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Member Forum

September 24, 2021

Board Chair Report

Welcome

- Debbie Bennett, President & CEO, Hillcroft Services, Inc.

Today's Agenda

- Managed Care Educational Presentation – Mike Nardone, Health Policy Consultant
- Association Update - Nanette Hagedorn, INARF
- Industry Update - John Barth, Katy Stafford-Cunningham, Brian Carnes and Phillip Parnell, INARF

Upcoming Events

Professional Interest Section Meetings / Professional Development:

- October 14 - Child and Family Services (10 AM-Noon)
- October 28 - Business & Industry / Certified Ability Indiana Organizations (10 AM-Noon)
- November 2 - Community Supports (10 AM-Noon) / Employment Supports (12:30-2:30 PM)
- November 4 - Pieces to the Group Home Financial Puzzle Training
- November 11 - Financial Management (10 AM-Noon) / Human Resources (12:30-2:30 PM)

Upcoming Member Forum and Board of Directors Meetings:

- October 22 - Member Forum / Board of Directors Meeting - Hybrid - at Marriott East
- November 19 - Board of Directors Meeting only - Virtual
- December 17 - Member Forum / Board of Directors Meeting - Hybrid - location TBD

Registration for each meeting is available 3 weeks in advance. Recordings and materials will be available on the INARF Member Portal within 2-3 business days following each meeting.

Managed Care Educational Presentation

Mike Nardone, Health Policy Consultant

MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS INARF PRESENTATION

Michael Nardone

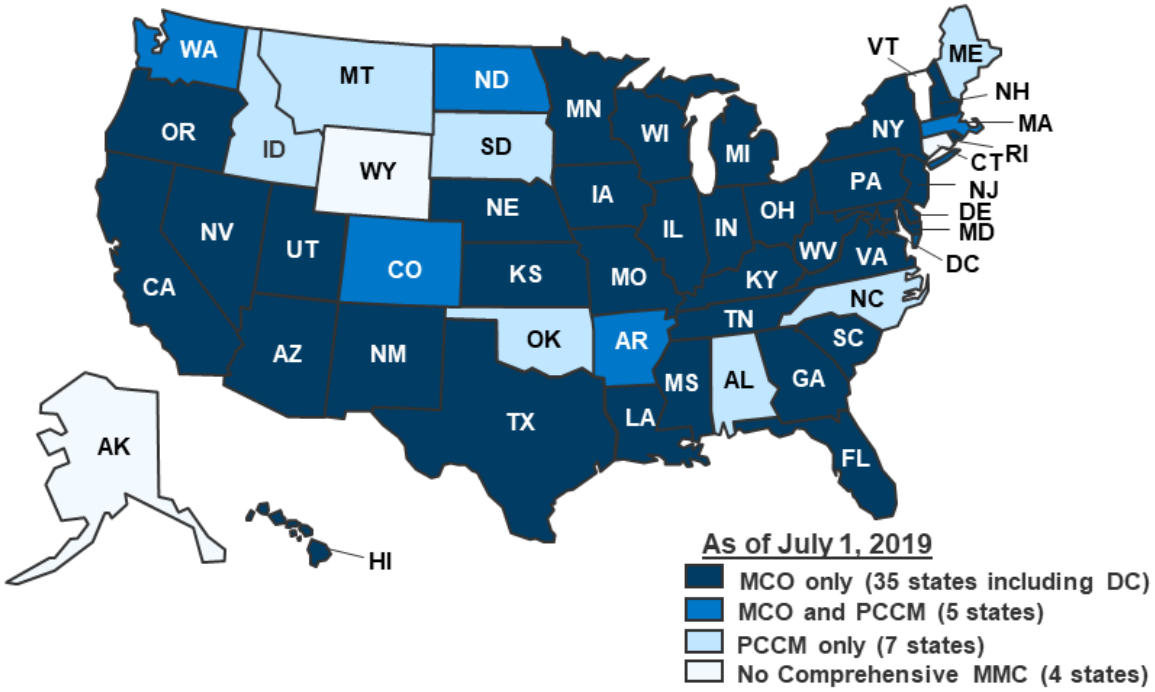
SEPTEMBER 24, 2021

Medicaid Managed Care

- Capitated managed care is the predominant delivery system now employed by state Medicaid programs
  - 40 states utilize comprehensive risk-based managed care organizations (MCOs) to provide services
  - 33 of these 40 states had more than 75% of their Medicaid beneficiaries enrolled in MCOs as of July 1, 2019.
  - Other variants of Medicaid managed care models include limited benefit prepaid health plans (e.g. behavioral health, long term services and supports) and state primary care case management (PCCM) programs
- Over time, States have expanded managed care to include additional populations (e.g. aged, blind, and disabled; ACA expansion populations, kids with special needs) and carve-in additional services (e.g. behavioral health; long term services and supports)
- Indiana a leader in implementing managed care programs

