Long-Term Services and Supports Reform

November 2021, Medicaid Advisory Committee

Indiana Family and Social Services Administration

Current as of November 30, 2021

Why Reform Indiana's LTSS System?

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%.

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. NEW: Recruitment, retention, and training of workforce (in development- updates to come)

Updates and Key Activities

Indiana Family and Social Services Administration

Connecting the Dots: National Results

Why Managed Long-Term Services and Supports?

Choice

Rebalanced systems toward HCBS

Allow more people to age in their home and community

Quality

Increase in member satisfaction

Improved physical health measures

Cost

Decrease in Medicaid expenditure growth rate

Reduction in HCBS waiver wait list

*Source: Arizona For Better Medicaid, Growth in MLTSS and Impacts on Community-Based Care, July 2021 and Arizona for Better Medicaid, Managed LTSS Improves Quality of Care, July 2021

Connecting the Dots: mLTSS for Indiana

MLTSS builds on Indiana's long-standing, statewide partnerships offering comprehensive benefits to Hoosiers – **85% of current Medicaid members receive services through managed care plans**.

CHOICE

- Creates **better opportunities** for Hoosiers **to age at home**
- MLTSS plans responsible for making sure every **member** has **access to <u>all</u> eligible services**
- Promotes **integration** with the community and **consumer access** to LTSS

QUALITY

- Single point of **accountability**
- MLTSS is the **best path** for **aligning benefits** and improving experience **for duals** (80% of program)
- Extending care coordination to older Hoosiers and offering **single point of contact** for every member
- Comprehensive monitoring of **member satisfaction**

COST

- Creates **financial incentive** to improve health outcomes, especially for members receiving services in two programs: Medicaid and Medicaid
- Drives **system accountability**
- Promotes **rebalancing** of expenditures
- **Prevention** of waste & abuse

Indiana's Managed Care Oversight

Our top priority – be the best at Managing Managed Care!

Indiana Medicaid

- Historically, 70-100 team members oversee large Medicaid Managed Care delivery system

Commitment to Growth and MCE oversight:

- Hiring 25 new full time employee positions.

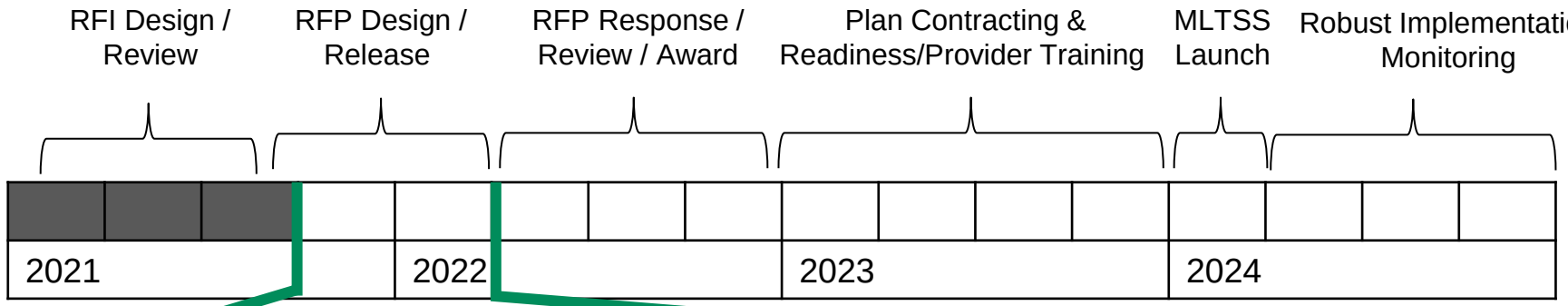
- Clinical operations and Program evaluation teams to support current managed care oversight function plus addition of complex LTSS population.

Managed LTSS 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

Key Result Progress Update

Key Result (KR)/Overall Objective	Progress Update
KR 1: Ensure at risk Hoosiers have access to home- and community-based services within 72 hours	• Met with the Centers for Medicare and Medicaid Services (CMS) to discuss long-term approach • ~2,460 applications processed; ~2,200 individuals approved for immediate coverage
KR 3: Link provider payments to improved health and wellness (value-based purchasing)	• Completed an initial quality analysis and drafted initial quality goals • Discussed quality goals with stakeholders on 11/19 • Continue analysis of HCBS CAHPS and caregiver surveys
KR 4: Measure outcomes across the continuum of LTSS services	• Exploring Minimum Data Set (MDS) for event notification • Supported KR3's analysis of current data for the quality framework and continue to support evaluation of KR1's expedited eligibility pilot
KR 5: Promote the recruitment, retention, and training of Direct Service Workforce (DSW)	• Recruiting for a DSW advisory committee to begin in Q1 2022 • Prepared a request for WISE Indiana to support a DSW gap analysis • Continue to participate in technical assistance with CHCS and CMS

Stakeholder Engagement

Since January 2019, FSSA has conducted stakeholder engagement sessions to gather input regarding the future managed Long-term Services & Supports (mLTSS) program.

