mLTSS RFI Co-Design Workgroup

Date
Wednesday, June 16, 2:15 pm – 4:15 pm, virtual meeting

Presenters
- Natalie Angel, Office of Medicaid Policy and Planning, Director of Operations
- Jesse Wyatt, Division of Aging, Deputy Director

Learning Topics
- mLTSS Program Design
- Current focus group work

Agenda
1. Welcome and Meeting Purpose
2. Program Design
   - Level of Care, Eligibility, and Intake Workflows
   - Care Management
3. Eligibility and Level of Care Focus Group Recap
4. Questions and Discussion

   The presentation slides will be shared along with the minutes.

Summary of important facts from the presentation
Welcome and Meeting Purpose: Dan Rusyniak, FSSA, Chief Medical Officer
- Dr. Rusyniak opened the meeting and shared the framing slides that present the guiding principles for LTSS Reform and the project's key goals.

Program Design – Level of Care, Eligibility, and Intake Workflows: Natalie Angel, Office of Medicaid Policy and Planning, Director of Operations
Opening remarks:
- Before discussing the workflows, Natalie presented two slides to level set with the workgroup on both what the structure of a future mLTSS program will look like as well as how stakeholder considerations have been taken into account for mLTSS design choices.
- The current plan for the mLTSS program is that FSSA would pair a new 1915(b) authority and a new 1915(c) authority and would bring together all Medicaid members aged 60 and older currently enrolled in separate programs like the Aged and Disabled (A&D) waiver, Hoosier Care Connect (HCC), and Fee-for-Service (FFS) programs which would include individuals in nursing

facilities.

- Natalie also acknowledged and expressed appreciation for stakeholder contributions and input. Many ideas and concerns that stakeholders voiced throughout the process and have been and are being incorporated into program design. This included ideas such as:
    - Member choice, enrollment, and access
    - Ensuring choice in programs and MCEs
    - Overall assurance members will be treated fairly and well

Following opening items, FSSA shared recommendations related to level of care, options counseling, and health plan selection:

- To move to an mLTSS program, there will need to be changes to specific aspects of the current system such as:
    - Level of care assessments
    - Options counseling
    - Health plan selection
    - Care management
- Some key guiding principles throughout the design process were:
    - Consistency in the level of care determinations and options counseling
    - Conflict-free case management and health plan selection/assignment
    - High-quality post-enrollment beneficiary supports
    - High level of integration for dually-eligible enrollees
- mLTSS would introduce a third-party enrollment services vendor that would be responsible for the level of care assessments and determinations, options counseling for some individuals, and MCE selection for all mLTSS members. In addition, the third-party vendor would be required to assist members with completing the full IHCP application for Medicaid eligibility as well as member grievances and appeals—both services that are not provided currently.
- As part of a new mLTSS program, different providers including nursing facilities, hospitals, MCEs, assisted living facilities, and FSSA's Division of Family Resources would all conduct and submit level of care assessments to the third-party vendor through a uniform process and using the same tool. This ensures consistency across all level of care determinations regardless of who made the assessment.
- The third-party vendor would additionally make the level of care determinations for individuals under 60 to be enrolled in the traditional A&D waiver program. This ensures additional consistency in level of care determinations for all individuals receiving A&D services regardless of service delivery method.
- The State would retain oversight for third-party vendor determinations and would require a higher level of review before a level of care is denied. This is to better ensure the third-party vendor makes determinations and provides services that are independent and conflict-free.
- The third-party vendor would also help with the completion of the full IHCP application for

Medicaid eligibility either indirectly through provider support or direct outreach to individuals.

