RFI Co-design Stakeholder Meeting Minutes

January 25, 2021, 1p.m., virtual meeting

Stakeholder Attendees:

Ambre Marr, AARP Indiana
Ben Harvey, Indiana Primary Health Care Association
Brenda Buroker, Indiana Department of Health
Cara Veale, Indiana Rural Health Association
Carl Ellison, IMHC
Connie Benton Wolfe, Aging & In-Home Services of Northeast Indiana
Dan Kenyon, Leading Age Indiana, INALA & IHPCO
Dr. Kathleen Unroe, Indiana University
Elizabeth Eichhorn, Indiana Health Care Association (IHCA)/Indiana Center for Assisted Living (INCAL)
Ellen Miller, University of Indianapolis Center for Aging & Community
Eric Essley, Leading Age Indiana
Evan Reinhardt, Indiana Association for Home and Hospice Care (IAHHC)
Hannah Carlock, The Arc of Indiana
Jim Leich, LeadingAge Indiana
JoAnn Burke Indiana Commission on Aging
John Barth, INARF
Kelli Tungate, Caregiver Homes of Indiana
Kim Dodson, The Arc of Indiana
Kristen LaEace, Indiana Association of Area Agencies on Aging
Mark Lindenlaub, Thrive Alliance (AAA)
Megan Smith, Indiana Association of Adult Day Services (IAADS)
Michael Kaufmann, State EMS Director
Michelle Stein-Ordonez, IAHHC
Natalie Sutton, Alzheimer's Association
Peggy Homeier, Franciscan Senior Health and Wellness
Sarah Waddle, AARP Indiana
Sherri Hampton, American Senior Communities
Tauhric Brown, CICOA Aging & In-Home Solutions
Terry Cole, Indiana Hospital Association (IHA)
Terry Miller, Hoosier Owners & Providers for the Elderly (HOPE)
Zach Cattell, IHCA/INCAL

FSSA Attendees:

Jen Sullivan, Michael Gargano, Dan Rusyniak, Allison Taylor, Sarah Renner, Jim Gavin, Natalie Angel, Andrew Bean, Meredith Edwards, Tim McFarlane, Kathy Leonard, Jesse Wyatt, Lindsey Lux Kleman, Elizabeth Darby, Nonis Spinner, Darcy Tower, Cathleen Nine-Altevogt, Erin Wright, Amy Rapp, BreAnn Teague, Steve Counsell, Kim Opsahl, Lynn Clough, Elizabeth Peyton, Michael Cook, Maria Finnell, Ali Bippen, Lynn Clough, Elizabeth Killian, Scott Piller, Mackie Rios, Amelia Hilliker, Erica Ng, Maggie Novak, Kevin Hancock, and Christine Mytelka

I. Background

- Initiative Objectives: Improve access to community-based LTSS to match preference for individuals who have expressed a desire to age-in-place

i. Supported by quicker access to community-based LTSS
ii. Supported by navigation through the health care and LTSS system
iii. Supported by high quality service delivery – focused on outcomes-based services iv. Supported by an integrated data system across a beneficiary's entire continuum of care • This group will co-design a managed LTSS RFI over the coming months. An RFI will be used as central vehicle to gather stakeholder input on program design

• Presentation -
  - Reviewed key topics for RFI design
  - RFI considerations related to services to carve-in and carve-out and the CMS waiver authority of managed LTSS were discussed
  - See PowerPoint presentation for additional details

II. Discussion/Questions from Participants:

1) **Services to carve-in vs carve-out:**

a) ARC of Indiana: What will happen to the 1,400 individuals on A&D waiver with an I/DD diagnosis?

FSSA: No decisions have been made and a recommendation from the Arc and others is welcome. One of the considerations for this discussion would be coordination of services for medically complex older adults who also have an I/DD.

b) IAHHC: How would this impact the payment of nursing facility room and board services for dually-eligible Medicare/Medicaid hospice members?

