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Leadership, innovation, collaboration
for state Aging and Disability agencies

MLTSS Care Coordination

November 16, 2022

Agenda For Meeting

WELCOME AND INTRODUCTION

TODAY'S SPEAKER

MCE CARE COORDINATION PROCESSES

QUESTIONS

FUTURE EDUCATION TOPICS

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Today's Speaker – Camille Dobson

Camille Dobson
Deputy Executive Director

- Currently provide intensive TA to states operating MLTSS programs
  - Develop and manage semi-annual full day conferences on MLTSS
  - Co-author of eight MLTSS Institute papers
- Senior Policy Advisor on Medicaid Managed Care at CMS
  - Primary author of CMS MLTSS guidance and MLTSS sections of Medicaid managed care regulations
- 20 years experience in Medicaid managed care policy and operations

Delivery System Changes for Older Hoosiers

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

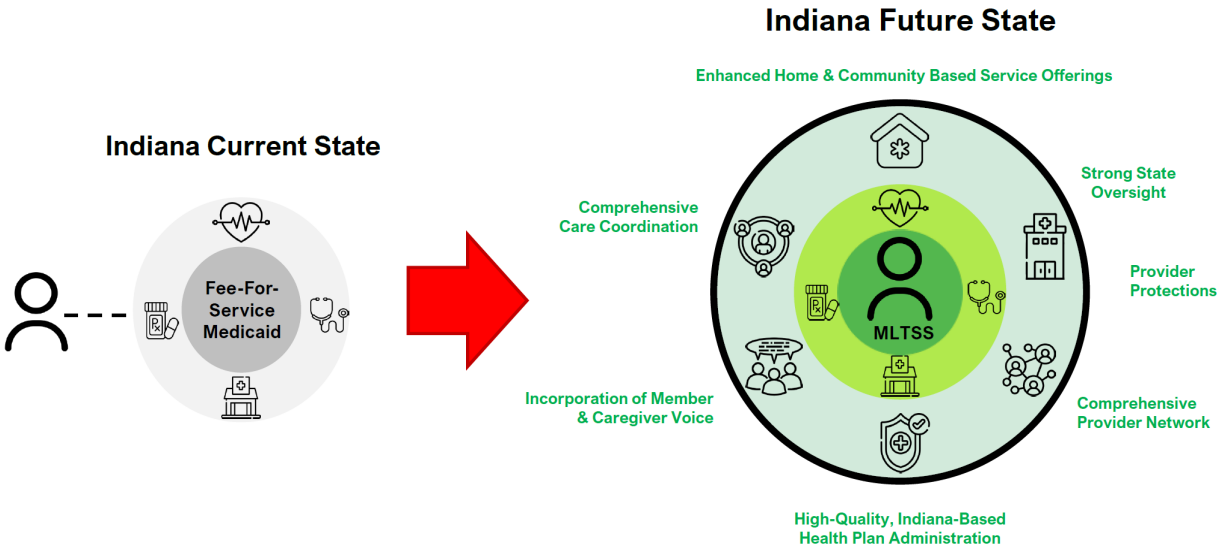
- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

*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



The Basics

Hoosiers aged 60 and over who are eligible for Medicaid will be enrolled in new MLTSS program

Some are already in managed care

- About 10% will be Hoosiers between 60 and 65 who are not getting LTSS now and are enrolled in MCEs under Hoosier Care Connect

Most are in FFS

- About 40% are in NFs or on the A&D waiver
- About half (50%) are Hoosiers over 65 who are on Medicare

The Basics

Current A&D waiver providers and NFs will have to join the network of each managed care entity (MCE) selected by the state in order to continue serving Hoosiers over the age of 60

Each MCE will pay providers for services rendered to their enrollees, rather than FSSA

Each MCE will be responsible for providing care coordination for A&D waiver clients

Overview of MLTSS Care Coordination

New Care Coordination Structure

- All members must be offered person-centered Care Coordination (CC)
- MCEs must have two levels of CC:
  - Care Management (available to all members); and
  - Complex Case Management (for members with high risk/high needs)
- For members receiving LTSS in NFs or HCBS, MCEs must provide Service Coordination in addition to Care Coordination
  - These members must be in Complex Case Management as well
- Will ensure that acute/primary AND HCBS needs are addressed and coordinated

New Care Coordination Structure

- Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of each member.
- The Service Coordinator is responsible for the development and implementation of the LTSS-specific Service Plan.
- For the first 2 years of the program, MCE must ensure that at least 50% of its enrolled members receiving HCBS waiver services receive service coordination using current Aged & Disabled waiver care management entities.

