Indiana Pathways for Aging Codesign Workgroup

Care and Service Coordination

January 31, 2023

Agenda

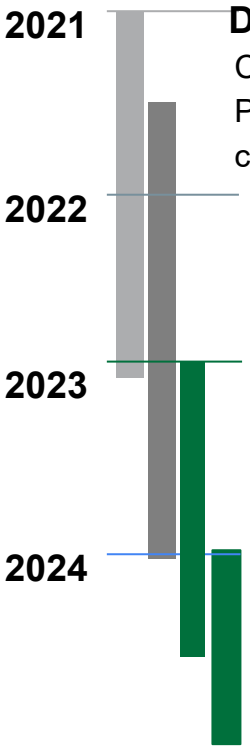
- Brief LTSS Updates & Reminders
  - Our Objectives
  - Indiana Pathways for Aging Timeline
  - New Indiana Pathways for Aging and Hoosier Care Connect Director & Program Manager
- Caregiver Outcome Assessment
- Overview of Care Coordination and Service Coordination Manual
- Q&A

Long-Term Services and Supports Reform

Overall Objective: 75% of new LTSS members will live and receive services in a home and community-based setting

- Faster eligibility
- Move to MLTSS (now **Indiana Pathways for Aging**) in early 2024
- Pay for outcomes, not transactions
- Integrate LTSS data systems
- Support the growth, retention and training of the HCBS direct service workforce
- Create Home Health Roadmap
- Integrate HCBS waivers

Indiana Pathways for Aging Milestones



2021

Design Program and Procure Health Plans (’21-’22)

Co-designed program with stakeholders over the course of a year to release a Request for Procurement in June 2022. Health plans bid on the RFP for a contract with the state through a competitive process facilitated by the Indiana Department of Administration

2022

Implementation and Readiness (’22-’24)

FSSA conducts systematic review of staffing, policies, processes, documents, subcontracts, system capabilities and provider network to ensure state and health plans are ready for the program launch

2023

Award Health Plan Contracts and Onboard (’23-’24)

Contracts will be awarded to health plans in early 2023

Continue readiness review activities to ensure state and health plans are ready for the Pathways program launch

2024

Program Go-Live (’24)

Program to launch in 2024

New Indiana Pathways for Aging and Hoosier Care Connect Staff

- Welcome (back), Karen McKinney, LCSW!
  - Pathways and HCC Director

- Congratulations to Clarissa Loveall!
  - Pathways Program Manager

Caregiver Outcome Assessment

Dr. Kathleen Unroe, Indiana University School of Medicine

Why Assess Caregivers?

- The State of Indiana has made the health and well-being of informal caregivers a priority, including creating and mandating an outcomes assessment that will be conducted by MCEs participating in the IN Pathways for Aging program.
- Support global efforts to keep caregivers healthy and match them with the support they need to continue in their caregiving roles.
- Caregiver stress and burden is associated with institutionalization of persons with LTC needs.

Who are Caregivers?

- Informal Caregiver - Family members, partner, friends, or neighbors who provide care for a member and is routinely involved in providing unpaid support and assistance to the member.

RFP Language – Caregiver Assessment

- “The Service Coordinator, as applicable, shall conduct an informal caregiver assessment using a tool developed or determined by the State and in accordance with protocols specified by the State as part of its onsite visit with new members receiving LTSS and as part of its onsite intake visit for current members applying for LTSS. The consent of the member and informal caregiver is required.”

§ At a minimum, the informal caregiver assessment shall include:

(1) an overall assessment of the informal caregiver(s) providing services to the member to determine the willingness and ability of the informal caregiver(s) to contribute effectively to the needs of the member, including *employment status and schedule, and other care-giving responsibilities*

(2) an assessment of the informal caregiver's *own health and well-being, including medical, behavioral, physical, social, or environmental limitations, such as but not limited to any food, utility, housing, and healthcare insecurities*, as it relates to the informal caregiver's ability to support the member

(3) an assessment of the informal caregiver's *level of stress* related to caregiving responsibilities and any feelings of being overwhelmed

(4) identification of the informal caregiver's *needs for training in knowledge and skills* in assisting the person needing care;

(5) identification of any *service and support needs* for training in knowledge and skills to be better prepared for their care-giving role. Additionally, a Social Determinants of Health (SDOH) assessment for informal caregivers shall be included to identify needs such as current or potential lack of healthcare, food insecurity, utility instability, housing insecurity, transportation issues, and more.

