COMMISSION ON AGING
May 19, 2022 minutes
10:00 a.m. to 12 noon
IGCS – Conference Room 1

Call to Order: Chairperson JoAnn Burke called the meeting to order and did role call. Members present include Judith Schoon, Katie Ehlman, Dan Mustard, Kelli Tungate, James Goen, Deb Lambert and Jennifer Lantz. JoAnn said with 8 members in attendance they need one more member for a quorum to approve the minutes or have an election of officers. JoAnn asked if there were any corrections or amendments to the minutes. Judith said she had a question; "Who is Amy Rapp?" She wanted to make sure she was not a new member. JoAnn stated that she is a Division of Aging staff member. JoAnn said she will file minutes and delay the election of new officers until the next meeting if they have a quorum. JoAnn said she is looking forward to their presentation long term services and supports reform, D-SNPS and Triple A's advancing care coordination for Indiana's dually eligible and Andrew Bean who is the Medicare Medicaid coordination manager for Indiana Medicaid FSSA and following his presentation they will also have Dr. Counsell presenting with him.

Presentation: Andrew Bean said he is the Medicare and Medicaid Coordination Manager with the Office of Medicaid Policy and Planning. Andrew said that he and Dr. Counsell are really excited about the work that they have been doing with the long-term services and supports reform and talking about dually eligible special needs plans which they refer to as D-SNPs. This has really started to enhance the care coordination process with the area agencies on aging. He is going to provide the precursor to Dr. Counsell's discussion around care coordination, but they're really talking about how they have begun building Medicare and Medicaid integration in Indiana particularly with the eligible special needs plans. They will discuss how some of the policy decisions have resulted in the growth of these steps in Indiana over time and then talk about the state Medicaid agency contracts, which are contracts that the D-SNPs have to sign with the Indiana Medicaid authority to be able to operate within the state market. That is the requirement that they have and can use those for very beneficial reasons. Dr. Counsell will talk about the care coordination workgroup that they've built out of this process and some of the real progress that they've made and then talk about where they're headed and how that enhances care coordination for next year. And then Dr. Counsell will talk about age friendly health systems.

Andrew said first is to put things in context in terms of Indiana's LTSS reform. They've kind of put LTSS goals in pillars for LTSS reform and one of those pillars is CHOICE. They've seen over time and through a lot of different resources that Hoosiers want to age at home. And so, trying to figure out ways in which they can make sure that they're eliminating barriers to access so that folks have the choice to receive assistance at home if they so choose. Another pillar is cost, developing some long term sustainability for the system. Indiana currently has about 2% of the U.S. population but over 3% of the nursing facilities and that really puts a lot of pressure on cost. The third pillar is quality, so making sure that the care that members in Indiana do have is the best care that's available. We are ranked at the bottom in AARP's scorecard, we moved up from 51st on the previous scorecard to 44th but there is still a lot of work to do. Those are the 3 pillars that set the stage for what they're doing with the D-SNPs.

Currently Indiana has about 230,000 dually eligible members who are currently enrolled in Indiana Medicaid, about 72% are full benefit duals, which means that they have full Medicaid benefits along

with Medicare and 28% are partial benefit, which means that they pretty much pay the cost sharing as well as the premiums for Part B for those individuals, which means that they don't have full Medicaid benefits.

Indiana dually eligible recipients are all enrolled in Indiana fee for service. There are no managed care entities that currently operate and serve the dually eligible on the Medicaid side. They typically see the dually eligible experience high level of care fragmentation since they must navigate to big government healthcare systems that don't really communicate and weren't really built from the beginning to communicate. Many users who are dually eligible are receiving care either in long-term stay nursing facility or through home and community-based service waivers particularly the Aged and Disabled Waiver. He thinks it's pretty much safe to say that Indiana spends disproportionately more for its dually eligible than institutional settings than it does in the community, despite the evidence that home and community-based services can be made more available for the aging population.

In 2019 Indiana really began to place a higher priority on implementing dual policies that positively impact quality and outcomes. That is where his position comes from, Medicare and Medicaid Coordination Manager position that became new in August of last year, so we're really committed to dual eligible and really improving access to care for those populations. Even with the increased focus over the last couple of years they're still kind of at a low level of integration of Medicare and Medicaid. This is something that him and Dr. Counsell are trying to remedy and try to impact, but they're building their capacity internally and just starting to work on building these systems and practices that are really going to improve the care of the elderly. Something that they've really talked about a lot is Medicare and Medicaid integration and the slide shows what they mean when they talk about integration. They're talking about bringing together the services and the administrative processes and the systems that kind of populate both Medicare and Medicaid bringing them together so that they work together seamlessly. And they work in a positive non-repetitive and efficient way for dually eligible. So, when they talk about integration, they're really talking about both the services aspect as well as the administrative processes.

