Pathways 101: A Primer for the Changing World of MLTSS

(As of Today)

March 6, 2024

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We strongly encourage you to consult legal counsel on specific matters involving employment law, and important personnel policies and practices prior to adoption or implementation.

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Topics for Today's Discussion

- The Basics
- The MCE's Onboarding and Readiness Review
- MCE Provider Contracting
- Enrollment
- Service Planning and Care Coordination
- Claims Payment
- Nursing Facility Reimbursement

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The Basics

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Key Terms and Definitions*:

1) **Dually-Eligible Individual (Dual)**: Dually-eligible individuals are eligible for both Medicare and Medicaid. To be considered dually-eligible, individuals must be: (1) eligible for Medicare Part A and/or Part B; and (2) receiving full Medicaid benefits and/or Medicare Savings Program assistance.
2) **Full Benefit Dually Eligible Individuals (FBDEs)**: Individuals who are eligible for Medicare and are also categorically eligible for full (comprehensive) Medicaid benefits.
3) **Partial Benefit Dually Eligible Individuals**: Individuals who are enrolled in Medicare Part A and/or B and MSP benefits but do not receive full (comprehensive) Medicaid benefits.
4) **Dual Eligible Special Needs Plan (DSNP)**: A specialized Medicare Advantage plan that can only enroll individuals eligible for both Medicare and Medicaid. A DSNP must contract with the State Medicaid Authority in order to operate within that state.
5) **State Medicaid Agency Contract (SMAC)****: Contract between Medicare Advantage Organization (MAO) and the state Medicaid agencies in which the MAO operates a DSNP. These contracts must describe how the D-SNP will facilitate coordination of Medicare and Medicaid services for their enrollees. SMACs are often referred to as "MIPPA" contracts from the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. MAOs must enter into a SMAC with a state's Medicaid authority in order to operate in that state. States have discretion as to whether to enter into these.
4) **Alignment**: The coordination and streamlining Medicare and Medicaid regulations, policies, and operations to increase overall program effectiveness; to identify and eliminate conflicting program requirements and competing program incentives; as well as to bridge identified program gaps.
5) **Integration**: Providing a full array of Medicaid and Medicare benefits through a single delivery system to provide quality care for dual eligible enrollees, improve care coordination, and reduce administrative burdens.

*Definitions 1-3 are adapted from the Integrated Care Resource Center, Glossary of Terms Related to Integrated Care for Dually Eligible Individuals ; definition 4 is adapted from the CMS Medicare-Medicaid Coordination Office "Aligning Medicare and Medicaid" page; definition 5 can be located on Medicaid.gov on the "Integrating Care" page
**Indiana's CY2022 SMAC can be found HERE

Source: FSSA Pathways presentation to IHCA 8/7/23

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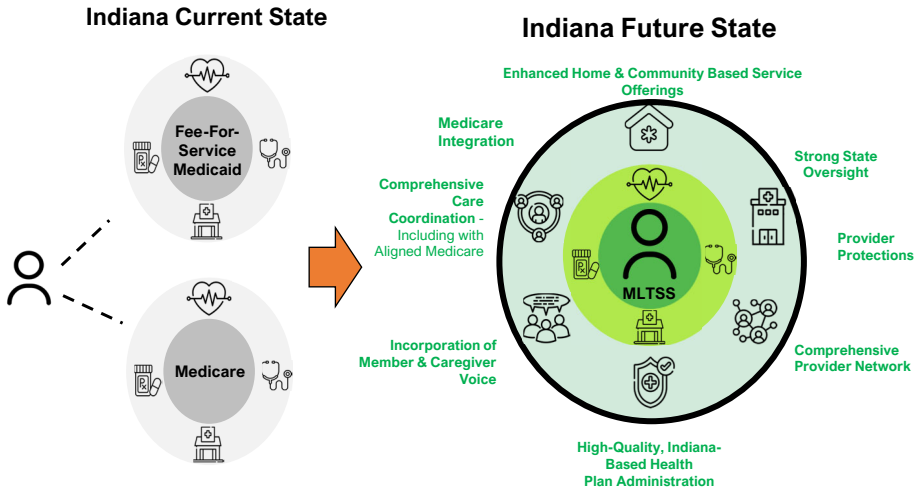
Where We Started & Aiming for the Future



Source: FSSA Pathways presentation to IHCA 8/7/23

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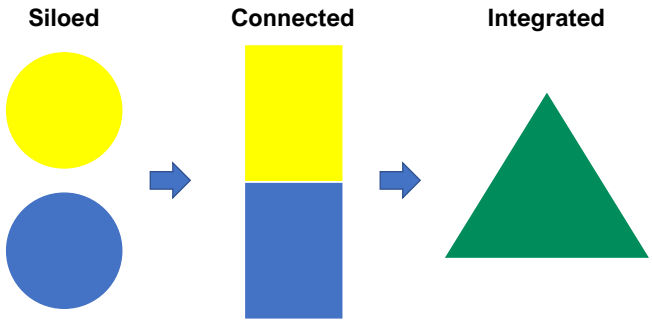
Medicaid & Medicare Dual-Eligible Population



Source: FSSA Pathways presentation to IHCA 8/7/23

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PathWays Services

Dual Eligible Members	All Members
Medicare Services*	Traditional Medicaid (partial list)
Part A: hospital care, SNF, hospice, labs, surgery, home health **Part B:** Dr visits, medical, preventive care, DME, mental health (some prescriptions) **Part D:** prescription drugs **Part C: (Medicare Advantage)** Includes full Part A and Part B benefits. Most also cover Part D. These plans also have some flexibility to provide additional supplemental benefits like over the counter drugs, transportation, wellness programs, vision or dental services, home delivered meals or other services.	• Hospital care • Labs/tests • Surgical care • Preventive care • Primary care visits • Prescriptions • Mental health and addiction treatment • DME • Home health • Hospice • Dental • Vision • Hearing aids • NEMT • **Care Coordination – A crucial component of the mLTSS program. A future presentation cover in more detail**

Source: FSSA Pathways presentation to IHCA 8/7/23

PathWays LTSS Services

For those individuals with a Level of Care (LOC) making them eligible for LTSS, the following services are included in the benefit package. All members receive comprehensive, person-centered care coordination – including duals.