Figure 2

Comprehensive Medicaid Managed Care Models in the States, 2019



NOTES: ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare. SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

KFF
HENRY J KAISER FAMILY FOUNDATION

Medicaid Fee for Service (FFS) vs. Managed Care

Major Differences	Medicaid Fee for Service	Medicaid Managed Care
Overarching Administrative Framework	State Medicaid Programs Operating a health plan system and directly provide for services to Medicaid beneficiaries States Directly Contract with Providers to Provide Medicaid Services	States Contract with Managed Care Organizations (MCOs) which assume the risk of providing services to Medicaid beneficiaries States provide oversight of MCOs to ensure state and federal standards are met
Payment Methodologies	States responsible for ensuring that payments to providers are consistent with efficiency, economy and quality of care and are sufficient to enlist sufficient providers CMS State Plan Amendment Approval Process and Public Notice Requirements	State must provide capitation rates to MCOs for services and associated administrative costs that are actuarially sound CMS Reviews MCO rates to ensure they are “reasonable, appropriate and attainable.”

Medicaid FFS vs Managed Care

Major Differences	Medicaid FFS	Medicaid Managed Care
Freedom of Choice	States must permit beneficiaries to have access to any qualified and willing provider, who is enrolled and has a provider agreement with Medicaid	This requirement is waived under Medicaid managed care MCOs must meet network adequacy requirements set by the state
Comparability of Services	States must offer services to all beneficiaries that is equal in amount, duration or scope	This requirement is waived and states may provide different benefits to beneficiaries enrolled in an MCO, including “in-lieu of” and “value-added” services
State-wideness	Medical Assistance must be offered statewide	States may implement Medicaid managed care in specific areas of a state, e.g. by region or county

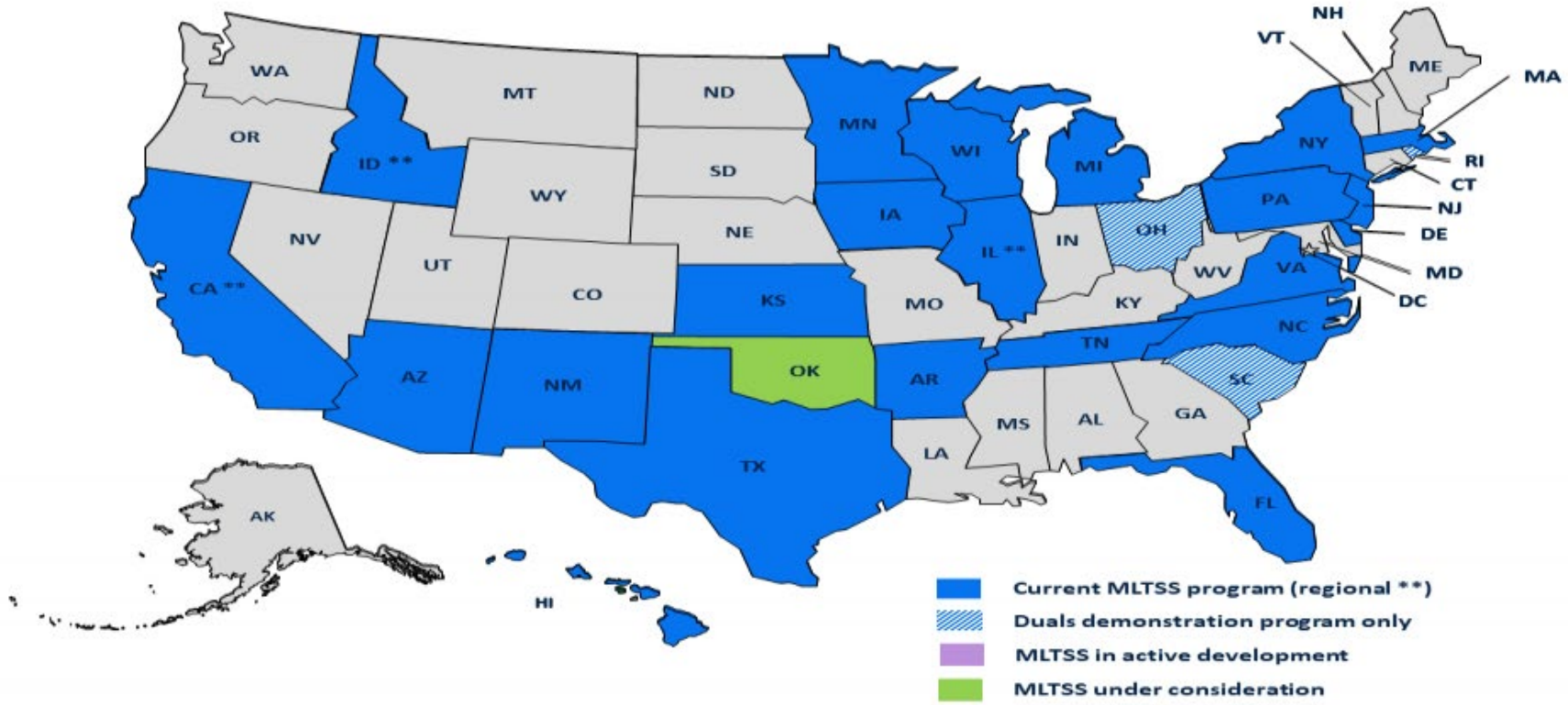
Medicaid Managed Long Term Services and Supports (MLTSS)

