PathWays Stakeholder Update

April 18, 2024

Presented by the Family and Social Service Administration (FSSA)

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Long-Term Services and Supports (LTSS) Reform Goals

- Faster eligibility
- Move to Managed Long Term Services and Supports (MLTSS), also known as **Indiana PathWays for Aging** in July 2024
- Pay for outcomes, not transactions
- Integrate LTSS data systems
- Support the growth, retention and training of the direct service workforce
- Create Home Health Roadmap
- Integrate HCBS waivers

Indiana PathWays for Aging Overview

Managed Long-Term Services and Supports (MLTSS)

- MLTSS is a delivery system that uses managed care entities (MCEs) to coordinate medical care and long-term services and supports (LTSS) to enrolled Medicaid beneficiaries
- Indiana has introduced an MLTSS program for Medicaid-eligible Hoosiers 60+ called **Indiana PathWays for Aging**
- Enrollment in PathWays is officially underway
- MCEs participating in PathWays will deliver acute and preventive care services as well as Home and Community-Based Services (HCBS) and Nursing Facility (NF) services

What is IN PathWays for Aging?

Indiana PathWays for Aging is a managed **Medicaid** program launching **July 1, 2024.**

- Person-Centered Services and Supports
- Ensuring Smooth Transitions
- Access to Services

PathWays members can choose one of three Managed Care Entities (MCEs) (health plans):

- Anthem
- Humana
- UnitedHealthcare

Who is Eligible?

Indiana residents who are Medicaid enrollees that meet the following requirements:

- 60 years of age and older
- Eligible for Medicaid based on age, blindness, or disability

It may also include individuals:

- Eligible for full Medicare benefits (dually eligible)
- Residing in a nursing facility
- Individuals receiving home and community-based services (A&D Waiver)

Who is not eligible:

- Anyone aged 59 and under
- Partial Medicare benefit dually-eligible
- DDRS waiver recipients (including TBI waiver)
- I/DD residents in an ICF
- PACE recipients
- RCAP, ESRD Waiver, MA-12, ESO Family planning only, MAGI, TBI out of state.

What are the benefits covered by PathWays?

All Members

- 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

Dual Eligible Members*

*Medicare pays primary if also a covered Medicaid service. Medicaid pays Medicare Part B premiums and/or cost-sharing.

Part A: Hospital care, short term SNF, hospice, labs, surgery, short term home health

Part B: Physician/provider visits, medical, preventive care, DME, behavioral health, limited outpatient prescription drugs

Part D: Prescription drugs

Part C (Medicare Advantage plan/D-SNP): If member is enrolled in a Medicare Advantage plan or D-SNP, Part A/B and usually Part D benefits and services are covered by the plan. These plans also provide supplemental benefits like OTC drugs, fitness/wellness programs, vision, dental, home delivered meals, and/or other service

How will PathWays support Members?

- *<u>Enrollment Broker:</u> To help members choose a managed care entity, just call 877-284-9294*
- *<u>Care Coordinator</u>: To support member health care needs*
- *<u>Service Coordinator</u>: To support member waiver needs*
- *Assistance with navigating both Medicaid and Medicare benefits*
- *<u>Member Support Services Vendor*:</u> Helps members or caregivers resolve issues they may experience while enrolled in PathWays*

* This is in addition to the Long-Term Care Ombudsman

What is a Care Coordinator and Service Coordinator?

- A Care Coordinator is a person who may contact you to create a personalized care plan based on your preferences and needs. They can also help answer questions about your health care and help you with your providers.
- A Service Coordinator is a person who will work with you to create a personalized Service Plan to help coordinate your Home and Community-Based Services. The Service Plan will help develop a plan of care of services and supports that best meet your needs and goals

PathWays Member Video

PathWays Enrollment

Enrollment Activities Timeline

FEB - MAR 2024

- Member receives Plan Selection Notice from Enrollment Broker for PathWays
- Members in a Nursing Facility or receiving HCBS via waiver will receive phone calls from the Enrollment Broker to select a plan

MAR – APR 2024

- Ongoing member calls to make plan selection. If no plan is selected by the end of April 2024, the member will be auto-assigned in May.

MAY 2024

- Members receive Path-Ways Implement ation notice plan benefit and contact information

JUNE 2024

- Member receives Welcome Packet from assigned Plan (June 2024)

JULY 1, 2024

- PathWays coverage becomes effective (and changes from fee-for-service or Hoosier Care Connect)

How to Enroll?

