Deliberative and Confidential

Managed Long Term Services and Supports (mLTSS) Stakeholder Update

January 14, 2022

Agenda

- LTSS reform recap & status update
- Updates on the following topics:
  - Care and service coordination
  - Member appeals and grievances
  - Updated RFP timeline
- Next steps and upcoming meetings

Why Reform Indiana's LTSS System?

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%. Indiana's disjointed system must be reformed to meet growing demand and to ensure Choice, drive Quality and manage Cost.

Choice: Hoosiers want to age at home

- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home*
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing long-term sustainability

- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers deserve the best care

- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

*Accurate as of January 2020

Indiana Family & Social Services Administration FSSA

Indiana's Path to Long-term Services and Supports Reform

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

Key Results (KR*) to Reform LTSS

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. Recruitment, retention, and training of direct support workforce

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Care Coordination and Service Coordination Philosophy and Goals

- Incorporates our MLTSS goals (11/19 meeting):
  - Person-centered supports and services
  - Ensuring smooth transitions
  - Access to services
- Additionally:
  - Strengths-based
  - Alignment across Medicaid-Medicare for members who are duals
  - Interdisciplinary
  - Promotes member choice
  - Inclusive of caregivers

Care Coordination and Service Coordination Overview

Service Type	Description
Care Coordination	• Members will receive holistic, person-centered **Care Coordination** reflective of their medical, physical, and cognitive needs. • Care Coordination services will focus on assisting members in planning, accessing, and managing their health care and health care-related services.
Service Coordination	• All members who are NFLOC and receive HCBS or institutional LTSS will be eligible for **Service Coordination** for their LTSS and LTSS-related environmental and social services. • Service Coordination focuses on assisting members with LTC, medical, social, housing, educational, and other services, regardless of their funding sources. • Service Coordinators work with and supplement members' Care Coordinators and care teams to ensure LTSS is integrated into the member's overall care and that service delivery is seamless.

Care Coordination and Service Coordination: Member Choice

- Care Coordination services shall be provided to all members unless they specifically ask to be excluded.
- MCEs shall not engage in any activities that encourage members to exclude themselves from Care Coordination or LTSS-specific Service Coordination.
- Both Care Coordination and Service Coordination will be person-centered, and members can choose who participates in assessments, care planning activities, and care team meetings, as applicable.
- Additionally, members will have the opportunity to opt-out or otherwise reduce the frequency of contacts made by Care Coordinators and Service Coordinators to reflect their personal preferences and needs.

Care Coordination: Levels of Service

- There will be a minimum of two Care Coordination levels of service based on member needs:
  - **Care Management** - available to all members
  - **Complex Case Management** - available to high-risk/high-need members and those receiving HCBS
- The State will define who qualifies for the more intensive Complex Case Management, although MCEs may extend Complex Case Management services to other members.
- At a minimum, members will be reassessed on an annual basis and upon a change in health status to address their changing needs and the appropriateness of their Care Coordination assignment.
- Both Care Coordination levels of service will have minimum member contact requirements, but members will be able to opt out or request a reduced frequency of these contacts.

Care Coordination: Interdisciplinary Approach

- For members in Complex Case Management, an MCE must use an interdisciplinary care team (ICT) to plan and deliver care. ICTs will include at a minimum:
  - The member
  - The member's Care Coordinator
  - The member's Service Coordinator (applicable only for members who are NFLOC or receive LTSS)
  - Any member-selected supports, <u>including informal caregivers</u>

- Based on the member's specific needs, MCEs must incorporate or make additional expertise and resources available to the ICT, which could include the member's:
  - PMP, physicians/NPs, facility care team (if in an institutional setting), PTs, OTs, speech/language therapists, nutritionists/dieticians, pharmacists, and mental health specialists

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Care and Service Planning Process Overview

Screening and Assessment

- Standardized comprehensive assessment covers the member's functional needs and social determinants of health
- Additional LTSS-specific screenings and assessments will be based on the member's specific needs and circumstances
- Standardized caregiver assessment
- Informs "stratification," meaning it helps identify members needing the more intensive complex case management
- May be conducted in person
- All LTSS and NFLOC members receive service coordination
- This assessment is separate from a NF/LTSS Level of Care determination performed independent of MCE (but could result in a referral for a level of care determination if additional needs are identified)
- Reassessments occur at a defined interval or if circumstances dictate (change in status)

Individualized Care Planning

- A detailed, person-centered, strengths-based **care plan** is developed with the member, caregiver, and members of ICT, as applicable
- Describes members' needs and preferences and how they will be addressed
- For those members receiving LTSS or that have NFLOC, a person-centered **service plan** is also developed with the member in coordination with individualized care plan. This plan includes identifying, coordinating, and assisting members in gaining access to LTSS services. Services included in completed service plans do not require additional prior authorization.