- The third-party vendor would serve the traditional enrollment broker function in assisting member selection of an MCE. The vendor would also provide PACE counseling for members who live within a PACE service area.
- For individuals going into the traditional A&D waiver, the third-party vendor would provide options counseling and assistance with selecting a service coordinator. For mLTSS, the vendor would assist in selecting an MCE who will then act as a service coordinator.
- Individuals can still choose their MCE within 60 days of enrollment and will have the opportunity to change MCEs once every year with their annual redetermination.
- After member enrollment, the third-party vendor would also assist beneficiaries in navigating the grievance and appeals process with the MCE. This assistance is required under managed care but the State welcomes the requirement as it provides the member with an independent advocate with the MCEs.
- The grievance and appeals process in mLTSS will be the same as the current process in State managed care programs with the member first filing a grievance with the MCE. If the issue cannot be resolved at that level, the member can file an appeal to the State. The third-party vendor would provide members with information on how to file their appeal with the State.
- The third-party vendor would not be responsible for developing the initial care plan for members. The MCE will develop initial care plans for individuals when they enter mLTSS. For members who transition between programs or from other MCEs, the mLTSS program will have protections that will ensure existing care plans are honored for a period of time after a transition. Individuals entering the traditional A&D waiver will have an initial care plan developed by their chosen service coordination entity.
- Natalie offered two example workflows of potential enrollment scenarios for mLTSS. These workflows did not represent every scenario mapped out by the design team but were chosen to illustrate member experience through the process as well as some of the more unique aspects of the mLTSS process.
- Q&A is located at the end of this document. Additional stakeholder input is welcomed.

Program Design – Care Management: Jesse Wyatt, Division of Aging, Deputy Director

- FSSA presented recommendation related to care management. See PowerPoint for details regarding how the terms care management, care coordination, and service coordination within the context of these notes.
- Jesse discussed the current state of care coordination and care management. There is no universal definition of care coordination and terms are often used interchangeably. There is care coordination for Hoosier Care Connect (HCC) that is stratified into levels of service which vary according to risk and complexity. A&D individuals receive care management service which is specific to those receiving HCBS through an Area Agencies on Aging (AAA) or a Case Management Agency.
- The prospective mLTSS population would include ~18,000 A&D, ~20,000 NF, and ~67,000 other individuals. There will be ~106,000 total with about 60% of individuals not receiving LTSS

currently.

- Proposed mLTSS future state: recommend two member-centric features of both mLTSS care coordination and the addition of service coordination. All mLTSS members would receive care coordination. This would help them in planning, accessing, and managing their healthcare and healthcare-related services. The idea is to model this around the DSNP Model of Care (MOC) with requirements for unaligned members.
- Service coordination will be specific to recipients of LTSS with a future state that would include institutional LTSS, not just A&D waiver services.
- Stakeholder Considerations:
    - Member eligibility
    - Member choice
    - Person-centered interdisciplinary team approach
    - State specified minimum requirements
    - Communication
- Role of AAAs in Service Coordination—Peer State Approaches:
    - Difference between state mLTSS designs and terminology
    - Subcontracting approaches are specific to service coordination only
    - This is in the initial phase of high-level design
- Peer State Approach—"Allowing Service Coordination Subcontractors
    - *Flexible Business Models*
        - By permitting but not requiring subcontracting, Illinois found that their MCEs developed multiple different business models/relationships for delivering service coordination (from entirely in-house to subcontracted in-part and subcontracted in-full).
        - Most plans pursued both subcontracts and internal capacity-building activities which allowed them to leverage existing community networks and to adapt flexibly and quickly with in-house resources by avoiding the time/costs associated with external contract negotiations.
    - *Subcontract Administration*
        - Since MCEs can subcontract for different functions or areas, the burden of contracting with and ensuring compliance with multiple MCEs falls on the AAAs in this model. In Pennsylvania, challenges with meeting MCE delivery and quality requirements led to fewer AAAs choosing to participate in the service coordination market.
        - In Illinois, AAAs formed an alliance to make the subcontracting process easier. This included negotiating master contracts with MCEs and supporting some administrative functions for its AAA members.
    - *Single Business Model*
        - Ohio required MCEs to subcontract services coordination functions to AAAs, who traditionally provided such services under Ohio's HCBS Waiver, to ensure continuity

of care for waiver recipients during the mLTSS transition and for those aging into the mLTSS program.

