Care Planning: Care Coordination & Service Coordination

May 21, 2024

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Agenda For Meeting

- Overview of MLTSS Service and Care Coordination Structure
- Service Plan
- PathWays Care Transitions

Overview of MLTSS Service &
Care Coordination Structure

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

Care Coordination

- 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

Care Coordination Structure

- All members must be offered person-centered Care Coordination (CC) reflective of their needs to assist them in planning, accessing, and managing their health care and health care-related services
- MCEs must have, at minimum, 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 <u>in addition to Care Coordination</u>
    - Members receiving HCBS in the community must be in Complex Case Management as well
- Will ensure that acute/primary AND HCBS needs are addressed and coordinated

Care Coordinator

Care Coordinators shall be located in Indiana and must be one of following:

(1) Have an Indiana Licensed registered nurses in good standing,
(2) have an Indiana Licensed Master's degree in social work or therapist

And have training, expertise, and experience in providing case management and care coordination services for individuals, including specialized populations such as older adults and/or individuals with physical or developmental disabilities and/or individuals determined to have a serious mental illness (SMI).

Service Coordination

- 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.
- In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will receive 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

- Service Coordinators shall be located in Indiana while performing job responsibilities.
- Service Coordination is a vital service to members and the Service Coordinators should be engaged in the communities they serve.

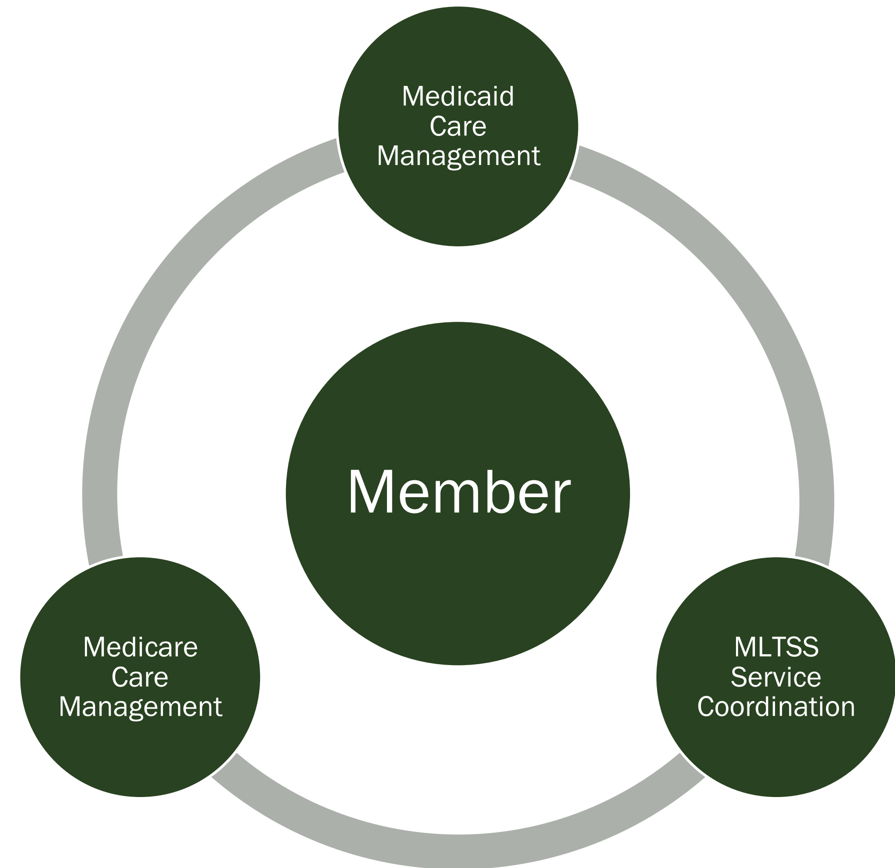
  A. Service coordinators may be an individual continuously employed as a care manager by an AAA since June 30, 2018;

  B. OR an Indiana licensed registered nurse, or a bachelor's degree or an associate's degree with one year of experience delivering health care/social services or care management,

  C. or a master's degree in a related field, which may substitute for the required experience and have training, expertise, and experience in person-centered planning.

Integration of Medicare and Medicaid Services

Integration of Medicare and Medicaid services and promote the seamless coordination of their care, this may include but is not limited to an integrated assessment and care coordination process that spans all MA and Medicare services, including behavioral health services.



