it well and states who have not done it well. There certainly is an additional cost but he thinks if you look at these numbers they have an opportunity to save state dollars. They are going to be spending more if you look at the demographics, and he knows that just from the growth of the waivers. More people need LTSS services, so expenditures are going to continue to rise. However, when you look at four fifths of their total costs for LTSS in Indiana are for nursing facilities, and on the average, home based services cost less, they have the opportunity to shift some of the costs and perhaps save dollars. Jesse said he hopes that answered her questions and told Deb that it had been incredible working with her also. Deb said it did answer her questions, and if there is ever anything that she can do as far as staffing, she is willing to help, because that is going to be the biggest challenge.

JoAnn said she has a question building on what Deb has brought forward. We are blessed in Indiana to have two QWEPS bringing some federal dollars to Indiana to address some of their workforce issues. Has there been a way that the DOA or FSSA has addressed these two issues or thought about it? Jesse said that Dr. Counsel has been very involved with the QWEPS and they've had several conversations around it, but utilizing the QWEPS in the workforce conversation that Deb is bringing up, to be honest, they have not made that connection, but he thinks it is an important one to make. It is a great suggestion.

Amy Rapp said they've had a really incredible relationship with Dawn Butler. She's been their primary contact person to help shape their training series which has been focused on care managers and Options Counselors. They are now preparing for their 3rd series of training, so very excited. Within the training itself it's really designed to not be a traditional lecture but it's really to look at a skill set, so the care managers and Options Counselors can be empowered to apply these skill sets. It's also embedding our person centered practices. It's a very healthy strategic marriage of all the work that they're doing in the Division of Aging to empower care managers to do the work that they really enjoy and are passionate about. The outcome has been really incredible for the care managers from their feedback, it seems like they've really hit the mark in meeting their needs. They have 3 more years working with QWEPS and they are not going to slow down they're very excited with everything they've done so far.

Jesse said he knows a lot of case managers have been attending, but they've had some non-case management providers participate too. Amy said that they have opened it up; Darcy Tower has part of their core hub and Kathleen with APS, their audience has definitely expanded from not just care managers and Options Counselors but also APS investigators and their geriatric service providers.

Katie Ehlman thanked Jesse for his presentation. She had one question regarding the QWEPS coming out of USI. He mentioned the multi-year process related to the innovation coming out of the different programing at the state level; is that something for those who want to follow that process? Is there a website or something that outlines the process if they wanted to follow that or share it with constituents in areas of the state? Jesse said he would have to get back to her because he's not 100% certain if they have a website setup that kinds of delineates some of this yet or not. They've had several

communications with a wide range of provider groups and other stakeholders. Dr. Burke has been present for the Commission, but he's not 100% sure if they have a site set up where a consumer could go. Sarah said he is correct they do not, but it is coming. Katie said her second comment was related to workforce. They have 2 QWEPS in the state of Indiana which is unusual, there are only 48 QWEPS in the country. If fully funded, this would bring quite a lot money to the state in this area of workforce, especially improving the lives of older adults with a focus on primary care. Their QWEPS has only been in existence for 18 months. She would be interested in exploring how they might be able to align some of our initiatives with some of the state needs. What comes to mind are pockets of potential workforce that haven't been identified. If we can somehow get into those areas and align what we are doing for the needs of the state it maybe a win for older adults in the state.

Katie offered to discuss this with Jesse outside of this meeting. They are constrained by the objectives, but it's an opportunity to look at the objectives they have to follow and see if there are opportunities to expand those or realign them so that they are consistent with some emerging needs in our communities. Jesse asked if there were any other questions or concerns. JoAnn said her concern is that the Commissioners understand what is happening in the state regarding the move forward from a fee for service system for people on Medicaid with long-term services and supports. What that means as they move into a managed care system where they will have undetermined numbers of managed care organizations, could possibly/probably be insurance companies that will be offering something like the Medicare Advantage program. She just wants people on the Commission to understand what this will mean. If you have any questions, feel free to ask because there are no dumb questions. They are in the formation process, so that people understand what they are doing, this is a major move for Indiana long overdue. I you have a question to ask, she doesn't want to rush this.

Dan at Mill Race Center stated that when he did disability services, they went to a value based purchasing type of system and a dark underbelly of that was that there was a disincentive for providers to serve the folks who had the most challenging circumstances. There was a little bit of an incentive to cherry pick so that people would have a better opportunity to hit milestones for payment. He wants to make sure they are building safeguards into the system so that folks with more significant challenges aren't going to be left behind. Is there a tier possible to the model for services so that folks will still have the opportunity to perhaps be able to receives services in their home, but do that in a way that providers can still do that and not lose out financially?