New Care Coordination Structure

- Service Coordinators must:
  - Be an RN or LPN
  - have at least 1 year of experience serving the program population;
  - have bachelor's degree, or
  - associate's degrees with one (1) year of experience delivering healthcare/social services or case management
- Service Coordinators may have a caseload of no more than 100 (weighted) members

Care Coordination Provisions in MLTSS SOW

Care Coordination Provisions in SOW *

- All members will get a Comprehensive Health Assessment
  - For all members getting LTSS in NFs or HCBS, must be done in person within 30 days of becoming a member of the MCE
  - Member may request alternative modes (phone, etc) or in different location
- LTSS-Specific assessments are required for members in NFs or getting HCBS
  - Monthly loneliness assessment
  - Quarterly needs assessment (using FSSA-developed or approved tool)
  - Annual LOC reassessment
  - Annual informal caregiver assessment

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.8, page 105

Care Coordination Provisions in SOW *

- Service Plan
  - Service Coordinator is required to initiate a written Service Plan which addresses the member's LTSS and LTSS-related needs during the first visit with the member
  - In combination with a member's Individualized Care Plan (focusing on non-LTSS services), the Service Plan will be considered the member's CMS-required "Person-Centered Service Plan."
  - The PCSP must meet the requirements in Federal regulation [42 CFR 441.301(c)]

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.10, page 111

Care Coordination Provisions in SOW *

- The written Person-Centered Service Plan must:
  - Reflect that the setting in which the individual resides is chosen by the individual.
  - Reflect the individual's strengths and preferences.
  - Reflect clinical and support needs as identified through an assessment of functional need.
  - Include individually identified goals and desired outcomes.
  - Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
  - Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.10, page 111

Care Coordination Provisions in SOW *

- The written Person-Centered Service Plan must:
  - Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
  - Identify the individual and/or entity responsible for monitoring the plan.
  - Be finalized and agreed to, with the informed consent of the individual in writing, and **signed by all individuals and providers responsible for its implementation**.
  - Be distributed to the individual and other people involved in the plan.
  - Include those services, the purpose or control of which the individual elects to self-direct, and
  - Prevent the provision of unnecessary or inappropriate services and supports.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.10, page 111

Care Coordination Provisions in SOW *

- The member must sign the Service Plan. A signed copy must be provided to the member and anyone else the member included in the service plan development process.
- If the member disagrees with the contents of the Service Plan, the Service Coordinator must:
  - provide the member with a denial notice within two (2) business days that includes their right to file a grievance; and
  - assist the member through the process as appropriate.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.10.3, page 114

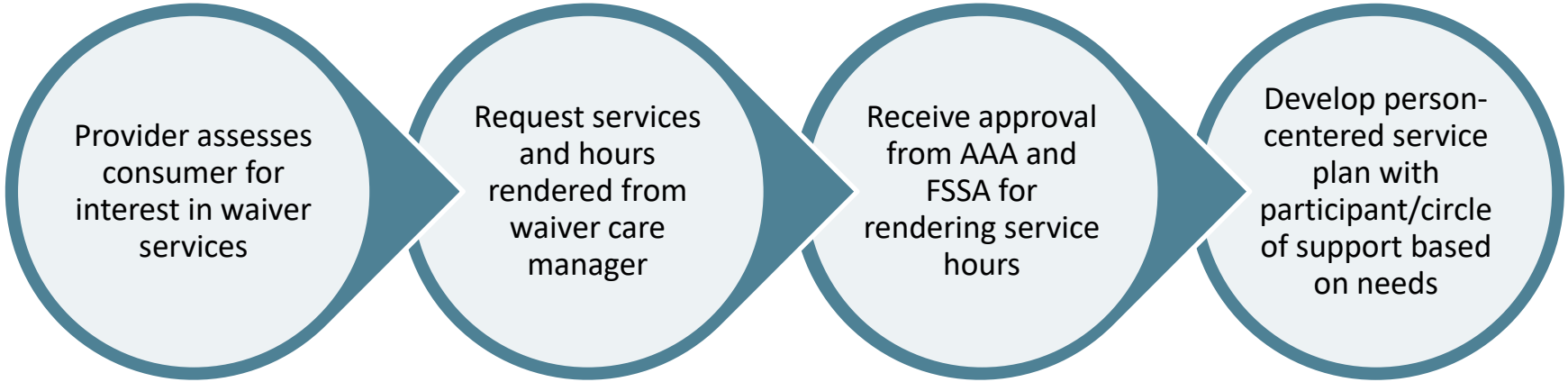
Care Coordination Provisions in SOW *

- At program implementation, MCEs must honor existing Service Plans for 180 days.
- However, within the first 90 days of enrollment, a Service Coordinator must conduct an initial face-to-face visit with the member
  - the member's Service Plan may be updated IF additional HCBS are needed.
- After 180 days, the member's Service Plan may be modified by the Service Coordinator
- The Service Plan serves as the service authorization

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 4.10.6, page 115

Service Plan Development – Today and Tomorrow

Service Planning Process
Today: Fee-for-Service



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Service Planning Process
Tomorrow: MLTSS

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Service Plan Development Tools

MCE has authority to use tools of their choosing, but must be approved by FSSA

May use tools to enumerate tasks and hours

Questions

Future Education Topics

HCBS Provider Virtual Sessions

	Quality and Managed Care Oversight

The presentation materials and recordings from earlier sessions on MLTSS 101, MLTSS Contracting, Provider Success Stories and MLTSS Claims Payment are available here: http://www.advancingstates.org/long-term-services-and-supports-provider-training

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Resources/Contacts

Website	www.informindiana.com
FSSA Provider Bulletins	https://www.in.gov/medicaid/providers/provider-references/news-bulletins-and-banner-pages/bulletins/
Email	informIN@advancingstates.org

More information on person-centered service plans and Federal requirements can be found here: https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf

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