Managed Long Term Services and Supports (mLTSS) Stakeholder Update

December 1, 2021

Agenda

- LTSS reform recap & status update
- Updates on the following topics:
  - Network participation
  - Network adequacy
  - Continuity of care
  - Prior authorization
  - Provider claims payment
- 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'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

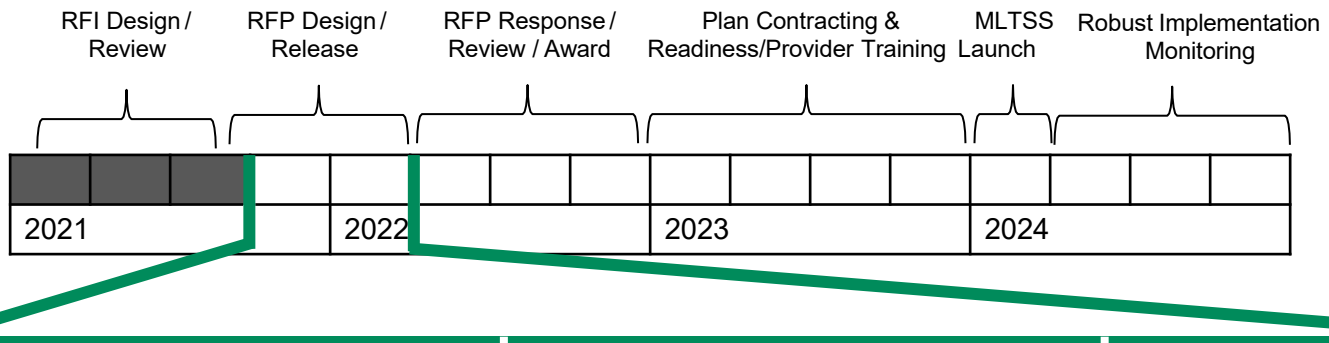
1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state
5. Recruitment,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

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.

Managed LTSS Timeline



November December	January February	March
• Discuss RFP requirements with stakeholders: - Quality Framework - Provider Protections - Member Protections - Intake and Care Coordination • Comprehensive RFI completed • Draft capitation payment rates	• Review Indiana's existing managed care contracts highlighting standard language and protections • Reconfirm design recommendations, and provide updates • Develop provider training materials based on results of ADvancing States' environmental scan	• Release Request for Proposal (RFP). • Begin provider training to continue all the way through 2024

Managed Care Principles and Protections: Commitment to Quality Providers

Principle	Additional Detail
Commitment to Quality Providers	FSSA health plans may only credential providers who are enrolled with the Indiana Medicaid program (IHCP).

Network Participation: Enrollment & Credentialing Recommendations

Topic	Recommendation
Enrollment	• All providers must enroll as an Indiana Health Coverage Programs (IHCP) provider in order to provide care to a Medicaid recipient • HCBS providers will still be required to meet criteria established by the Division of Aging in order to be certified. The process for being certified will be updated to reflect the addition of managed care and the MCE will have a role in assuring that HCBS providers meet certification criteria
Credentialing (Network Participation)	• FSSA has been focused on reviewing the network participation process as part of our managed care alignment initiative – standardization of forms, timelines, and documentation • FSSA – via ADvancing States – will support LTSS providers by providing training and TA ahead of the managed care go-live

Network Participation: Provider Credentialing, & Contracting Recommendations Cont'd

Topic	Recommendation
MCE & provider contracts	• State must approve agreements between the MCE and their providers. State provides some standard provisions • MCEs are not allowed to limit who their providers contract with and cannot ask providers to sign exclusive agreements to work only with select MCEs • FSSA – through ADvancing States – will provide training and technical assistance to providers to assist with the contracting process in 2023

Network Adequacy Recommendations

Topic	Recommendation
Network adequacy – at Go-live & Ongoing	• Goal is to ensure members have access to safe & quality services in or near their communities of origin. Managed care entities must be network adequacy standards • Primarily will mirror existing managed care contracts for most medical providers • New network adequacy standards will also be developed for LTSS providers • Network adequacy standards consider geography (e.g., rural vs. urban)
"Out-of-network" Access	• Members can seek care at any Indiana Medicaid provider and have no difference in cost sharing. FSSA will include contract language that prohibits out-of-pocket for out of network providers (as long as the provider is an Indiana Medicaid provider and service is covered and approved)
Network Data & Reporting	• OMPP evaluates network adequacy using actual member utilization and travel data through our federally required External Quality Review (EQR). EQR will continue under on mLTSS • Currently post and will continue to post the EQR results publicly • CMS is publishing new requirements