Draft Instrument of Assessment

- ❑ Validated Scales
- ❑ Comprehensive
- ❑ Comparison-ready
- ❑ Outcome-oriented
- ❑ Policy and Program Relevant
- ❑ Quantitative and Qualitative

List of Survey Instruments that Identify Caregiver Burden

Depression Scale (C.E.S.)	**20-item** Questionnaire.
Ways of Coping Questionnaire (Folkman et al)	**37-Item** Questionnaire.
PROMIS Global Physical Health	**4-Item** Questionnaire: 1. "General rating of physical health" 2. "Perceived ability to carry everyday physical activities such as walking, climbing stairs; carrying groceries, or moving a chair" 3. "Average fatigue rating 4. Average pain rating.
PROMIS Global Mental Health	**4-Items** Questionnaire: 1. Perception of quality of life; 2. General rating of self-perceived mental health, including mood and ability to think; 3. Satisfaction with social activities and relationships and **4.** Frequency of being bothered by emotional problems such as feeling anxious, depressed, or irritable.
Zarit Caregiver Burden	**29-item** questionnaire. 22 items in revised edition.
Caregiver Satisfaction	**1 Question:** what is you level of agreement with statement: "I get a great deal of satisfaction from being a caregiver."
Caregiver Confidence	**1 Question:** "Overall, how would you rate your confidence as a caregiver? Would you say very confident, somewhat confident, a little confident, not very confident, or not at all confident?"
UCLA Loneliness Scale	**20-item scale** used for a variety of populations.
Financial Strain	Various modifications to measure financial strain.

Caregiver Profile (for primary caregiver only)			
Are you paid to provide care for [care recipient's name]?	☐ Yes	☐ No	**(If Yes, stop here)**
Is there another person who provides care or could provide care if you were unable?	☐ Yes	☐ No	**If Yes, provide the name and relationship to the individual.**
Are you the only non-paid person providing care to (care recipient's name)?			☐ Yes ☐ No
How long have you provided care for (care recipient's name)?			☐ year(s) ☐ month(s)

How often do you provide care to (care recipient's name)? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once per month

Do you have children younger than 18? ☐ Yes ☐ No

Are you also providing care to any other individuals? ☐ Yes ☐ No

Distance to care recipient's home: (Select one) ☐ 0–10 miles ☐ 11–40 miles ☐ 41–100 miles ☐ Over 100 miles

Caregiver Employment and School (for primary caregiver only)			
Are you employed?	☐ Full-time	☐ Part-time	☐ Not Employed
Are you enrolled in school?	☐ Full-time	☐ Part-time	☐ Not In School
Have your caregiver responsibilities ever affected your employment or school?	☐ Yes	☐ No (If No, go to Caregiver Skills and Training Assessment Section)	

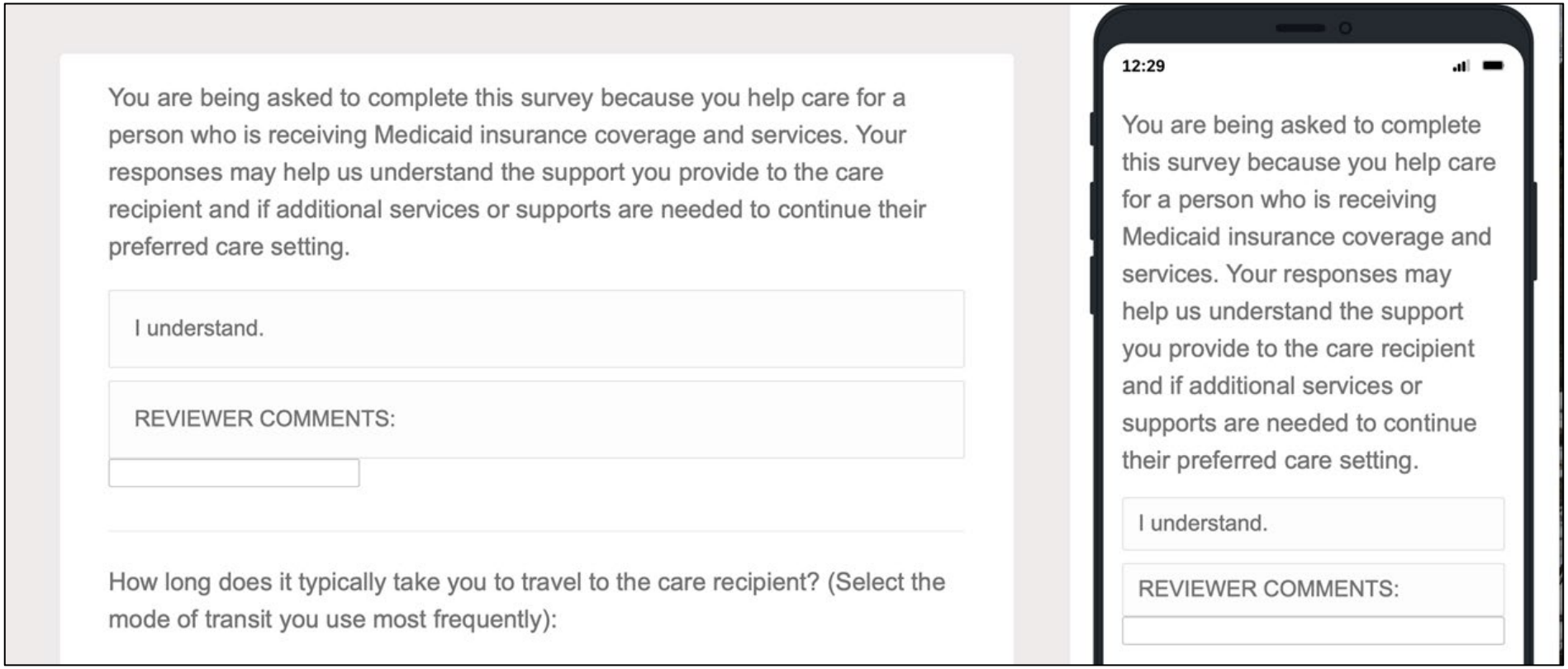
Comments: Click here to enter text.

