Managed Long-Term Services and Supports Scope of Work Excerpts Frequently Asked Questions

Questions & Answers in *italics* are newly added as of June 2022.

Section 1: Waiver Services

1. **Will an individual be able to receive Aged and Disabled waiver services and MLTSS concurrently?**

   Yes, individuals 60 years of age and over who qualify for the A&D waiver will receive MLTSS. There will be no need to disenroll from MLTSS to access A&D waiver services.

   The A&D waiver services will be provided to those who meet Nursing Facility Level of Care and several services are in the process of being added to the waiver to ensure a smooth transition into MLTSS.

   Note individuals under age 60 who are functionally and financially eligible for the A&D waiver will continue to receive fee-for-service Medicaid for their A&D waiver services and will not be in the MLTSS program.

2. ***Of the new services provided under the HCBS waiver (informal caregiving coaching and behavior management, goal engagement and customized living), what waiver will be utilized to provide the services? Will there be a requirement to provide these services once they are included in a Waiver?***

   The A&D waiver for individuals aged 60 and over, under a new HCBS 1915(b)/(c) Managed Care Medicaid Waiver, will be utilized to perform the new services. For the members who qualify for the HCBS waiver services, the MCEs will be required to provide these services and follow an individualized, person-centered care planning process with the member to determine which specific HCBS options meet the member's needs.

3. ***Will the state require the use of current Waiver Care Management entities by the health plans?***

   The state will require the MCEs to contract with current Aged & Disabled waiver care management entities (i.e., Area Agencies on Aging) and independent care management providers) to provide for at least 50% of the plan's HCBS service coordination in the first two years of the program.

   Following the two-year period, the MCEs may continue to contract for service coordination or submit a transition plan to the state.

Section 2: Eligibility and Level of Care

4. **Will the Aged & Disabled Level of Care work be done by the enrollment coordinator?**

FSSA is finalizing plans related to the Level of Care determinations and will continue discussions with stakeholders. A&D waiver Level of Care determinations will remain independent of the managed care entities.

5. **What is the process and timeline for selecting contractor(s) for Nursing Facility Level of Care and MLTSS plan selection?**

   The nursing facility Preadmission Screening and Resident Review will continue to be an essential component of the LTSS continuum following all federal and state rules and regulations.

   With the introduction of MLTSS, FSSA will also be required to employ a contractor to assist individuals who are deemed eligible with selection of a health plan.

   FSSA is finalizing details related to these two essential duties and will continue to provide updates to stakeholders in the coming months. Competitive procurements are anticipated in alignment with State policies and procedures.

6. **Who will determine the reasonably expected period of nursing home use for 30, 60, 90, or 120 days (currently the "short-term" stay)?**

   Will there be a 120+ day time period for nursing facility placement (currently the "long-term" stay)?

   The member's length of stay is determined by the Level of Care and the Preadmission Screening and Resident Review process. This process will be conducted independent of the managed care entity and the determined length of stay will be honored by the managed care entity.

7. ***How can or will AAAs be involved in HCBS waiver Level of Care determinations?***

   FSSA will contract for several federally-required functions that broadly fall under the category of "enrollment services."

   These services include: Nursing Facility Level of Care Assessment and Determination (including PASRR for individuals seeking Nursing Facility services), Intake Counseling, MLTSS Plan Selection, and Beneficiary Support Services ("MLTSS Ombudsman"). Individual entities such as AAAs or a network that includes aging and disability community-based organizations (as well as any other interested respondent) may submit a response to any resulting RFPs and/or serve as a subcontractor. Procurement activity is expected to begin during summer 2022.

8. ***Will individuals with intellectual and developmental disabilities fall under "vulnerable subpopulations"?***

   Yes, individuals with intellectual and developmental disabilities are included in the state-

identified list of Subpopulations at Greater Risk of Negative Health Outcomes (previously described as "vulnerable subpopulations").

Section 3: Eligibility & Level of Care Redetermination Questions

9. **The phrase "assure…accurate level of care" [in the Scope of Work] appears to require the contractor to verify the work of the enrollment contractor – who's determination carries – the Enrollment Broker or MCE?**

   What happens if and when there is disagreement on Level of Care determination between the contractor and the enrollment contractor?

   Are the Medicaid members notified? Are the Medicaid member's providers notified?

   An independent Level of Care determination contractor is responsible for determining Nursing Facility Level of Care.