- This approach guarantees that MCEs leverage community resources and support the existing AAA network, but may limit the flexibility and opportunities that MCEs and AAAs have to innovate on a traditional service delivery system.

- *Subcontract Administration*
  - Even though all MCEs must contract with AAAs, there is still variation in how MCEs operate and an expectation that AAAs must adapt to the individual systems and practices of MCEs. For example, in Ohio MCEs required AAAs to dedicate specific staff to work exclusively and separately for each plan (even when co-located) to protect MCEs' proprietary information.

Updated Regarding Eligibility and Level of Care Focus Group Recap: Jesse Wyatt, Division of Aging, Deputy Director

- Held second focus group on eligibility and level of care in early May. The first meeting in March was focused on the speed of service delivery, the expedited eligibility pilot, conflict of interest concerns, and state control of determinations.
- For the May focus group, topics included: feedback on what the right timeline was to deliver service and the preferred timeline for different elements of the process; important themes or features around eligibility or LOC; and PACE and options counseling today to enroll in PACE.
- Summary of feedback:
  - Positive feedback on proposed timelines
  - Not much disagreement on proposed important features like accuracy, fidelity, centralization, access, information, assistance, and consistency
- Discussed challenges for PACE providers and why challenges exist

Questions/Answers

Leading Age: Can we get this slide deck today if possible?

FSSA: Yes, we will send.

IAAAA: Where in the process with CMS is the proposal? This seems to mirror the program design that Pennsylvania implemented. I thought we made a good case that we could mitigate conflict of interest within the AAA network between intake and care management. Have any discussions been had with CMS on alternative proposals? Or is this what we know has been approved in other states so we are going in this direction?

FSSA: We have not had any discussion with CMS, and we have not submitted anything to them. When we get to the point of submitting a waiver, then those steps would happen. But we have not taken any of those steps yet. We are basing it off of other successful state examples.

IAAAA: We have talked a lot about the Indiana way and doing things our own way, and is there still an opportunity to think of it in some different ways? Given the discussion around creating our own system,

is this a done deal? Are we still going to have additional discussions around this? What is our opportunity here to do something different than what other states have done?

FSSA: We are borrowing successful things other states have done. We are looking at many states and looking at successful things there and pulling them in. From those best practices in other states, we are trying to fit what pieces work best for Indiana. Is your concern around the third-party vendor itself?

IAAAA: Just divorcing the AAA from intake and assessment. We know we can't do enrollment. We talked about our concern of divorcing this population from the AAA and this has the potential to do that and create an inconsistency with other populations and other funding sources. Our hope was for a consistent experience for all those populations, but we are creating a different experience for the Medicaid Waiver population. We thought we made clear the firewalls in place could mitigate conflict of interest concerns.

FSSA: This proposed third-party vendor would be working with all individuals coming into mLTSS. They would have a very consistent and broad contact for this program. They would be doing LOC assessments for individuals coming into A&D waiver and then they would be referred to AAAs. We are thinking about the whole population as the vast majority are not going to be A&D waiver individuals. We are trying to create as much consistency as possible.

IAAAA: Can you remind us of the A&D waiver population versus the entire population?

FSSA: For A&D, you're looking at about 20,000 individuals and there are about 80,000 non-waiver individuals.

American Senior Communities: Natalie mentions there are other workflow slides for how someone moves along the system. I would love to see the slides for other situations too.

IAHHC: Agree with American Senior Communities –the additional slides would be helpful for all stakeholders.

FSSA: We will get those out.

IHCA: What is the timing of the rollout of this enrollment broker?

FSSA: They would likely need to be up and running several months before the MCEs to be able to help members make a transition and pick an MCE.

Thrive Alliance: It is not uncommon for AAAs to need to switch funding sources for clients due to budgetary or other reasons. If we keep the consumer experience consistent, it will make any funding switch transparent to the consumer. Alternatively, a set of different experiences tied to funding sources will create additional complexity.