Members with Nursing LOC	Members with Waiver LOC
Traditional Medicaid	HCBS Waiver Services**
• Long Term Care (Nursing Facility)	• Adult Day Service & Family Care • Assisted Living • Attendant Care, Self-Directed ATTC, & PDHCS • Caregiving Coaching and Behavior Management • Service Coordination • Community Transition • Environmental Modifications & Assessments • Home and Community Assistance (FKA Homemaker) • Home Delivered Meals • Nutritional Supplements • Personal Emergency Response System • Pest Control • Respite • Specialized Medical Equipment and Supplies • Structured Family Caregiving • Transportation • Vehicle Modifications

Source: FSSA Pathways presentation to IHCA 8/7/23

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PathWays Additional Services

One of the advantages of the PathWays program, is the ability of the MCEs to offer additional programs/services:

Commonly Offered Programs/ Services			
Category	**Anthem Blue Cross and Blue Shield**	**Humana Healthy Horizons**	**UnitedHealthcare Community Plan of Indiana**
Member Rewards Program	Earn gift cards and other items when you complete certain preventative care visits.	Earn gift cards and other items when you complete certain preventative care visits.	Earn gift cards and other items when you complete certain preventative care visits.
Member portal	Online tool available 24 hours a day, 7 days a week to help you find a doctor, view benefits, and view a free health library.	Online tool available 24 hours a day, 7 days a week to help you find a doctor, view benefits, and view a free health library.	Online tool available 24 hours a day, 7 days a week to help you find a doctor, view benefits, and view a free health library.
Tobacco cessation and dependence treatment	Programs available in partnership with the Indiana Tobacco Quitline at 800-QUIT-NOW.	Programs available in partnership with the Indiana Tobacco Quitline at 800-QUIT-NOW.	Programs available in partnership with the Indiana Tobacco Quitline at 800-QUIT-NOW.
Caregiver Supports	Support for adult family members or other informal caregivers providing care to individuals.	Support for adult family members or other informal caregivers providing care to individuals.	Support for adult family members or other informal caregivers providing care to individuals.
Housing supports	Assisting with transition or post-transition activities including requests and referrals, special needs/accommodations and location of housing options.	Assisting with transition or post-transition activities including requests and referrals, special needs/accommodations and location of housing options.	Assisting with transition or post-transition activities including requests and referrals, special needs/accommodations and location of housing options.

https://www.in.gov/pathways/pathways-health-plan-comparison/

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Anthem Additional MCE-Specific Programs

One of the advantages of the PathWays program, is the ability of the MCEs to offer additional programs/services:

Additional MCE- Specific Programs	
Anthem	
Fresh Food Connect	Healthy food options that meet your lifestyle needs, delivered to your doorstep.
Companion Connect	Connect with a loved one 24/7 through a smart video speaker.
Healthy Adults, Healthy Results	Online resources to promote stability, mobility and strength, plus choice of home fitness kit.
Home Safety Benefit	Safety items like medication lockbox, non-skid tub mat, smoke alarm, fire extinguisher, carbon monoxide detector.
COPD/Asthma/Allergy Relief Products	Choose from items like hypoallergenic bedding, HEPA air filters, pillow and mattress covers, inhalers, nebulizers.

https://www.in.gov/pathways/pathways-health-plan-comparison/

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Humana (Arcadian) Additional MCE-Specific Programs

One of the advantages of the PathWays program, is the ability of the MCEs to offer additional programs/services:

Humana	
Enhanced Dental	Members can receive allowance to apply towards additional cost incurred during dental services.
Enhanced Vision	Members can receive allowance to apply towards purchasing glasses (frame and lenses) and/or contacts.
Enhanced Hearing	Members can receive unlimited visits for fitting and evaluations, allowance to use towards purchasing hearing aids and supplies for hearing aid batteries.
Over-the-Counter Pharmacy Allowance	Members can receive allowance to purchase over the counter products such as pain relievers, cold relief medicine and first aid equipment.
Home-Delivered Meals	Members can receive home delivered meals at no cost after inpatient hospitalization or discharge from nursing home.

https://www.in.gov/pathways/pathways-health-plan-comparison/

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United (UHC) Additional MCE-Specific Programs

One of the advantages of the PathWays program, is the ability of the MCEs to offer additional programs/services:

	United
Virtual Visits	If you need health advice, we have online options. Get help with medical, dental and mental health questions.
Fitness Memberships	Want to work out? Our program includes many gyms across Indiana. Over 20,000 online classes are also available.
Fresh Food	Refrigerated meals or fresh fruits and vegetables are available when you need them most.
Respite Support	If you get help from a friend or family member, we offer a special program to support them.
Virtual Community Center	It's never too late to learn how to use and enjoy the internet. Connect with peers who can help you interact online!

https://www.in.gov/pathways/pathways-health-plan-comparison/

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Enrollment Population

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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Enrollment Population

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

Proposed Population aged 60 and over:

- w/Medicaid Eligibility linked to age, blindness or disability
- A&D waiver members

Proposed Population aged 60 and over:

- Nursing facility residents
- All other individuals currently enrolled in FFS or HCC

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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The Basics

The following individuals will be excluded from enrollment in MLTSS

- Aged 59 and under
- Enrollment not based on age, blindness or disability (e.g. HIP enrollees over age 60)
- Enrolled only in Medicare savings program
- Receiving PACE services
- Receiving Room and Board Assistance
- Residing in a Group Home (ICF/IDD)
- Enrolled in a 1915(c) waiver with ICF/IDD Level of Care
- Enrolled in TBI Waiver/TBI out of state placement
- Eligible for emergency services only

It is currently estimated that 10% - 15% of current SNF population will remain FFS.