Medicaid Managed Long-term Services and Supports (MLTSS) refers to institutional and home and community based long-term services and supports delivered through a managed care model.

MLTSS MCOs generally cover a range of LTSS from personal attendant to nursing facility care, but there is much state variability in LTSS and other services (e.g., physical health, behavioral health, pharmacy) included under the managed care model.

In addition to benefits covered, MLTSS varies significantly across states depending on populations served, mandatory vs. voluntary enrollment and geographic reach, among other factors.

MLTSS Adoption by States Has Increased Significantly Over Time



State MLTSS Programs Differ by Benefits Covered

- MLTSS Can Be Characterized Along a Continuum:
  - *Medicaid Managed LTSS Only Plans* responsible for providing only MLTSS benefits, usually both institutional and HCBS services, although there are some limited to managing HCBS only or with limited risk for institutional services
  - *Comprehensive Medicaid MLTSS Plans* that provide both Medicaid LTSS as well as non-LTSS services, e.g. physical health. These packages vary based on what services are carved in and carved out.
  - *Integrated Medicaid and Medicare Plans* that cover all Medicare and Medicaid benefits, including LTSS, for individuals who are dually eligible.
- Most states (21) report employing a comprehensive Medicaid MLTSS model (Gifford et. al)

MLTSS Programs Differ By Populations Served

- Seniors and Persons with Physical Disabilities have generally been populations served by MLTSS
- States have been slower to implement MLTSS programs for the IDD population.
- Only 10 states identified as having some form of MLTSS program for IDD population – AR, AZ, IA, KS, MI, NC, NY, TN, TX, WI
- MLTSS for elderly and physically disabled individuals represented 24% of Medicaid spend for LTSS but only 7% for the IDD population (Eiken et. al. 2018)

States' Goals for MLTSS

- States implement MLTSS for a variety of reasons. Primary goals cited in a survey of 12 states with MLTSS (Dobson et al. 2017), included:
  - Rebalancing LTSS spending—increasing the proportion of Medicaid LTSS spending used for HCBS while decreasing the proportion of spending for institutional services;
  - Improving beneficiary care experience by increasing care coordination to improve health and quality of life;
  - Better Integration of Medicaid (and potentially Medicare) services
  - Reducing or eliminating HCBS waiver waiting lists to address access gaps and to provide care in the setting that the beneficiary chooses;
  - Providing budget predictability and potentially containing costs via rebalancing, efficiencies, and improved quality

States Have Generally Been Slower to Implement MLTSS for IDD Populations

- Lack of Potential State Savings – IDD HCBS providers rely on Medicaid reimbursements that are generally low and higher proportion of services are provided in home and community-based settings rather than in institutions.
- Strong Advocacy at the State Level including family members, providers, professionals and people with IDD themselves
- Limited experience of MCOs in providing for the specific service needs of the IDD population
- Lack of managed care experience among IDD providers
- Unique Role of IDD case management and supports coordination
- State capacity to set I/DD rates under MLTSS

(See: Sharon Lewis et. al, 2018)

Medicaid Managed Care Requirements

- CMS provides overarching regulatory framework within which states can design their MLTSS Programs.
- Medicaid MLTSS must adhere to same requirements as Medicaid Managed Care, including:
  - Actuarial Soundness of MCO Rates – Rates must provide for all reasonable, appropriate and attainable costs and be approved by CMS.
  - Network Adequacy Standards – MCOs must have a network sufficient to serve expected enrollment and provide access to needed services
  - Quality Requirements – Plans must have Quality Assessment and Performance Improvement (QAPI) Program and state must implement a quality strategy that includes all plans
  - Grievance and Appeals, Beneficiary Support Program and other Enrollee Protections built into the regulations
  - Other Administrative Requirements, such as Program Integrity

