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

March 30, 2022

Agenda

- Welcome
- MLTSS Reform Overview
- Follow-up from 3/24 Meeting
- 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.

Follow-up from 3/24 Meeting

- Stakeholders requested the CMS guidelines for MLTSS. They can be located here: https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf
- Stakeholders requested a list of items MCEs are not responsible for. This list includes:
    - Eligibility determination
    - Plan selection
    - Level of care determination
    - Determination of covered benefits (FSSA sets the services each program covers)
    - Coverage for short of list of drugs and services (e.g., state hospital, MRO)
    - State fair hearings
    - Coverage for members during their initial retroactive eligibility segment)

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

Eligibility (SoW Section 2.1 & 2.1.1)

Stakeholder Feedback

- State should continue to make eligibility requirements
- MCE should not conduct the Level of Care (LoC) assessment
- MCE should not determine acuity level for nursing facility residents
- Automatic assignment of an individual to an MCE should take into consideration factors like continuity of care

Addressed in the Scope of Work (SoW)

- MCE shall not complete the LoC determination, but work with the FSSA Enrollment Contractor and member to have the LoC determined annually and when a change in the member's condition occurs

- The FSSA Division of Family Resources (DFR) makes eligibility determinations. Nursing facility LoC is determined based on state law and administrative rule.

Long-Term Care Functional Screen (Section 2.1.2)

Stakeholder Feedback

- Use InterRAI for Level of Care (LoC) assessment system and MCE should not conduct the LoC assessment

Addressed in the SoW

- Functional eligibility is determined using the InterRAI-HC assessment
- State will notify the Contractor of any changes in functional eligibility criteria

MCE Assignment
(SoW Section 2.1 Eligibility and Exhibit 4 Section 3.2)

Stakeholder Feedback

- Consider nursing facility or assisted living community residence for MCE assignment
- Consider D-SNP alignment for MCE assignment
- Flexibility for members to change plans

Addressed in the SoW Exhibit 4

- Favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable).
- Auto-assignment procedure subject to federal requirements
- Members can change a health plan:
  - within sixty (60) days of starting coverage,
  - at any time their Medicare and Medicaid plans become unaligned
  - once per calendar year for any reason,
  - at any time using the just cause process
  - during a plan selection period which will be aligned with the Medicare open enrollment window (mid-October to mid-December) to be effective the following calendar year.

NCQA Accreditation (SoW Section 2.3)

Stakeholder Feedback

- Interested in MCE accreditation authority and who is providing independent/third party oversight (related to operations)

Addressed in the Sow

- The Contractor shall be an accredited Health Plan by the National Committee for Quality Assurance (NCQA) with the LTSS Distinction
- NCQA is a widely recognized, evidence-based program dedicated to quality improvement and measurement. It provides a comprehensive framework for organizations to align and improve operations in areas that are most important to consumers, states, and employers. It's the only evaluation program that bases results on actual measurement of clinical performance (HEDIS® measures) and consumer experience (CAHPS® measures)
- The LTSS distinction goes further by focusing on person-centering planning, care transitions, coordination of services, critical incident management systems, and qualifications and assistance for LTSS providers

Key Staff, Other Required Staff, Staff Training (SoW Section 2.4.1 - 2.4.3)

Stakeholder Feedback

- MCEs must have experience with the LTSS population
- MCEs should require a portion of staff to be local
- MCEs must have a local plan liaison for providers

Addressed in the SoW

- MCEs shall have staff in all operational areas (e.g., member services, provider services, claims) with experience in LTSS and geriatrics.
- Additionally, the MCE shall employ a staff geriatrician and require all care managers, service coordinators, and utilization management staff working on this program to have experience with LTSS and working with the program population.
- All team members who OMPP marks as key staff including the CEO, CFO, and Medical Director, are required to be local
- MCEs are required to have a local Care/Service Coordinators, Transition Coordinators, Provider Representatives, and Provider Claims Educators

Supplemental Payments (SoW Section 2.8.3)

Stakeholder Feedback

- The UPL program should use a pass-through payment approach for the initial three years of managed care and then transition to a directed payment approach

Addressed in the SoW

- Payments for the Nursing Facility Upper Payment Limit (UPL) supplemental program will not be integrated into the capitation payment. Payments will be made through either pass-through payments or State-directed payments.
- The intricacies of the UPL/supplemental payment will continue to be discussed in the finance workgroups being led by Kathy Leonard

Minimum Fee Schedule (SoW Section 2.8.4)

Stakeholder Feedback

- MCEs reimburse Nursing Facilities and HCBS providers based on the state fee schedule for 5 years

Addressed in the SoW

- In and out of network Skilled Nursing Facility, Home Health, Hospice and HCBS providers shall be reimbursed at no less than Fee for Service rates (i.e., a rate established by OMPP) for the first five years of the program.

Subcontracts (SoW Section 2.9)

Stakeholder Feedback

- Concerns regarding subcontracting for utilization management (UM)

Addressed in the SoW

- Subcontractors must comply with MCE contract (including experience with LTSS and/or older adults) and federal and state rules and regulations
- MCE must provide 90-days notice to FSSA prior to use of a subcontractor with a written plan on continuity of services during any transition. FSSA must approve vendor changes.
- Medical utilization management may not be subcontracted, with the exception of dental, vision, and pharmacy
- Annual subcontracting reports required
- Encourage subcontracting with entities located in Indiana

Integration and Alignment of Medicare and Medicaid (Section 2.21)

Stakeholder Feedback

- Foster aligned experience for dually-eligible members
- Establish a single point of contact that works across Medicaid and Medicare

Addressed in the SoW

- The MCE is responsible for coordinating all Medicare and Medicaid services for its full-benefit dually-eligible members, including conducting single assessments for care coordination and ensuring members have access to both DSNP and MCE benefits.
- The MCE is responsible for providing continued member, provider, and staff education and assistance pertaining to Medicare and Medicaid and their interactions.
- The MCE and DSNP will have a single unified member benefit card within the first year of the program

Wrap-up

- The LTSS Reform webpage is located at: https://www.in.gov/fssa/long-term-services-and-supports-reform/home/
- ADvancing States will be kicking off the next round of MLTSS engagement and business acumen work. Keep an eye on your inboxes
- Questions about readiness and implementation? Engagement? Next steps? Backhome.indiana@fssa.in.gov

Workgroup Next Steps

- Next stakeholder sessions:
  - April 7, 2022 at 11:00 am. Near-final Scope of Work excerpts will be sent and posted on April 5th. Topics we plan to include: Services, Caregiver Supports, Continuity of Care, and Care Coordination
  - April 14, 2022 at 9:30 am
  - April 19, 2022 at 12 pm
  - April 27, 2022 at 12 pm