Current enrollees were sent an enrollment letter in the mail. All letters were mailed in late February and during the month of March.

In that letter they will find the Indiana PathWays for Aging Helpline number that they can call to enroll in a health plan that best meets their needs **87-PATHWAY-4 (1-877-284-9294)**

Individuals can call the helpline and ask or go to the health plans website to research which providers are in that health plan's network.

Individuals must call and enroll in a health plan by **the end of April 2024.**

What Members Need to Enroll

- Members should have the following available before calling the helpline to enroll in a plan
  - Medicaid ID or SSN (can use case #)
  - The correct phone #, address and DOB on file with FSSA
  - Primary medical provider
  - Waiver Service provider(s)
- Since providers and plans are still in the contracting process, provider directories will continue to be updated so it's important to remember that all MCEs will have an open network until network adequacy is met
- The template letters are available on the website at www.in.gov/Pathways

What happens if a Member doesn't pick an MCE?

- If a member doesn't pick a health plan, they will be automatically assigned to one and notified of this in May.
- Members will have the chance to change their PathWays health plan:
  - within 90 days of starting coverage,
  - at any time their Medicare and Medicaid plans are not the same,
  - once per calendar year for any reason,
  - at any time using the just cause (e.g. poor quality of care); and
  - 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

How Providers and AAAs can Educate, Explain and Assist Members

- Remind members of the change coming in July and what that means for their waiver services
  - Access to all the same benefits they get now plus enhanced benefits
- Explain the specific letter that your client received
- Consult with the authorized representative prior to assisting a member with their enrollment call
- Have the enrollment broker phone number on hand, and assist members in contacting the enrollment broker
  - 87-PATHWAY-4 (877-284-9294)
  - The helpline is open M-F 8am-7pm ET

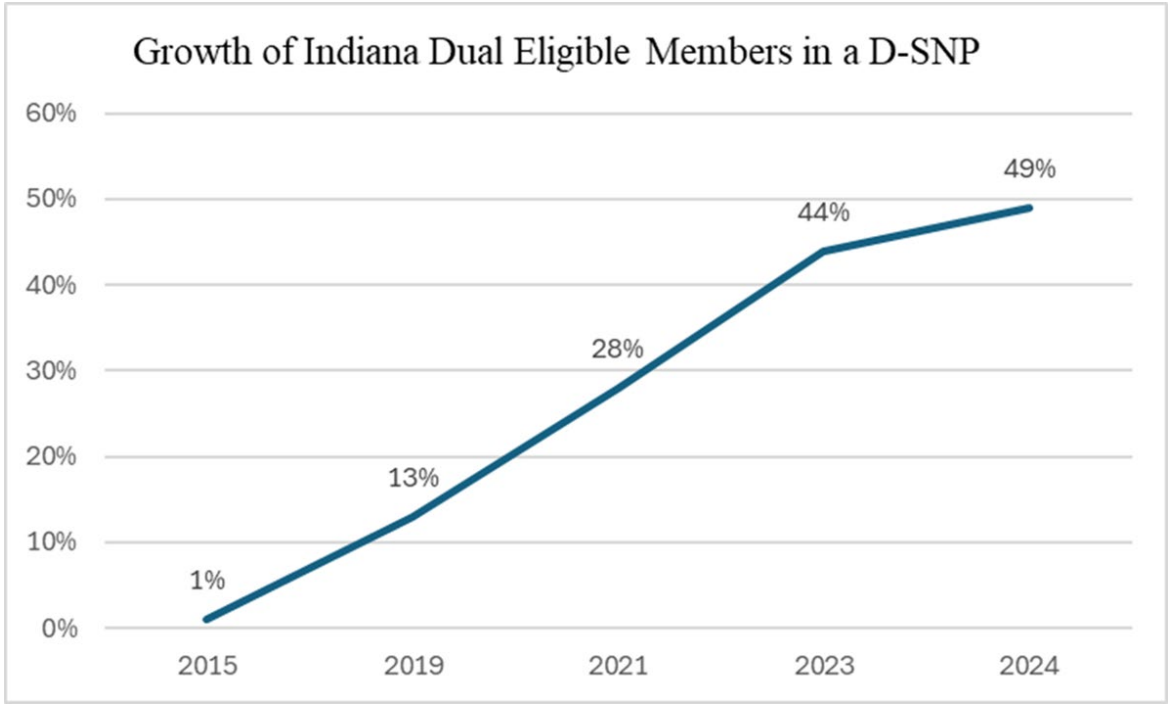
Enrollment Support & Materials

- A member's Authorized Representative and/or Area Agency on Aging can help a member call the PathWays helpline and select a plan
- PathWays Notice Webinar: https://www.in.gov/pathways/stakeholder-engagement/
- Copies of the notices are available on the PathWays website: https://www.in.gov/pathways/
- Health plan comparison: https://www.in.gov/pathways/pathways-health-plan-comparison/

Dual Eligible Information

Dual Eligibles

Over 80 percent of individuals enrolled in PathWays are “duals” meaning they will have a PathWays for Aging Medicaid health plan and Medicare health plan. **Integrating care for the duals populations is a foundational principle of the PathWays program**.