Additional CMS Guidance Related to MLTSS

- CMS guidance on 10 key elements of best practices for implementing Medicaid MLTSS that should be incorporated into state programs
- These elements are reflected in various managed care regulatory provisions and are used by CMS in their review, approval and monitoring of State MLTSS programs
- Include guidance on adequate planning and transition strategies, stakeholder engagement, beneficiary support, qualified providers, and a quality framework, among other elements
- They may serve as guideposts as Indiana goes down the path of MLTSS

See: CMS Guidance on 10 Essential Elements of MLTSS

Challenges in Moving to MLTSS

- Understanding the goals for MLTSS and ensuring that reducing costs is not primary motivator
- Sufficient time for planning and program development
- Ensuring sufficient stakeholder engagement
- Maintaining beneficiary access to providers, at least for a transition period
- Program Oversight – States need to manage their managed care plans
- Staff capacity – Different skill set required for managing MLTSS compared to FFS
- Building an incentive structure that rewards MLTSS plans for priority program goals, e.g. rebalancing, efforts to increase employment
- Program Evaluation and Quality Infrastructure
- Transparency

Challenges for HCBS Providers

- Lack of experience working with MCOs and vice versa. Steep learning curves on both sides.
- Requirements of contracting with several MCOs, as opposed to just the state
- Need to enhance administrative infrastructure to address credentialing, billing, reporting and other requirements of multiple plans.
- Will likely encourage consolidation and competition in the HCBS marketplace as providers vie to subcontract with MCOs

Potential Advantages from the Provider Perspective

- Capitation rates must be actuarially sound and MCOs generally have more flexibility within these cap rates to pay providers, compared to FFS systems
- MLTSS Plans also have more program flexibility:
  - “in lieu of” services -- services or settings a plan substitutes for similar service covered under the contract. Factored into rate development.
  - Value-added benefits. -- Additional benefits that a plan chooses to provide to beneficiaries beyond contract requirements. Not included in capitation rate.
  - Flexibility within administrative capitation rate
- Incentive mechanisms built into capitation rate to encourage MLTSS outcomes, such as achieving a better balance between HCBS and institutional services
- MCO Contract provisions to leverage MCO activity of particular priorities, e.g. value-based purchasing, housing, other social determinants of health

State MLTSS Models Serving IDD Population

- Some States (KS, IA) have folded IDD services into a comprehensive managed care program, where MCOs are responsible for managing all Medicaid populations, including individuals requiring MLTSS
- Most others have developed tailored programs specific to the IDD population
- Programs designed for IDD population, rather than general Medicaid and MLTSS population, more likely to have MLTSS contract provisions specific to IDD.

State MLTSS Models Serving IDD Population

- States utilize different entities to manage care for IDD Population:
  - Multi-State Commercial Managed Care Organizations (KS, IA, TN)
  - Regional, non-profit managed care entities (NC, WI)
  - Regional Governmental entities (MI)
  - Provider-led Managed Care entities (AR) -- Provider-led Arkansas Shared Savings Entities (PASSE Providers)
    - PASSEs are Risk Based Provider Organizations (RBPO) licensed by the Arkansas Insurance Department that have enrolled in Medicaid
    - 51% owned by PASSE Provider Partners, responsible for providing health care services, including a licensed/certified direct service provider of Developmental Disabilities Services;
    - Providers of behavioral health services, and a licensed hospital and physician practice must also be part of the membership group

Strategies for Implementing MLTSS

- Continuity of Care Period
  - Contract Provisions that require beneficiaries to stay with existing providers for a period post-implementation
    - Tennessee contract includes a 180 day continuity period
    - Such provisions also found in non-IDD MLTSS contracts, e.g. Pennsylvania's MLTSS Community Health Choices Program
- Minimum Fee Schedules for Providers
  - While state contracts give MCOs flexibility in setting payment rate to providers, many set minimum payments for providers, e.g., setting Fee for Service rates as the Floor for Provider Payments
    - TN contract requires IDD services to be reimbursed at the rate set by TENNCare, the State Medicaid agency

