Managed Long-Term Services and Supports (MLTSS) Stakeholder Update

April 27, 2022

Agenda

- Welcome
- MLTSS Reform Overview
- Timeline
- Scope of Work Excerpts
- Next Steps

LTSS Reform Overview

We are reforming our Long-Term Services and Supports (LTSS) program to align with our values of Participant **Choice**, **Quality**, and **Sustainability**.

Our objective

1) **75% of new LTSS members will live and receive services in a home and community-based setting**
2) **50% of LTSS spend will be on home- and community-based services**

1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state
5. Recruit, retain, and train of direct support workforce

MLTSS Quality Framework Goals:

- Person-Centered Services and Supports
- Ensuring Smooth Transitions
- Access to Services (Participant Choice)

High-Level Managed LTSS Timeline

Implementation Phase	General Timeline	Key Highlights/Deadlines
Design	Jan '21 - May '22	•RFI Codesign Workgroup •RFI Released (July '21) •RFI Codesign 2.0 & 3.0 Workgroups
Competitive MLTSS Procurement Preparation for MCE Onboarding	May '22 - Q1 '23	•RFP Release (June '22) •Readiness Review Project Preplanning & Project Initiation (Q3 - Q4 '22) •RFI Codesign Workgroup 4.0 •MLTSS RFP Awards (Q1 '23)
MCE Readiness Review & Onboarding	Q1 '23 - Q1 '24	•MCE IT System Testing (Q2 - Q3 '23) •Member & Provider Transition and Communication (Q1 '23 - Q4 '23) •CMS Waiver Submission (Q2 '23) •Continued stakeholder engagement
Robust Implementation Monitoring	Q1 '24	•MLTSS Go-Live (Q1 '24) •Continued stakeholder engagement

Stakeholder engagement will be ongoing throughout all phases of the timeline.

MLTSS Scope of Work Excerpts

- Distributed for the purpose of sharing how stakeholder feedback has been incorporated
- Excerpts are available here in near-final draft form
- The State's process has been focused on internal development of detailed scope content based on the topical feedback we have received from stakeholders
- The State is focused on ensuring materials are kept free from the influence of potential bidders
- “State” means the Family and Social Services Administration and “Contractor” with a capital “C” means the managed care entity

Claims Processing Capability (Section 9.7.1) and Compliance with State and Federal Claims Processing Regulations (Section 9.7.2)

Stakeholder Feedback

- Require MCEs to simplify and streamline claims submissions processes
- Require MCEs to allow the R69 diagnosis code for HCBS provider claims

Addressed in the SoW

- Required MCE provider communication and submission requirements to be efficient, standardized, and not burdensome for any providers, including continual assessment to identify and change onerous administrative billing requirements
- MCE required to have a claims processing system to support electronic claims submission for both in- and out-of-network providers
- MCE required to accept ICD code R69 for members receiving Home and Community Based Services
- MCEs prohibited from requiring out-of-network providers to establish a Contractor-specific provider number to receive payment for claims submitted
- MCEs required to bill providers using the providers' FSSA assigned Member ID number

Claims Payment Timelines (Section 9.7.3) and Rate Update Timelines (Section 9.7.4)

Stakeholder Feedback

- Prevent Contractors from denying payment for clerical errors
- Require MCEs to pay interest
- Prompt payment requirements and timeframes aligned with FFS (weekly)
- Have MCEs offer assistance to revise claims

Addressed in the SoW

- MCEs pay or deny clean claims within:
  - 21 days of receipt for electronically-filed
  - 30 days of receipt for paper claims
- MCEs reject or deny unclean claims within 30 days of receipt
- MCE required to pay providers with interest if MCE fails to pay, deny, or paid late a clean claim within these timeframes and subsequently reimburses for services in the claim
- Provider filing limit for submission of claims to the MCE:
  - Out-of-network: 6 months from the date of service
  - In-network: 90 days from date of service
- MCEs required to pay claims via EFT and check runs at least weekly.
- MCEs have local claims educators to help LTSS providers (from previously shared excerpts)
- MCEs required to have policies and procedures in place to load new fee schedules and fee schedule updates from FSSA into their claims processing systems