How Do Medicare & Medicaid Work Together?

- **Dually-eligible individuals** are eligible for both Medicaid and Medicare and receive benefits from both programs at the same time.
- There are Medicare Advantage Plans tailored to duals, called **Dual Eligible Special Needs Plans (DSNPs).** DSNPs have to contract with the State Medicaid Authority in order to operate.
- **PathWays MCEs are required to offer *aligned* D-SNPs** (i.e., through their same parent company) to provide enhanced coordination and a more integrated experience for dually-eligible individuals.
- FSSA's goal is to ensure that dually eligible individuals have **access to the highest possible level of coordination and alignment** of their Medicare and Medicaid benefits.
- All dual eligible individuals will retain **freedom of choice** to enroll in a Medicare plan: original (fee-for-service), Medicare Advantage (non-SNP), or D-SNP - of their choice.

What is an Aligned Plan?

An aligned plan in PathWays is an enrollment with an MCE that also operates a Dual-Eligible Special Needs Plan (D-SNP) to provide Medicare benefits

It is available for people who have both Medicaid and Medicare (aka a dual-eligible individual)

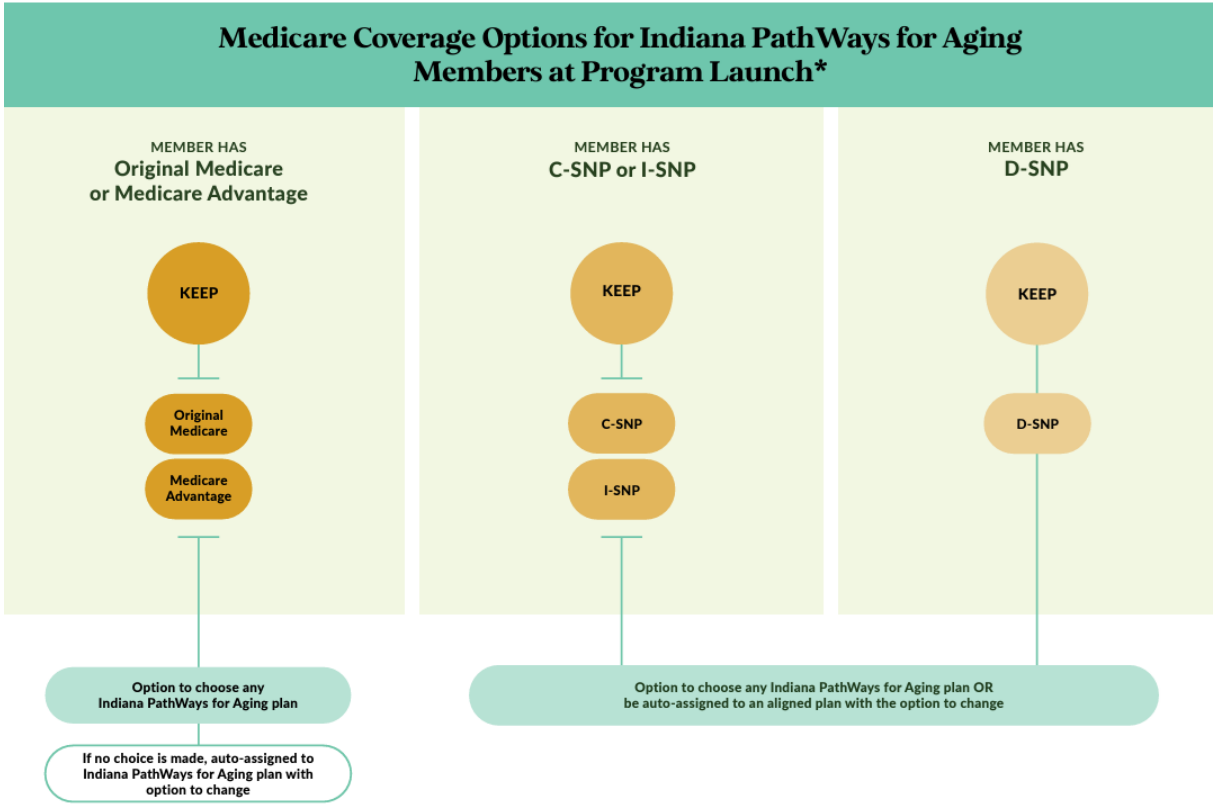
PathWays members who have decided to join a D-SNP run by Anthem, Humana or UHC for their Medicare benefits will automatically be enrolled in the same PathWays MCE.