Strategies for Implementing MLTSS

- Phased-In Approach
  - Tennessee
    - Populations phased in over time for inclusion in MLTSS
    - At outset (2016), Employment and Community First (ECF) Choices Managed Care program limited to new enrollees and those on the waiting list. As of July 1, 2021, IDD beneficiaries with more intense needs as well as ECF Choices members being folded in to comprehensive MCO contracts.
  - Wisconsin
    - Regional approach to implementation of MLTSS
    - MCOs only manage LTSS services
- Minimum Training Requirements for care managers and MCO staff:
  - Several states (Kansas, North Carolina, and Tennessee) require plan staff (including senior leadership) to have ID/DD-specific experience, especially for medical directors and LTSS directors
  - Tennessee case managers are required to have received training on cultural competency, family supports, transition planning for youth, health and safety training that includes acknowledgement of the dignity of risk, housing options, and assistive technology.
  - Kansas and New York require a care manager to have a certain amount of experience working with individuals with ID/DD. (Source: MACPAC 2018)

Strategies for Implementing MLTSS

- Specific IDD Quality Metrics
  - AR PASSEs monitored on 5 process metrics related to care coordination, e.g. maintaining minimum caseloads; failure to meet 2 of the 5 target benchmarks may result in financial penalties.
  - Tennessee contracts with the Department of IDD to monitor quality of services under managed care.
- IDD-specific stakeholder engagement requirements
  - Arizona and New York both require IDD-specific advisory committees that include members and families to provide input into the plan.
  - Tennessee identifies specific IDD organizations that the MCOs must include in their stakeholder engagement efforts.

Concluding Comments: Lessons Learned

Elements that have been key to successful implementation in other states:

- An approach tailored to meet unique needs of IDD population
- Stakeholder engagement that is early and often, including post-implementation
- A transition process that is sufficient to ensure minimal disruption in beneficiary services and providers
- A state administrative infrastructure with the capacity to manage managed care
- Quality infrastructure to ensure MLTSS meets program goals



Questions

Sources

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- Centers for Medicaid and CHIP Services, Medicaid and CHIP Managed Care Rule, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules/index.html
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Sources

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SOURCES

- MACPAC, “Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution.” Report to Congress on Medicaid and CHIP, June 2018. https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf
- Caitlin Murray, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. “Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018.” Chicago, IL: Mathematica, January 7, 2021. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf
- CMS Medicaid Managed Care Rate Setting Development Guide: https://www.medicaid.gov/medicaid/managed-care/downloads/2020-2021-medicaid-rate-guide.pdf

Association Update

Nanette Hagedorn, INARF

Membership Recruitment

Welcome New Associate Member …

 = 36

Guardian Pharmacy of Indiana. As a proud member of the Guardian family since July 2012, Guardian Pharmacy of Indiana is dedicated to delivering the highest possible level of care to residents of assisted living, skilled nursing, and residential mental health facilities, as well as outpatient consumers. Their Indiana team includes pharmacists, licensed pharmacy consultants, certified pharmacy technicians, a registered nurse, billing experts, and experienced medication couriers. By combining the personal service of a local pharmacy with the technology, resources, and support of a national brand, they are able to empower the communities they serve to spend less time on pharmacy needs and more time caring for and improving the lives of their residents. At Guardian Pharmacy of Indiana, it's about more than just providing medication. It's about their ongoing commitment to long-term pharmacy care and the communities and residents they serve every single day.

We invite you to contact Kevin Kleva, Director of Sales and Marketing, to learn more 317.670.7885.

Membership Recruitment

Welcome New Associate Member …

 = 37

Gibson. Located in South Bend, Indiana, Gibson offers the perfect combination of insurance, benefits, safety, and compliance for your business - the piece that covers your bases, helps you grow, and sets you apart from other companies in the eyes of talent. They're Advisors, not just Brokers. They exist to pursue your best interests. And they do it together, sharing what they learn from client to client, moment to moment, and digging deeper to see things others can't – or don't bother to. That's how they get to the proactive side of insurance, where your company really gains the edge.

We invite you to contact Becky Beckman, Director of Marketing, to learn more 419.265.1717.

Association Current Initiatives

2021 Pre & Annual Conference: In less than 2 weeks, we will bring together …

- A resilient audience: approximately 85 individuals for the Pre-Conference and approximately 265 per day for the Annual Conference
- An engaging line-up of Educational Opportunities
- An Expo Hall of solution and efficiency focused Exhibitors
- A wide array of crafts on display within the Artisan Alley

…. Thanks to all of **YOU**!