   The MCE will be responsible for communicating with the contractor regarding whether they suspect an error in the determination and that another determination should be performed. The member will continue to have appeal rights if a Nursing Facility Level of Care is denied by the independent contractor and will be notified as required by federal statute.

10. **What is the MCEs role in functional eligibility re-determination?**

    How do members undergo functional eligibility re-determination after enrollment in the program, including members who do not have a change in condition?

    What happens if a member no longer has a Nursing Facility Level of Care?

    A member is functionally eligible to receive LTSS and HCBS services, if they meet an indefinite nursing facility Level of Care.

    A member will have a nursing facility Level of Care as determined by the InterRAI assessment.

    This Level of Care assessment will be completed by the state and independent enrollment contractor(s), not the managed care entity. Managed Care Entities will not determine the member's Level of Care for the purpose of establishing and maintaining eligibility.

    The MCE is responsible for making sure that the information about a member's Level of Care is current and accurate and that a member has a re-determination at least annually by the independent enrollment Contractor regardless of change in the member's condition.

    A member could be re-assessed more than once a year. A re-assessment will occur at any point the member's condition changes and following certain trigger events to ensure

that the member continues to be eligible for services and authorizations that align with their condition and Level of Care needs.

Section 4: Plan Enrollment

11. **Can Medicaid members still choose a different Medicare benefit after default enrollment into the aligned D-SNP product?**

    Yes, FSSA recognizes the importance of maintaining and honoring Medicare freedom of choice.

    All D-SNPs required to default enroll will have to meet requirements pertaining to notifications and notification time periods for members to disenroll and to make a different choice.

    A key component of default enrollment is that the member will be enrolled into a Medicare plan that will be aligned with the member's Medicaid plan, but FSSA understands that there might also be highly valid reasons why a member wants to remain in an unaligned Medicare service delivery system.

12. **Will there be any guardrails put in place so that members aren't requesting to switch MCE's without a just reason?**

    A member may choose a new MCE during the annual plan selection period, whenever the member's D-SNP and MCE become unaligned, once per year without cause or reason, or at any time for a just cause reason. There is a defined list of criteria for just cause plan changes. Those include: Receiving poor quality of care; Failure to provide covered services; Failure of the contractor to comply with established standards of medical care administration; Lack of access to providers experienced in dealing with the member's health care needs; Significant language or cultural barriers; Corrective action levied against the contractor by the office; Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence; A determination that another MCE's formulary is more consistent with a new member's existing health care needs; Lack of access to medically necessary services covered under the contractor's contract with the state; A service is not covered by the contractor for moral or religious objections; Related services are required to be performed at the same time and not all related services are available within the contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk; The member's primary healthcare provider dis-enrolls from the member's current MCE and re-enrolls with another MCE; or Other circumstances determined by the office or its designee to constitute poor quality of healthcare coverage.

Section 5: Member Supports

13. **Will someone be responsible to help the member if they lose Medicaid?**

    The MCE's are allowed to reach out to members to remind them of their redetermination

time frames. However, they can't assist beyond basic assistance.

An MCE cannot fill out the application for a member, but they can help the member identify materials.

There are navigators in the state, FSSA Division of Family Resources, and AAA team members to assist members with the redetermination process.

FSSA is also looking at enrollment services vendor functions to have some requirements to help members with Medicaid eligibility and as part of required beneficiary support services, there will be support for members related to appeals processes. These are the types of details that may not necessarily be in the MLTSS Scope of Work because they are not MCE responsibilities.

14. **How will the fair hearings process work?**

    If a member has a complaint, the member should first submit it to their MCE. The member will receive a ruling/feedback from the MCE. The member can appeal this ruling to the state fair hearing.

    The MCE is required to send information to members about the appeals and grievances process. Grievance and appeal information must be included in any notice of action (such as a denial of an authorization), in the member handbook, and on the MCE's member website.

    Eligibility determinations, which are performed by FSSA, are appealed directly to state fair hearings. The notification letter to the member will include the process.

15. ***What is the difference between Options Counseling, Choice Counseling, and Intake Counseling as defined in the MLTSS continuum of care? Which role helps a member pick a MCE?***

    Which role helps a member pick HCBS waiver service options?

