# RFI Co-design Stakeholder workgroup 2.15.2021

February 15, 2021, 1:15p.m., virtual meeting

Notes and Agenda:

1. Meeting kick-off
    a. Secretary Sullivan and Dr. Rusyniak provided an overview of goals, objectives, and key results for Long-Term Services and Supports (LTSS) reform (2 slides).
        i. Looking to reform Indiana LTSS in a way that provides more choice for Hoosiers
    b. Secretary Sullivan provided an overview of meeting goals to engage stakeholders in RFI design process
        i. Introduced Presenters Zach Cattell, Eric Essley, Terry Miller

2. Zach Cattell and Eric Essley: Presentations on managed LTSS models (see slide deck)
    a. Eric Essley Presentation:
        i. Raises caution and noted commitment to being good partners
        ii. Suggests slow implementation, suggested 2024 implementation date
        iii. Provided overview of mLTSS models, and noted reservations on dual integration
        iv. Supports rebalancing but believes that it is something that should occur organically
        v. Workforce availability to support rebalancing goals is a consideration
        vi. Supports careful planning
        vii. Supports stakeholder engagement
        viii. Supports any willing provider enrollment
        ix. Highlighted operational challenges of payments and policies for providers working with managed care entities
        x. Highlighted need to ensure beneficiary choice and local care management options under a new model
        xi. Highlights data sharing as an opportunity in the managed care model
        xii. Provided overview of Financial Alignment Initiative (FAI) dual alignment model
        xiii. Financial savings is a point of concern

    b. Zach Cattell Presentation
        i. Focused on models that are not necessarily full capitation
        ii. Recommended investing in home health, family care giving, assisted living, and care management rather than managed care
        iii. Advocates for managed fee-for-service using Alabama, Georgia, and North Carolina. Reiterated focus on robust local care management
        iv. Supports focus ensuring caregiving supports, investing in Home and Community-Based Services (HCBS) and assisted living
        v. Noted areas where outside of mLTSS where changes can be made to delivery of LTSS services today
            1. Expand expedited eligibility pilot for immediate HCBS service access, will immediately support rebalancing based on current provider network
            2. Advocates for initiating value-based purchasing (VBP) in the current fee-for-service system as soon as this legislative session

3. Advocates for locally grown data systems
vi. Letting providers engage in insurance based managed care
vii. Supports development of unique Indiana system leveraging statewide Health Information Exchange (HIE)
viii. Need a clear schedule for detailed design inputs for the develop of the mLTSS program

c. Jen Sullivan: We have been thinking about the timeline too, and appreciate the thinking behind your recommendation for rolling out mLTSS in 2024. We also appreciate your thoughts about the things we can do sooner such as data integration, UPL VBP, working through COVID, and exploring how to do expedited eligibility going forward.

3. Kevin Hancock: Presentation on fully capitated mLTSS models (see slide deck)
   a. 25 mLTSS models operating across the country today, this presentation provides more detail on Pennsylvania (PA), Virginia (VA), and Arizona (AZ)
      i. AZ oldest in country, robust caregiver supports, opportunities for evaluating quality and sustainability
      ii. VA statewide program, heavy emphasis on integration between physical and behavioral health
      iii. PA model, phased implementation approach focused on rebalancing the long-term care system
   b. AZ – Oldest mLTSS program in the country; robust caregiver supports; opportunities for evaluating quality and sustainability; operated via 1115 waiver
      i. AZ since inception offer choice of setting for mLTSS participants
      ii. Robust nursing facility system which is about 20% of enrollment for program
      iii. Look for opportunities to integrate all different kinds of LTSS, built out program for Intellectual/Developmental Disability (IDD) population
      iv. Statewide basis, managed care oversees services on a geographic focus
      v. AZ has a sophisticated method of data collection to support evaluation
   c. VA – Statewide since 2017 with Commonwealth Coordinated Care (CCC) Plus
      i. Took an approach for statewide implementation because they were a dual demonstration
      ii. Managed care plans in duals demo platform, leveraged as way to build out program
      iii. 210k individuals for mLTSS, waiver services, and complex case management for a broader population than the mLTSS population, does not included IDD
   d. PA – Program for people 21 years age or older, fully phased in implementation in 2020
      i. Dually eligible or eligible for mLTSS in community or nursing facility and over age 21
      ii. PA has 3 managed care organizations, all offer mLTSS
      iii. PA focused heavily on duals population, all duals enrolled in managed care program looked to align between Medicare and Medicaid services and coordination between LTSS, physical health, behavioral health services
      iv. Rebalancing – to reflect participant preferences 54% receiving LTSS in the community to 70.2% in 2020.
         1. This rebalancing occurred due population growth, with people going into the system being able to receive services in community, nursing facility