Dual Eligible Member Options

Medicare type prior to PathWays eligibility	Individual's path/options upon becoming eligible for PathWays for Aging
Individual is enrolled in a D-SNP that's *unaligned* with any PathWays Health Plan	• Remain in unaligned D-SNP through CY24 • Enroll in the D-SNP aligned with their MLTSS Plan • Enroll in a non-D-SNP MA Plan or Original Medicare
Individual is enrolled in a D-SNP with the same parent company as a PathWays Health Plan	• Auto-enrolled in the aligned PathWays Plan if no other choice is selected • Provided with information about disenrolling or changing their PathWays and/or Medicare plans
Individual is enrolled in a standard Medicare Advantage Plan (non-D-SNP) or Original Medicare	• Continue receiving benefits according to existing Medicare choice • Informed of their Medicare options in relation to Medicaid enrollment choices by the Enrollment Broker; referred to SHIP if needed.

Duals Resources

- We know the duals topic is complex, so we created this overview and posted on our website to ensure individuals are aware of their choices.



Provider Information

How Do Providers Contract with MCEs?

- Each MCE is required to contract with any willing provider until network adequacy is met, providers have a choice with which MCEs they choose to partner.
- Contracting is underway, and providers are encouraged to begin the contracting process with the MCEs if they haven't done so already.
  - Anthem: INMLTSSProviderRelations@anthem.com
  - United Healthcare: in_providerservices@uhc.com
  - Humana: InMedicaidProviderRelations@humana.com
- MCE Contracting Webinar: https://www.in.gov/pathways/stakeholder-engagement/

Where to Find Key Materials

- MCE Provider Manuals are available online and listed below:
  - Anthem Provider Manual
  - Humana Provider Manual
  - UnitedHealthcare Provider Manual

How Do Providers Participate in PathWays?

- Provider Enrollment and Certification
  - As already required today, all providers must be enrolled as a Medicaid provider through Indiana Health Coverage Programs (IHCP)
  - Additionally, HCBS providers must also be certified by the Division of Aging prior to contracting with any MCE.
  - In May 2024, HCBS provider certification will move to OMPP. Current providers will NOT need to recertify with OMPP beyond any routine recertification already required. Please see IHCP BT202442 for additional information and plan to join an upcoming webinar on May 1 at 10a.

How Will Providers Bill for Services?

- Providers will continue to bill through the IHCP portal as you do today for under age 60 Medicaid claims
- MCEs have their own portal, and FSSA is working together with all three MCEs to develop unified processes and operations. While portals may be different, MCEs are aligning as much as possible with operations.
- MCEs are required to pay or deny electronically filed clean claims within 21 days of receipt, with the exception of HCBS claims. The MCE must pay HCBS related electronically filed clean claims within 7 days of receipt. The MCE must pay or deny clean paper claims within 30 days of receipt.
- Provider claims submission testing will open in May.

PathWays Readiness Update

What is Readiness Review

A systematic large-scale review of MCE staffing, policies and procedures, processes, documents, member and provider communication, subcontracts, system capabilities, and provider network to ensure the health plan is prepared in advance of the new contract go live

Safeguards that the selected MCE is ready to accept enrollment, provide the necessary continuity of care, ensure access to the necessary spectrum of providers, and fully meet the diverse needs of the population

Readiness reviews includes both desk review of MCE documentation as well as onsite demonstrations of MCE capabilities