Andrew said the state Medicaid agency contracts are currently the mechanism used to contract with dually eligible special needs plans in Indiana. CMS requires that all D-SNPs who wish to operate within a state have to contract with the state Medicaid authority in order to be able to operate within the state. What's nice about this is that states have as kind of an expanded ability to leverage these contracts to really build out some good goals for dully eligible. So, they don't have to just do the bare minimum they can add things like data sharing, information sharing systems linkage which can build on state goals that are currently in practice. What the state has done to utilize D-SNP contracts and the market to kind of improve dually eligible outcomes and kind of drive state goals. In 2019 for the Hoosier Care Connect re-procurement they required that successful bidders had to establish a statewide D-SNP one year after the contract goes live. The whole statewide is important because of the Medicare network and making sure that people have access across the state. Even though it's not necessarily fully aligned, and you didn't have people in the same system on the Medicaid and Medicare side, it did reflect an increased investment in D-SNPs as a key vehicle to coordinate care for dually eligible. In 2019 CMS came out with information sharing requirements, which basically said that if you weren't a state that had a highly integrated program that the D-SNPs had to share information with state designated entities to make sure that care is coordinated. They got to define a high-risk population which is the Aged and Disabled

Waiver population, and this is a precursor of what Dr. Counsell will be talking about in terms of care coordination.

Andrew thinks it's important to say that these early policy decisions have played a key role in how they have shaped their decent landscape and how they have kind of targeted particularly the Aged and Disabled Waiver folks as a population that they can coordinate, and it has a high level of value and return on investment in terms of the coordination. He presented a slide that reflects 2021 data and they've grown since then from 2015 to 2021 they only had about 14 counties in the state that had D-SNP enrollment in 2015 that's grown to about 28% to 2021, now it's about 37% in 2022. So, they've really experienced a whole lot of growth in terms of their D-SNP market not only in terms of members but also in terms of statewide, they are pretty much in every Indiana county in terms of the D-SNPs market. The next slides goes to the further market growth of D-SNPs in 2021 that had 5 D-SNP plans that were on the market in 2022 they actually added 4 so they now have 9.

In terms of realizing state vision, they've started to build a decent market, he thinks its important to understand they've now started to build them into their contracting language and they're codifying what their goals are for dual eligible special needs plans and seeing the dual special needs plans is a key vehicle for integration in the state of Indiana. These are in their 2022 contracts to make sure that folks understand that they see integration as a highly valuable mechanism to coordinate care and that they will see this as a critical component going forward as they move forward with LTSS reform.

The opportunity that they recognize are by the numbers, currently 38% of Indiana's dual eligible members are currently enrolled in a D-SNP. Of those members 10,047 Aged and Disabled Waiver members are enrolled in one of these networks, which means about 1 in 9 individuals enrolled in D-SNPs are Aged and Disabled Waiver members and designated as high risk via their contracts. And because they are high risk, they are focusing more of their coordination efforts on that. JoAnn said if she could ask a question, she always tries to bring it down to the level of the public in this meeting. If I'm an older person having several health care problems, qualify for Medicaid and she's 68 and on Medicare who helps me understand this. Andrew said Dr. Counsell will answer that part but one thing he would add to that is they understand that there is a knowledge gap that needs to be filled and people need to be informed about what these plans are doing and if these plans are the best option for folks with Medicare and Medicaid because there's other ways in which someone can have Medicare and they want to make sure that choice is honored. They've partnered with their state health insurance assistance program which has a lot of volunteers to share with their SHIP counselors and have worked on getting them information to make sure that folks know what's going on.

JoAnn said she is not trying to be negative, and some people don't know what SHIP is, so if they're involved with the Triple A they'll probably get referred to SHIP, otherwise people would probably understand it's very difficult. Judith Schoon said for us because we sell the D-SNPs for them that's where their education comes in, they make sure that they are fully educated and know the ends and outs, the upside downs and everything about them. So, in all honesty they really should be pushing the agents and not SHIP because SHIP really doesn't have the information that they have. JoAnn said she really wanted to do whatever they can to educate the public and there's never any money for that. She knows that it's difficult and it's an issue, but people really are floundering out there. Judith for them what they do is seminars she does 4 seminars every month explaining to people that need D-SNPs what products there are and what companies are out there. That's their job to educate the people on what

these products can do for them. JoAnn said would you say you're the private market, Judith said yes, so we need the private market and the SHIP program helping.