system did not see that much of a change, and new enrollees were able to receive care in the community

4. Comments and Q & A
    a. IAAAA: When looking at the goals related to spend and setting, are we looking inclusive of the IDD population?
        i. FSSA: The State's goals are about aging population, and there will be some overlaps, but our primary focus remains on the aging populations. We also understand that we still need to work on quality improvements for existing and remaining groups in FFS.
    b. IAAAA: Numeric goals related to 50% of spend and 75% of persons is in reference to the aging population?
        i. FSSA: Correct, it is on the defined population.
    c. IAAAA: A question came up from the Area Agencies on Aging (AAAs), concerning the spend, how things are moving, and their ability to get arms around them. How much decision making will be a done deal by the time the RFI goes out and how much will be able to be influenced post RFI?
        i. FSSA: There is opportunity for change and growth post RFI. We hope that some decisions are at least tentatively made so that information can be collected. RFI responses may challenge us to think a bit differently.
    d. Indiana Statewide Independent Living Council and Indiana Disability Rights: What about younger, working people with disabilities who are on the Aged & Disabled Waiver? Who is representing their interests in this discussion? Will Waiver participants be invited to these stakeholder meetings?
        i. FSSA: The primary target group is older adults. We recognize disability interests as we make shifts. Changes with older adult population may have impacts on disability populations. ARC of Indiana is represented along with INARF, INSILC invited as well. Hopefully, bringing the right folks to the table so we can make sure we are looking at this through all of the right lenses.
    e. IHCA/INCAL: The calendar of both of the design and Finance meetings go to the end of May, what is the tentative timeline for issuance of the RFI and responses to the RFI? Requesting more than 30-days be allowed for a response.
        i. FSSA: We would love to get an RFI out by late spring or early summer with a robust time for response. But it is being designed via these sessions. The more than 30-day response timeline request was acknowledged.
    f. IHCA/INCAL: [To presenter, Kevin Hancock] AZ is an odd state, nursing facility population is small in comparison to other states (other than OR and WA). Between the three states, providers in each of these states have extraordinary difficulty interfacing with these systems. How do we ensure streamlining for all providers? Nursing facilities set up ok to do this but smaller providers many not be able to do this. How do providers handle this in other states?
        i. Kevin Hancock: When PA implemented mLTSS, the community had a long-term relationship with the nursing facilities. We asked nursing facilities what they thought would be the pain points: billing related concerns, communication and being able to work with managed care organizations, compared to 1 department and 1 billing system, and talked about loss of market share. They came forward with a lot of really good suggestions, such as looking for any willing provider in

the agreement, making sure nursing facilities would be offered the opportunity be part of all the networks for a period of time and to go through technical assistance (TA) sessions during the testing periods. Those sessions and those provisions were the least turbulent, and we did have prudent payment provisions in PA and nursing facilities got paid faster than under Fee-for-Service (FFS). Transition was seamless –there was not a single nursing facility that did not get a contract with all Managed Care Organizations (MCOs).

ii. IHCA/INCAL: In Indiana FFS payment is faster than managed care by 15 days. This is a lot of what causes concerned relative to the insurance operations. Supported local care management with increased AAA funding to improve timing.