Managed Care Principles and Protection: Continuity of Care

Principle	Additional Detail
Provider Choice and Continuity of Care	Federal and state rules require members to have a choice of providers and settings and access to services in a timely manner. Currently Hoosier Care Connect health care plans must ensure that members have continuity of care with previous Medicaid enrolled (IHCP) providers and honor past authorizations for at least 90 days. FSSA is moving towards requiring this as a minimum standard for all programs.

Continuity of Care at Go-Live Recommendation

Type of Transition	Recommendation
Program Go-Live	At the launch of the new MLTSS program, a member who has a medical prior authorization issued by the FFS Medicaid program or other Medicaid MCE will have that PA honored by their new MCE for one of the following durations, whichever comes first: • The first 120 calendar days, starting on the member's effective date in the new plan • The remainder of the PA dates of service • Until approved units of service are exhausted A member with an approved Care Plan will have that care plan honored for 180 days.

Continuity of Care - Ongoing Operations Recommendations

Type of Transition	Recommendation
On-Going Program Operations	A member who has a medical prior authorization issued by the FFS Medicaid program or other Medicaid MCE will have that PA honored by their new MCE for one of the following durations, whichever comes first: • The first 90 calendar days, starting on the member's effective date in the new plan • The remainder of the PA dates of service • Until approved units of service are exhausted A member with a Care Plan approved by any MCE will have that honored for 90 days.

Continuity of Care - Ongoing Operations Recommendations Cont'd

Type of Transition	Recommendation
Nursing Facility Admissions and Discharges	When an MLTSS member needs to be admitted to a nursing facility, MCEs will be required to mirror state FFS long-term care policy regarding Level of Care Level I, Level II and PASRR screening. The MCE must coordinate care for its members that are transitioning into long-term care by working with the facility. The MCE is responsible for payment (for up to 60 days) for its members placed in a long-term care facility while the level of care determination is pending. When a member is being served in a residential facility and loses LOC or is ready for discharge, the MCE must continue coverage until a safe and successful transition is complete. A specific process will be determined.

Managed Care Principles and Protection: Service Authorization

Principle	Additional Detail
Service Authorization Timeframes	To ensure services are authorized in a consistent, efficient, and timely manner, FSSA health plans are required to meet standard authorization timeframes and process requirements. This includes using a standard authorization form.

Prior Authorization & Utilization Management Recommendations

Topic	Recommendation
Commitment to Best Practices	• Plans required to meet national NCQA standards or a more stringent Indiana standard
Reduction of provider abrasion	• Require standard prior authorization processes • Current prior authorization timeliness standards including for urgent/emergent situations: 7 days standard, 72 hours expedited/urgent pre-service, 24 hours concurrent • Forbid retraction of previously approved prior authorizations
Services in approved LTSS Care Plan	Will <u>not</u> require additional prior authorization
Access to Hospital and Nursing Facility Care	• The State supports member choice • State will establish standard processes for determining necessity in light with national and Indiana medical guidelines
Emergency Services	• State utilize a prudent layperson standard for covering emergency services (IC 12-13-12)

Level of Care Determinations & Care Plans approvals for Long-Term Services and Supports are not synonymous with prior authorization.

Provider Claims Payment Recommendations

Principle	Additional Detail
Provider Payment	FSSA health plans are required to pay claims within the same timeframe as fee-for service. Plans issue provider payments at least weekly.

Topic	Recommendation
Prompt Payment Standards	OMPP currently requires and will continue to require the following in our managed care contracts: • Plan will pay or deny electronically filed clean claims with 21 calendar days of receipt • Plan will pay or deny paper clean claims within 30 calendar days of receipt • Plan must pay the provider interest for failure to pay clean claims timely per IC 12-15-21-3(7)(A)
Denial of Claims	• Provider may dispute claims payment with the plan • NCQA and state laws govern the dispute process • State will handle complaints regarding MCEs failure to resolve disputes over claims

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:
  - December 8, 2021
  - Postponed due to the 12/16 Medicaid Forecast. Will send a new invite for early January.