If employed, how has your employment been affected? (Select all that apply)

Schedule	Pay	Leave	Work Relationships	Performance
☐ Changed jobs	☐ Has taken a second job	☐ Takes leave frequently	☐ Feeling of isolation	☐ Decreased confidence in own ability
☐ Decreased hours or went part-time	☐ Has lost wages or periods with no income	☐ Used all paid leave; no leave remaining	☐ Less co-worker interaction	☐ Decrease in productivity
☐ Has taken extended leave with pay	☐ Has taken leave without pay (LWOP)	☐ Exceeded Family Medical Leave Act (FMLA)	☐ Tension or problem with co-worker	☐ Difficulty with concentration or focus
☐ Quit job	☐ Missed promotion opportunity		☐ Tension or problem with supervisor	☐ Fear of losing job
	☐ Received pay cut or pay decreased			☐ Perform or manage caregiver tasks at work

Key Domains

- ❑ Who are caregivers? (Demographics)
- ❑ What services do caregivers provide?
- ❑ What supports do caregivers need?
- ❑ Care burden (financial and health)?



Please read Caregiver Outcomes Assessment

Questions 1-32: questions for caregivers.

Questions 32-34: questions for *you,* only.

Feedback Needed – by February 10th!

- We are seeking feedback on this instrument!
- Please use the link to the Qualtrics mock-up and provide feedback in the survey.
- Feedback may also be emailed to: **backhome.indiana@fssa.in.gov**
- You can provide feedback yourself or ask someone in your organization to do so.
- If you would like to walk through the survey or provide more detailed feedback, I would be happy to do so.

Overview of Care Coordination and Service Coordination Manual Table of Contents

Courtney Schill, Office of Medicaid Policy and Planning

What is the Pathways Care Coordination and Service Coordination Manual?

- Audience
  - Manual for Pathways for Aging Managed Care Entities (MCEs)
- Purpose
  - To provide detailed guidance and direction related to Care Coordination and Service Coordination requirements as defined in the Scope of Work (SOW)
  - To ensure that person-centered care planning principles are integrated into guidance and direction given to MCEs

Why is the Manual being Developed?

- The manual is being developed for multiple reasons including:
  - Translation of contractual requirements into well-defined actionable expectations
  - Ensure that person-centered care planning framework is fully integrated into MCE guidance and expectations
  - Help to facilitate consistency of member experience among and between MCE's
  - Ensure that requirements and expectations are explicitly defined
  - Provide clear guidance and direction for MCEs about state expectations – consistency
  - Support MCE compliance

Approach to Development of Care Coordination and Service Coordination Manual

- Scope of Work (SOW) as the foundation
  - Defines contractual requirements
- Identified components of SOW that are:
  - Directly related to MCE care coordination and service coordination responsibilities
    - For example: Documentation of specific requirements related to assessments such as types of assessments, timeframes for completion, etc.
  - Indirectly related to care coordination and service coordination responsibilities and which care coordinators and/or service coordinators should know about as they may have need to support or educate members about the subject
    - For example: Documentation of grievance and appeals steps and timeframes
- Organized manual to bring together relevant and/or related components of the SOW into larger categories
  - For example: Included requirements related to MCE responsibilities to assist members with Medicaid recertification into the section on Eligibility