Dr. Counsell said one of the questions he frequently gets from presenting is wow why is this growing so fast that we have 38 to 40% who have signed up for Medicare Advantage Plans and that's rapid growth. So, they're still learning about that, but somehow the word is getting out and people are finding out about these and signing up with them. But it is a lot of work that they intend to try to be very deliberate about how are people getting this kind of information. He is going to tell you about how they're starting to kind of move forward in helping people just realize that there are other options than nursing homes. He thinks that's where they're really kind of back to the basics in their LTS reform and looking at how can we help people better become aware and access home and community-based services that most of the public and healthcare providers aren't aware of. We've been a nursing home kind of default state for a long time, so this is exciting and a joy to work with Andrew and the Medicaid office and others in the Division of Aging team around this. But he thinks it's also something that the Commission on Aging has cared about for a long time and yearned for better integration between healthcare and social services and supports. Just a little bit more about D-SNPs, you've got traditional Medicare Part A, B and D and then Medicare Advantage that's the Managed Medicare, special needs plans if you're a normal Medicare Advantage plan you must enroll anyone with Medicare. But you can apply to the Centers for Medicare and Medicaid to become a special needs plan where you're allowed to enroll only a segment for a subpopulation of those who have Medicare. There are 3 flavors there is the institutional SNP special needs plan that they can enroll people who live in a nursing home and there's a chronic condition or C-SNP, they can enroll people with a chronic condition like heart failure or diabetes only. A D-SNP is special for duals, this is a special population and they've discussed before that have higher numbers of chronic illnesses, typically more behavioral health, lower resources, and social challenges. SNPs are recognized by CMS as a subpopulation that could warrant a plan gearing it' benefits and its healthcare coverage around their specific needs.

Dr. Counsell said they probably know more about the area agencies on aging and the Division of Aging and when they talk about home and community-based services, that's what the Division of Aging is all about. And these services are primarily accessed through the area agencies on aging defined by county across the state. There are 16 planning and service areas and one of the area agencies on aging covers 2 of those areas, so they have 15 organizations. This work is looking to get those 2 groups the healthcare health plan ide to work together with the area agencies on aging side to better connect people together. To work together in an interprofessional manner and teamwork approach and even developing individualized care plans with the whole person in mind. The work has been running almost a year, they meet a couple of times a month and the goal is to improve health outcomes for the D-SNP members. There are 90,000 of them currently who complex needs so their focus is on those members especially those who need help in their activities of daily living. They do that through enhanced care coordination, and integration of the healthcare and the social services. They started with silos, many of the health plans and personnel had no idea what the Triple A even stood for, let alone know what they do and that their health plan member is getting in-home supports and care management through an area agency on aging or independent care manager. So, they started out just connecting the two and now they are working towards these integration. In their meetings they refer to their success stories, this was something Andrew came up with a triangular moment, so you can see the yellow and the blue combine to attract a green triangle where everyone is really working together in the interest of the patient, the beneficiary and the client.

The D-SNP workgroup is the Division of Aging, OMPP folks and the 9 dual special needs plans and the four area agencies representing the 15 across the state, Aging and In-home Services of Northeast Indiana, CICOA, Thrive Alliance and Lifespan Resources. They regularly share the triangular moments and then dive into two components, so last year they started with care coordination for waiver patients, one out of 9 of their members are enrolled in the waiver program. It was surprising to him most of them didn't know what a area agency was but they didn't know who of their members were actually enrolled in the Aged and Disabled waiver program getting in-home supports because they were both nursing home level of care needing help in 3 or more activities of daily living. Also, the recipient qualified for Medicaid and getting services coordinated through a care manager with an area agency on aging or an independent care management group. That was their first place to start care coordination for those people that they share in common and get them working together. The second pillar that they've been working on in more recent weeks and months is to backup those people who are not on the waiver but have risks and strong predictors of needing help, this is where the proactive referral comes in. They typically have no idea of what's out there and how they can help, how they can access services. They have proactive referrals from the health plan to the local area agencies on aging for information and assistance and Options counseling to figure out what is out there. This has been real collaborative work, the D-SNPs have been all in as well as the 4 representative area agencies on aging. They've worked through processes and mapped them out, and it's been laborious at times, but everyone is coming, and it really is a workgroup collaboration.

Dr. Counsell said the first area is around information sharing that Andrew described that is required of D-SNPs to share information on hospital and skilled nursing facility admissions with the state on a population that the state chooses. They chose the waiver participants, and they are sending them hospital and D-SNP information it goes into CAMS the state's care management system, and it sends an email to the waiver care manager alerting them that the person was admitted to the hospital or a skilled nursing facility. It gives them some basic information and they can loop back and start to coordinate care with the health plan, hospital or skilled nursing facility. That's been their original focus to start to work together with the care manager at the health plan and the waiver care managers.

In January and February, they had over 1,200 D-SNPs records formed this information coming into the state goes into CAMS, which says you've got a D-SNP record on this waiver participant because they just were admitted to the hospital. In PSA 8 they have the largest of these with Fort Wayne having the 2nd largest, but this is happening across the state with all the area agencies on aging and the independent care management organizations getting these D-SNP alerts. They are showing about 60% of the area agencies on aging and the independent care management groups are acting on this information and starting to coordinate care with the health plan, hospital or D-SNP. They are tracking this, and it has improved overall since October and November. On the health plan side, they in return are telling them how many emails they're getting from the waiver care managers to start care coordination and how quickly they're responding back to them in a timely way. The numbers in the slide are primarily focused in Anthem, Humana and United Healthcare which have about 95% of the D-SNP members in Indiana. So that's the first focus care coordination of people who are already connected with the area agencies on aging and the independent care management groups, because they're enrolled in the wavier program and getting support.