    Options Counseling, is an Area Agency on Aging function, as defined by the Older Americans Act, and will be a service AAAs continue to provide (e.g., counseling pertaining to Title III services, Social Services Block Grant, OAA, etc.) in their role as Aged and Disabled Resource Centers. MCEs do not conduct Options Counseling.

    An individual seeking to receive HCBS waiver services or nursing facility admission first receives a Level of Care Assessment and Determination.

    As noted in the Scope of Work excerpts and elsewhere, the LOC Determination is completed by an independent entity, not a MCE.

    Intake Counseling helps the individual understand what support (institutional and HCBS) they can receive based on their needs and LOC Determination as well as what programs they qualify to enroll in to receive those supports (e.g., PACE, MLTSS, etc.).

    Intake Counseling will also be conducted by an independent entity and will not be a MCE

responsibility.

Individuals who qualify for and opt to enroll in MLTSS can further receive "(Plan Selection) Choice Counseling," which helps individuals pick a MCE through the provision of unbiased information about MCEs and support in understanding MCE offerings, including the MCEs' provider networks.

Choice Counseling will be conducted by an independent entity and will not be a MCE responsibility.

For MLTSS members with an appropriate LOC Determination and desire to live in the home or community, an MLTSS service coordinator will assist the member with selecting their home and community-based services and developing their service plan. This service coordination and service planning process is a responsibility of the MCE and entities subcontracted with the MCE.

Section 6: Care Coordination (Case Management, Service Coordination)

16. **Will NCQA accreditation also be required for Care Management entities?**

    No, this is not a requirement within the MLTSS Scope of Work.

    If a MCE contracts with care management entities, the contracted entity must meet the same NCQA standards and contract requirements the MCE is required to meet. The care management subcontractor wouldn't necessarily have to be accredited by NCQA.

    If MCEs partner with care management entities, the MCEs are expected to conduct oversight of their care management subcontractors to ensure those contractors are meeting NCQA and the Scope of Work care management requirements.

17. **How does the Care Management/Care Coordination Manager duties connect with the Utilization Management Manager Duties?**

    A member's care and service coordinators will be responsible for developing the care plan in partnership with the member and as the member desires, their interdisciplinary care team.

    The care plan will include all necessary LTSS services for those who meet functional and financial eligibility. The care plan approval process serves as the utilization management approval, and no further utilization management will be needed for LTSS services.

    Medical services (e.g., surgeries) still must go through any required utilization management process with the Medicare or Medicaid plan, depending on which plan is providing the services.

18. **Would the quality improvement goals and performance improvement activities be the same across the various MCEs that are selected as subcontractors providing direct services?**

    Could these targets/goals be different between the multiple MCEs?

Broadly FSSA has defined a quality framework for the MLTSS program (person-centered service and supports, access to services, and smooth transitions), and FSSA would expect to see this framework woven into quality improvement and performance improvement activities.

However, each MCE may choose to subcontract different functions and subcontract with different entities, thus there may be variation in specific quality improvement goals and performance improvement activities as they relate to the specific relationship and duties of the subcontractor, as well as, over time, that subcontractor's performance.

19. ***How will FSSA know that the member is receiving the right care?***

The member will qualify for services and care based on standardized procedures and assessments. MCE staff with clinical expertise and training review the treatment and services authorized for a member in accordance with clinical practice criteria and guidelines. MCEs are also subject to third party audits. MCE care and service coordinators are responsible for connecting a member with resources and services to meet their needs in accordance with the members' care plan.

The MCE will be prohibited from restricting a healthcare professional from advising or advocating on behalf of the member. Further, members have the right to participate in the decisions regarding their healthcare, including treatment options and have rights to file grievances and appeals.

For members with informal caregivers, the MCE is required to include the informal caregiver in the assessment and planning process and provide training and support. Additionally, FSSA will monitor the performance of MCEs through care plan audits and compliance reviews.

20. ***What is the difference between a care plan and a service plan?***

A care plan is primarily focused on the member's medical needs, while the service plan is focused on the member's LTSS needs. For members receiving LTSS, members would have both plans - developed together.

21. ***Has the Comprehensive Health Assessment Tool been updated for the MLTSS procurement? Will the tool be available to stakeholders for review and feedback?***

The state-developed Comprehensive Health Assessment Tool will be all-inclusive and identify the clinical, psychosocial, functional and financial needs of the member to ensure appropriate referrals to MCE programs and community-based organizations.

The CHAT has not been updated yet and will be updated during the next phase of the project.