Jesse said thank you, within the Division he thinks they are well aware of some of the pitfalls of VBP and the one he outlined he thinks is a very important feature to keep in mind. He has been very focused on making sure they meet the needs of some of the folks who cost the most, who have the most hours needed, who have the highest level of need in the home based system. He doesn't think that particular example will fail to be thought through during their VBP process, Elizabeth Patton from the Division of Aging is leading that particular group. He is certain that the pitfall he outlined will be considered. Elizabeth said thank you for voicing your concerns the design of the VBP program will be very stakeholder driven, they will be including stakeholders as they gear up those conversations, they just haven't gotten to that point yet.

Judith Schoon said if you follow the Medicare Advantage Program there is a special group called PACE that takes care of the people who need the most significant care. If we are following the Medicare program, then something like the PACE program would be something that would take care of the

people. Jesse said thank you, PACE is a separate program and it will co-exist with MLTSS so PACE will continue to exist as a separate program. JoAnn asked if there were other questions, as she wants to make sure people understand and have the opportunity to ask questions.

Jesse said things would change as the state moves to managed care; the state currently pays providers directly. When you move into managed care those providers will bill a managed care entity, not the state. The managed care entity itself will bill the state and it will be a capitated rate. We will pay a monthly amount to the MCE per person, but then the individual providers will be billing the managed care entity for services that they deliver. They are the new intermediary between the state and providers.

Megan asked if the value-based program is going to be modeled after what we have with Medicare right now. Jesse said that we bill MCE's and there's a percent that comes out of that based on services provided, or if you meet their standards they pay you "x" amount. Previously what Medicare had was a fee for service similar to what we have with Medicaid, but then they switched to a value-based program. It's based on different factors. You get codes based on what their needs are and how much service you provide, and what kind of service you provide, and you're paid a portion up front and at the end based on actual service provided. Is that kind of what Medicaid is looking at doing as well. Elizabeth said there are other types of payment structures within contracts with managed care entities, such as pay for outcomes and incentive programs. Those are more capitation, which is more like what you're talking about. For the VBP program, it's really a relationship between the managed care entity and the providers and holding the providers accountable to meet certain metrics to get the payment. Megan expressed that her concern is for people who will not be having improvement outcomes, the elderly population who are not going to improve past a certain point. Will there be a cap on how much they pull out? Elizabeth said she thinks the plan is to have risk-adjusted measures.

Deb said that she had a quick question for Jesse. He alluded to the fact that Indiana has a value based system now, and she knows that her community is a population that many people aren't willing to take care of. Therefore, their quality measurement at times appear to those who don't know their community and who they serve, to be a little bit worse than they are. For example, they have residents who have Huntington's disease, so their fall numbers aren't going to be as good as folks who choose not to take care of folks with Huntington's disease. She also knows at their level they do show discretion knowing who they are and they have blessed so far to earn the full reimbursement. Will that be consistent with what they are looking to do in the future with some of this programming, as many of them have pointed out there are some facilities that it's their mission to take care of those folks that many other folks simple choose not to care for?

Jesse said Elizabeth might want to speak to this since they are talking about VBP; he thinks the idea would be to have a system where they don't have to make exceptions. To him, a big downfall of their VBP system is what Dan brought up, they do unfortunately disincentive providers from taking the most needed folks in the community. That's not great, as they move forward that's a big consideration in how VBP should work. Today they have no VBP for home and community based services. They do on the nursing facility side but none for folks in the community, and that's where they want to move. Jesse asked Elizabeth if she had any comments she wanted to add to that. Elizabeth said this kind of builds off what Megan was talking about; no two individuals enrolled in the program are the same. They all have different health conditions, disabilities, varying levels of functional ability and that's where they are

going to be looking at risk-adjusted type of measures because there is only a certain extent that providers have control over. But they do have their eye on the social determinants of health and how those influence outcomes. These risks are definitely something they are going to be taking into account. She hears their concerns and this is why they want this to be a stakeholder driven process so they can hear all of those concerns and address them to the best of their ability.

JoAnn said that she is going to throw in one other issue because she thinks that it needs to be addressed. Equity issues for underserved populations; how are they going to ensure the underserved minority populations get services they need? Elizabeth said she would comment. Equity is a domain they are considering for VBP. It's a common theme among all their LTSS discussions. This morning before the call, they met with their new chief health equity officer, and this is a big push within the Division of Aging specifically, but also moving forward with the transition to managed care, and so they will have their eyes on this topic.