The second group that they just really started more recently to kind of try to go upstream and consistent with their LTSS goals to help increase awareness and access to services before people become nursing

home level of care. Maybe they can help them way before that and even if they do become nursing home level of care, they might access home and community-based services first before or maybe instead of institutional care. They identified one risk factor for needing long term nursing home placement and its having been in a nursing home before. If a Medicare plan had someone admitted to a skilled nursing facility and they're not already covered under the waiver, they flag those folks and make referrals and talking to the members asking them if they know about the local area agency on aging, do you mind if I make a referral for you. They do that through the online referral form to the area agency on aging and then their Option folks will then contact that person and go forward according to their personal preferences and needs. They've just started working on identifying people in the health plans who have a diagnosis of dementia, so they can flag those folks and their caregivers and their families to proactively refer them to find out more about what's available in the community to help support them.

They have 365 new skilled nursing facility admissions or about 90 a week across the state who are members of these D-SNPs but not in the waiver program. They're tracking these process measures to see how successful the D-SNPs is in contacting their members who are admitted to a skilled nursing facility and offering them referrals. How often are they making an online referral to those folks and the numbers have improved over the last 2-3 months. Dr. Counsell said it's interesting that when health plan contacts the folks some of them don't want to refer and some already connected and it was a mistake and they're already enrolled in the waiver program and some of them don't want to go home they want to stay in the nursing facility, hang up, etc. How many referrals are the area agencies on aging receiving, when they heard there were 90,000 D-SNP members and they were going to require referrals to the Triple A's there was a minor freakout. But when it came down to it only about 25% get referred and that's about 80 or 90 a week, so its only about 20-25 people a week that are new referrals statewide. They now have the other eleven area agencies on aging report to them on how many D-SNP referrals they have had. They had to do some work to standardize the online referral form across the state and have a special checkbox on the online referral form so the D-SNPs could check the box that the D-SNP was the referral source so the area agencies would know.

They are getting their arms around the skilled nursing facility admissions and proactive referrals of those folks. Next, they are going to identify people who are D-SNP members who have a diagnosis of dementia. Most of the health claims do not have special programming for people living with dementia and their caregivers. The state legislature law requires a dementia strategic plan, and the Division of Aging has a big focus on supporting caregivers, the family and informal caregivers. They had a workgroup yesterday and United Healthcare provided them with their data, and they have over 1,200 members that have had a diagnosis in their records of dementia, and they gave them the ICD 10 diagnosis codes to filter through and identify these folks. About 30% of waiver participants have a diagnosis of dementia and the slides shows that 2/3 of those United Healthcare members are waiver participants, so its that 421 non waiver that they're starting to work with. It has been decided that the area agencies on aging don't want United Healthcare to refer all 421 on the same day, but they're going to figure out some way to stagger and prioritize those referrals.

Where they are going next, they will be focusing on coordinating care for people already enrolled in the waiver and then proactively referring people who have strong predictors of needing help in the home. And then they want to expand and build on that, so for the care coordination of waiver, they're going to require now that the waiver care manager is integrated with the health plan care manager. They work together and share care plans and the health plans care plan incorporates the waiver service plan in

their overall individualized care plan. The second is that the health plan will be required in the waiver participants that are enrolled in their plan to assess and document what matters most to those members, so they can have advanced directives or help them designate a healthcare representative. The next steps for the proactive referrals for those folks, if they've had a D-SNP, met diagnosis, dementia and a third one they're going to be working on if they have one or two ADLs. In addition to providing the referral to the Triple A they want them to access and document informal caregiver supports and needs to help get their arm around what can we do as a state to better support informal caregivers.

In 2023 they're requiring access to address social determinants of health, so this is even a broader touch looking at social risk factors and social needs will be especially focused on, food security, transportation, and housing. They will expect the health plans to address and try to build those things in. They won't be able to act or have interventions for all that but at least address and include that in their person-centered care planning and collaborate with the state and the area agencies on aging around coordinating and optimizing the use of all the home and community-based services. They know the Older Americans Act has limited funding and the waiver requires certain criteria, but the D-SNPs have a lot of leeway about what supplemental benefits they can provide. So, they want to coordinate that so they can make the most out of the resources they have in this state.

Dr. Counsell said something that is near and dear is the age friendly health systems, it is gaining a lot of momentum nationally, person centered approach to help maintain the health of older adults based on evidenced based care. A lot of research has been done here in Indianapolis through the IU School of Medicine and other institutions as to how they can deploy programs that have been proven to better support older adults and aging in place. Employing the 4M framework that have incorporated into their D-SNPs Triple A planning. They are "what matters" prioritizing care to older adults, "medications" avoid deprescribed high risk medications, "mentation" prevent/identify delirium, dementia and depression and "mobility" encourage older adults to move safely to maintain functional ability and do what matters.