Stakeholder Engagement

183 Meetings to Date

100+ Individuals Have Participated

661 Responses to HCBS FMAP Survey.

Stakeholders include:

- Consumers & caregivers
- Providers
- AAAs
- Trade organizations

ADvancing States

National expertise from other states on mLTSS.

3 Meetings with OHC Advisory Committee

22 Focus groups

Environmental scan

Topics include:

- Consumers and caregiver focus groups
- Provider outreach and technical assistance
- Direct Service Worker Advisory Committee

Finance Workgroups

13 Meetings to date

4 Distinct workstreams

Topics include:

- Rate setting
- Supplemental payment
- Value Based Purchasing

Stakeholder Engagement Updates

Update:

- Reconvened stakeholder meetings on design
  - Initial meetings held on November 3, 10, and 19
  - Near weekly meeting scheduled through mid-December

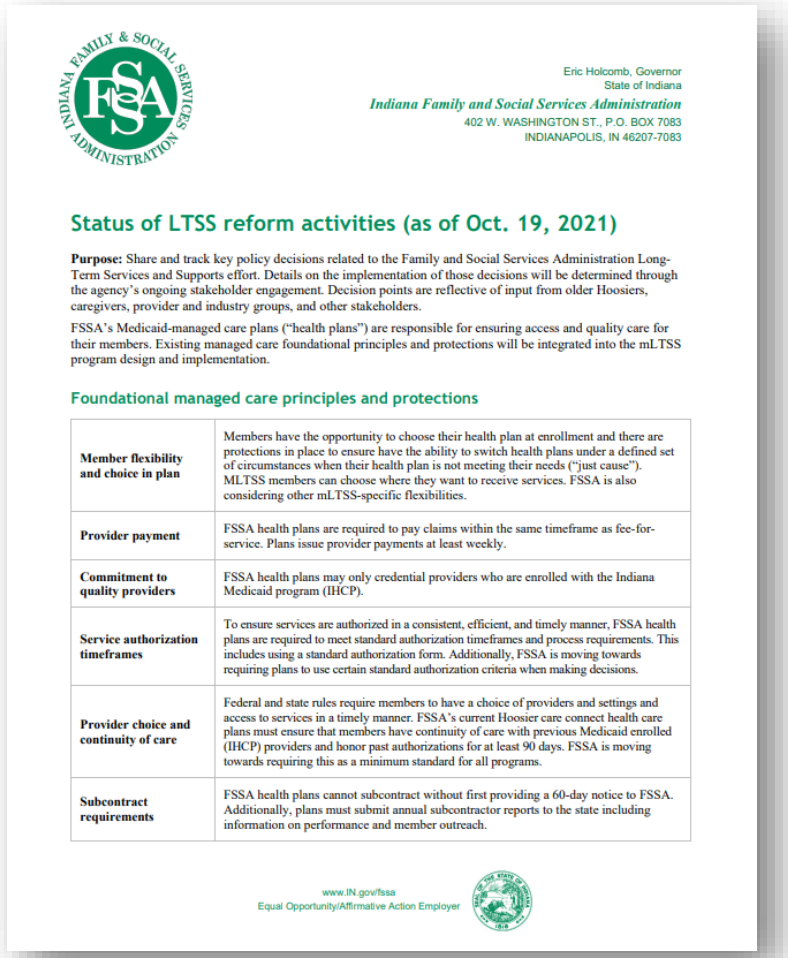
Schedule for Upcoming Engagement	
Date	**Planned Topics**
November 3	Review of topics discussed in prior engagements
November 9	Continued review of topics discussed in prior engagements
November 19	Quality framework and managed care plan performance
	Break - Happy Thanksgiving!
December 1	Provider protections and managed care interactions
December 8	Member protections and State oversight of managed care plans
December 16	Intake, enrollment, and care coordination

Stakeholder Engagement Updates

Additional Updates:

- First round of consumer engagement – we held 22 virtual events with 199 participants. Additional focus groups in January and February.
- Held a MLTSS 101 educational session for providers with over 200 attendees. The recording is available online.
- Using the HCBS environmental scan results to build a training plan for 2022
- Continued meetings with nursing facility industry to work through provider abrasion concerns
- Policy Decision Log published to FSSA's LTSS Reform webpage. Will be updated regularly.