Jesse said he would add a little to that. It's something they've done over the last few years, and continue to do that he thinks doesn't often get highlighted. Medicare doesn't pay for assisted living; 90% of assisted living in Indiana is private pay, so Medicaid is 10% of the total assisted living market in Indiana. Assisted living can be quite expensive, so for Medicaid to be able to provide some access to individuals who otherwise would not afford assisted living is a huge win for many individuals and families who choose that setting. With IHCDA, the housing and development authority for Indiana, the Division has collaborated with what's called "affordable assisted living" where tax credits help fund the construction of the facility itself and the A&D waiver comes in and covers the operating costs. This partnership has produced more than 30 brand new buildings in Indiana. That is nearly 100% focused on the Medicaid and low-income population to help individuals who otherwise wouldn't be able to afford assisted living type services. They have more than 4,000 Medicaid recipients being served in assisted living today. Assisted living isn't for everyone, it's a personal and family choice, but for those who want it, they are proud they can offer it to a wide range of individuals. JoAnn said that she thought that the Commission needed to hear more about affordable senior housing and how it relates to services provided by the DOA. Maybe they can get a speaker in on that.

JoAnn said the Older Americans Act in 1965 established the administration for aging at the federal level; as she understands it, every state must have at least one area agency on aging and in Indiana we have 15 with one area agency serving 2 plan service areas. As Indiana moves towards managed long term services and supports, by federal law, the area agencies on aging remain. There may be some changes happening with certain functions within them, but they must remain by federal law under the Older Americans Act. Also in Indiana we have the CHOICE program, which is another line of funding. There are many questions about what's going to happen as Indiana moves forward with managed long term services and supports. As she understands it, we are still in the formation stage. Are there any comments on what she just said? Jesse said MLTSS is not going to include non-waiver programs, the CHOICE program and Title III and they have a small social services block grant funding that they receive from DCS, which won't be included in MLTSS. Just because they aren't included doesn't mean they won't be impacted. There is definitely an impact in how people are transitioned between the two. He thinks that's an important piece to work through. The Triple A's designations won't be impacted by MLTSS either.

JoAnn said that in the past few months they have been hearing about the Senior Center Coalition of Indiana from Dan Mustard as senior centers play a very important role for older adults in Indiana.

Dan Mustard said he would hit some highlights; part of the work for the Coalition has been to provide opportunities for senior center leaders to be able to network and share information. They have had a coalition in the past, but it went dormant. Maybe one of the positive aspects of COVID has been the fact that through virtual meetings, they have been able to get together on a regular basis and they have probably been able to move forward more quickly because they have access to virtual programs. Right now, they are collaborating with the fundraising school at IUPUI, and they are going to be hosting a webinar on making the case for support for funding in the philanthropic community coming up in April. It's especially focused on how the pandemic has hit fundraising for many not for profits, especially senior centers, because most senior centers don't receive public funding and so the work is done through private fundraising as well as revenue generating businesses. It's going to be a very important webinar for them.

They are going to begin a brown bag session program for senior center leaders and staff starting in April, to be able to get together and share information, talk about best practices and programs. A big part of their work has been the dissemination of information around COVID. Some senior centers have been open. Mill Race Center in Columbus has been open since last June. They are very proud of the fact that they have been open since June and they've had no cases of community spread. They are a large senior center with 2,000 members, so the recommendations of the CDC and our local health department work. Many senior centers continue to operate, but are not open to the public, and so a lot of it is just sharing information about best practices, how they can provide services safely to folks.

Many senior centers have been helping to provide information about vaccines, helping people register as well as serving as vaccine sites. But with the new CDC guidelines that just came out in the last week or so, they are getting a lot of questions from folks about returning to normal activities if people have both of their vaccines, and what will be the rules regarding the wearing of masks. They are getting a little bit more push back now because they want them to bring back some of the activities. They are not comfortable resuming some higher-risk activities, back but they are working with their local health department and their COVID task force to try and phase in some of the activities safely, and they are sharing that information with other senior centers. Virtual programs are still a big part of what senior centers are doing, they have been involved serving in a guiding role with a new program called gerishare.com and it allows senior centers to share their virtual programming with folks throughout the country. Gerishare is the work of a graduate student in North Carolina who found himself trapped in California because of COVID, and he completed his work out in California. Gerishare.com is now up and running and it allows senior centers to be able to share their programs virtually so folks can participate. Some of those programs can be put behind a paywall, so if you have specialized programs or presentations those can be ticketed events, but most of the programs are free and happen in real time. It is built as an app on the Zoom platform, and it is very easy to use. The developer was very careful to make sure it was user friendly and low tech so as long as someone has a smartphone, IPAD or access to a computer, they shouldn't have any trouble accessing the program.