FSSA: Once an individual enters the waiver, it is unlikely they are going to revert to a non-waiver program (CHOICE, Title III). Among CHOICE, Title III, and SSBG, it is very common to switch between funding streams because there is overlap between the services and eligibility requirements. Individuals on those programs do enter into the A&D waiver, but is much less common to go in reverse where they go back to a non-Medicaid funding stream.

IHCA: Are there particular states that you see doing this well? Which states are you seeing as models for this intake process where it has gone smoothly?

FSSA: Some states we have looked at more closely than others are Minnesota, Washington, Arizona, Pennsylvania, and Ohio. We are looking at each of them for different pieces. Some of this is from Pennsylvania for the enrollment broker model.

IHCA: I did not imagine this being a broken part of the system. Totally upending this into another third-party vendor and divorcing the Division of Family Resource's (DFR) assistance from this is troubling. What is the role of the options counseling component within the AAA network?

FSSA: We do not see this as a divorce from DFR. This vendor is assisting people with the application they are submitting to DFR so it is just feeding into that process. One of the things we need to work through is how this works with expedited eligibility. On your second question on the role of the AAA, there is still a lot of discussion around how that works as we go forward. There is a lot of development still.

IHCA: Is there a way the State could tell us what problem they are trying to solve with this?

FSSA: One aspect is the consistency in the LOC determinations. This ensures consistent LOC assessment and determination. Also, by having the one door and the same format to determine LOC, we are expediting the process as well.

IAAAA: We do use non-waiver funding sources to cover services for A&D waiver recipients that are not Medicaid covered services. How will this be handled?

FSSA: If a member was in this program and also working with their AAA with some additional service or program, there would likely be a noticeable difference than the service coming through their managed care entity.

American Senior Communities: So, this sounds a bit like IBM—the eligibility program that was a flop... what are you learning from that to ensure this does not end up being very difficult to the consumer and Providers?

FSSA: Not answered.

IHCA: When will the RFP for this new Enrollment Vendor be released?

FSSA: Generally, we like to give ourselves at least a year on a big contract and then we have to build in time for readiness review and to make sure they are up and running before the mLTSS program. It is well before 2024, but we do not have a date. We are still vetting ideas, so once we have all ideas, it will be easier to plug into timeframe.

Aging and In-Home Services: There are ways we could test/achieve consistency and guide workflow with current system that might be worth exploring.

FSSA: We would love to hear any suggestions you might have that would work for mLTSS workflow.

Aging and In-Home Services: Working with the current system and the ways we can better achieve the kind of consistency we want could be done with more workflow guidance technology in the field. That may be a solution that may be worth looking at as a group.

IHCA: Would there be a requirement that staff of this entity be in Indiana –that there be a presence here?

FSSA: Absolutely, that is something that can be drafted into a contract that they be located here in the state. They will need to have staff in the state and a big presence in Indiana as some of these services are going to be done face to face and in person.

IAAAA: I am not aware that we have ever had data regarding how inconsistent the AAAs are. That would be really helpful if we are trying to solve a problem around consistency. Do we have anything that tells us the magnitude of that consistency problem?

FSSA: Over the past few years, the number one complaint the Division of Aging has received about services has been about this intake process. Division of Aging gets complaints from providers, from consumers, legislators, and it does not stop—it is constant. When we look what we have done with Ascend on Preadmission Screening and Resident Review (PASRR) and NF LOC admit process, we do not get those complaints. It works. This model is very similar to what we do with Ascend though it is different. Specific examples are shared very directly with the AAAs.

IHCA: As this gets further down the road, it would be helpful to have a review of the administrative processes of this from the provider side.

FSSA: Anytime we go live with a system, there is user acceptance phase, so this would be helpful with go-live of a system to make sure it is going to work.

IAHHC: When can we anticipate receiving the slides from this presentation? This will be helpful to review and then send feedback to the RFI co-design inbox. Thank you.