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Source of Member Enrollment

- At Go Live, PathWays will be available to people currently enrolled in Indiana Medicaid
  - -Individuals enrolled in Hoosier Care Connect who are age 60 or older will transfer to Pathways (14% of anticipated PathWays Enrollment)
  - -Individuals enrolled in FFS who are age 60 or older and not exempt will transfer to PathWays (86% of anticipated PathWays Enrollment)
- This includes individuals that are receiving Home and Community services on a waiver and those that are living in nursing facilities
- Once Pathways is implemented individuals in HCC and FFS Medicaid will transfer to PathWays when they turn 60, provided they are not exempt
- New Applicants who are over 60 will enroll in PathWays once their eligibility is determined

Source: FSSA Pathways presentation to IHCA 8/7/23

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Expected Pathways Recipients July 1, 2024

LTSS:	Recipients
HCBS	28,000 - 30,000
Nursing Facility	24,000 - 25,000
Total LTSS	50,000 - 55,000
Non-LTSS	75,000 - 80,000
Total Pathways	125,000 - 135,000

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Nursing Facility Resident Funding Examples

Current	Future
Fee For Service (Age 60 and Over)	Indiana Pathways
Fee For Service (Age 59 and under)	Fee For Service
Hoosier Care Connect (Age 60 and Over)	Indiana Pathways
Hoosier Care Connect (Age 59 and under)	Hoosier Care Connect/Fee For Service as in current system
Medicaid Pending (Age 60 and Over)	Indiana Pathways (process changes from current system)
Medicaid Pending (Age 59 and under)	Fee For Service (same as current process)

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Home and Community Based Services (HCBS) Waiver Transition

What is happening?
Individuals aged 60 and above enrolled in the Aged & Disabled Waiver will transition to the Indiana PathWays for Aging waiver program as announced in 2022. The Aged & Disabled waiver for ages 59 and under will become the Health & Wellness waiver. Waiver services will remain aligned for both of these waivers. Individuals who are identified to move to the PathWays for Aging program will be notified in writing.

What is the overall objective?
To foster a positive and smooth experience for waiver recipients and providers by enhancing A&D and TBI waiver structure through the transition across divisions; by March 2024, submit final waiver amendments.

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Source: DDRS Advisory Council Presentation 2/24/2024

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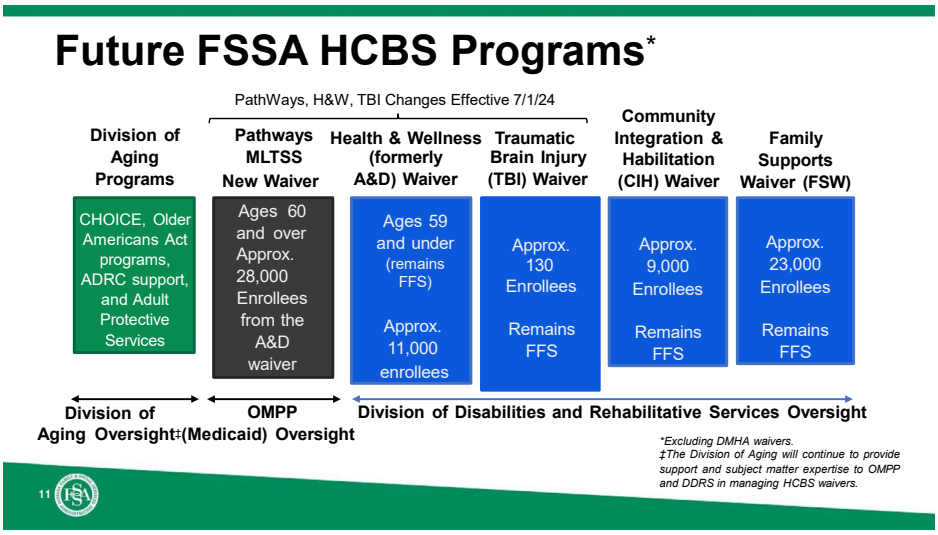

Source: DDRS Advisory Council Presentation 2/24/2024

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Assisted Living Facility Resident Funding Examples

Current	Future
Fee For Service including HCBS Waiver Services (Aged 60 and Over)	Indiana Pathways
Fee For Service including HCBS Waiver Services (Aged 59 and Under)	Fee For Service/H&W Waiver
Hoosier Care Connect/Fee For Service – No HCBS Waiver Services (Age 60 and Over)	Indiana Pathways
Hoosier Care Connect/Fee For Service – No HCBS Waiver Services (Age 59 and under)	Hoosier Care Connect/Fee For Service as in current system
Medicaid Pending (Age 60 and Over)	Indiana Pathways (process changes from current system)
Medicaid Pending (59 and under)	Fee For Service (same as current process)

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The MCE's: Onboarding and Readiness Review

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Pathways Awarded Managed Care Entities (MCEs)

On March 1st, 2023 following a competitive procurement process, FSSA and IDOA announced 4 awarded vendors for the Indiana Pathways for Aging program:

MCE	Medicaid Experience	LTSS Program Experience	Indiana D-SNP Experience
Anthem	11.1M members across 26 states/territories	416K members in 10 states	~40K members
Humana (Arcadian)	1M members across 5 states	40K members in 3 states	~23K members
Molina	4.6M members across 17 states	360K members in 11 states	N/A
United Healthcare	7.9M members across 32 states + DC	350K members in 10 states + DC	~30K members

This table presents an overview of background information about the awarded vendors (listed alphabetically) and does not represent any evaluation criteria. Member enrollment figures are estimates provided by the MCEs as of 2022.

Note: While Molina was awarded a potential contract, they could not get a CMS approved DSNP in place prior to the September 1, 2023 deadline. As such, they lost their award. So only three MCEs will serve the program.

Indiana Pathways for Aging Codesign Workgroup 3/1/23

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Current Medicaid Enrollments 60 and Older

Enrollment by Age Group and Health Program
January-2024
Statewide Grand Total: 2,007,805
As of Date: 02/03/2024

	Hoosier Care Connect				Healthy Indiana Plan						Fee for Service	
Age Group (in years)	Anthem	MHS	UHC	Total	Anthem	CareSource	MDwise	MHS	Unassigned[1]	Total	Total	Grand Total
60-64	6,976	2,980	576	**10,532**	20,893	5,135	8,284	7,843	2,458	**44,613**	**31,062**	**86,211**
65-69	1,621	783	192	**2,596**	2,563	599	1,050	1,016	321	**5,549**	**49,581**	**57,727**
70-74	958	476	135	**1,569**	3	2			5	**10**	**32,542**	**34,121**
75-79	649	303	86	**1,038**		2			1	**3**	**20,804**	**21,845**
80-84	390	210	47	**647**							**13,998**	**14,646**
85+	289	155	17	**461**	1					**1**	**16,322**	**16,785**
Total:	***10,883***	***4,907***	***1,053***	***16,843***	***23,460***	***5,738***	***9,334***	***8,859***	***2,785***	***50,176***	***164,309***	***231,335***

State of Indiana
Office Of Medicaid Policy and Planning — Enrollment by Age Group - Page 1
Data Source: EDW - FSSA — OP-43625
Feb 5, 2024 — 11:59:01 PM

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Medicaid Enrollments 60 and Older January 2024

	HCC	HIP	Total
Anthem	10,883	23,460	34,343
United	1,053	0	1,053
Humana	0	0	0
Other	4,907	26,716	31,623
Managed Care Total	16,843	50,176	67,019
Fee For Service			164,309
Total*			231,328

*Includes excluded populations e.g. people on CIH or FSW Waivers

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What is Readiness Review?

