Managed Long Term Services and Supports (mLTSS) Stakeholder Update

November 9, 2021

Agenda

- LTSS reform recap & status update
- Updates on the following topics:
  - mLTSS staff experience requirements
  - Plan selection and assignment
  - Population specific oversight functions
  - Reporting requirements
  - MCE subcontracting standards
- 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, manage Cost, and drive Quality.

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'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

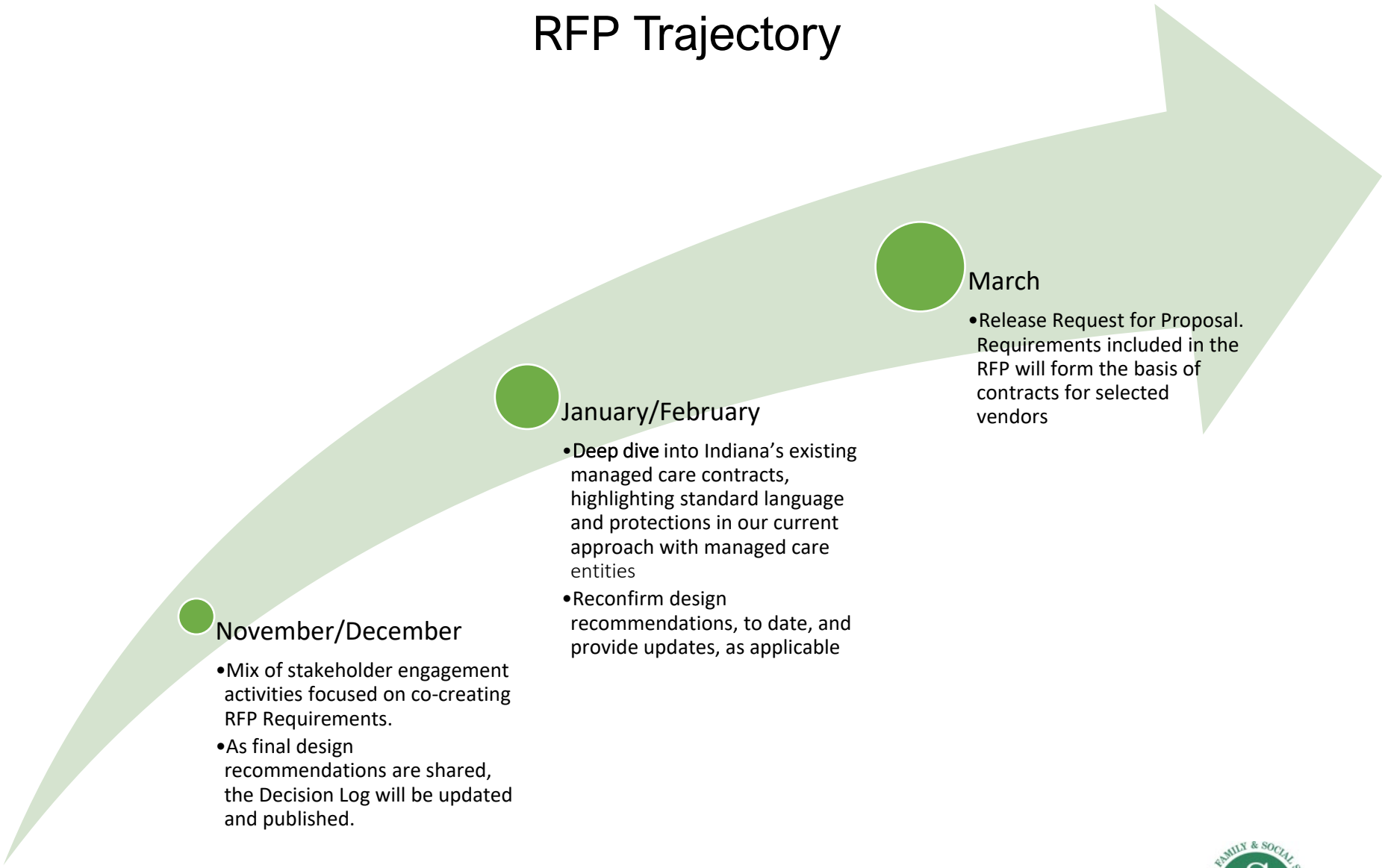
1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state
5. Recruitment, retention, and training of workforce objective (in development - updates to come)