FSSA: A workgroup is set up to specifically address finance topics including those that take into consideration how hospice care in nursing facilities is currently paid through fee-for-service. c) Aging and In-home Services: Related to what we "carved in" vs "carved out," what factors were considered?

FSSA: These are initial recommendations. To clarify, the carve-out means that programs and populations carved-out will not see changes in their services, and these carved-out programs will not be dissolved.

d) IAADS: Does 'carved out' ultimately mean dissolving of programs like CHOICE and PACE?
FSSA: No.

e) IAHHC: Given all state plan services would be carved in to this MLTSS program and since home health and hospice as state plan services support pediatric patients, what safeguards are being considered particularly since these individuals are not likely to show "improvement" in their health status?

FSSA: Pediatric patients are not being considered at this time for the program population. Home health providers experience a bit of both managed care and FFS, and we see this as an opportunity to improve upon our collaboration with the home health industry to foster better alignment and minimize administrative burden. The challenges to applying an outcomes approach to those populations is understood but quality in end-of-life and delivery of services will be explored.

2) **Waiver authority:**

a) IHCA: The discussion regarding waiver authority is too broad on the call.

FSSA: We are engaging stakeholders starting in the early stages of this process and bringing forward design components as they are co-developed.

b) CICOA: Based on experience in another state, does Indiana plan to have providers be considered health plans like a prepaid alternative health plan as part of the 1915 b/c waiver? FSSA: This is not decided but your experience will be valuable in helping to think it through. 3) **Other questions/comments**:

a) IAAAA: Can you please help draw the line between the end of the LTSS workgroups in December 2019 to the specific decision for MLTSS? It sounds like an incredible amount of work has been done towards this already. We are wondering about other models that were explored or considered, and why MLTSS was selected.

FSSA: Indiana has 80% of individuals in managed care and is considered to be a managed care state. Regardless of the payor model, this co-design workgroup is where all stakeholders will be asked to help design the components of the program. For example, care coordination is central to this program, and whatever model is used needs to provide care coordination, transparency, and accountability. This effort at reform is designed to help people receive their services in the community and to improve population health overall.

b) Caregiver Homes of Indiana: Would you do a mandatory enrollment with opt out? Will mandatory happen all at once? Will we implement passive enrollment initiatives? Will individuals have the opportunity to opt out?

FSSA: The current thinking is mandatory enrollment without the opt-out provision and input and other suggestions are welcome

c) IHCA: How does the objective to of having 75% of LTSS recipients be in HCBS line up with known medical acuity of existing populations being served? Is it intended that the 75% metric be a performance measure for an MCE to achieve?

FSSA: The objective to outcomes-based and performance-based programming is to be bold. Tying this percentage to a payment structure will need to be discussed further and outcomes-based approaches will be considered across the spectrum of LTSS services and other services in the program.

ICHA: (continued): Is this metric based on actual patient data? How will acuity be because the goal of 75% community-based care seems high.

FSSA: States have achieved higher rebalanced percentages than 75% but acuity will be a consideration in any program design element advocating for such a goal. In addition, part of the program's objective will be to address need before acuity is exacerbated.

d) CICOA: Will there be new conflict-free workflows that will be part of this at some point? If so, what could we reasonably expect (e.g., conflict-free LOCD, case management, or more)? FSSA: We are looking at areas that have raised questions of conflict with CMS and will discuss when they are identified. If anyone has concerns about conflict-free case management, please bring that forward as that will be very helpful for the entire group to be aware of.

e) IAAAA: Other than PA, are there other states you are particularly modeling on? FSSA: This will be an Indiana model in the end. We are reviewing all of the states with mLTSS and will be incorporating best practices from across the country and noting pitfalls to avoid. We welcome stakeholder suggestions on models to review.

The allotted time for the meeting ran out before the following questions could be discussed.

f) AARP: Can you talk about inclusion of legislators in this process? Is there anything that needs to be considered around the moratorium bills that have been filed?

g) Thrive Alliance: How do these carve-in/carve-out recommendations "score" against the goal of driving equitable health outcomes?

h) Aging and In-home Services: Do you have a full timeline established at this point?