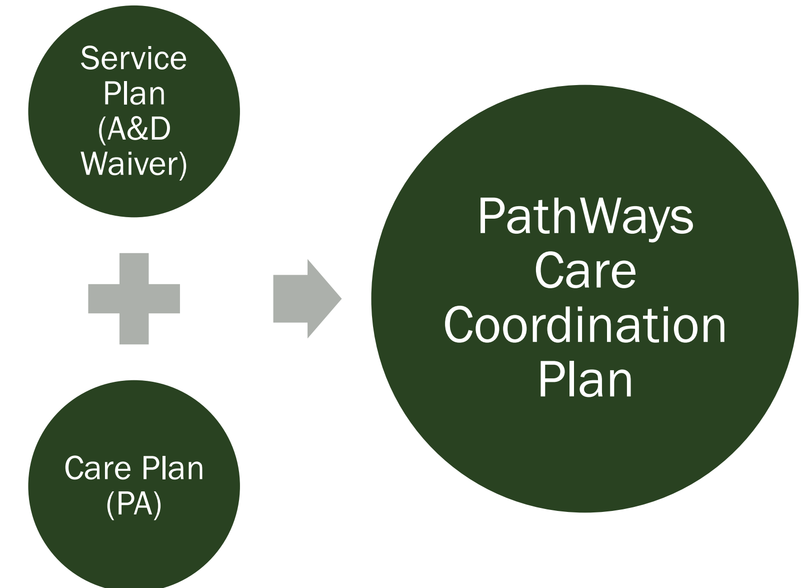
Service Plan

Person-Centered Care

Person-Centered Care: Integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together. This strengths-based, holistic person-centered approach that includes cultural considerations, is trauma-informed, and accounts for SDOH factors and health equity implications.

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 Service Plan.
- The Service Plan must meet the requirements in Federal regulation [42 CFR 441.301(c)]



Service Plan Continued

- The written 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.
  - 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 involved in the Service Planning process**.
  - 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.

Service Planning Process Tomorrow: MLTSS

MCE Service Coordinator assesses member for support needs

MCE Service Coordinator develops Service Plan with member based on support needs

MCE Service Coordinator sends referral to provider; provider receives NOA to start services

Continuity of Care

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

Collaboration

- If at any time the member indicates a needed change to their Service Plan – the SC coordinates with the Care Coordinator to have a joint discussion to modify the Service Plan.
- In addition to regular member contacts and visits, the SC meets with the Care Coordinator no less than 1 time per month to discuss member care.
- Additional contacts and visits with individual members will be required for a change in condition, change in Participant Directed Attendant Care (PDAC), ICT Meetings and Care Coordinator requests.
- The SC must be included in ICT Meetings and will collaborate with the member's Care Coordinator. SCs shall be responsible for ensuring the member's LTSS-specific Service Plan is incorporated into the ICP and any LTSS-specific updates are reflected in ICP on an ongoing basis.
- Changes to the Service Plan must be discussed with the Care Coordinator.
- The SC shall provide needed information through data exchanges to ensure HCBS and non-HCBS Services are working for the member.
- Increased complexity in working with three MCE processes and three systems.
- The SC shall work with the Housing Coordinator (through the MCE) related to requests and referrals and assistance for housing.

Interdisciplinary Care Team(ICT)

Interdisciplinary Care Team (ICT)- the MCE uses an ICT for the coordination of care for each member assigned to the Complex Case Management level of service. The MCE shall use its companion D-SNP's CMS-approved MOC to provide ICT services. At a minimum, a member's ICT must include the following:

- The member
- The member's Care Coordinator
- The member's Service Coordinator (applicable only for members who are NFLOC and receive LTSS)
- Medicare Care Coordinator (if applicable)
- Any member-selected supports, including informal caregivers

Additional resources and ICT participants may include, but are not limited to:

- The member's PMP if requested by the member or the facility's medical director as applicable
- Participants from the member's facility's care team if the member resides in a facility
- Physician(s), Nurse Practitioner and/or Physician Assistant's involved in the care of the member or who have relevant expertise to assist the member and ICT
- Physical therapists
- Occupational therapists
- Speech/language therapists
- Nutritionists or registered dieticians
- Pharmacists with polypharmacy or geriatric experience
- Behavioral health specialists

PathWays Care Transitions

Transition of Care – Continuity of Care

- Prior to effective date of enrollment MCE will receive:
- Member data
  - 6 months of claims data
  - Diagnosis
  - Hospitalizations
  - Emergency room visit history
  - High dollar – over $50k
  - Existing service plan
  - Existing assessment and level of care assessments
  - Existing authorizations – Medical and MLTSS and HCBS