Pathways for Aging Care Coordination and Service Coordination Manual Sections

Sec #	Section
1	Introduction and Purpose
2	Age-Friendly Care, Person-Centered Care Coordination and Service Coordination Framework
3	Annual Care Coordination Program Plan
4	Eligibility
5	Care Management Staffing
6	Select Covered Benefits
7	Care Coordination
8	Care Management
9	MLTSS and Medicare Care Coordination Alignment
10	Subpopulations at Greater Risk for Negative Health Outcomes
11	Assessments
12	Individualized Care Plan
13	Service Plans
14	Minimum Member Contact
15	Transitions
16	Care Coordinator Requirements
17	Interdisciplinary Care Team (ICT)
18	Member Inquiries, Grievances & Appeals
19	Health Equity and Cultural Competency
20	Advance Directive Information
21	Incident Reporting and Management
22	Utilization Management Program
23	Electronic Visit Verification (EVV) Requirements
24	Performance Reporting and Incentives
25	Integration and Alignment of Medicare and Medicaid
	Appendix

Detailed Table of Contents

Detailed Table of Contents Cont'd

Detailed Table of Contents Cont'd

Detailed Table of Contents Cont'd

Sample Section

Section 4.0 Eligibility

Pathways MCE's have a responsibility to work with their members to ensure that they maintain eligibility for the program. To this end, the MCE's need to ensure that staff that engage and interact with members, especially care coordination and service coordination teams, have detailed understanding of eligibility requirements and the role that the MCE plays in supporting members.

4.1 Eligibility Requirements

The State of Indiana has sole authority for determining individuals meet the eligibility criteria necessary to enroll in Pathways. Eligibility determinations are made by The Indiana Family and Social Services Administration (FSSA) Division of Family Resources (DFR).

To qualify for the Indiana Pathways program beneficiaries must be in the specific age and Medicaid target groups. Overall, the Pathways program is targeted to individuals 60 and older who are eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources. All members aged 60 and older in the target eligibility categories are included unless the individual meets an exclusion. This includes members who have a full Medicare benefit and those in a nursing facility.

Eligibility is evaluated based on age, Medicaid eligibility category, functional eligibility, residency, and Medicare elections.

1. ***Age:***
    - Individuals must be 60 or older
2. ***Medicaid Eligibility:***
    - Eligible for Medicaid on the basis of age, blindness, or disability and have limited income and resources (see categories below)
    - Not otherwise excluded (see below)

Included/ Excluded	Criteria
Included	• Individuals aged 60 years of age or over who are enrolled in Medicaid based on eligibility as: – Aged (MA A) – Blind (MA B) – Disabled (MA D) – SSI recipients (MASI) – MED Works (MADW, MADI)

Sample Section

Section 5.0 Care Management Staffing

Overview

The Indiana Family & Social Services Administration (FSSA) mission is to develop and implement program, policies, and activities that promote positive health outcomes and are consistent with current medical standards. To achieve this, FSSA requires that MCEs employ specific key staff dedicated as a full-time employee (FTE) and reserves the right to approve or deny the individuals in these positions. In addition to the key staff members, the MCE must also employ the additional staff necessary to ensure compliance with the state's performance requirements.

5.1 Required Care Management Related Staffing

Key Care Management related staff members have been identified by FSSA as follows:

Medical Director – The MCE must employ the services of a medical director who is an Indiana-licensed Indiana Health Coverage Programs (IHCP) provider board-certified in geriatrics, family medicine, or internal medicine. The medical director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the MCE's operations are compliant with the terms of the MCE's contract with the state. The medical director is responsible for the following:

- Oversee the development of the MCE's clinical practice guidelines; review any potential quality of care problems.
- Oversee the MCE's clinical management program and programs that address special needs populations.
- Oversee health screenings and medically frail assessments.
- Serve as the MCE's medical professional interface with the MCE's primary medical providers (PMPs) and specialty providers.
- Oversee the development and implementation of the MCE's disease management, case management, and care management programs.
- Work closely with the Pharmacy Director to ensure compliance with pharmacy-related responsibilities.
- Direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions, and other quality management, utilization management, or program integrity activities.
- Attend all state quality meetings, including OMPP quality meetings, and Quality Strategy Committee meetings, designating a representative to take their place if they are unable to attend. The representative is responsible for relaying key information to the medical director about the meeting's agenda topics discussed and any action items.

If the medical director is not board-certified in family medicine, they must be supported by a clinical team with experience in pediatrics, behavioral health, adult medicine, and obstetrics/gynecology. The medical director must be dedicated full-time to the MCE's Indiana Medicaid product lines.

Next Steps

- Obtain feedback from stakeholders about
  - Overall approach
  - Specific themes, areas, or requirements that should be highlighted or emphasized
- Complete initial draft
- Integrate feedback and recommendations
- Complete additional review focusing on
  - Documentation of regulatory or contractual citations
  - Consistency among and between manual sections related to requirements, terminology, structure, etc.
- Future versions of manual will incorporate additional content prior to Pathways go-live

Questions?

Please reach out to the backhome.indiana@fssa.in.gov for questions or feedback related to Indiana Pathways for Aging.

Thank you!!!

Next Codesign Meetings:
Tuesday, February 28 at 10 am ET
Tuesday, March 28 at 10 am ET