Association Current Initiatives

2021 Pre & Annual Conference: In-Person Meeting and Event Protocols

I. Guiding Resources continue to be - Centers for Disease Control and Prevention (CDC) Guidelines; Indiana Executive Orders and County Transmission Data

II. Safety Protocols will include –

- Mask wearing is recommended, and customized masks will be provided to all Conference attendees
- Registration Desk will be fitted with plexiglass guards
- Social distancing accommodations will be offered when possible
- Signs will be posted as reminders to wear masks, wash hands often, and "air wave"

Industry Update

John Barth, Katy Stafford-Cunningham, Brian Carnes, and Phillip Parnell, INARF

INARF/Arc FSSA Welcome Reception

- On September 2, 2021, INARF and The Arc held a joint welcome reception for the new FSSA Secretary & DDRS Director
- Among other topics, Dr. Rusyniak reaffirmed his commitment to maintaining the on-going collaborative relationship between FSSA, INARF, and The Arc of Indiana

Secretary Dr. Dan Rusyniak Meeting

- John and Katy met with Dr. Rusyniak and COS Michael Gargano on September 15
- FSSA Vision: Dr. Rusyniak shared his vision for FSSA:
  - Collaboration
  - Data Informed
  - Simplicity
  - Public Service
- LTSS Managed Care: Dr. Rusyniak reaffirmed Dr. Sullivan's previous commitment that CIH/FSW waiver services will not be included in the upcoming procurement. This commitment is good through the end of the Governor's term.

Secretary Dr. Dan Rusyniak Meeting

- Wage Parity for Group Home DSPs: Reaffirmed previous statements that the pending INARF request for a solution to this issue is included in the overall requests that FSSA has submitted to SBA.
- Telehealth: Expressed INARF position on the need for continued flexibility to provide telehealth services by non-licensed providers during the public health emergency.
- Biden Administration's Vaccine Mandate: No additional information on the status of the Biden Administration's recent announcement regarding vaccine mandates.

Upcoming 1102 Task Force Meeting

- The Intellectual & Developmental Disabilities Task Force will meet on October 14, 2021, at 10:00 am
- <u>Topics Include:</u>
  - 988 Overview and Update
  - Employment – Overview and Discussion
  - Waiver Redesign Update
  - Priority Waiver Category Overview and Discussion

9-8-8 Crisis Support System

- New Core Area Planning Committees to be Formed
  - Core Area 1 and 3 • (1)Ensure Statewide 24/7 Coverage for 988 Calls, Chats, and Texts • (3)Expand and Sustain Center Capacity to Maintain Target In-State/Territory Answer Rates for Current and Projected Call, Text, and Chat Volume
  - Core Area 2 • Secure Adequate, Diversified, and Sustained Funding Streams for Lifeline Member Centers
  - Core Area 4 and 7 • (4)Support Crisis Centers in Meeting Lifeline's Operational Standards, Requirements, and Performance Metrics • (7)Ensure All State/Territory Centers Can Provide Best Practice Follow-Up to 988 Callers/Texters/Chatters
  - Core Area 5: Internal 988 Planning Team and Core Area Committees • Convene a Coalition of Key Stakeholders to Advise on 988 Planning and Implementation
  - Core Area 6 • Maintain a Comprehensive, Updated Listing of Resources, Referrals, and Linkages; Plan for Expanded Services
  - Core Area 8 • Plan and Implement Marketing for 988 in Your State/Territory
- Provider Focus Group
  - Led by DDRS
  - First focus group is Oct. 4

DSP Wage Increase Update

- BR202137 corrected previous information on claims payments for services subject to the 14% rate increase
- Claims for those waiver services with dates of service from July 1, 2021 to August 17, 2021 **should be resubmitted for payment**
- 79 providers did not submit their DSP Wage Increase plans
- If you have not done so, please submit your plans and email Katy Stafford-Cunningham and let INARF know it was submitted
- OMPP has told us "Any provider that did not submit a plan to DDRS, they are expected to bill for the (old) procedure code and modifier combination."