Recap: 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-Winter 2021 – 2022 (Ongoing)
Request for Proposal (RFP) Release	Early 2022 (Q1) to ensure adequate time to incorporate all stakeholder inputs
RFP Award	Late 2022 (Q4)
Contracting/ Readiness/ Implementation	Late 2022 through 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.

RFP Trajectory



November/December

- Mix of stakeholder engagement activities focused on co-creating RFP Requirements.
- As final design recommendations are shared, the Decision Log will be updated and published.

January/February

- Deep dive into Indiana's existing managed care contracts, highlighting standard language and protections in our current approach with managed care entities
- Reconfirm design recommendations, to date, and provide updates, as applicable

March

- Release Request for Proposal. Requirements included in the RFP will form the basis of contracts for selected vendors

*All dates are estimates and subject to change.

mLTSS Staff Experience & Access Requirements

FSSA broadly agrees with stakeholders that key mLTSS staff must have LTSS experience.

Key concepts:

- MCEs must have staff and leadership with LTSS experience and subject matter expertise. FSSA will also expect the MCE to have a geriatrician on staff.
- Care management staff must meet specific experience and/or education requirements (*topic for future presentation)*
- Key Staff named in the contract (e.g., CEO and Chief Medical Officer) must be located within the state of Indiana. In addition, the majority of customer service, care management, provider relations and utilization management staff must be located in Indiana
- FSSA is exploring requirements related to local MCE provider relations teams
- MCEs will be expected to have a housing coordinator on staff who can work with care managers to assist members in finding appropriate housing (*as noted earlier in this presentation)*

Managed Care Entity (MCE) Choice & Assignment

A foundational concept of managed care is the member selects the plan into which they want to enroll. States must have a process in place to assign members to a plan if they do not select one after becoming eligible.

Member Choice and Assignment Principles	
Topic	**Key Principles**
Member Choice of Plan	First and foremost, members have the option to select their mLTSS plan.
Auto-Assignment	There is an assignment process in place for members that do not select a plan on their own
Initial Assignment	The plan a member is assigned to is based on their choice or auto-assignment.
Change of Plans	Members enrolled in managed care have the ability to switch health plans under a defined set of circumstances

Managed Care Entity (MCE) Assignment & Enrollment

If a member does not select a plan there will be an assignment process in place. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable.

Member Enrollment Profile	Key Enrollment Details
New Medicaid Members	• MCE assignment will be effective on the date of eligibility approval • Medicaid coverage may be effective up to 3 months retroactively from their application date
Members Transitioning from Another Medicaid Program	• MCE assignment will be effective the first day of the month following the notice of change in eligibility
Members with a Need for HCBS	• When a new Level of Care (LOC) is established, health plans will be required to provide additional HCBS services in the month the LOC was determined

Plan Changes After Enrollment

To ensure members are satisfied with their health plans, individuals will have the chance to change a health plan:

- Within 60 days of starting coverage
- Any time their Medicare or Medicaid plans become unaligned
- Once per calendar year for any reason
- During the Medicare open enrollment window (mid-October – mid-December) to be effective the following calendar year
- At any time for "just cause" (42 CFR 438.56(d)(2)(iv)) such as but not limited to:
  - Receiving poor quality of care
  - Failure of plan to provide covered services
  - Failure of plan to comply with established standards of medical care administration
  - Significant language or cultural barriers
  - Corrective action levied against the plan
  - Limited access to primary care or other health services in reasonable proximity
  - Determination another plan's formular is more consistent with a member's need
  - Lack of access to medically necessary services

Population Specific MCE Oversight Functions

Many of the Waiver oversight functions in place today are to protect members and will continue under managed care in a shared responsibility between the State and MCEs.