- A systematic large-scale review of an MCE's staffing, policies, processes, documents, subcontracts, system capabilities, and provider network to ensure the health plan is prepared in advance of the new contract go live.
- Safeguards that all selected MCEs are 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.
- Developed to meet all requirements of 42 CFR 438.66(d).
- Ensures MCEs understand and assist FSSA with meeting the Pathways program goals of Participant Choice, Quality, and Sustainability.
- Readiness reviews includes both desk review of MCE documentation as well as onsite demonstrations of MCE capabilities.

Indiana Pathways for Aging Targeted Workgroup 2/16/24

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Topic Schedule

Month	Topics
July 2023	• Administrative Requirements • Staffing Plan • List of Subcontractors • Implementation Plan • List of Systems/Platforms
August 2023	• Care and Service Coordination Overview • List and Overview of Enhanced Benefits and Incentives
September 2023	• Provider Contract Templates • Provider Materials
October 2023	• Enhanced Benefits • Member Incentives • Provider Incentives
November 2023	• Care Coordination Program Plan
December 2023	• Marketing Materials and Plan • Member Materials • Member Services • Websites and Provider Directory • Member Grievances and Appeals
January 2024	• Sub-Contracts • Provider Network Adequacy Review • Care Coordination • Service Coordination • Disease Management

Source: Indiana Pathways for Aging Targeted Workgroup 2/16/24

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Topic Schedule

Month	Topics
February 2024	• Covered Benefits • Behavioral Health • NEMT • Quality • Utilization Management • Pharmacy • Medicare Integration • Critical Incident Reporting
March 2024	• Information Systems • Member Liability and Penalties • Claims • Electronic Visit Verification (EVV) • Sub-Contracts
April 2024	• Provider Network Validation • Performance Reporting • Program Integrity • Staffing Plan • Direct Service Workforce
May 2024	• Final Resubmissions • Final Demonstrations

Source: Indiana Pathways for Aging Targeted Workgroup 2/16/24

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MCE Provider Contracting

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FSSA Provider Protections

- FSSA has required each contracted MCE to offer a contract to any provider who is willing to accept the MCE's contract terms
- Provider cannot be dropped from the MCE network for the first 3 years of the program*

* For the first three (3) years of the program, the Contractor shall accept into their network any LTSS or HCBS provider that agrees to the Contractor's standard provider agreement and meets all applicable State and Federal participation requirements. https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 6.2.18, page 178

Source: FSSA MLTSS Contracting 10/19/22

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Tomorrow: Provider Qualification Requirements

- Policies and Personnel Manual
- Maintain Records of Services Provided
- Insurance
- Financial Information
- Incident Reporting
- Compliance Reviews
- Quality
- Data Collection

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Meeting provider qualification requirements of each MCE to be "in-network"

Source: FSSA MLTSS Contracting 10/19/22

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MCE Provider Networks

- What is being in a provider network?
  - Doesn't exist in FFS – akin to the pick-list
  - Hoosiers in an MCE can only be served by providers that are under contract with that MCE
- Providers have to demonstrate that they are qualified to deliver services (aka 'get credentialed')

Source: FSSA MLTSS Contracting 10/19/22

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Importance of MCE Provider Contract

- **Separate and distinct from ICHP/DA 'enrollment' process**
  - Will include both familiar (in current IHCP contract) and new elements
- Will dictate the terms of the relationship between the provider and MCE
  - Spells out the requirements for being included in the MCE's provider network
  - Obligates the provider to meet those requirements

Source: FSSA MLTSS Contracting 10/19/22

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Out of Network Services

- In and out of network Skilled Nursing Facility, Home Health, Hospice and HCBS providers shall be reimbursed at no less than Fee for Service rates (i.e., a rate established by OMPP) for the first few years of the program.

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IHCA MCE Contracting Training Opportunity

- Wednesday March 13 – Noon – 1 pm
- Registration will not be required/collected for that webinar.
- Link to the webinar: https://link.edgepilot.com/s/e8bd4338/oIE1FfJJ2EKzHyQML5zatw?u=https://www.ihca.org/mltss-resources/

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Enrollment

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Vendors in the PathWays Ecosystem

Vendor Name	Services	Example Member Interaction
Enrollment Broker (Maximus)	Helps individuals select or change their PathWays MCE	An individual gets a letter that they're eligible for PathWays and a number to call to enroll. The EB helps them enroll with an MCE that has the individual's current doctor in its network.
Level of Care Assessor Representative (LCAR) (Maximus)	Assesses whether individuals meet Nursing Facility Level of Care (NFLOC) to qualify for LTSS • Sometimes referred to as "functional eligibility"	An Area Agency on Aging refers an individual to LCAR for an NFLOC assessment as a first step toward receiving waiver services.
Dual Eligible Special Needs Plans (D-SNPs), type of Medicare Advantage Plan	Cover and coordinate Medicare services, specifically for dual-eligible individuals With PathWays, each D-SNP will have an aligned MLTSS Plan (same parent company), to allow for greater coordination between Medicare and Medicaid benefits.	A D-SNP case manager works with the member's PathWays team to make sure that an individual's transition from a hospital to a short-term skilled nursing facility stay to the home/community goes smoothly.