Remittance Advice Requirements (Section 9.7.6)

Stakeholder Feedback

- Stakeholders have requested additional payment safeguards to ensure that claims are paid in a timely manner and that denials don't occur for without reason

Addressed in the SoW

- MCEs must provide, at a minimum, the following remittance advice related to the MCE's payments and/or denials to providers:
  - Appropriate explanatory remarks related to a payment or reason(s) for denials and adjustments,
  - A detailed explanation/description of all denials, payments and adjustments,
  - The amount billed,
  - The amount paid,
  - Application of COB and copays, and
  - Provider rights for claim disputes
- MCEs must include contact information for local provider relations team in addition to instructions and timeframes for claim disputes and corrected claims

Claims Systems Audits (Section 9.7.7)

Stakeholder Feedback

- Audit system for LTSS claims processing prior to go live and include provider participation

Addressed in the SoW

- MCE internal claims audit function required to include
  - Verification that provider contracts are loaded correctly
  - Accuracy of payments against provider contract terms
- MCEs must regularly audit provider contract terms with documented methodology
- MCEs must document audit findings and conduct corrective action for any deficiencies
- FSSA has the right to perform a random sample audit of all claims and MCE must fully comply with the requirements of the audit

Recoupments (Section 9.7.8) and Claims System Changes (Section 9.7.9)

Stakeholder Feedback

- Stakeholders have expressed ongoing interest in MCE claims systems and processes

Addressed in the SoW

- MCE's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims
- MCEs are required to ensure that changing or making major upgrades to the information systems that affect claims processing, payment or any other major business component, is accompanied by a plan that includes a timeline, milestones, and an outline of adequate testing to be completed before implementation

MLTSS and Supports Contracts - EVV Requirements (Section 9.10)

Stakeholder Feedback

- Require all MCEs to utilize the existing data aggregator for all EVV activity, including for home health

Addressed in the SoW

- MCEs required to implement an EVV solution in compliance with the 21st Century Cures Act
- MCE required to use the State Sponsored-EVV Solution's aggregator of EVV records including for all impacted personal care and home health services during claims adjudication
- MCE may only utilize EVV for claims payments on services determined by FSSA to require EVV and only enforce claims denials for missing or inaccurate EVV records based upon the timeframe established by FSSA

Reporting (Sections 10.0 and 10.1)

Stakeholder Feedback

- MCEs should be required to publicly publish data on provider network capacity

Addressed in the SoW

- FSSA requires and uses various deliverables, performance targets, industry standards, national benchmarks and program-specific standards in monitoring the MCEs performance and outcomes
- Topics of required reports include: member service, network development, provider service, financial, quality management, utilization and authorization, claims, care & service coordination, health outcomes and clinical, and CMS reporting
- FSSA intends to publish key performance metrics including, claims performance, prior authorization data, quality performance metrics, network adequacy and/or utilization reports
- FSSA reserves the right to publicly share survey results and other data elements
- In 2nd year of the program, the State may use performance outcomes as a factor for MCE auto-assignments and enrollment materials developed to facilitate member choice of an MCE
- Requirements for MCEs to have process to ensure financial and performance data accuracy. FSSA reserves the right to audit the Contractor's self-reported data.
- On an annual basis, MCEs must submit program specific audited financial reports

Utilization Management Program (Section 7.8)

Stakeholder Feedback

- Stakeholders have expressed interest in how the State will monitor the MCEs' Utilization Management (UM) activities

Addressed in the SoW

- The MCE must have its own utilization management program and include utilization management measurements in their Quality Management and Improvement Program Work Plan. The program must link members to disease management, care management, complex case management and service coordination.
- UM program must have systems in place to identify instances of over- and under-utilization of Emergency room services, non-emergency medical transportation services and other health care services
- Staff will also identify aberrant provider practice patterns, ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues
- The MCE cannot delegate utilization management functions to subcontractors with the exception of pharmacy, vision, and/or dental. Subcontractors are subject to FSSA's approval and annual audits by the MCE.