Readiness Review Topics

	2023				2024			
Operations	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Document Development 8/1/2022 – 3/15/2023			✓ CC Manual ✓ IR Manual ✓ SOW Updates ✓ P&P Manual					
Systems Development: CORE, IEDSS, EDW 1/17/2023 – 2/28/2024								
Managed Care Entity Readiness Review 7/1/2023 – 6/30/2024			Provider: ✓ Contracts ✓ Manuals ✓ Website ✓ Other Materials	Member: ➢ Call Center ➢ Website ➢ Collaterals ➢ Enhanced Benefits	➢ Care Coordination ➢ Quality ➢ Covered Benefits ➢ Claims	➢ Network Adequacy ➢ Staffing ➢ Program Integrity ➢ Performance Reporting		
Projected Readiness Updates to Provider Workgroup 1/1/2024-6/30/2024					Provider: ✓ Contracts ✓ Manuals ✓ Website ✓ Other Materials Member: ✓ Call Center ✓ Website ✓ Collaterals ✓ Enhanced Benefits	Early-mid Q2: ✓ Care Coordination ✓ Quality ✓ Covered Benefits ✓ Claims End of Q2: ✓ Network Adequacy ✓ Staffing ✓ Program Integrity ✓ Performance Reporting		
Post-Implementation 7/1/2024 – 11/30/2024					**PathWays Program Go-Live 7/1/2024**		★	

Readiness Review Update

- There are 256 readiness requirements that will be validated over the course of the readiness review Q3 2023- Q2 2024.
  - 93% of the requirement have been reviewed to date.
- The State has received approximately 3,600 documents to review as part of the readiness desk review process. Every document is reviewed by at least two FSSA subject matter experts to verify compliance with the PathWays Statement of Work requirements and program goals.
- The State has conducted a total of six onsite demonstrations over the course of September to March. Additional onsite demonstrations are planned for April and May.

PathWays Quality and Oversight

Quality and Oversight

- Robust reporting required by Managed Care Entities
  - Rapid Response
  - Weekly reporting in initial implementation phase
- State's Quality Strategy Plan outlines expectations
- Category of Quality Metrics will be used to predict and evaluate performance
  - Early Indicator (Ex. Preventive Services)
  - Process and Outcomes Measures (Ex. Emergency Room Utilization)
  - Watch Metric (Ex. Consumer Surveys)
  - Pay for Outcomes (Ex. Completion of Health Needs Screen)

Quality Measure Categories

Quality Measure Categories

Early Indicator Metrics

- Measures used to **monitor MCE progress** towards performance measurement goals
- May indicate a deficiency or **area for potential improvement** in one or more Process and Outcome Measures

*OMPP links Early Indicator Metrics to **one or more** Process and Outcomes Measures*

Process and Outcome Measures

- Measures used to evaluate MCE performance
- May be compared and trended to national and state performance over time or linked to specific targets

*OMPP may adopt **some** Watch Metrics as Process and Outcomes Measures*

Watch Metrics

- Measures that cannot be used for evaluation yet because they are new or have had significant specification changes
- Includes measures that **do not yet have enough data** to be considered for another category

*OMPP will select a **subset** of Process and Outcomes Measures as P4O Measures*

Pay for Outcomes (P4Os)

- Measures used to provide additional financial incentives to MCEs if conditions are met

Quality and Oversight Continued

- Clinical Oversight
  - Service/Care Plan Audits
  - Service Utilization reviews
  - Critical Incident/Quality of Care review
- Operational Oversight
  - Utilization Management
  - Care Coordination
  - Grievance/Appeals
  - Pharmacy

PathWays Outreach and Resources

Where can I find more information?

PathWays Upcoming Stakeholder Engagement

Upcoming Stakeholder Engagement				
Event	**When**	**Where**	**Topic(s)**	**Audience**
IHCP Roadshows	April and May	Across IN	PathWays Education	Providers
Provider Education	May 21	Virtual	Care and Service Coordination	Providers
PathWays Stakeholder Update	June 7	Virtual	PathWays Update	Providers, Associations, Advocacy Organizations, etc.
Provider Education	June 18	Virtual	Authorizations	Providers

- Stakeholder engagement presentations and recordings can be found here: https://www.in.gov/pathways/stakeholder-engagement/
- Individuals can sign up for email updates through FSSA's listserv on the website

More Information/Resources

- Check out the IN PathWays website at www.IN.gov/Pathways

FAQs on the PathWays Website

- Covers topics including:
  - General Program Overview
  - Eligibility, Enrollment, and Plan Selection
  - Coverage and Benefits
  - Service Plans/Processes
  - Care and Service Coordination
  - Claims/Contracts/Authorizations
  - Other Services/Service Change Questions
  - AAA and Case Manager Questions
  - Medicare/Duals/D-SNP

Next Steps

Next meeting is tentatively scheduled for June 7, 2024

PathWays FOR AGING

Indiana Family and Social Services Administration