Key Policy Decision Log



Eric Holcomb, Governor
State of Indiana

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Status of LTSS reform activities (as of Oct. 19, 2021)

Purpose: Share and track key policy decisions related to the Family and Social Services Administration Long-Term Services and Supports effort. Details on the implementation of those decisions will be determined through the agency's ongoing stakeholder engagement. Decision points are reflective of input from older Hoosiers, caregivers, provider and industry groups, and other stakeholders.

FSSA's Medicaid-managed care plans ("health plans") are responsible for ensuring access and quality care for their members. Existing managed care foundational principles and protections will be integrated into the mLTSS program design and implementation.

Foundational managed care principles and protections

Member flexibility and choice in plan	Members have the opportunity to choose their health plan at enrollment and there are protections in place to ensure have the ability to switch health plans under a defined set of circumstances when their health plan is not meeting their needs ("just cause"). MLTSS members can choose where they want to receive services. FSSA is also considering other mLTSS-specific flexibilities.
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.
Commitment to quality providers	FSSA health plans may only credential providers who are enrolled with the Indiana Medicaid program (IHCP).
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. Additionally, FSSA is moving towards requiring plans to use certain standard authorization criteria when making decisions.
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. FSSA's current 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.
Subcontract requirements	FSSA health plans cannot subcontract without first providing a 60-day notice to FSSA. Additionally, plans must submit annual subcontractor reports to the state including information on performance and member outreach.

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Policy Decision	Final Recommended Decision
Who is included in the mLTSS program?	Program will include qualifying adults 60 years of age and older, including those on the Aged and Disabled waiver or living in a nursing facility. It will not include individuals enrolled in the Family Support Waiver or Community Integration and Habilitation waiver.
Will mLTSS coordinate care for duals?	Yes – this is foundational. The new mLTSS program will encourage all Medicaid and Medicare Advantage (Duals Special Needs Plans) benefits to be administered like a single benefit package and every member will have a care coordinator assisting them to navigate their care.
Will the program be statewide?	Yes – mLTSS health plans will be required to operate statewide.

Policy Decisions Under Consideration

Policy Decision	Considerations
What benefits and services will be included in the comprehensive mLTSS benefits package?	To deliver holistic services that support individuals in aging at home, FSSA is “carving in” services to include nursing facility services and current home and community-based waiver services with a heavy emphasis on self-direction and structured family caregiving in the benefits package. These would be in addition to traditional Medicaid coverage (e.g., hospital care, labs, preventive care). Medicaid Rehabilitation Option, Adult Mental Health Habilitation Program and Behavioral and Primary Care Coordination will remain available to members and be offered outside of the mLTSS benefit package

Policy Decisions Under Consideration

Policy Decision	Considerations
What requirements will be placed on mLTSS plans to ensure quality and transparency?	**Staff experience**: MCEs must have staff with LTSS experience and subject matter expertise. FSSA plans to require positions unique to LTSS such a geriatrician and a housing coordinator to assist members with finding appropriate housing
	Reporting requirements: In addition to standard reporting in current managed care programs (e.g., utilization, quality management), FSSA will expand oversight and reporting specific to LTSS. • Examples include but are not limited to: HCBS provider network, utilization of HCBS and nursing facility care, and self-direction utilization
	Subcontracting standards: Contracting safeguards will be put into place to ensure managed care is operated according to FSSA's term and conditions and Scope of Work. An example includes required approval for subcontracting and reporting on subcontractor performance

Policy Decisions Under Consideration

Policy Decision	Considerations
What member supports and protections will be required to ensure smooth transition to managed care and high-quality care once the program is in place?	**Enrollment and transitions between plans**: A foundational concept of managed care is the member selects the plan into which they want to enroll. • FSSA will have processes in place to assign members a plan if they do not select one • Plan assignment for those who do not select plan will align Medicare and Medicaid • After enrollment, to ensure members are satisfied with their plan, requirements will be put in place to permit members to change their plan.
	HCBS-MCE Oversight Function: Many of the waiver oversight functions in place today are to protect members and will continue under managed care in shared responsibility between the State and MCEs. Examples include settings rule compliance and incident reporting.

Next Steps

Stakeholder engagement will guide RFP process

Next 30 days

- Continue stakeholder engagement sessions around key RFP policy decisions
- Continue stakeholder engagement sessions around Nursing Facility rates and UPL payments
- Update the policy decision log as decisions are reached through stakeholder sessions
- Recruit Direct Support Workers for the DSW Advisory Group
- Finalize Summary from Community Conversations with Older Adults and Caregivers
- Complete HCBS provider environmental scan analysis and finalize 2022 provider training calendar
- Complete analysis of HCBS CAHPS and Caregiver surveys

Legislature engagement

- Report to Legislative Council and State Budget by Feb.1, 2022 (HEA 1001-2021, Sec. 138)
- State Budget Committee to review overview of RFP (HEA 1001-2021, Sec. 138)