FSSA: The slides will be sent today.

IAHHC: I agree with Zach about the Indiana presence [for the third-party vendor]. An Indiana presence is imperative. The AAAs service as a single point of entry and they are aware of the community resources in their area.

FSSA: We all agree on that.

INSILC: How will accessibility for consumers be ensured from the third-party vendor for enrollment?

FSSA: This is something we will need to be thoughtful about and inclusive of in any contract with a vendor to make sure they are accessible to individuals.

IHCA: Would you be willing to share your readiness review tool for the enrollment vendor for stakeholder input?

FSSA: We do not have it ready yet but should be able to share when the time comes.

IHCA: It would be good to have input from stakeholders at that point.

FSSA: Absolutely.

IHCA: What does the State expect as far as the mLTSS resident going from their community to a NF and having this role duplicated for what is already being handled by NF staff? What is the vision relative to the institutionalized patient?

FSSA: We would reiterate these are proposals, but as far as the advantages, this provides for someone who is independent of the facility itself. Just like we have care management on the waiver and they do not work at providers like Assisted Living, it provides independent source of information, assistance, and advocacy.

INARF: On slide 3, should the slide say AAAs *and independent entities* to continue to provide "care management" functions?

FSSA: The vast majority of individuals on the A&D waiver do receive care management through the AAAs, but there are individuals receiving care management through independent case

management agencies too. One of our goals around this was to reduce the help in the transition of the individual so in that respect it would make a lot of sense.

INARF: In the future-state slides, did you suggest some version of plans contracting with AAAs and independent entities as a potential model or is that the model?

FSSA: We presented what some other states do. In both Illinois and Pennsylvania, those states allow other plans to contract with AAAs and other agencies but do not require it. Ohio did require that contract requirement between MCEs there and AAAs. That is how other states have organized it. We are certainly taking all feedback here and all suggestions. We are really just presenting on how other states have done it.

INSILC: How might or can the self-directed care model work within this mLTSS case management/service coordination?

FSSA: The A&D does offer a self-directed option. Not many individuals currently use it. It is certainly feasible to use self-direction with MCEs. Several states who use mLTSS and self-direction have a much greater numbers of individuals/consumers utilizing self-direction than we do today. It is definitely possible the State could see an uptick as we move to mLTSS.

INSILC: An increase in the use of self-directed care via the MCEs would be wonderful!

IAHHC: I sent my non-disclosure agreement (NDA) in the day that it was emailed. When can I anticipate receiving the draft RFI? To clarity –if a person sent in the non-disclosure form, when can the individual anticipate getting the draft RFI?

FSSA: We will be sending draft out for review very shortly and we will discuss the RFI during the meeting on June 21st. You will have to have signed NDA to be let into that meeting. We will also give you until the 25th to submit feedback. We are going to have a survey that individuals can use to submit feedback as well. The link to that survey will be also be sent out.

IAAAA: There is only a week to provide feedback on the RFI—was wondering if that timeline could be extended at all?

FSSA: The State will discuss timelines internally, but we have already agreed to leave the RFI out for 45 days which is pretty atypical. We will get the RFI to you as soon as we can.

American Senior Communities: Is it possible to share the list of comments and questions that we have gathered?

FSSA: We will take that question back.

INSILC: Capturing feedback from consumers seems to be much less of a priority. I strongly implore the State to please, please, please offer more opportunities to gather input directly from those in the aging and disability communities. Happy to have in-depth conversation on this!

FSSA: We agree that consumer feedback is critical. We are just starting our consumer engagement plans with ADvancing States and the plan on that. We are strongly committed to getting consumer input on that. We are happy to share more information very soon. We anticipate virtual engagement over the summer and in-person meetings over the fall. We are looking forward to partnering with the Indiana Minority Health Coalition as well. We are also collecting information from two new consumer surveys. The first survey is around family caregivers and the second is a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. It has absolutely been a priority to conduct consumer engagement.