The last slide is borrowed from Dr. Glenda Westmoreland on how the IU Workforce Enhancement program is applying these 4Ms teaching future healthcare professionals as well direct care workers these principles. This is stemming out of funding and support through the John A. Hartford Foundation. They have had strong support from the foundation in the IU geriatrics program for several years. What really got this going nationally is the connection with the Institute for Healthcare Improvement and their quality improvement efforts and age friendly health systems, age friendly clinics, and age friendly nursing homes that they are working on. They're wanting to work towards age friendly health plans. Dr. Counsell said he would quite there and take any questions. A question was asked for the seniors that are on the BDDS waiver, is there a focus or a timeframe that they're looking at incorporating them into the D-SNP process for those that qualify. Andrew said they've reached out to DRS to kind of start having the conversation, but it takes a lot of planning, and he doesn't think they have a real set timeline. But they want to continue to work with them so that they're targeting that population group. And he has been outreached by the ARC of Indiana as well and they've asked to talk about Medicare and Medicaid coordination, folks need to understand how these can benefit them. Dan asked if there have been any conversations about replicating for seniors the supported living model that they currently use for people who receive services through the BDDS waiver? It seems to work well when it's done. Is that an option? Andrew said he not as familiar with that model as he probably should be. He thinks that

what their goal is is to bring in best practices and on what's in Indiana so that they can make sure that "a" their visible to the plans and the plans can then start incentivizing those types of care that they're doing in Indiana already. JoAnn said bring that down to the general public's understanding she hasn't worked on the DD side, so she doesn't understand all of that. Currently in Indiana we do or do not have licensed group homes for the older adults on the DD side, we have waiver homes, and we have group homes, if we bring that over the aging side what do we have. Kristen said there are licensed residential care facilities which are licensed assisted living facilities that can be wavier eligible. There are also registered housing with services establishments which are not licensed but provide some level of supportive service for an older adult such as meals, transportation, etc. and waiver services can in. Finally, she believes it still on the wavier there are adult family care homes which would be considered like adult foster care. Those are the 3 options that she is aware of. Dr. Counsell said that there is a real gamut of home and community-based services out there, but people don't know about it and they don't know how to connect. This is really what they're trying to do is at least better connect people and grow this awareness and get the health plans to work together with the area agencies on aging and the independent care management groups around this particularly vulnerable population. JoAnn said they must register with the Division of Aging. Erin said yes, they must file an annual housing with services disclosure form. JoAnn said is there a limit on how many people in the house. Erin said for the housing with services there is not, for the adult foster care she doesn't know off the top of her head, she can find out. Kristen aid it also gets into local zoning because there are zoning requirements that only allow a certain number of unrelated adults to live in the same unit and a lot of these housing with services establishment are individual units like studio apartments, one-bedroom apartments, etc. It's really when you get into the adult foster, the adult family care situation where you start to look at adults living in the same housing unit together, maybe in different bedrooms, if that helps you kind of visualize these options.

Judith Schoon said she had a question you said there was a major freak out with companies, and she can understand that because these are run by private insurance companies. It's their money, it's their services and they have worked extremely hard to get their services in front of people. They've worked hard on transportation, they've worked hard on food, just giving them a $50 a month gift card so they can get healthy food every month. They've worked very hard in getting this done and now you're requiring them to do one more step. Dr. Counsell said yes, they've had good receptivity from the D-SNPs from the health plan side, the freak out was on the area agencies on aging just how they were gonna handle so many referrals. But it turned out to not be substantial at least so far it hasn't generated the hundreds or thousands of referrals that was potentially thought to be coming in.

Judith Schoon said let her explain when they get a new client for D-SNP they actually have a questionnaire that they have to fill out with then that asks them all their priorities. They ask them their healthcare, what they need, what's going on in their lives, their mental capacity and how are they feeling. That all must be done before they can even take the application, so that helps them out a lot and the other thing that they're doing is they get a summary of Medicaid coverage benefits. This is in every booklet that they give every single client, and it tells them that the following services are not covered or may not be fully covered by which ever company but are also available through Medicaid and it gives a whole 2 page of list. It also gives them a phone number to call to talk to Medicaid, so they're working very hard to coordinate with them. Dr. Counsell said they have a D-SNP website at the state that has that information from each of the health plans and yes, they're trying to kind of help everyone kind of learn more about what's out there and what these D-SNPs Medicare side can cover,

what's available for Medicaid. The area agencies on aging have other resources potentially available through the Older Americans Act and other community supports that can benefit.

Judith asked how does PACE work into all of this. Dr. Counsell said PACE is separate from the Medicare Advantage plans and separate from the waiver. But is has many similarities in terms of the population served 55 and over and they must be nursing home level of care and qualify for Medicaid and Medicare. But once you're in a pay site then you would not be in a Medicare Advantage plan including a D-SNP. You would be in a PACE program that's paid separately by Medicare and Medicaid. Judith said so PACE isn't going away. He said no PACE isn't going away it's growing in Indiana, but it's still he thinks serves under 500 people in the state, it's a program for all-inclusive care for the elderly and disabled.