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Care Coordination: Medicaid and Medicare Alignment

- To increase alignment for dual-eligible members, MLTSS care coordination requirements will align with CMS guidelines for Medicare Advantage Dual Special Needs Plan (D-SNP) Models of Care (MOC).
- A dual-eligible member's Care Coordinator will be responsible for coordinating with all Medicare payors, Medicare Advantage plans, and Medicare providers as appropriate to coordinate their care and benefits.
- For members in an MCE's aligned, companion D-SNP, staff will have access to all of the information needed to coordinate the members' dual benefits, and the MCE's systems and business process should support an integrated MLTSS/Medicare approach.
  - Further administrative integration–between an MCE's MLTSS program and companion D-SNP–is expected to evolve over the life of the MLTSS program.

Care & Service Coordinator Qualifications and Training

Service Type	Description
Qualifications	Care coordinator: registered nurse, Master's in social work, Bachelor's in social work with at least 2 years of experience. Also require experience in working with elderly or persons with I/DD Service coordinator: registered nurse or licensed practical nurse, Bachelor's degree in social work, psychology, or other related fields with practicum experience <u>or</u> associate's degree with one year of experience delivering healthcare/social services or case management, <u>or</u> at least 2 or more years in care planning, care management, or delivering healthcare or social services
Training	Examples of training elements that must be included (this is not a complete list): • Person-centeredness • Advanced care planning • Recognizing, screening and monitoring for quality-of-care concerns, abuse, neglect, and exploitation • Member rights and responsibilities • Continuum of services available including self-direction • Cultural competency

Member Grievances and Appeals with MCEs

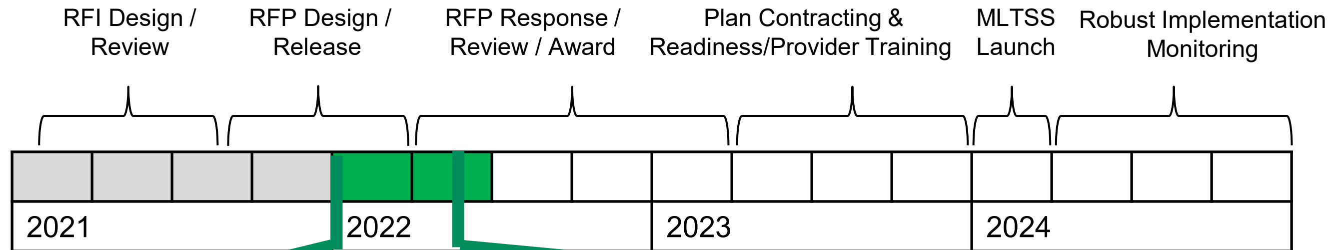
- Members, individuals on behalf of members (including providers, ombudsman, advocacy organizations, or family/caregiver), and authorized representatives can submit a grievance or appeal
- Processes in place at each plan for a member (or their authorized representative) to file a grievance or appeal related to the services provided by their MCE
  - MCEs must have an expedited review process, and members will have access to an external grievance process, and the State's fair hearing system
- Each plan must have a FSSA approved plan for grievances and appeals
- FSSA will have strong oversight of the appeals and grievances processes:
  - Each MLTSS plan will be required to employ an Appeals and Grievances Manager fully dedicated to the Indiana MLTSS plan
  - Performance of grievances and appeals processes will be incorporated into FSSA's quality strategy with the MCEs. MCEs will be required to routinely review grievance and appeal data to determine how to improve the member experience

Update: mLTSS Timeline

Milestone	Timeframe*
Request for Information (RFI) Co-Design Workgroup	Jan. 2021 to Early-Summer 2021 (Complete)
RFI Release	July 12, 2021 (Complete)
RFI Responses Received and Reviewed	Late-Summer/ Early-Fall 2021 (Complete)
Continued Stakeholder Engagement on Design Topics	Fall-Spring 2021 – 2022 (Ongoing)
Request for Proposal (RFP) Release	May 2022 to ensure adequate time to incorporate all stakeholder inputs
RFP Award	Early 2023 (Q1)
Contracting/ Readiness/ Implementation	2023
mLTSS Implementation	Q1 2024
Public forums/webinars	Will be held and stakeholder engagement will continue past the implementation

*All dates are estimates and subject to change.

Updated Managed LTSS Timeline



January February	March April	May
• Continue discussion with stakeholders and reconfirm design recommendations, and provide updates • Review Indiana's existing managed care contracts highlighting standard language and protections • Draft capitation payment rates • Launch provider training informed by ADvancing States environmental scan		• Release Request for Proposal (RFP). • Continue provider training to continue all the way through 2024

Workgroup Next Steps

- Feedback can be submitted to the Back Home inbox (backhome.indiana@fssa.in.gov)
- FSSA will update and share policy decision log
- Continued discussions with stakeholders