Utilization Management Staffing and Training (Section 7.8.1)

Stakeholder Feedback

- Stakeholders have expressed interest in training and qualifications of MCE Utilization Management staff

Addressed in the SoW

- Utilization management staff are required to receive ongoing training regarding interpretation and application of the utilization management guidelines
- MCEs are required to provide a written training plan, which must include dates and subject matter, as well as training materials, upon request by FSSA
- MCEs cannot provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services and required to adhere to prior authorization timelines regarding transitions and Continuity of Care

Medical Service and Pharmacy Prior Authorization – Non-HCBS Services (Section 7.8.2)

Stakeholder Feedback

- Don’t require recertifying every 60 days if the individual’s condition remains the same

Addressed in the SoW

- MCE shall not use improvement in function as a criteria for approving continuation of services that enable the member to maintain their health status or prevent the member from experiencing a more significant decline

Special Consideration for LTSS Service Authorization (Section 7.8.3) and Special Consideration for HCBS Service Authorization (Section 7.8.4)

Stakeholder Feedback

- Stakeholders want to ensure that MCEs are aware of the nuances of service authorization in the provision of LTSS and HCBS
- A member's service plan should serve as the service authorization

Addressed in the SoW

- MCEs cannot interfere with the member's setting of choice once level of care is determined
- MCEs' utilization management program shall include distinct policies and procedures regarding HCBS and shall specify the responsibilities and scope of authority of Service Coordination in authorizing LTSS and HCBS
- MCEs may not require a provider to submit an additional authorization for services present in the member's person-centered service plan (the service plan is the authorization) and the MCE must alert the relevant provider of the services approved in the person-centered service plan using the timelines specified for utilization management approvals and denials

Authorization of Services and Notices of Actions (Section 7.8.5)

Stakeholder Feedback

- Provide clarification on timing of prior authorization practices
- Keep service authorization timeframes the same as fee-for-service

Addressed in the SoW

- MCEs utilization management programs are required to meet government regulations and current NCQA standards and must include appropriate timeframes for completing initial requests, completing initial determinations, completing appeals, notifying providers and members about MCE decisions on prior authorizations and appeals.
- MCEs must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested based on specified timeframes:
  - Notify members of standard authorization decisions not pertaining to medications as expeditiously as required by the member's health condition, not to exceed 7 days after the request for services
  - If the standard timeframe could seriously jeopardize the member's life or health, the MCE shall make an expedited authorization decision no later than 48 hours after receipt of the request for service
  - For requests related to HCBS, the MCE shall make an expedited authorization decision within 24 hours of the decision to deny authorization for services contained in the member's Service Plan
  - For concurrent reviews within 72 hours of a non-urgent request and within 1 business day of an urgent request
  - For decisions to terminate, suspend or reduce previously authorized covered services at least 10 days before the date of action

Authorization of Services and Notices of Actions (Section 7.8.5) and Authorization Systems and Technology (Section 7.8.6)

Stakeholder Feedback

- Prohibit retroactive denials
- MCE staff must be available to approve authorizations on weekends
- Pay nursing facilities for 5 days through successful discharge or transfer
- Request for electronic prior authorization look-up tool

Addressed in the SoW

- MCEs required to have staff available on weekends to ensure that utilization management decisions and notifications are delivered within required timelines
- MCEs may not retroactively deny authorization for the continuation of care unless the provider submitted the authorization untimely
- For authorizations originally approved by the MCE, if the MCE denies continuation of services with the skilled nursing facility or long-term attendant care the MCE must provide at least 5 days of coverage for the services from the date of the notice of denial
- MCEs must establish an electronic prior authorization look-up tool that provides verification of whether a service requires authorization, including for LTSS services. Requires look-up tool to be easily found on the MCE website and without a provider creating a separate account

Quality Improvement (Section 7.0)

Stakeholder Feedback

- The State's monitoring of MCE quality and performance should include person and family-centered measures of beneficiary and family caregiver experience
- Health quality objectives should be monitored by the State

