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

April 7, 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 (May ‘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

Relevant Definitions

Stakeholder Feedback:

- Define informal caregivers as: a family member, partner, friend or neighbor who provides regular or periodic paid or unpaid care for a Participant

Definitions Exhibit:

- **Informal Caregiver** - Family members, partner, friends, or neighbors who provide care for a member and is routinely involved in providing support and assistance to the member. A caregiver may be also designated by the member as a representative for consumer direction. Members may have more than one Informal Caregiver. Any paid Informal Caregivers must be enrolled as a Medicaid provider with the state and contracted and credentialed with the Contractor.
- **Caregiver Supports** - Training, education, and resources that support the Informal Caregiver with the necessary knowledge and skills to promote safe and appropriate services and supports to the member.

Relevant Definitions

Stakeholder Feedback:

- Explain the difference between care coordination and service coordination

Addressed in the SoW

- **Care Coordination** -The Care Coordination Program Plan shall include, but not be limited to, descriptions of how the Contractor shall comprehensively address the following Care Coordination critical elements and their associated factors: Care Coordination Staff Structure, Comprehensive Health Assessments, Individualized Care Plan, Interdisciplinary Care Team, Continuity of Care and Care Transition Protocols. The Contractor's Care Coordination Program Plan and service delivery must contain evidence of person-centered practices. The State strongly encourages a strengths-based approach in all aspects.
- **Service Coordination** - In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will be eligible for Service Coordination for their LTSS and related environmental and social services. Service Coordination specifically focuses on supporting members in accessing long-term services and support, medical, social, housing, educational, and other services, regardless of the services' funding sources. All members receiving Service Coordination will have an assigned Service Coordinator who works with the member's Care Coordinator to ensure cohesive, holistic service delivery.

Relevant Definitions

Stakeholder Feedback:

- Explain the difference between care coordination and service coordination

Definitions Exhibit:

- **Care Coordinator** - An individual meeting Indiana required residential, education, and/or experience requirements that is assigned to every member with the primary responsibility for coordination of the member's physical and behavioral health, and LTSS services.
- **Service Coordinator** - Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are receiving LTSS, to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS providers as well as other community resources to provide a combination of services and supports that best meet the needs and goals of the member and informal caregiver(s).

Covered Services for Members in MLTSS

Dual Eligible Members	All Members
Medicare Services*	Medicaid (partial list)
Part A: hospital care, short term SNF, hospice, labs, surgery, short term home health **Part B:** Dr visits, medical, preventive care, DME, behavioral health, limited outpatient prescription drugs **Part D:** prescription drugs **Part C: (Medicare Advantage)** Includes full Part A and Part B benefits. Most also cover Part D. These plans also have some flexibility to provide additional supplemental benefits like over the counter drugs, transportation, wellness programs, vision or dental services, home delivered meals or other services.	•Hospital care •Labs/tests •Surgical care •Preventive care •Primary care visits •Prescriptions •Behavioral health and addiction treatment •DME •Home health •Hospice •Dental •Vision •Hearing aids •NEMT

Covered Services for Members in MLTSS

Nursing Facility Level of Care Determined	
Member chooses to reside in Nursing Facility	**Member Chooses to Reside at Home or in the Community** *New Waiver Service **More info at https://www.in.gov/fssa/da/medicaid-hcbs
Medicaid	HCBS Waiver Services**
•Long Term Care (Nursing Facility)	•Adult Day Service & Family Care •Attendant Care, Self-Directed ATTC, & PDHCS •Informal Caregiver Coaching and Behavior Management* •Community Home Share Assisted Living •Community Transition •Customized Living* •Home Modification Assessment •Home Modifications •Goal Engagement (Capable)* •Home and Community Assistance (FKA Homemaker) •Home Delivered Meals •Integrated Health Care Coordination •Nutritional Supplements •Participant-Directed Attendant Care •Personal Emergency Response System •Pest Control •Respite •Specialized Medical Equipment and Supplies •Structured Family Caregiving •Transportation •Vehicle Modifications

Nursing Facility Services (SoW Section 3.8.1)

Stakeholder Feedback

- MCEs should contract with any willing provider for at least 3 years
- MCEs should allow a choice of setting (e.g. nursing facility - if the individual meets the State eligibility and level of care criteria.)

Addressed in the SoW

- For the first three (3) years of contract operations, MCEs must contract with any willing nursing facility provider who meets the criteria of licensure and IHCP enrollment and is willing to accept the provisions of the MCE's contract.
- Individuals that remain eligible for nursing facility level of care and Medicaid may choose to be admitted to a facility or provided with care in a home or community setting.
- MCEs cannot deny authorizations for nursing facility care to those that qualify via the Level of Care assessment. PASRR assessment must also be completed. The member must have their choice of a home or facility setting honored.

Services (SoW Section 3.4)

Stakeholder Feedback

- Consider no prior authorization for emergency services

Addressed in the SoW

- No prior authorization for emergency services is consistent with policies in existing managed care programs.