FSSA plans to host additional rounds of stakeholder engagement to solicit stakeholder feedback and can add the CHAT as a topic of potential discussion.

22. ***Are there any particular requirements in the MCE contracts in terms of people under guardianship?***

FSSA has requirements regarding guardianship throughout the Scope of Work. As part of the CHAT process, the MCE shall coordinate with the member to include in the care team and care planning process, the member's family member, informal caregiver, Supported Decision Maker(s), legal guardian, and/or Authorized Representative.

Section 7: Network Adequacy

23. ***How will FSSA ensure MCEs comply with the "any willing provider" provision including through the MCE and provider contracting process?***

    FSSA will strictly enforce this requirement.

    First, FSSA will review each MCE's provider agreement/contract during readiness review and will address any concerning language at that time. If a provider believes a MCE is not complying with any willing provider, the provider should report their concern to FSSA immediately.

24. ***What are the Skilled Nursing Facility ratios for network adequacy?***

    FSSA will require MCEs to maintain a provider network with a ratio of 1 SNF per every 400 members, as well as 1 SNF per county, if one is available.

25. ***Does the "any willing provider" requirement for the first three years of contract operations only apply to nursing facilities?***

    No. For the first three years of the program, the MCEs shall accept into their network any LTSS, institutional or HCBS, provider that agrees to the MCEs' standard provider agreement and meets all applicable State and Federal participation requirements.

Section 8: Payment and Claims

26. ***Will the MCE be required to pay for out-of-network care if the MCE is unable to provide the necessary covered medical services within the required time, distance, and access standards within the provider network contractual standards?***

    Yes, MCEs will be required to authorize and pay for all out-of-network services if the MCE is unable to provide the necessary services in-network that comply with the contract standards and requirements.

27. ***Will MCEs be required to process Medicare coinsurance claims and provide a denial of payment to nursing facility providers when no payment is due?***

    Yes, the MCE must process Medicare coinsurance claims for any kind of provider and provide a denial if Medicare covered the full Medicaid allowable. MCEs will be required to follow the IHCP requirements for Medicare cost sharing payments for crossover claims.

Section 9: Grievances and Appeals

28. ***Is there anything in the Scope of Work that notifies the MCE that the members have the right to work with an outside or external entity through the grievances and appeals process?***

    The MCE is required to provide a member with written notice that must include information about the procedure to request an external grievance procedure (External Review by Independent Review Organization). As noted in question #7 and Section 5.14.9 Ombudsman of the Scope of Work, there will also be a beneficiary support vendor ("MLTSS Ombudsman") who can support members with grievances and appeals, if the member desires this support. The MCEs must collaborate with this vendor.

Section 10: Functions of MLTSS

29. ***In MLTSS what are some functions that will not be the responsibility of the MLTSS plan?***
    MCEs will not be responsible for:
    - *Level of Care Assessment and Determination;*
    - *Intake Counseling;*
    - *Plan Selection;*
    - *Beneficiary Supports aka an "Ombudsman" role: provides members with assistance in navigating their health plan coverage, in understanding and exercising their rights as they transition into the program, in obtaining general information and education about the program, and in resolving and investigating member complaints to support members in the grievances and appeals process.*

Section 11: General Updates

30. ***What changes, updates, and clarifications have been made to the MLTSS Scope of Work since the original draft excerpts were posted?***

    As FSSA has continued to refine the Scope of Work, numerous updates have been made. The following list highlights key changes, updates, and clarifications.
    a. *2.4.5 Staff Training and Qualifications – MCE staff training on cultural competency and health equity shall be performed and created in partnership with **disability and aging-led organizations.***
    b. *2.21.2 Dual Eligible Special Needs Plan Requirements and Coordination – Added clarification that the MCE's companion D-SNP shall offer a separate plan benefit package that enrolls only full-benefit dually eligible Medicaid enrollees (Qualified Medicare Beneficiary Plus, Specified Low Income Beneficiary Plus, other Full Benefit Dual Eligible) under sixty (60) years of age who are not eligible for [MLTSS Program Name].*
    c. *3.10 Participant-Directed Attendant Care – For members electing self-direction of HCBS services, MCEs shall allow eligible members to utilize the State's financial management services vendor(s). MCEs shall treat the State's financial management services vendor(s) and all direct service workers employed under the financial management services vendor(s) as in-network providers. A member's chosen care providers shall enroll as Indiana Health Coverage Programs providers under the State's financial management services vendor(s), unless those care providers are already IHCP enrolled through another means.*