IAAAA: Can someone talk a little bit more about the face-to-face interaction with the enrollment broker? And the role of the options counselor? What is the proposed consumer experience of options counseling with an enrollment broker?

FSSA: The enrollment broker itself is not doing a lot of the options counseling. They will do LOC determination and member will either go to A&D waiver—that process would look a lot like it does today—and that is where the options counseling would take place. If it is a person going into mLTSS, then they would be referred to MCE with LOC and the MCE would be responsible for initial options counseling piece and initial care plan development. The MCE being accountable for this does not mean the MCE will be doing it though.

IAAAA: Is the LOC assessment entirely remote?

FSSA: Yes—at this point the LOC assessment would be submitting information electronically through a tool and then the actual determination process could start. At that point it could be face-to-face or over the phone.

IAAAA: Who is making the determination in this proposed system?

FSSA: This would be the vendor. There would still be the same level of state oversight.

IAAAA: Will the service plan development will be vested with the MCE?

FSSA: Yes.

IHCA: For the states you are modeling from, which companies are the enrollment vendors in those states?

FSSA: We do not know. Maximus is a big player nationwide but we have not looked into the specific vendors.

American Senior Communities: Can you refresh me regarding the areas PACE participates? We know Indy (St Francis) & South Bend, but where else?

FSSA: Here is a list of PACE locations in IN: https://www.in.gov/fssa/da/program-of-all-inclusive-care-for-the-elderly/

IAAAA: Are PACE providers now going to have their LOC assessment done by the enrollment broker as well?

FSSA: That is not currently in the plan. PACE enrollment would be outside mLTSS. We will take that back as we had not discussed where that would occur.

Closing comments

Dan Rusyniak, Chief Medical Officer, FSSA

Thanks everyone for today—there was great discussion. FSSA has held over 80 meetings with various stakeholders and legislators regarding LTSS reform. We are very invested with getting everyone's feedback throughout the remainder of the summer.

Stakeholder Attendees

- John Barth, Indiana Association of Rehabilitation Facilities (INARF)
- Connie Benton Wolfe, Aging & In-Home Services of Northeast Indiana
- Tauhric Brown, CICOA Aging & In-Home Solutions
- Jennifer Carnahan, Indiana University Center for Aging
- Zach Cattell, Indiana Health Care Association (IHCA)

- Terry Cole, Indiana Hospital Association (IHA)
- Elizabeth Eichhorn, Indiana Health Care Association (IHCA)
- Eric Essley, LeadingAge Indiana
- Sherri Hampton, American Senior Communities
- Kristen LaEace, Indiana Association of Area Agencies on Aging (IAAAA)
- Mark Lindenlaub, Thrive Alliance
- Ambre Marr, AARP Indiana
- Ellen Miller, University of Indianapolis Center for Aging & Community
- Terry Miller, Hoosier Owners and Providers for the Elderly, Inc. (HOPE)
- Amber O'Haver, Indiana Statewide Independent Living Council (INSILC)
- Lisa Reed, Caregiver Homes of Indiana
- Beth Skinner, CICOA Aging & In-Home Solutions
- Michelle Stein-Ordonez, Indiana Association for Home and Hospice Care (IAHHC)
- Chris Taylor, Suburban Health Organization (SHO)
- Kelli Tungate, Caregiver Homes of Indiana
- Maureen Widner, Aging and In-Home Services of North Indiana, Inc. (AIHS)

FSSA Attendees

Adrian Bottomley, Allison Taylor, Andrew Bean, Brenda Buroker, Dan Rusyniak, Darcy Tower, Erica Ng, Erin Wright, Gus Habig, Hamilton Smith, Jennifer Sullivan, Jesse Wyatt, Kim Opsahl, Kristie Garner, Lucy Morrell, Lynn Clough, Maggie Novak, Meredith Edwards, Michael Gargano, Natalie Angel, Rebecca McClaren, Sarah Renner, Shannon Effler