Source: FSSA Pathways presentation to IHCA 8/7/23

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Vendors in the PathWays Ecosystem

Vendor Name	Services	Example Member Interaction
Area Agencies on Aging (AAA)	Coordinate, offer, and connect older adults to services to support them in their home and community Contracted at a local/regional level with the State to provide Older Americans Act services (Federal program), CHOICE (State program), and waiver services–including waiver care management.	A family contacts a AAA to get information and resources when they discover that Grandma has been having trouble caring for herself at home.
Independent Case Management companies (ICMs)	Like AAAs, ICMs offer A&D waiver care management services today. Under PathWays, MCEs will subcontract with existing A&D care management providers to perform PathWays Service Coordination.	A PathWays member who qualifies for HCBS works with their Service Coordinator (subcontracted through an ICM) on an LTSS-specific Service Plan.
Member Support Services (MSS) (Vendor TBD – in procurement)	Assists members with understanding and navigating their coverage and rights under PathWays Supports members in resolving MCE issues and navigating the grievance and appeal process • Also called "Beneficiary Support Services" as federally required	An MCE denies a PathWays member a service they think they need. The member contacts the MSS to learn what their options are and how to file an appeal.

Source: FSSA Pathways presentation to IHCA 8/7/23

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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 (Arcadian) or UHC for their Medicare benefits will automatically be enrolled in the same PathWays MCE, but will have the choice to enroll with another MCE if they feel that is a better fit for their care.

Source: FSSA February 2024 Member Enrollment Presentation HCBS Providers

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Why Stay in an Aligned Plan?

- A person in an aligned plan gets coverage for both Medicaid and Medicare through the same company
- The member will get one ID card, have one member services number and will have one unified grievance and appeal process
- Most importantly, the aligned plan will connect the medical and community supports that a member needs. They can also help a member get access to services not covered by Medicare.

Source: FSSA February 2024 Member Enrollment Presentation HCBS Providers

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Member Choice - Medicare

- Member **always** has the right to choose whether they stay in traditional Medicare or select a Medicare Advantage plan.
- Member has the right to select any type of Medicare Advantage Plan not just one of the aligned DSNP plans under Pathways. (This choice includes selecting an ISNP plan)
- Members can also change Medicare Advantage plans at certain times of the year and/or due to specific circumstances
- If the member is enrolled in a D-SNP sponsored by a Pathways MCE or parent company, they will be auto-assigned to an aligned PathWays plan

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Member Choice - Pathways

- Member **always** has the right to choose their PathWays MCE
- If they do not choose, FSSA will assign them to an MCE
  - If the member is enrolled in a D-SNP sponsored by a Pathways MCE or parent company, they will be auto-assigned to an aligned PathWays plan
- Whether they choose or are assigned, the member has the right to change their MCE:
  - At anytime before July 1, 2024
  - Within 90 days of enrolling in an MCE (before September 30, 2024)
  - Annually at open enrollment
  - Anytime a member's Medicare and Medicaid MCEs are unaligned
  - Once per calendar year for any reason
  - Anytime using the just cause process

Source: FSSA February 2024 Member Enrollment Presentation HCBS Providers

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Enrollment Timeline

FEB - MAR 2024	MAR – APR 2024	MAY 2024	JUNE 2024	JULY 1, 2024
• Member receives Plan Selection Notice from Enrollment Broker for PathWays (2/2024) • Members that do not have an aligned plan receive calls from Enrollment Broker • Members in a Nursing Facility or receiving HCBS via waiver will receive 3 phone calls from the Enrollment Broker to select a plan (2/2024 to 3/2024)	• Member calls to make plan selection • If no plan is selected by April 2024, the member will be auto-assigned	• Members receive 60-day notice of PathWays Enrollment with plan benefit and contact information (May 2024)	• Member receives Welcome Packet from assigned Plan (June 2024)	• PathWays coverage becomes effective (and changes from FFS or HCC)

Source: FSSA February 2024 Member Enrollment Presentation HCBS Providers

Plan Selection Notices

Aligned D-SNP Member - Sent to aligned DSNP Members. A member who is already with a current PathWays MCE (Medicare Anthem members, Medicare UnitedHealthcare members, and Medicare Humana members).

Aligned HCC Member - Sent to aligned Hoosier Care Connect Member. A Member who is aging in from HCC and already with a current PathWays MCE. (HCC Anthem members and HCC United members)

Unaligned HCC Member - Sent to unaligned Hoosier Care Connect Member. Managed Health Services members aging into PathWays. (HCC Managed Health Services members.)

NF Member Notice - Sent to members who reside in a Nursing Facility.

Waiver FFS Member - Sent to members who currently receive home and community-based services and supports through the Aged and Disabled Waiver.

General FFS Member - Sent to Traditional Medicaid members. These are members who are unaligned or in Traditional Medicaid (Unaligned D-SNP members, Fee For Service Medicare members, and Medicare Advantage Plan members)

AI/NA Opt-In - Sent to members of a federally recognized tribe.

Hospice Opt-In - Sent to members who are receiving hospice services.

60-Day Prior to Go Live - Sent to all members who selected an MCE or were auto-assigned. Will be sent this notice 60-days before go-live to notify them of their assigned PathWays MCE.

Source: https://www.in.gov/pathways/resources/

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Sample Process for New Medicaid Eligible Recipient who is 61 Years Old under Pathways

Step in Process	Vendor
• Process Medicaid application (Financial Eligibility)	• Division of Family Resources
• Select Managed Care Plan	• Enrollment Broker (Maximus)
• Level of Care Assessment (Nursing Home/Waiver eligibility)	• Level of Care Assessment Representative (Maximus)
• Plan Development	• AAA or ICM
• Assistance with Service Delivery Issues	• Member Support Services Vendor (TBD)

Note: Timeframes for the processing of each step of the above have not been established

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Maintaining Recipient Eligibility

Per Pathways FAQS:

Do I still need to renew my coverage; how do I do that?
You must renew your coverage every year. You can do this by visiting your local Division of Family Resources office or through your portal account at https://fssabenefits.in.gov/bp/#/. Your health plan (Anthem, Humana or UnitedHealthcare) can also assist you in renewing your coverage.

What happens when a D-SNP member loses Medicaid eligibility?
D-SNPs typically allow their members a 6-month grace period after losing Medicaid eligibility during which the individual may remain in the D-SNP.