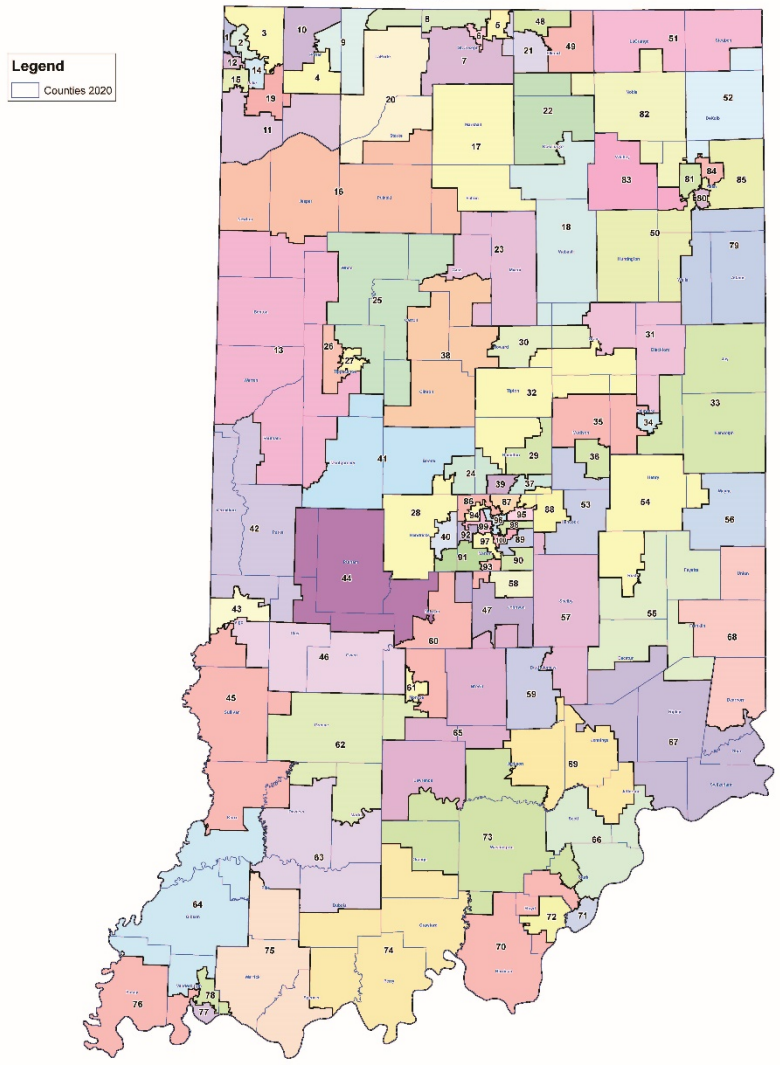
Billing Issues

- INARF has recently been alerted by various members that billing rates are not correct for various services including pre-voc and at least one RHS-D level
- We have reached out to OMPP and are awaiting a response, but if you find that you are experiencing these issues, please let us know by emailing Katy@inarf.org

Redistricting Update

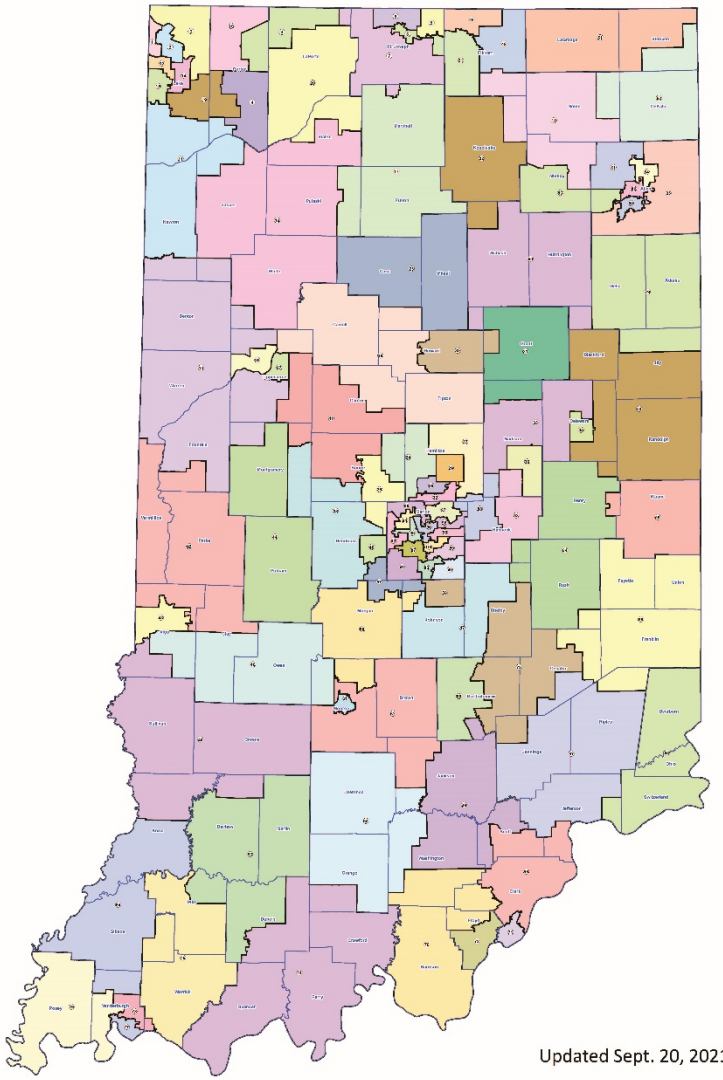
CLICK EACH MAP TO VIEW A MORE DETAILED VERSION