Services Cont'd (SoW Section 3.9, 3.10, 3.12, 3.17)

Stakeholder Feedback

- Allow payment of caregivers that are relatives
- Cover consumer directed care that includes the ability to use paid family caregivers

Addressed in the SoW

- Structured Family Caregiving is a covered service for members that qualify for HCBS services
  - FSSA to allow payment of caregivers who are spouses, children, parents of adult children, and other relatives of participants eligible for HCBS

- Participant-Directed Attendant Care services is included as well

Informal Caregiver Supports (SoW Section 3.11, 3.11.1, 3.14, 4.8.2)

Stakeholder Feedback

- Provide informal caregiver supports for training and education
- Provide telephone numbers that link informal caregivers to resources
- Add caregiver supports as a required service to be offered by MCEs
- MCEs should identify social determinants of health (SDOH)

Addressed in the SoW

- Includes training and education for informal caregivers
- Informal Caregiver Coaching and Behavior Management will be a covered service for HCBS Waiver eligible members
- The MCE provide nurse triage telephone services for members and informal caregivers to receive medical advice 24/7
- Requires MCEs to refer caregivers to resources to assist with addressing SDOH as part of informal caregiver assessment

Services Cont'd (SoW Section 3.9, 3.12, 3.17)

Addressed in the SoW

- Non-emergency medical transportation (NEMT) services are covered and provided by the MCE
- Supportive housing services are included but not limited to ensuring housing needs are evaluated as part of independent living goals and service planning, housing search and application assistance, etc. The MCE is expected to participate in local and statewide housing collaboratives

Continuity of Care (SoW Section 3.22) & Out of Network Requirements (SoW Section 3.23)

Stakeholder Feedback

- Continuity of care protections should provide at least 180 days after the start of the program
- After the start of the program, continuity of care protections for new members to an MCE must be at least 60 days during which individuals must be provided the same services they were receiving prior to MLTSS enrollment.
- Honor existing approvals and out of network providers during transitions
- Recipients should be able to access in or out of network providers at no higher out-of-pocket cost

Addressed in the SoW

- For the first year of the program, the MCE will provide continuity of care for existing authorizations and providers for 120 days. For a member who qualifies for LTSS and has an existing care plan approved by FFS or another MCE, that care plan will be honored for 180 days from the date of enrollment.
- After year one of the program, there will be a 90 day continuity of care period from the date of member enrollment for existing authorizations and providers. The MCE shall honor previous approved FFS or other Medicaid MCE care plans for 180 days after year one of the program.
- The cost to the member for out-of-network services shall be no greater than in-network.

Enhanced Services (SoW Section 3.24)

Addressed in the SoW

- The State allows MCEs the flexibility to cover additional programs that focus on enhancing the general health and quality of life of members. Enhanced services may include, but are not limited to:
  - Enhanced transportation arrangements (i.e. transportation to obtain pharmacy services, attend member education workshops on nutrition);
  - Enhanced tobacco dependence treatment services;
  - Disease management programs or incentives beyond those required by the State;
  - Incentives for receiving preventive care;
  - Supplemental additional covered services (such as extra dental cleanings)

Care Coordination (SoW Section 4.1)

Stakeholder Feedback

- Person-centered care management should be available to all MLTSS members, not just HCBS recipients.

Addressed in the SoW

- The Contractor must offer all members person-centered Care Coordination reflective of their needs to assist them in planning, accessing, and managing their health care and health care-related services.
- There will be a minimum of two Care Coordination levels of service: Care Management (available to all members) and Complex Case Management (available to high-risk/high-need members who meet State-defined criteria).
- All members must have an assigned Care Coordinator to facilitate the development of a longitudinal and trusting relationship with the member toward improved quality, continuity and coordination of care.
- Members who meet NFLOC will also be offered LTSS-specific Service Coordination in addition to Care Coordination.

Care and Service Coordination for MLTSS members

Non- NFLOC Determined Members

Care Coordination

Care Management

Complex Case Management

NFLOC Determined Members

Care Coordination + Service Coordination

NF residence:
Care Coordinator and Service Coordinator partner with the NF to support the NF's service plan.

HCBS residence:
Care Coordinator and Service Coordinator work as a team.

Care Coord. Cont'd - Medicare/Medicaid Alignment (SoW Section 4.3)

Stakeholder Feedback

- Align the Medicare and Medicaid service delivery systems to provide better integrated care for duals
- Medicare freedom of choice must be preserved within the MLTSS program design

Addressed in the SoW

- MLTSS Care Coordination Programs must align with the Contractor's Companion Dual Special Needs Plan (D-SNP) Model of Care (MOC).
- The Contractor shall be responsible for ensuring seamless coordination of discharge planning on behalf of members enrolled in its companion D-SNP (Dual Eligible – Aligned) and for coordinating with other Medicare payors and plans, including traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs) for members who are in unaligned Medicare products.