d. *4.1 Care Coordination Program Overview – For the first 2 years of the program, the MCE shall provide Service Coordination to at least 50% of its enrolled members receiving HCBS waiver services through current Aged & Disabled waiver care management entities (list will be provided by State). Examples of approved waiver care management entities include the Area Agencies on Aging, a network of care management providers, and independent care management providers.*
e. *4.4 Changed section title to "Subpopulations at Greater Risk for Negative Health Outcomes" (originally called "Vulnerable Subpopulations") – Terminology changed throughout Scope of Work to reflect this modification.*
f. *4.9 Individualized Care Plans – Clarified language stating that the member drives the care planning process: MCEs must ensure that there is a mechanism for members to drive and add the ICP development. Such a mechanism should allow the member's family, informal caregivers, or others to participate in the ICP development process, if desired by the member.*
    a. *Additionally, language included the Bureau of Developmental Disability in the list of entities that will coordinate with the member's care coordination staff as specified in a member's ICP.*
g. *4.10 Service Plan – Expanded the definition of Natural Supports to emphasize that they are relationships that enhance the quality and security of a member's life.*
    a. *Explicitly defined a provider-owned/controlled residential setting: settings where the beneficiary lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS to the individual)*
h. *4.10.2 Nursing Facility Service Plans – For individuals with Intellectual and Developmental Disabilities in a nursing facility, the Service Coordinator shall coordinate with the member's Bureau of Developmental Disabilities Services / Omnibus Budget Reconciliation Act service providers. The Service Coordinator shall regularly assess the member's specialized service needs including their need for self-advocacy support, and assist the member in connecting to and coordinating with BDDS/OBRA.*
i. *4.13.3 Care Coordinator Training Requirements – Expanded upon the cultural competency training requirement to specify that it must be **performed or created in conjunction with disability and aging-led organizations**.*
j. *Added a new section: 4.14.4 Service Coordinator Contracting – Added requirements around subcontracting for service coordination:*
    a. *The State will require the MCEs to contract with current Aged & Disabled waiver care management entities (i.e. Area Agencies on Aging (AAAs) and independent care management providers) to provide for at least 50% of the plan's HCBS service coordination in the first two years of the program. Following the two-year period, the MCEs may continue to contract for service coordination or submit a transition plan to the State.*
k. *4.18.4 Care Coordination/Service Coordination Reviews – Clarified that the MCE shall conduct reviews of subcontracted Care Coordination and/or Service Coordination providers **including subcontracts with Aged & Disabled waiver care management entities.***
l. *5.1 Marketing and Outreach – Specified that marketing materials and plans shall be **neutrally** designed to reach a broad distribution of potential members across age and gender categories.*
m. *5.5 Member and Stakeholder Education and Engagement – MCEs shall include a cross representation of members in its member advisory committees, specifically a majority of people with lived experiences. MCEs must include compensation for attendance (through an enhanced benefit) to facilitate member participation. MCEs*

must also include organizations that are led by individuals with special health care needs, aging individuals, and SDOH organizations for participation in member advisory committees.

n. *5.7.2 Member Handbook – Expanded upon the required information to be included in the MCE member handbook: Information on how to contact the Enrollment Broker,* ***the MLTSS Ombudsman (5.14.9) and other State-designated entities involved in enrollment services, member support services, and choice counseling****.*
o. *6.2 Network Composition Requirements – Added an Extended Facility (Skilled Nursing Facility) provider to member ratio of 1:400 and clarified there must be at least one in-network facility located in each county, unless there is no facility located in a particular county.*
p. *6.11 Provider Education and Outreach – Added a new requirement for LTSS Provider Engagement. MCEs shall participate in a state-facilitated LTSS provider forum to solicit feedback from providers to continuously improve provider experience. Each MCE shall develop and submit an LTSS provider engagement plan to the State that details multimodal communication methods, and identified trends in provider questions and concerns and action steps the MCE implemented to improve.*
q. *7.8.5 Authorization of Services and Notices of Actions – Added clarification that for requests related to HCBS, the contractor shall make an expedited authorization decision and* ***give notice to the member*** *within 24 hours of the decision to deny authorization for services contained in the member's Service Plan.*