Addressed in the SoW

- FSSA has established the following program quality goals, which will remain in effect for the duration of the contract:
  - Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses SDOH
  - Ensure continuity of care and seamless experiences for members as they transition into the program or among providers, settings, or coverage types
  - Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life

Quality Management and Improvement (Section 7.1)

Stakeholder Feedback

- Stakeholders have expressed interest in how the State will monitor MCE quality and performance

Addressed in the SoW

- In accordance with NCQA and CMS standards, as well as the State-defined elements listed below, the MCE shall develop and implement an ongoing Quality Management and Improvement Program (QMIP) for all services it provides to its members
- The program must be uniquely designed to serve MLTSS members and must not be combined with quality programs for other Indiana Medicaid programs, other states, or other lines of business
- Through its QMIP, the MCE shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services and long-term services and supports to members
- The MCE shall provide quality program progress reports to the State on no less than a quarterly basis. The MCE must be prepared to periodically report on its quality management activities to the State's Quality Strategy Committee.

7.1.5 Quality Management and Improvement Committees (Section 7.1.5.2)

Stakeholder Feedback

- FSSA should create an independent oversight committee or task force to monitor and report on the implementation of managed care
- Committees should include representation of members including aging and disability advocates

Addressed in the SoW

- MCE Quality Management and Improvement Committee must include members, aging and disability-led advocacy groups, medical and behavioral health providers, LTSS providers, community partners, advocates, and caregivers
- FSSA will form and convene a quarterly independent Aging and LTSS Advisory Committee
  - Membership includes members, aging and disability-led advocacy groups, caregivers (formal and informal), subject matter experts, and other independent stakeholders
  - The committee will provide recommendations and proposals for the requirements and measures related to quality, reporting, transparency, and data to FSSA staff
  - It will also be a forum for discussing concerns relating to service by providers and the MCEs to meet member needs
  - MCEs will not have voting membership but must send designees to all committees to support the work

Cooperation with the State (Section 7.1.10) and Publication of Quality Performance Reports (Section 7.1.11)

Stakeholder Feedback

- Stakeholders have expressed interest in how the State will monitor MCEs, ensure contract compliance, and sharing performance information publicly

Addressed in the SoW

- FSSA will conduct ongoing monitoring of the MCE to ensure compliance with MCE requirements and performance standards. The method and frequency of monitoring is at FSSA's discretion.
- Monitoring procedures for operations related to
  - Member enrollment, disenrollment, satisfaction, grievances and appeals,
  - Processing Provider Claim Disputes and Appeals,
  - Performance and findings related to quality measures and audits
  - Reports and summaries of data related to medical management, finances, encounter data, and DSNPs
- FSSA can publish Contractor-level and provider-level quality performance data and information such as MCE performance related Quality Program Goals, the status and impact of quality improvement initiatives and interventions, and Corrective Action Plans (CAPs)

Surveys (Section 7.2)

Stakeholder Feedback

- Stakeholders have expressed interest in how the State will be incorporating member voice into the program

Addressed in the SoW

- The MCE is required to perform and/or assist with the following annual surveys: Member Surveys, Informal Caregiver Surveys, and Provider Surveys
- The MCE shall incorporate and address findings from surveys and other analytic activities to assess the quality of care and services provided to members and identify opportunities for improvement
- The MCE shall submit a report to FSSA summarizing the member and informal caregiver survey methods and findings and identifying opportunities for improvement
- The MCE shall provide survey results to FSSA (including de-identified member-level data) from all independently administered survey, by stratifications defined by the State
- Summary results of MCE's surveys may become public information and available to all interested parties on the FSSA's public website

Workgroup Next Steps

LTSS email: backhome.indiana@fssa.in.gov

LTSS Website with stakeholder meeting materials and FAQ posted https://www.in.gov/fssa/long-term-services-and-supports-reform/home/

ADvancing States' upcoming provider education and Business Acumen workshops information: http://www.advancingstates.org/inform-indiana