Kristen LaEace said she had 2 comments, one has to do with why we have seen such a huge explosion in D-SNP and Medicare Advantage. She had an interesting conversation on Monday with the Regional Vice President for Medicare from Anthem, Neil Stephens who started his Medicare career at OMPP. One of the things that he pointed out was that maybe 5 or 6 years ago you started to see a much more extensive direct to consumer marketing for Medicare Advantage plans, also in the last couple of years these telemarketing firms are calling older adults unsolicited marketing pitching Medicare Advantage plans. The other thing that came into being is the special supportive benefits for the chronically ill. They had high hopes as the Triple A network that this would be Medicare is getting into home and community-based services. But because there are so many ways in which Medicare Advantage plans can customize who those are offered to and what they look like they're also very limited, so they're not long-term kinds of benefits. They're not directed to how can we use this to produce a clinical outcome, it's more about how we can sell more plans. So, there's been this big demand from consumers asking, enrolling, and bypassing independent agents who used to be the primary salespersons as well as SHIP programs who do the same kind of education. She found that very interesting and it kind of woke her up to some things they are seeing in the Senior Medicare Patrol Program, the fraud prevention program that they run. They're getting more calls from people who have been tele-marketed into Medicare Advantage plans that are not to their benefit, they're not getting that in depth counseling and education that a SHIP, or an agent would provide. Just a little bit more information on PACE it is a form of managed care, so a PACE provider is taking on the risk. The financial risk for covering all the care that the person needs including nursing facility care, but at the same time they are geographically based, so you're only going to find them in the bigger population centers where people can get to the PACE Center. And it must be an organization that is very well capitalized these re multi-million dollars startups and so you find them in health systems, you find them in provider networks across the state and country. They've seen larger area agencies on aging starting to partner and capitalize but that's not going to grow as fast as the waiver because of those financial considerations and the geographic considerations. Erin said there was comments from the chat, could they get a copy of the slides, yes, they will be available. Another comment Kelli Tungate said she greatly appreciated the presentation care coordination is such a critical need and supporting dually eligible Hoosiers and their caregivers.

JoAnn said she had one other question on integration and asked if Mitzi Daffron was on the line, she answered that she was. She said she was wondering how CMS with quality improvement is interfacing with what is happening at the state level with integration of services. She asked Mitzi to comment and then she'll asked Dr. Counsell or Andrew to comment. Her question is with your scope of work how is that integrating with what is happening at the state level with some of these high-risk older adults. Mitzi said she honestly doesn't know that it is, quite frankly, their work is heavily focused and becoming

more heavily focused on nursing home quality. Dr. Counsell said certainly around the pandemic they saw that the quality improvement organizations focus even more on nursing facility quality and infection control. There is an I-SNP in Indiana, and institutional special needs plan where they can enroll only people who are long term stay residents. It is rather small and not growing nearly at the rate as the overall dual special needs plans.

JoAnn asked Mitzi in the scope of her work she doesn't believe CMS is looking at persons with dementia, is that correct. Mitzi said yes. JoAnn thanked for the presentation and Mitzi for her comments.

Division of Aging Update: Erin Wright said as they talk about how they can increase education awareness and coordination they are currently soliciting feedback on their 2023 and 2026 State Plan on Aging. This is a 4-year plan submitted to the Administration for Community Living as required in the Older Americans Act and it's due to ACL this summer. It is an Older Americans Act requirement and is really intended to encompass more than just the Older Americans Act and highlight some of the state's broader efforts on behalf of the older population, but by no means is it intended to encompass anything, everything.   ACL provides states with the plan requirements, including specific guidelines for areas of focus and priority, as well as some of the objectives that must be included. When drafting the plan, they consulted with the area plans that were submitted by each of the area agencies on aging last year, the Community Assessment Survey for Older Adults that they recently completed as well as some of the other recent surveys and stakeholder engagement efforts that have been going on as part of the LTSS reform. They are again working with the Center for Community at the University of Indianapolis to facilitate their stakeholder engagement and feedback on the plan.   They are hosting a series of public feedback sessions around the state as well as virtual sessions. The first one is this upcoming Tuesday at 6:30 p.m. and she will make sure that everyone has the information and can hopefully join them and help spread the word. She asked if there were any questions on the plan and that was her main update today.   JoAnn said she read the plan and thank you for the Living Longer Living Better collaborative idea that was in there.