Dan said the other area that they are focusing on is trying to determine what role senior centers can have in the discussion of long-term services and supports and part of that is just shaping the conversation. We often talk about senior services in terms of illness and disability, but they quite often

lack the discussion on wellness programs and health maintenance as a way to impact the quality of senior life and how to reduce the cost of care by hopefully reducing some of the dependence on in home health care services and nursing care facilities. The Senior Center Coalition feels that this is an important conversation to have; how can we help people to maintain their wellness and avoid the need for services. One example is the "100 Mile Challenge." This started off as an experiment, so they printed up flyers that had graphics on them so people could keep track of how many miles they walked, jogged, ran or bicycled. They were stunned by the response to it among the membership. They did a two month cycle and people logged over 23,000 miles. They had no idea people would participate at that level and the response would be like that. People are interested in maintaining their health even during the pandemic. In their facility, they partnered with their local hospital and they have a fitness center that is run by Columbus Regional Health, so fitness is a big part of what they do but he thinks it can be done at any scale. It's just simple motivation, their first prize was a membership to Mill Race Center and they gave away tee shirts, it was a very inexpensive thing to do. Moving to a big focus of the Senior Center Coalition will be how they can discuss wellness programming and the impact they can have on the whole discussion of long term supports and they are also talking about the implementation of the Living Better Living Longer Guide. They are having a conversation with Dr. Burke on Monday about how the Senior Center Coalition can help with the facilitation of moving the work of the guide forward. If anybody has any questions he would be happy to answer questions and he will also include the full report in the minutes. JoAnn said thank you and she looks forward to talking to them.

Judith Schoon said they've started working on walkability and they've gotten a grant to start work on their broken sidewalks. What else is it that they can do in their communities to help their seniors? JoAnn said that Living Longer Living Better Guide has quite an extensive section and she would be happy to talk to her after the meeting on some things she might start thinking about up in her area.

I-4A Update: Kristen LaEace welcomed everybody and said that in her eleven years that this has been one of the greatest discussions the Commission on Aging has ever had. She appreciates the discussion the Division of Aging and JoAnn lead about some of the MLTSS and other kinds of transitions. She knows they had the opportunity to ask questions but if they are interested in the Triple A's perspective they are welcomed to ask now or they can connect with her off line.

Kristen wanted to touch on the reversions to CHOICE. This is related to the statewide reversions because of the decrease in tax revenue due to the pandemic, as well as the ongoing proposed budget for the next biennium, which includes a similar cut to CHOICE. They want to continue to encourage people to reach out to their senators and their representatives, since the budget is currently in the second half of the session and it is in the Senate right now. This is the chamber we need to work on at the moment, and they've been concentrating on reaching out to members of the Senate Appropriations Committee, particularly the Republican members, and they've had some successful meetings. At least people are hearing them and understanding their concerns. They probably won't see a decision from the legislature made on this until the April revenue forecast comes out, but the more contacts they can make the better. She has shared some of the talking points in information previously, and she is happy to share that again if they need a refresher on that. The cuts proposed in the budget represent 2,000 people based on the current level of care plan expense. The reversions this year are having an effect. They've had at least one Triple A this year who has had to cut services to existing clients, many Triple A's are expanding their waiting lists, many Triple A's are not able to expand services to existing clients who are requesting additional services. So this isn't money that is able to be filled in from other pots. This is

effecting real people in real time and certainly the Triple A's take advantage of funding flexibility any way they can to keep people covered and served, but sometimes there just isn't any additional flexibility or money out there to be had. Again, they want to focus on the impact of real people and real time both now and into the future.

Kristen said she is going to share her screen so she can walk through the educational packet. They talked about the state budget in the legislative report, she's noted the bills they've been working on if it's marked in red they don't like what its doing and they're working on it. The first one is the state budget and they've talked about that a little bit. One that they are monitoring and have been prepared to weigh on is civil immunity related to covid-19. There's been one version of this issue that passed the legislature which the Governor has signed providing immunity to most kinds of businesses. HB 1002, which has not passed yet specifically, looks at a lot of health care stuff and they've been watching to make sure that it is not too broad. They want to make sure that if there is immunity provided it is focused on covid-19 and it's not a wide door for any immunity for any bad thing that happens in in-home health, nursing facility, hospital etc. Right now it looks like it is appropriate and they don't feel the need to weigh in on it. There are some bills that they are following, some they like and support they just haven't put a lot of time into them because they aren't a high priority. One is the state health and improvement grant program one that they have weigh in on is the strategic plan on dementia that bill looks a little different than the original introduced version the current version places the responsibility within the Division of Aging to develop the strategic plan. One thing that was taken out as it moved from the House to the Senate was setting up a standard advisory committee, this version of the plan calls for annual reports seemingly in perpetuity which is good.