Service Planning and Care Coordination

Service Planning and Authorization Process
Tomorrow: MLTSS

Source: FSSA - A Look into the Future: Managed Long-Term Services and Supports 9/28/22

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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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Care Coordination: Medicaid and Medicare Alignment

- To increase alignment for dual-eligible members, MLTSS care coordination requirements will align with CMS guidelines for Medicare Advantage Dual Special Needs Plan (D-SNP) Models of Care (MOC).
- A dual-eligible member's Care Coordinator will be responsible for coordinating with all Medicare payors, Medicare Advantage plans, and Medicare providers as appropriate to coordinate their care and benefits.
- For members in an MCE's aligned, companion D-SNP, staff will have access to all of the information needed to coordinate the members' dual benefits, and the MCE's systems and business process should support an integrated MLTSS/Medicare approach.
  - Further administrative integration–between an MCE's MLTSS program and companion D-SNP–is expected to evolve over the life of the MLTSS program.

Source: FSSA Pathways presentation to IHCA 8/7/23

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Care Coordination Definition

- **Care Coordination** -The Care Coordination Program Plan shall include, but not be limited to, descriptions of how the Contractor shall comprehensively address the following Care Coordination critical elements and their associated factors: Care Coordination Staff Structure, Comprehensive Health Assessments, Individualized Care Plan, Interdisciplinary Care Team, Continuity of Care and Care Transition Protocols. The Contractor's Care Coordination Program Plan and service delivery must contain evidence of person-centered practices. The State strongly encourages a strengths-based approach in all aspects.

- **Care Coordinator** - An individual meeting Indiana required residential, education, and/or experience requirements that is assigned to every member with the primary responsibility for coordination of the member's physical and behavioral health, and LTSS services.

Source: FSSA Pathways presentation to IHCA 8/7/23

New Care Coordination Structure

- Care Coordinators must be located in Indiana and :
  - Be an RN
  - Have a master's degree in social work
  - have bachelor's degree in social work, psychology, special education or counseling and have at least 1 year of experience serving the program population; or
  - Be an LPN
- Care Coordinators may have a caseload of no more than 50 (weighted) members

Source: Scope of Work

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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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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New Service 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.

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Service Coordination Definition

- **Service Coordination** - In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will be eligible for Service Coordination for their LTSS and related environmental and social services. Service Coordination specifically focuses on supporting members in accessing long-term services and support, medical, social, housing, educational, and other services, regardless of the services' funding sources. All members receiving Service Coordination will have an assigned Service Coordinator who works with the member's Care Coordinator to ensure cohesive, holistic service delivery.

- **Service Coordinator** - Individuals meeting Indiana residential, educational and/or experience requirements responsible for the development and continuous modification of the Service Plan for members who are receiving LTSS, to establish goals and priorities, comprehensively assess needs, evaluate available resources, and develop a plan of care; and to identify LTSS providers as well as other community resources to provide a combination of services and supports that best meet the needs and goals of the member and informal caregiver(s).

Source: FSSA Pathways presentation to IHCA 8/7/23

New Service Coordination Structure

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

Source: Scope of Work

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Service 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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Service 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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Service 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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Service 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

Source: FSSA MLTSS Care Coordination Presentation 11/16/22

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Claims Payment

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Tomorrow: MCE Claims Payment Requirements

MCE #1 will maintain its own claims processing system MCE #1 will provide its own training MCE #1 remittance advice might include additional/different information (i.e reason codes)	MCE #2 will maintain its own claims processing system MCE #2 will provide its own training MCE #2 remittance advice might include additional/different information (i.e reason codes)	MCE #3 will maintain its own claims processing system MCE #3 will provide its own training MCE #3 remittance advice might include additional/different information (i.e reason codes)

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Claims Provisions in SOW *

- MCE shall ensure that provider submission requirements are not burdensome and align with standard billing practices and IHCP guidance.
- MCE shall employ a local Provider Claims Educator to work collaboratively to educate LTSS providers transitioning from fee-for-service reimbursement to managed care.
- MCE shall offer provider participation in testing and auditing for accurate payment to LTSS providers.
  - MCE shall report to FSSA on their collaborative effort at least ninety (90) days prior to initial contract implementation

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of- Work.pdf, Section 9.7, page 238

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Claims Provisions in SOW *

- HCBS providers shall be reimbursed at no less than Fee for Service rates for the first five years of the program (current FSSA/MCE contract term).
- In-network providers must submit claims to the MCE within ninety (90) calendar days from the date of service.
- MCE must permit the submission of diagnosis code R69 (illness, unspecified) for members receiving HCBS.
  - Used to permit reimbursement on claims where diagnosis code is required but provider does not know the member's medical condition

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of- Work.pdf, Section 9.7, page 238

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Claims Provisions in SOW *

- MCE must pay or deny "clean" electronically filed claims within twenty-one (21) calendar days of receipt.
- MCE must pay or deny clean paper claims within thirty (30) calendar days of receipt.
  - A "clean claim" is a claim for covered services that can be processed without obtaining additional information from the provider of the service.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 9.7, page 238

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Senate Bill 132

The office of Medicaid policy and planning shall convene a workgroup for purposes of this section…… The workgroup shall do the following:

1. Develop a uniform billing format to be used by the managed care organizations participating in the risk based managed care program established under subsection (c).
2. Seek and receive feedback on the claims submission testing period conducted under subsection (d).
3. Advise the office of Medicaid policy and planning on claim submission education and training needs of providers participating in the risk based managed care program established under subsection (c).
4. Develop a policy for defining "claims submitted appropriately" for the purposes of subsection (g)(1) and (g)(2).

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Senate Bill 132

The office of Medicaid policy and planning shall establish a temporary emergency financial assistance program for providers that experience financial emergencies due to claims payment issues while participating in the risk based managed care program established under subsection (c). (The bill defines when such an emergency exists.)

To be eligible for a payment of temporary emergency financial assistance under the program established under subsection (g), a provider:

1. Must have participated in the claims submission testing period
2. Must submit a written request to OMPP (bill defines components of the request)

OMPP shall review and determine if an emergency exists within seven calendar days of receiving the request

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Senate Bill 132

If the office of Medicaid policy and planning determines that a provider is experiencing a financial emergency for purposes of the program established under subsection (g), it shall direct each managed care organization with which the provider is contracted under the risk based managed care program established under subsection (c) to provide a temporary emergency assistance payment to the provider.