Oversight functions	
Self-direction	MCEs will be required to provide the functionality to offer self-direction on attendant care (or any other service DA adds to self-direction before 2024).
Settings rule	MCEs will be accountable to assure providers meet requirements of the Settings Rule.
Incident reporting	MCEs will be responsible for completing and/or requiring incident reporting, typically monthly and/or quarterly.
Quality Improvement Strategy (QIS) reporting	MCEs will be required to implement QIS and provide QIS reports to OMPP compliance, with the expectation that MCEs reports will be leveraged for required State reporting to CMS.

Population Specific MCE Oversight Functions Cont'd

Oversight functions continued	
Compliance review	MCEs will be responsible for monitoring provider compliance, addressing and reporting compliance issues.
Mortality review team and committee	MCE will be required to be an active part of the State's mortality review committee for waive recipients
Waiver slot tracking	Expect mLTSS quarterly and annual reports from MCEs that can be leveraged to support required CMS reporting on available waiver slots.
Housing supports	MCEs will be expected to have a housing coordinator on staff who can work with care managers to assist members in finding appropriate housing.

Standard Managed Care Reporting Requirements

The State closely monitors MCEs in current programs and MCEs will be required to provide comprehensive reporting on a monthly or quarterly basis.

Standard Managed Care Reporting Areas	
Claims and encounters	Utilization
CAHPS survey summary	Prior authorization
Grievances and appeals	Network development and access
Call center/helpline performance metrics	Quality management and improvement
Select HEDIS outcomes measures	Program integrity

Additional MLTSS Reporting Requirements

mLTSS Additional Reporting Requirements	
Topical Area	Type of Information Needed
Level of care (LOC)	Number of LOC assessments completed by MCE, number of referrals to the LOC vendor, and number of referrals that are confirmed or denied
Nursing facility	Number of placements (skilled or LTC), transitions out of NF to community (Skilled or LTC), transitions to Assisted Living, and Length of Stay prior to transition
Self-direction	Number of people utilizing the service
Waiver slot tracking	Recipient identification numbers (RIDs) of unique individuals with paid claim in the waiver year
Settings rule compliance indicators	MCEs must report any instances of non-compliance along with remedy to the issue
Incident reporting	Report on all instances of incidents, trends, and interventions to reduce incidents
HCBS provider network	Mirror current provider enrollment reporting but add standards for Hospice, Home Health, and nursing facility (vent dependent)

Additional mLTSS Reporting Requirements Cont'd

mLTSS Additional Reporting Requirements	
Topical Area	Type of Information Needed
1915(b) and 1915 (c) waiver reporting	Any reporting required by the waivers, including Quality of life survey
Grievance and appeals (G&A)	Incorporate Medicare advantage G&A to existing reports
Utilization of HCBS services	Services utilized per HCBS member/per month, people who transitioned out of nursing facilities, and how many units/what services people are using for Health Days at Home
Care coordination and service coordination	Case loads, number of assessments, care plans developed, and time from care plan development to service delivery
Enrollment services vendor interaction	Time to follow up after level of care determination, timely re-auth of level of care
Q1 reporting	mLTSS MCEs will be required to implement QIS and providing QIS reports to OMPP compliance, expectation that MCEs reports will be leveraged for required CMS reporting
Compliance review	mLTSS MCEs are responsible for monitoring provider compliance, addressing and reporting compliance issues
Mortality reporting	mLTSS MCEs will be required to report mortality rates