Care Coord. Cont'd - Comprehensive Health Assessment (SoW Section 4.6)

Stakeholder Feedback

- Use a standardized health risk assessment of participant needs and individually tailored service plan development that is conducted by an interdisciplinary team comprised of people and professionals selected by the participant

Addressed in the SoW

- The State will develop a standardized comprehensive health assessment tool for all MCEs to use. It will be based on the interRAI (for functional assessments) and the Accountable Health Communities (AHC) SDOH questionnaire.
- For members who qualify for Service Coordination, the Service Coordinator shall use the results of the member's comprehensive Health Assessment Tool and LOC assessment as the foundation of the strengths-based, LTSS-specific service planning process.

Care Coord. Cont'd - Reassessments (SoW Section 4.7)

Stakeholder Feedback

- Require MCEs to assess and reassess members on a predetermined basis and following a trigger event, including loss of a caregiver

Addressed in the SoW

- The State requires MCEs to assess and reassess members on a predetermined basis and following a trigger event. The State has identified several trigger events, including "change or loss of informal caregiver".

Care Coord. Cont'd - LTSS-Specific Assessments (SoW Section 4.11, 4.8)

Stakeholder Feedback

- Require Service Coordinators to conduct monthly telephonic check-ins and quarterly in-person visits
- Require MCEs to assess caregivers through a standardized caregiver assessment

Addressed in the SoW

- The State will require Service Coordinators to conduct monthly telephonic check-ins and quarterly in-person visits with members who are NFLOC and receiving HCBS. Service Coordinators will conduct quarterly visits for NFLOC members in institutional settings.
- The State will allow members receiving Service Coordination to opt-out of higher frequency contacts, based on their personal preference.
- The State will require that caregivers are identified as part of all Individualized Care Plans and offered supports and resources.
- Informal Caregivers of NFLOC members are further assessed through a standardized caregiver assessment administered by Service Coordinators.

Care Coord. Cont'd - Individualized Care Plans (SoW Section 4.9, 4.10.4)

Stakeholder Feedback

- Require MCEs to identify and involve informal caregivers as part of all Individualized Care Plans
- Service planning process decision acts as an authorization for services
- FSSA must monitor to ensure that MCEs are not reducing participants' home and community-based services and must take action against any MCE that is inappropriately reducing services.

Addressed in the SoW

- MCE must describe and receive State approval how they plan to identify and involve informal caregivers, including in care planning as part of the member's ICT
- MCE is required to submit service plans to the State for review and approval should such Service Plans represent a reduction in previously-approved hours or services above a State-determined threshold

Care Coord. Cont'd - Transitions (SoW Section 4.12)

Stakeholder Feedback

- A member's care management journey must include discharge/transition support

Addressed in the SoW

- The Contractor is responsible for coordinating a member's care throughout the transition process, which includes both planning and preparation for transitions and the follow-up care after transitions are completed.
- Care Coordinators must conduct an on-site visit within 10 days of a member moving from the home/community into a nursing facility
- For members transitioning from an inpatient hospital stay or facility setting back to the home or community, the member's Care Coordinator must make an on-site visit to the member's home or planned residence within three days of transition.
- The Contractor must facilitate transitions even when a member is moving to a facility or service where the Contractor is not the primary payor (such as a state hospital)

Care Coord. Cont'd - Interdisciplinary Care Team (ICT) (SoW Section 4.17)

Stakeholder Feedback

- Stakeholders have expressed the importance of including a member's providers and informal caregivers in care planning IF the member would like these individuals to participate

Addressed in the SoW

- The MCE must use an ICT for the coordination of care for each member assigned to the Complex Case Management level of service
  - The MCE must use an ICT skilled in nursing, social work and behavioral health, with knowledge of local community resources to implement protocol-driven care modules for members
- ICTs will include at a minimum: the member, the member's Care Coordinator, the member's Service Coordinator (if applicable), and any member-selected supports, including informal caregivers.
- Based on the member's needs and risk factors, the ICT may also include: individuals from the member's residence/facility's care team, medical practitioners involved in the member's care, PTs, OTs, speech therapists, nutritionists, pharmacists, and behavioral health specialists.

Choice Counseling

Stakeholder Feedback

- Choice counseling must be conflict-free and robust. It must be provided by a high performing entity within or under contract with the State that has a clearly demonstrated ability to guide consumers through informed decision-making.

Outside the Scope of Work

- Choice counseling to be performed by an independent entity free from conflict of interest with the MCEs.

Workgroup Next Steps

Next stakeholder sessions:

- April 14, 2022 at 9:30 am. Topics we plan to include: Marketing and Outreach, Member Experience, Grievances and Appeals Process, Ombudsman, and Health Equity and Cultural Competency.
- April 19, 2022 at 12 pm
- April 27, 2022 at 12 pm

LTSS email and webpage - backhome.indiana@fssa.in.gov and https://www.in.gov/fssa/long-term-services-and-supports-reform/home/

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