- A managed care organization directed to provide a temporary emergency assistance payment to a provider under this subsection shall provide the payment in not more than seven (7) calendar days after the office directs the managed care organization to provide the payment.
- The amount of the temporary emergency assistance payment that a managed care organization shall make to a provider under this subsection is equal to seventy-five percent (75%) of the monthly average of the provider's long-term services and supports Medicaid claims for the six (6) month period immediately preceding the implementation of the risk based managed care program under subsection (c), adjusted in proportion to the ratio of the managed care organization's covered population membership to the total covered population membership of the risk based managed care program established under subsection (c).

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Senate Bill 132

Upon issuing any payment of a temporary emergency assistance to a provider under subsection (j), a managed care organization shall set up a receivable to reconcile the temporary emergency assistance funds with actual claims payment amounts. A managed care organization shall reconcile the temporary emergency assistance payment funds with actual claims payment amounts on the first day of the month that is more than thirty-one (31) days after the managed care organization issues the temporary emergency assistance funds to the provider.

If a temporary emergency assistance payment is issued to a provider, managed care organizations are still required to meet contract obligations for reviewing and paying claims, specifically claims that total a payment in excess of the temporary emergency assistance payment reconciliation.

However, if a managed care organization fails to comply with a directive of the office of Medicaid policy and planning under subsection (j) to provide a temporary emergency assistance payment to a provider, the failure of the managed care organization: (1) is a violation of the claim processing requirements of the managed care organization's contract; and (2) makes the managed care organization subject to the penalties set forth in the contract, including payment of interest on the amount of the unpaid temporary emergency assistance at the rate set forth in IC 12-15-21-3(7)(A).

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Lessons Learned from Other Transitions

- Will likely need administrative support to manage three or four MCE submissions/resubmissions/trouble-shooting
- Educate MCEs about payment problems under FFS model
- Identify 'pain points' as early as possible
- Understand your own claim volume and frequency to anticipate revenue cycle

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Lessons Learned from Other Transitions

- Become familiar with MCE resources (provider network or claims specialists)
- Check MCE provider websites regularly (as you do with IHCP)
- Participate in claims testing opportunities with MCEs directly or through your trade association (if applicable)
- Train, train, train
  - Really understand each MCE's claims portal
  - Make sure EVV data is accurate

Source: FSSA MLTSS Claims Payment Presentation 11/9/22

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Nursing Facility Reimbursement

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Comparison of Medicare Advantage to Indiana Pathways Medicaid SNF Reimbursement

Medicare Advantage	Pathways Medicaid
SNF Services (Typical Contract Terms)	SNF Services
• Meets Medicare qualifications for an SNF stay • Length of stay subject to prior authorization • Reimbursement levels subject to prior authorization • Reimbursement levels typically do not vary by facility • Additional services may be included in nursing facility rates or not (e.g. ancillary services)	• Does not meet Medicare qualifications for an SNF stay • Level of Care approval determined by Level of Care Assessor (Maximus) not by the MCE • Length of Stay determined by PASRR process • Single rate of reimbursement is determined by state not by the MCE • Rate of reimbursement determined by individual facility based on each facility's cost and MDS information as part of case mix index used in determining the SNF rate • Ancillary services currently reimbursed separately remain separately reimbursed • Additional reimbursement through supplemental payments

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New Nursing Facility Reimbursement System Guiding Principles

Modernize the Nursing Facility Reimbursement system:

- Move to a price based system to improve predictability and consistency across facilities
- In accordance with CMS directives, tie direct care reimbursement more closely to direct care staffing and spending
- Eliminate retrospective rate setting
- Maintain state rate setting

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New Nursing Facility Reimbursement System Guiding Principles

Support the Sustainability of UPL/IGT Program:

- Tie a significant portion of the UPL supplemental payments to quality
- Incentivize direct care staffing and spending
- Utilize more current data for UPL supplemental payments

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New Nursing Facility Reimbursement System Guiding Principles

Overall system improvement including improving efficiency and economy of operations:

- Incentivize the reduction of excess beds in the system consistent with other states' initiatives
- Incentivize private rooms and facility improvements
- Administrative simplification

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MLTSS Nursing Facility Reimbursement Base Rate Component Comparisons

	Current		Proposed
Direct Care	Cost w/limit		Price w/floor
Therapy	Passthrough		Passthrough
Indirect Care	Cost w/limit		Price
Admin	Price		Price
Capital	FRV		New FRV
Property Taxes	Cost w/limit		Passthrough
Quality	Add-on		in UPL
QAF	Add-on		Add-on
SCU	Add-on		*
Vent	Add-on		*

*SCU and Vent add-ons would no longer be in the base rate and qualifying patients would be billed with a qualifier that would pay them $12 more per day than the base rate for SCU patients and $80 per patient day (current est) for Vent patients.

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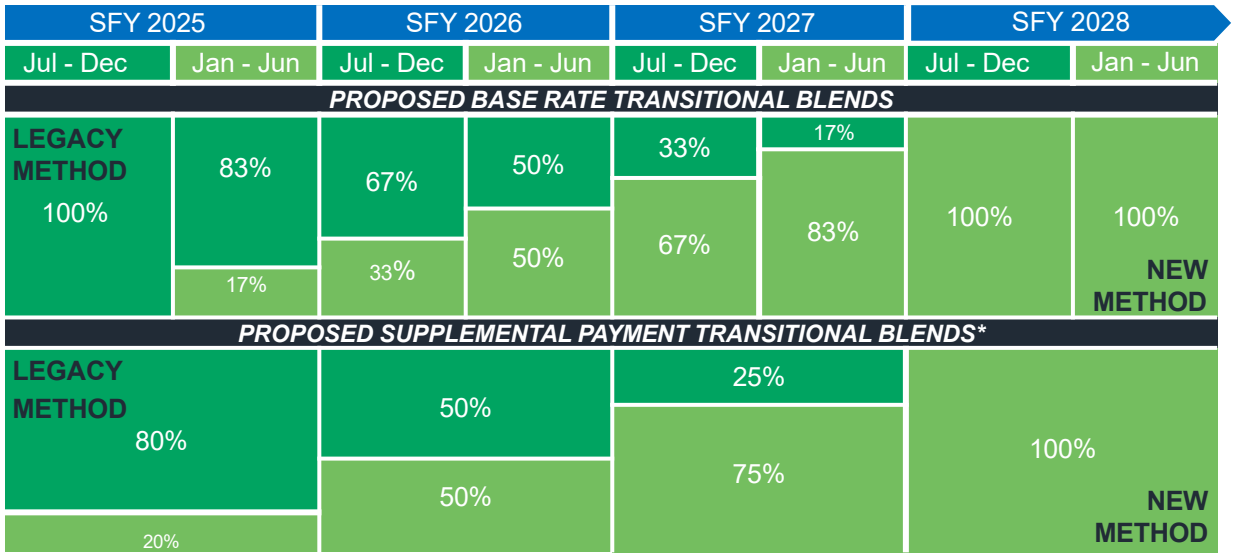
Transitional Rate Blends