Kristin said they have been paying very close attention to the telehealth bills that have been moving through the sessions. There are two versions; one in the House and one in the Senate. They like the one in the House. It is inclusive of organizations like Area Agencies on Aging who have Medicaid certified individuals providing telephonically supported telehealth services related to care management, Options counseling, and they just need to be certified by the state. The Senate version speaks to licensure; it's only allowing licensed individuals to continue to provide telehealth services. They have been working very hard trying to get Senator Charbonneau to budge off his position in Senate Bill 3 and they are hoping the legislature is hearing them on this issue. She wants to highlight a few bills, Senate Bill 1 has already passed, Senate Bill 3 they don't like that version, Senate Bill 47 is now in the House and it ensures that, going forward, pharmacies can provide the COVID vaccine the same way they provide the flu vaccine.

- Health care advance directives; they've supported this in conjunction with the Indiana Patient Preferences Coalition and it reorganizes and rewrites the health care advance directive statue and allows for other models of advance care planning to be recognized.
- Parent with disabilities is one that they've weighed in on particularly representing individuals who are younger and disabled and have children. The issue here is making sure peoples' disability is not a determining factor in their ability to parent and their rights and responsibilities as a parent.
- Powers of guardian after death; this is a topic that they've been working on in conjunction with the adult guardianship task force. This allows a guardian to sign off on final arrangements for their decreased ward. By Indiana law, the guardian's responsibility would end at death and this would allow the guardian to come in and make sure the decreased body is properly care for.

- They've been supporting and weighed in a couple of times with general support on all the broad band projects.

They are about in the middle of the second half of the session, and they have a few more weeks of committee hearings in the second half and then things will move to some of the final debates and eventually conference committee. They need to finish up by the end of April. There will probably be a special session related to redistricting later this year. She said she would stop to see if anyone had questions about what is going on in the legislature.

Judith said she gets a lot of information against the guardian act. Kristen said concerns regarding the guardian act have been addressed; originally there was a list of priorities and originally guardians were further up in the list now they are below the list of family members. To move it out of the Senate, there was a second reading amendment made, they want to see the legislation move forward. Judith said she had guardianship of her father and it wasn't an easy process and she can't see how family can't be involved. Deb said she could give her an example of how family members couldn't be involved. They had a long time resident and he had three sisters. They moved and they failed to tell them or give a forwarding phone number or address and didn't contact him in 8 years. After 8 years they showed up again but in the meantime they had gotten him a guardian because they couldn't get ahold of the family. They were floored that they didn't have their new number, even they didn't give it to them. They went to the guardian that had been assigned to him and wanted to co-guardian with them. Those are rare occasions where a family just disappears and then all of a sudden reappears. Kristen said most of the time guardianship is in place because there is either no family or family disfunction and the good point is a lot of these things are established per need, so this is really in the case if there aren't plans already. And her understanding is if the person has had a directive for after death it won't be changed by family members, but they may work with the funeral director.

JoAnn asked Kristen if she had other comments this afternoon before they finish. Kristen said other than the Indiana legislature there are some bills related to the legislature. She did want to talk a little bit about the American Rescue Plan that was passed at the federal level. There is a significant amount of Older Americans Act funding in the plan. It's about double what's been available in the FFRCA and Cares Act previously, ACL has not yet put out any kind of formula distribution to the states. It's good news, but again, it's one-time extra money to deal with pandemic related things. They are also moving into the regular appropriations cycle with a new administration at the federal level and N-4A has submitted a request that doubles the Older Americans Act allocation. There were other things in the American Rescue Plan that expands access to healthcare in general she will leave it at that they can read further information. It's Senior Nutrition Month and we need to recognize that, there is a new broadband assistance program coming out, this program would provide support to households that do not have broadband access and there is an office established and there is eligibility established but they haven't put out an application process yet.

JoAnn thanked Kristen and her information keeps them very informed on a number of levels. She said they've had a very full meeting and she anticipates that will continue as they work through some much needed changes in Indiana. They will meet again in May and with no further business the meeting was adjourned.