iii. Kevin Hancock: LTSS MCOs and Physical Health MCOs have different PA requirements which is what can result in longer payment times in current programs.

g. [To presenter, Zach Cattell] What is the difference between a FAI vs Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) model?

i. Zach Cattell: FAI is much more overarching and can be more creative (3-way contract). FAI is more designed to encourage whatever steps can be taken to coordinate. FIDE-SNP has more requirements, has to be approved by CMS and speaks to authority of the Medicare Advantage plan to oversee services for dual eligible individuals.

h. HOPE: [To presenter, Kevin Hancock] Did the 3 states use Upper Payment Limit (UPL)?

i. Kevin Hancock: AZ did not, PA and VA did. The challenge with UPL in PA was the transition between FFS and Managed Care. FFS model had to take UPL into consideration, whereas in managed care it was not as much of a consideration. Had more flexibility in managed care. We do have differences in PA compared to Indiana's model, but PA did find managed care to be a better approach and one of the reasons managed care was attractive.

i. INSILC: Will there be as much focus on transitioning folks out of Long-Term Care (LTC) facilities as focus on diverting folks from LTC Facilities under Indiana's mLTSS?

i. FSSA: A component of this effort is how to utilize Money Follows the Person (MFP) funding so that individuals have the opportunity to transition. We aim to make sure people are in the right place for the right treatment.

j. Aging & In-Home Services of Northeast Indiana: Glad to hear that may be looking at more time. I'm interested in ways to create a hybrid model. The numbers may be good in many states, but the consumer experience may be a range of experiences from the HCBS side. From the AAA perspective, because AAAs are close to consumers, AAAs might be the ones that hear more. It's tough to be the small kid on the block when talking to really large Managed Care Organizations. It is important to understand the dynamics and to ensure a collaborative growth experience for all involved –we all have to keep moving this forward. Design is about policy and finance but also reflects the culture of state and impact on consumers.

k. Thrive Alliance: Policy and finances should be how we codify the person-centered goals we want to achieve as a state.

5. Secretary Sullivan Comments

a. Acknowledged that content for planned sessions will be sent out soon to allow for preparation.
b. Offered commitment to Indiana specific model and building from current system.

Stakeholder Attendees:

- Ambre Marr, AARP
- Amber O'Haver, INSILC
- Dan Kenyon, INALA
- Cara Veale, IRHA
- Connie Benton Wolfe, Aging & In-Home Services of Northeast Indiana
- Ellen Burton, Center for Aging & Community
- Elizabeth Eichhorn, IHCA
- Emily Munson, Indiana Statewide Independent Living Council and Indiana Disability Rights
- Eric Essley, LAIN
- Evan Reinhardt, IAHHC
- JoAnn Burke, Commission on Aging
- Kathleen Unroe, IU
- Kelli Tungate, Caregiver Homes of Indiana
- Kent Rodgers, President, CarDon & Associates
- Kim Dodson, ARC of Indiana
- Kristen LaEace, IAAAA
- Lynn Clough, LTCOP
- Mark Lindenlaub, Thrive Alliance
- Megan Smith, IAADS
- Michelle Stein-Ordonez, IAHHC
- Phillip Parnell, INARF
- Robert Thomas
- Sarah Waddle, AARP Indiana
- Sherri Hampton, American Sr Communities
- Tauhric Brown, CICOA
- Teresa Lorenz, Thrive Alliance
- Terry Cole, Indiana Hospital Association
- Terry Miller, HOPE
- Zach Cattell, IHCA/INCAL

State Attendees:

Amy Rapp, Andrew Bean, Allison Taylor, Cathleen Nine-Altevogt, Dan Rusyniak, Darcy Tower, Elizabeth Peyton, Erin Wright, Hamilton Smith, Jennifer Sullivan, Jesse Wyatt, Kaitlyn Feiock, Kathy Leonard, Kevin Hancock, Kim Opsahl, Maggie Novak, Michael Gargano, Natalie Angel, Sarah Renner, and Steve Counsell