* Revised due to increase in UPL payments subject to passthrough cap

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MLTSS Nursing Facility Reimbursement UPL/IGT Supplemental Payments

During the earliest meetings, Milliman and FSSA expressed concerns that the current UPL/IGT supplemental payment methodology eliminated any incentive to increase direct care staffing or improve quality since all facilities received Medicare level payment for all Medicaid patient days regardless of the Medicaid base rate. Also, there were concerns expressed that the Medicare rate for the facility was based on a snapshot of CMI on the last day of the quarter.

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UPL/IGT Supplemental Payments Current System Examples

	Facility A	Facility B	Facility C
Average Medicare Rate	325.00	375.00	375.00
Average Medicaid Rate	250.00	250.00	210.00
UPL Supplemental Payment	75.00	125.00	165.00
Intergovernmental Transfer	25.28	42.13	55.61
Net UPL Supplemental Payment	49.73	82.88	109.40
Total Medicaid Payment Per Day	299.73	332.88	319.40
Total Inflated Cost Per Day (85%)*	294.12	294.12	247.06
Net Per Day	5.61	38.76	72.34

*For 4/1/22 Rates, Avg Statewide Rate (236.50)/Average Statewide inflated costs adjusted for Medicaid Therapy (277.19)

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UPL/IGT Supplemental Payments Change in Methodology

In order to encourage direct staffing and spending as well as to have a more sustainable model given CMS review of UPL programs, Milliman and FSSA have consistently wanted to base supplemental payments on a percentage of the base rate. Thus, facilities with higher base rates due to higher allowable spending, would receive higher levels of supplemental payments than those with lower base rates.

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UPL/IGT Supplemental Payments
MLTSS Payment Pools

The UPL pool will be determined and set in the spring prior to the start of the state fiscal year. It will utilize trended Medicaid census data and estimated Medicaid rates utilizing the latest LTCIS data which should be close to the final July 1 Medicaid rates since it will be using the same cost report data.

Eight pools will be created: four pools for MLTSS base rate (one for each quarter) and four pools for MLTSS quality (one for each quarter).

Initially the total UPL allocation between the base rate pool and the quality pool will be based on 90% of the total to base rate and 10% to quality. This will phase up over time to 80% base rate pool and 20% quality pool.

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UPL/IGT Supplemental Payments
FSSA Model Impact

The current FSSA model combines two changes in concept into one total change in UPL estimate. It is important for providers to consider the two different causes of UPL change in the model:

- Change to using current census: The model includes changing from prior cost report census (2020 cost report Medicaid days pro rated to the quarter) to current census for the quarter (April 1, 2022 to June 30, 2022)
- Change to methodology: The change of methodology from the facility specific difference between the estimated average Medicare rate and the average Medicaid rate to a percentage of the Medicaid rate.

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UPL/IGT Supplemental Payments Quality Pool

As previously discussed, the quality pool allocation will be based initially on quality performance on five metrics:

- % of Long-Stay Residents Experiencing One or More Falls w/ Major Injury
- % of High Risk Long-Stay Residents w/ Pressure Ulcers
- Number of Hospitalizations Per 1000 Long-Stay Resident Days
- Number of Outpatient ED Visits Per 1000 Long-Stay Resident Days
- Total Nurse Staffing Ratio – (CMS Staffing per PBJ plus Respiratory Therapy Hours per PBJ)/CMS Expected Staffing PBJ

UPL/IGT Supplemental Payments Quality Pool

As previously discussed, the quality pool allocation will be modified as CMS quality metrics change and based on input from a nursing home quality advisory committee that will meet periodically to review quality performance, propose changes in metrics as the industry and CMS changes, etc. This committee will be included in Indiana Administrative Code so that quality metrics become more dynamic and flexible over time.

UPL/IGT Supplemental Payments Quality Pool

Due to conceptual flaws identified in the quality allocation methodology based on a review of facility specific impacts in the current model, a revised quality model is being developed which will make changes to the allocation as follows:

1. Facilities with unreported long stay measures will receive the state average for the missing measure. The current model gives the facility the average of their other reported measures.
2. The distribution/performance points awarded will be modified to allow higher achieving facilities to achieve more reimbursement per day to compensate for the IGT being deducted from the UPL supplemental payment. (e.g. top ten percent may earn more than $28 per day which after IGT translates to $18.56 per day vs the current max of $18.45)

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UPL/IGT Supplemental Payments Quality Pool

Due to conceptual flaws identified in the quality allocation methodology based on a review of facility specific impacts in the current model, a revised quality model is being developed which will make changes to the allocation as follows:

3. In order to encourage performance and to rebalance distribution, a facility will need to be in the top 60% to earn any points in a measure. Points will be totaled for the five measures and a facility can still receive some quality reimbursement even if in the bottom 40% of total points
4. The staffing measure may increase over time to allow those that increase staffing to earn more as their staffing increases. In other words, the minimum and maximum scoring for staffing may increase over time based on input from the quality advisory committee

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Resources/Contacts

IHCA Website	https://www.ihca.org/mltss-resources/
FSSA Website	https://www.in.gov/pathways/
FSSA Provider Bulletins	https://www.in.gov/medicaid/providers/provider-references/news-bulletins-and-banner-pages/bulletins/
Email	informIN@advancingstates.org

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