Committee Updates: JoAnn said they are ready for the committee updates, and she is on first with the Living Longer Living Better Collaborative.   She did a presentation at the CMS Quality Conference in April on the guide, she got some acknowledgement across the country which was one of the reasons she wanted to ask Mitzi this morning on the QIO side how they were integrating with what we were doing here in the Division of Aging and Indiana Medicaid. She has made presentations in probably if not all the communities around Indiana. When they say community it's a regional idea of healthcare providers and social service organizations and they're trying to get more of these local community collaboratives underway and have worked through their QIO regional communities to do some of that. Dan can also talk how the Senior Center Coalition of Indiana is working very much to promote the local care collaboratives. In the Tipton area where she piloted the first one of those, they do have some senior affordable housing coming they've got a couple of them that have come of that.   She said some of her questions arise out of the local level people don't understand what long term services and supports reform really means. They know we need housing and transportation, and she is going to ask if the Division on Aging could provide information that local communities could use so they can better understand housing. What's available right now in those 3 categories of housing we talked about so that we could maybe get that board disseminated and she'd like to get those out to those communities Mitzi that you're holding around the state and Dan maybe more out through the Senior Center Coalition, so that local communities can understand, that's just going to be vital.   She hopes they don't

end up in Indiana with a lot of unlicensed boarding houses where we just have people and somebody taking their social security check and people aren't coordinated, we don't want that. She know this is a lot to ask but just some clarification on those 3 categories would be helpful. Erin said she would work on that.

JoAnn said they're continuing with their Living Longer Living Better initiative, there's a lot of work to be done and the focus is on helping local communities become more age and dementia friendly and their healthcare provider serving those areas become more age friendly. She is available to talk she has done a lot of presentations and will continue to do that and if there is anyone else on the Commission who wants to work with this, please let her know they have an advisory group with about 14 state agencies. She asked Judith do you have a report on the Shared Decision-Making Committee. Judith said sorry no report right now. They are working on a few things, but they haven't got together and finalize anything.

JoAnn asked Deb if she had a report from emergency housing. Deb said they had their first meeting on May 2nd, and they have scheduled the next meeting for May 31st. They're focusing on making sure they have the right people in the committee with them. She had a talk with Sarah because they would really like to have someone from APS and FSSA and then also a person from the shared decision making formal because that seems to be a barrier for emergency elder shelter as well. JoAnn said thank you, Dan could you give us a update on Senior Center Coalition of Indiana.

Dan Mustard the Coalition guiding team recently met in Tipton and their purpose was to develop a strategic plan moving forward. One of the main topics of that is to help senior centers develop kind of their value story in kind of perhaps changing the narrative a little bit about seniors and senior services especially for senior centers. Most of the services and conversations about older adults and resolve around treatment rather than prevention and the stocking trade for senior centers is to focus on wellness programming. Historically there has not been much of the funding stream for wellness programs and there are some things here and there but not much. So, for them it's really looking at the local level and having conversations with local government and county government and maybe changing the narrative a little bit and having senior centers and some other senior service providers present less ad charities and more on the economic development side. Some of the statistics that they share with folks is that people 60 and over are responsible for half of all consumers sending. Older adults pay nearly half of all federal taxes and 56% of state and local taxes. The affluence of elderly is historically unprecedented which is unusual he thinks for a lot of people it's a shock because we tend to present older adults as all living in poverty, which is the case for many people but not all.

People who age 75 and up currently have the highest median household net worth of any age bracket, the typical 80-year-old household has twice the net worth of the typical 50-year-old household. Homeownership rates are highest among people 50 and over the highest percentage which is 95% is among those who are 70 to 74. Older Americans are also the fastest growing segment of the workforce and people who are 55 and up donate 69% of all charitable giving. When we share those statistics with local government officials especially, it can be a little bit of a game changer in the way that they think about older adults rather than seeing seniors as being a potential burden they can change that conversation as one of being in an economic development engine. We spend a lot of time and effort in attracting younger people to the community when in fact maybe we should be attracting people who are older and presenting our communities as areas where people would want to retire and bring their money with them, that really changes the conversation quite a bit. They've had some positive conversations with some of the city council members2, with county commissioners in helping them to

see the benefit and economic benefit of older adults as part of the community. They are trying to change the conversation and create more of a value story and moving a little bit from the charity conversation along with their continued work and adapting the living longer living better plan. One of the things that they're trying to do is find ten geographically distributed senior centers throughout the state that they can help to develop that kind of new narrative.

The other thing that he would like to share is that the National Institute of Senior Centers which is called NISC is now offering free memberships. So, if you have senior centers in your area let folks know that membership is now free and that there's a lot of really good information that is available through them.

I-4A Update: Kristen LaEace said one thing that kind of addresses some of the conversations that they've had around housing. Thanks to the generosity of a grant from Humana, they've been able to contract with the Corporation for Supportive Housing to do some statewide housing needs work and policy conversations. The scope of work hasn't started yet and she knows there's some other things happening out there that they're going to have to coordinate with. It was originally built around the ides of we'd like to be able to put housing specialist in the ADRC Resource Centers to act as people who can go a lot more in depth, a lot more knowledgeable to be able to provide that specific community level knowledge about specific landlords, about tenancy, etc. So, they thought about a training that would be available to those kinds of personnel and so that as some of the genesis of this initial proposal to Humana. Their board just approved the final scope of work, and she is waiting on a timeline back from the Corporation for Supportive Housing. There are a lot of things happening MFP is kind of moving forward again in the state and we know that housing is a big issue and getting people out of nursing facilities. So those conversations are going to have to be coordinated there, also there's a housing task force that the legislature passed, and it's focused more on workers, but they're going to try to put in older adult issues as well and so there's just a lot of conversation right now about housing. She will keep them posted on what' happening with that.