- MCE initiates the member stratification and engagement process

Transition of Care - Members

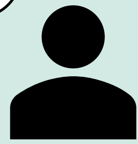
- Member handbook and welcome packet
- Introduction phone calls
- Identify language preferences
- Introduce care team
- How to reach care or service coordinator
- Reviews service plan
- Upcoming appointments
- Medications
- Member needs and priorities

Transition of Care - Providers

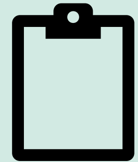
- Provide continuity of care authorizations starting 7/1/2024
  - Applicable to both in and out-of-network providers
- Coordinate care as required by the established service plans
- Ongoing provider engagement and communication
- IHCP Portal will contain MCE assignment 7/1/2024

Member’s Journey: Care Coordination Levels of Service

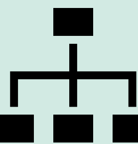
This outlines the process for members enrolling in Pathways for Aging and their assignment into a care coordination level of service.



Member enrolls with a Pathways for Aging Managed Care Entity (MCE)



Member receives an initial screening and is stratified into a care coordination level of service to ensure appropriate and timely support according to their needs



Member receives comprehensive health assessment to determine their immediate needs and health risks to aid in the creation of their care plan

Care Management

Who Qualifies: Available to all members
What’s Included: Assistance with making preventive care appointments and accessing care for needed health or social services; assigned care coordinator; 24-hour nurse call line; Individualized Care Plan (ICP); general health education
Contact Frequency*: Quarterly, in person or by phone

Complex Case Management

Who Qualifies: All high-risk/high-need members who meet State-defined criteria
What’s Included: All the services & benefits from Care Management + more comprehensive ICP and interdisciplinary care team (ICT) support
Contact Frequency*: Monthly, in-person or by phone, for members who don’t meet Nursing Facility Level of Care (NFLOC) or quarterly in alignment with service coordination activities for NFLOC members

Complex Case Management + Service Coordination

Who Qualifies: All members who are NFLOC and receive LTSS
What’s Included: All the services & benefits from Complex Case Management + a dedicated Service Coordinator to support LTSS needs and service planning
Contact Frequency*: Call or visit within 30 days of initial Service Plan activation to ensure services are delivered; monthly check-ins, in person or by phone (HCBS only); quarterly, in-person meetings to conduct needs assessments and screenings for loneliness and abuse, neglect, and exploitation; annual joint in-person meeting with the care coordinator for reassessment and care plan review

The member can choose to opt out or reduce the frequency of contacts to better fit their schedule or needs with their care coordinator. Additionally, for all members, the MCE must immediately identify and address trigger events when they occur (e.g., onsite visits within 10 days of a transition in care setting).

www.IN.gov/PathWays

IN.gov An official website of the Indiana State Government | Accessibility Settings | Language Translation | Governor Eric J. Holcomb

PathWays

Indiana PathWays for Aging

Information and Resources

- Who is eligible for the PathWays program?
- PathWays Health Plan Comparison
- PathWays History
- **Stakeholder Engagement**
- Important information and documents
- Frequently Asked Questions
- HCBS Provider Frequently Asked Questions
- Nursing Facility Frequently Asked Questions
- Glossary
- Promotional Toolkit

How PathWays Helps Hoosiers Like You

- Sofia
- John
- James

PATHWAYS / STAKEHOLDER ENGAGEMENT

Stakeholder Engagement

Stakeholder engagement is essential, and FSSA is committed to co-designing an Indiana Pathways for Aging program that is right for older Hoosiers. The state is engaging national experts, providers, members and caregiver communities to ensure a diverse range of voices is represented.

Stakeholders:

- Recipients and families
- Caregivers
- Nursing homes
- Assisted living facilities
- Home-based providers
- Health care providers
- Area Agencies on Aging
- AARP
- Advocates
- Experts in the needs and wellness of older adults
- Health coalitions (Indiana Minority Health Coalition, Faith-based groups)

The information on this website does not apply to long-term services and supports for adults with intellectual or developmental disabilities under age 60. To learn more about LTSS services available through the Division of Disability and Rehabilitative Services, please visit www.in.gov/fssa/ddrs.

Webinars/Announcements:

- MCE Joint Presentation LTSS Claims Testing (May 15, 2024)
  - Presentation
- MCE Joint Presentation: Provider Test Claims Training (4/29/24)
  - Presentation
- PathWays Stakeholder Update (4/18/24)
  - Presentation
- All MCE Joint Presentation Provider Claims Training (4/16/24)
  - Presentation
- Member Education (4/4/24)

*Slides and recordings are posted within a week to the Stakeholder Engagement section of the PathWays website

PathWays
FOR AGING

May 21, 2024