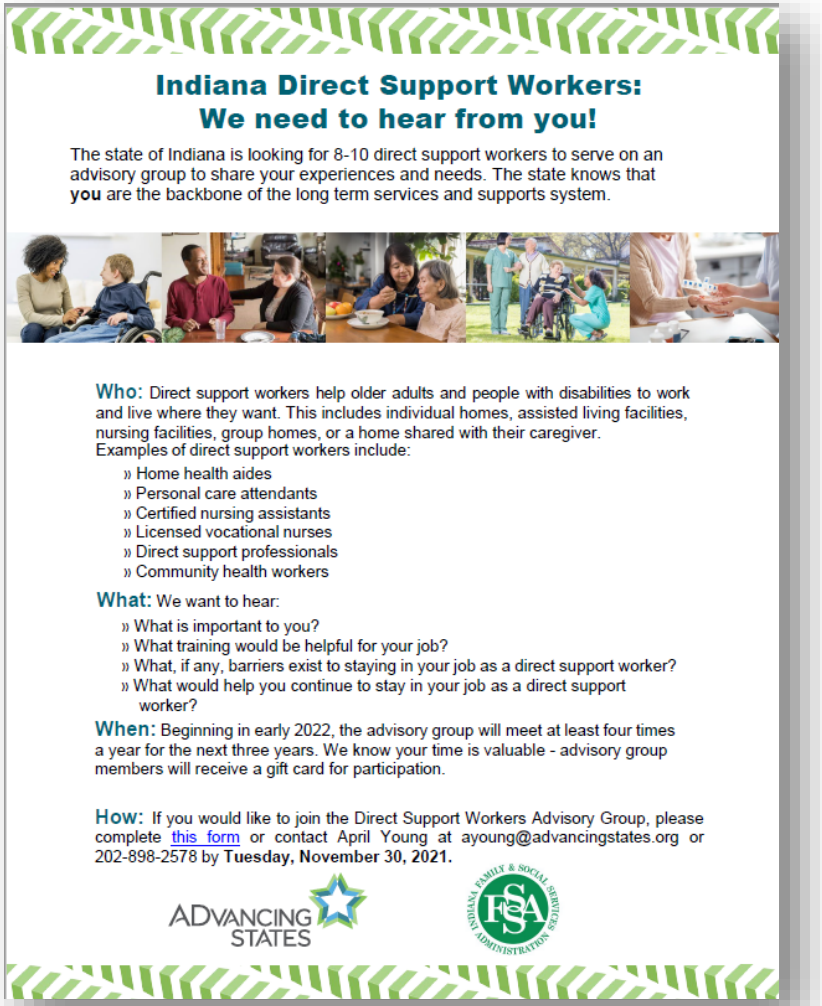
Subcontracting Standards

The State recommends the following contracting safeguards:

- FSSA health plans cannot subcontract without first requesting approval from FSSA at least 60-days in advance. Additionally, plans must submit annual subcontractor reports to the State including information on performance and member outreach.
- FSSA can consider certain prohibitions related to subcontracting specific functions, such as prior authorization.
- MCE subcontractors must comply with State of Indiana standard Terms and Conditions as would be required for any vendor. MCE subcontractors must adhere to all provisions in the contract between FSSA and the MCE.
- The Indiana Department of Administration, per Indiana Code, requests that vendors seek minority, women, and veteran subcontractor partners as part of the bidding process

Direct Support Worker Advisory Committee

Launching in 2022 -
Help us recruit!



Indiana Direct Support Workers: We need to hear from you!

The state of Indiana is looking for 8-10 direct support workers to serve on an advisory group to share your experiences and needs. The state knows that **you** are the backbone of the long term services and supports system.

Who: Direct support workers help older adults and people with disabilities to work and live where they want. This includes individual homes, assisted living facilities, nursing facilities, group homes, or a home shared with their caregiver.
Examples of direct support workers include:

- Home health aides
- Personal care attendants
- Certified nursing assistants
- Licensed vocational nurses
- Direct support professionals
- Community health workers

What: We want to hear:

- What is important to you?
- What training would be helpful for your job?
- What, if any, barriers exist to staying in your job as a direct support worker?
- What would help you continue to stay in your job as a direct support worker?

When: Beginning in early 2022, the advisory group will meet at least four times a year for the next three years. We know your time is valuable - advisory group members will receive a gift card for participation.

How: If you would like to join the Direct Support Workers Advisory Group, please complete this form or contact April Young at ayoung@advancingstates.org or 202-898-2578 by **Tuesday, November 30, 2021.**

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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
- Next meetings:
  - November 19, 2021
  - December 1, 2021
  - December 8, 2021
  - December 16, 2021