Kristen said Erin mentioned that the state plan on aging is soliciting public comment and at the same time the federal government is soliciting public comment on Older Americans Act regulations. It's not about the law the Older Americans Act is what governs everything, but these are implementing regulations and how ACL and the federal government can interpret that law. They were recently invited to have a conversation with some staff of the Special Committee on Aging at the Federal Senate. There is a Senate Special Committee on Aging whose purpose is to talk about older adult issues and rise awareness and educate. Its not a lawmaking or a legislative body or a legislative committee. They were looking for how's Indiana doing, they were looking about nutrition because it was during the Senior Nutrition Month, but they also got into a couple topics that their staff got really excited about that they hoped to follow up with. And this goes to the Older Americans Act regulations, one of them is the topic of how they're supporting older adults with pets because what happens when participants in home delivered programs and even congregate meal programs will give their food to their pets because they don't have enough money to feed their pets. There have been area agencies on aging and food pantries, etc. that have tried to establish special programs pet pantries, but there is no consistent funding source for it. So, they got really excited about it putting it in the public comment because they think they can do something either as part of the nutrition programming or as part of the Title III-EB other services or something like that in terms of making that more of an eligible activity and there would have to be guidelines about it, especially with animal hoarders so there's got to be limits. Because it can really affect an older adult's nutrition especially if they're on a special diet. Another thing people got

excited about was this aspect of FEMA being able to draw on the area agency on aging networks more with a lot more federal coordination around that, so a lot of times that disaster response happens locally through the local organizations, the COADS, etc. Up in South Bend the nutrition director reached out to the Food Rescue Organization and they started a kind of joint committee up in the South Bend area. How are we going to keep people fed during covid, they met weekly and worked among themselves to make sure those needs were met and continue to meet monthly because they think of themselves now as a critical part of the community response and disaster. He wanted FEMA to know that it's not just about your COADs look at the area agencies on aging networks as part of your integral response. So that's one of the things they've been trying to follow up with is really understanding what the current relationships ACL had with FEMA and looking at how can we formalize that FEMA ACL relationship if it's not already there. Those are the 2 things that the staff got really excited about.

In the educational packet first, it is Older Americans Month. The Governor did share a proclamation for the state and there's the national designation as well, there's also information regarding the President's budget. The presidential budget included significant increases for the Older Americans Act programs. She is going to highlight Thrive Alliance related to housing, they recently opened a senior apartment complex in Seymour and integrated that with the local hospital, which is apparently right next door. Another one of their area agencies on aging launching their own local housing initiative under the auspices of the economic development side of their agency is Thrive West Central and they're focusing on making the Terre Haute area a retirement destination. They are starting to have some conversations between the two Thrives about this, maybe some senior housing development there. There is a big section in their packet that has to do with the current economic outlook and effects on food prices and inflation and how that's affecting older adults and access to food. In addition, Feeding America published updates to its senior hunger studies, and she included the executive summaries of those reports. There is also going to be a White House Conference on Hunger broadly in September. There are bi-weekly stakeholder phone calls happening, listening sessions, they're going to be putting out a toolkit so local organizations can hold their own listening sessions. She is going to be talking to with their nutrition directors about how they can hold local events and get information on senior hunger. There is also information about the workforce shortage which they've all been hearing about.

Finally, they asked about MLTSS she has a little bit of an update. They are in this period where the RFP isn't out yet and so they have been releasing some information publicly about the RFP and what's in the RFP so that the stakeholders can have discussion about that as well as the managed care entities. They are doing it in a way that doesn't violate procurement because they don't want to mess that up. Depending on how they're able to mitigate conflict of interest there will be opportunities for area agencies on aging opportunities do not guarantee. It's kind of in the front end that they've talked about in the service coordination area and potentially for some of the one-off services that the Triple A's provide, transportation, nutrition, etc., but again it's going to be dependent on how the managed care entities want to contract. The good news is the opportunities are still there the Triple A's haven't been explicitly axed out of any one role but that's about all she can say. The RFP s now going to be released in June, one of the requirements that our legislators put in place was that the budget agency must be able to review the RFP, or the budget committee and the budget committee did not review it in April. But from the perspective of FSSA they don't feel like this delay and being able to release the RFP will affect their overall timeline.

JoAnn thanked Kristen and asked if there were any other issues that anyone would like to rise. A log of good work going on in Indiana we've made some real good progress. Moving along our next meeting will be in July again she invites people to come down, its good to see other people. If there's nothing else to being up, we will adjourn the meeting. Thank you.