INDIANA STATE HOUSE OF REPRESENTATIVES DISTRICTS
2011-2021



CLICK EACH MAP TO VIEW A MORE DETAILED VERSION

PROPOSED 2021 INDIANA HOUSE OF REPRESENTATIVES DISTRICTS



Updated Sept. 20, 2021

EVV Update

INARF met with OMPP and DDRS leadership on September 15 regarding EVV Implementation

FSSA Initiatives

- Submitted Indiana's EVV system certification to CMS
- As part of this certification, CMS is looking for a plan for when states will activate payment edits. **Potential target date of Spring 2022, FSSA plans to give six months' notice**
  - During the meeting, INARF discussed the potential problem of Sandata responsiveness delays affecting payment. FSSA responded by discussing a potential EVV immediate response system to ensure that system issues are addressed immediately and don't cause payment delays
- FSSA is deactivating the unauthorized service exception from the system due to technical issues. Estimated implementation date of November
- Reviewing random claims to check if billing records have matching verified EVV records
- Working with Sandata on stronger reporting of responsiveness and timeliness and to schedule a programmatic call between Alt EVV vendors and Sandata to discuss technical issues

EVV Update

24 Hour congregate settings & live-in caregivers

- Members would like these settings to be excluded from EVV requirements, consistent with CMS Guidance
- FSSA shared that it is trying to create billing modifiers to exclude both of those scenarios, but is concerned about the potential downstream effects that implementing the modifiers would have on the billing system
- No timeframe for this, but FSSA will work to elevate this issue's priority with Sandata and Gainwell

EVV Update

Percentage of verified EVV records in July

- Alt EVV – 86%
- Sandata – 72%

Top 5 Visit Exceptions

- Unauthorized services
- GPS Distance
- Visits without out-calls
- Missing service
- Unknown employees

COVID Vaccine Survey

- 42 organizations participated
- Organizations employ an average of 315 full time employees
- 29 organizations employ greater than 100 employees
- 39 organizations are currently turning away clients or have a wait list due to lack of staff
- On average, 35-45% of DSPs are fully vaccinated against COVID
- On average, over 75% of CIH clients are fully vaccinated against COVID
- On average, 55-65% of FSW clients are fully vaccinated against COVID
- On average, over 70% of Group Home clients are fully vaccinated against COVID

COVID Vaccine Survey

- 17 providers used financial or benefit-based incentives to encourage staff to get vaccinated
- Incentives include:
  - Bonus
  - Company store funds
  - Raffle
  - PTO to receive the vaccine

COVID Vaccine Survey

- Additional feedback regarding the proposed COVID vaccination and/or testing mandate is included below:
  - Potential to lose staff that don't want to be vaccinated, not only new staff but staff that have been with organizations for long periods of time
  - Proposed testing mandate could be a financial and logistical burden that could negatively affect service delivery, particularly for providers that do not have nursing or medical staff
  - Concern regarding whether franchise locations would be included (e.g. McDonalds) and the implications for workforce competition
  - Concern regarding the potential that ICF/IDDs could be included while waiver settings could be excluded

Case Management COVID Vaccine Survey

- 4 organizations participated
- Organizations employ an average of 146 full time employees
- 1 organization employs greater than 100 employees
- On average, 50-60% of Case Managers are fully vaccinated against COVID
- 2 CMCOs used incentives (e.g. raffle) to encourage staff to get vaccinated
- Additional Feedback includes:
  - Concern that CMCO would need to hire additional staff specifically to implement proposed weekly testing requirements
  - Concerned about mandating vaccination for staff and its potential effect on the recruitment and retention

Contribute to the PAC

Your contributions to the INARF PAC are a critical part of INARF's legislative advocacy efforts. They are used to support elected officials who serve as champions of the provider community. Please consider supporting the INARF PAC today.

INARF PAC

For more information and to contribute, visit: www.INARF.org/INARF-PAC

Upcoming Managed Care Education

- October 5 - INARF Pre-Conference Leadership Symposium
- October 7 - INARF Annual Conference Educational Session

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Thank you!

615 N. Alabama St., Ste. 410, Indianapolis, IN 46204
(t) 317-634-4957 / (f) 317-634-3221
inarf@inarf.org / www.inarf.org