The Indiana Family and Social Services Administration

Coordinated Care for Indiana Medicaid's Disabled Population

April 23, 2014






Agenda

- Overview of current programming for Indiana Medicaid disabled enrollees
- Upcoming changes
- Overview of new disabled coordinated care program
- Goals and values of new disabled coordinated care program
- Next steps

FSSA House Enrolled Act 1328 Process – Laying the Foundation for New Disabled Coordinated Care Program

- House Enrolled Act 1328, passed in 2013, tasked FSSA to report on managing Indiana Medicaid aged, blind and disabled enrollees
- This process laid the foundation for FSSA's recommendation to proceed with a new disabled coordinated care program

Aged, Blind and Disabled (ABD) Task Force

- Comprised of staff from across FSSA divisions

Analysis of Indiana Medicaid for the ABD

- Enrollment and expenditures
- Current programming
- Identification of practices within current programs aligned with managed care goals and processes

FSSA House Enrolled Act 1328 Process - Continued

Nationwide Trends

- Review of national trends in managing ABD populations
- Medicaid managed care strategies

Analysis of Impact of Managed Care Models

- Actuarial analysis of fiscal impact
- Development of key principles
- Review of options

Stakeholder Engagement

- Public meetings
- Presentations and written comments
- Stakeholder survey
- All materials available at http://www.in.gov/fssa/4828.htm

Overview of Current Programming and Upcoming Changes for Indiana Medicaid Disabled Enrollees

Indiana Medicaid – Current Programming for Disabled Enrollees

- Medicaid enrollees with a disability are currently served under the fee-for-service (FFS) program
- Voluntary enrollment in Care Select is available to a subset of the disabled population
- Care Select provides
  - Disease management
  - Care management
  - Complex case management
  - Assignment to primary medical provider

OVERVIEW OF FFS

Enrollees can seek care from any Medicaid enrolled provider

Enrollees are not linked to single entity or provider responsible for the overall management of healthcare needs and services

Recipients do not generally receive Medicaid funded assistance in accessing or coordinating services

Providers are reimbursed for each service rendered

Opportunities for Improvement in Care Delivery for Disabled Enrollees

- Within the current fee-for-service program there are examples of management strategies which seek to:
  - Encourage community-based versus institutional placement
  - Authorize services in the appropriate amount, duration and scope
  - Coordinate care
  - Promote quality outcomes
- There are additional opportunities for improvement in the delivery of care

SHORTCOMINGS OF THE CURRENT FFS MODEL

Does not tie service delivery to quality measures or clinical outcomes

Lacks integration and care coordination among delivery system providers

Lacks incentives to actively transition individuals to community-based vs. institutional care

No overarching entity or provider responsible for outcomes across the healthcare delivery system

Care Select

- Today, voluntary enrollment in Care Select is available to a subset of the disabled population
  - Non-duals*
  - Not enrolled in a HCBS waiver
  - Must have eligible diagnosis
- Care Select will be discontinued and enrollees will be transitioned to new disabled coordinated care program

SHORTCOMINGS OF THE CURRENT CARE SELECT MODEL

- Limited financial incentive for increased care coordination
- Limited financial incentive for contracted entities to manage risk
- Limited opportunity for flexibility in authorization of services
- No opportunity for negotiation of higher rate with providers to meet network requirements
- Does not provide budget predictability

*Individuals not enrolled in Medicare

Planned Improvements to Address the Needs of Disabled Enrollees

FSSA Goal: Improved processes and outcomes for disabled enrollees from eligibility determination through care delivery

Disability Eligibility Changes: 2014

- Outcomes of transition from 209(b) to 1634 status
  - Simplified eligibility processes
  - More comprehensive coverage for spend down members
  - Ability to cover more low income Hoosiers

Disabled Care Coordination Program Implementation: 2015

- Enrollment of a portion of the disabled population into new coordinated care program
- Anticipated outcomes include:
  - Improved care coordination across the healthcare delivery system
  - Promotion of preventive and holistic care addressing physical, behavioral, medical and social needs
  - Increased consumer engagement in the management and treatment of their conditions
  - Improved quality of care and health outcomes
  - Health plans introduce greater accountability

Disabled Coordinated Care Program Overview

Program Goals and Values

In designing the new disabled coordinated care program, FSSA sought to achieve the goals and values informed by stakeholder feedback to the ABD Task Force convened for House Enrolled Act 1328.

Improve quality outcomes and consistency of care across the delivery system

- Develop financial incentives aligned with quality outcomes
- Establish quality measures

Ensure enrollee choice, protections and access

- Provide and promote consumer choice and autonomy
- Provide person-centered and local in-person care

Program Goals and Values - Continued

Coordinate Care Across the Delivery System and Care Continuum

- Acknowledge the whole person and span the healthcare delivery system
- Reduce duplication and uncoordinated care

Provide Flexible Person Centered Care

- Promote flexible care plans which address the whole person
- Address unique client needs and develop individualized service plans

Transition Planning, Contract Oversight and Implementation Issues

- Ensure state oversight and contractor accountability
- Minimize client impact during transition

Overview: Contract with Managed Care Entities (MCEs)

- State develops contract with MCEs to provide statewide coverage to eligible enrollees
- MCEs receive per member per month payments and are at financial risk for all services included in contract
- MCE develops network of providers and reimburses claims
- MCEs are accountable for achieving metrics related to outcomes, process, quality and satisfaction
- Contract incorporates financial incentives tied to achievement of performance metrics

Overview: Examples of MCE Functions

Function	MCE Requirement Examples
Quality Improvement	• MCE to meet State-defined quality and process measures • Development of quality improvement program
Member Services	• Provision of care coordination, case management and disease management • Operation of customer service number and 24 hour nurse hotline • Processing grievances and appeals
Utilization Management	• Prior authorization and concurrent review
Provider Network	• Contracting and credentialing provider network
Information Systems	• Processing provider claims • Developing health information technology programs • Submitting data to the State
Administrative Requirements	• Development of infrastructure and staffing • Meeting requirements for solvency and financial stability • Meeting medical loss ratio requirements

Included Populations

Population	Description	Enrollees Over 21	Enrollees Under 21
MA-U	SSI recipients currently enrolled in Hoosier Healthwise (HHW). These individuals will move into an ABD category effective 6/1/14 due to 1634 transition. Will transition from HHW to new disabled coordinated care program.	5,500	11,000
M.E.D. Works Non-Dual	Individuals age 16-64 who are working and disabled with income below 350% of the federal poverty level.	1,500	-
Care Select Non-Dual	Individuals qualifying for Medicaid because of disability who have at least one chronic medical condition qualifying them for current Care Select program.	21,000	1,000
Spend Down Non-Dual	Individuals who will transition to full Medicaid eligibility with State's 1634 transition 6/1/14.	2,000	-
Community Non-Dual	Individuals qualifying for Medicaid because of disability who reside in the community and are not enrolled in a HCBS waiver.	29,500	4,000
TOTAL		59,500	16,000
GRAND TOTAL		**75,500**	

SFY 2013 Enrollment – Rounded to Nearest 500 – Excludes Retroactive Eligibility – Does not Reflect Un-Enrolled Individuals Receiving SSI

Excluded Disabled Populations

Population	Rationale for Exclusion
Individuals Dually Eligible for Medicare and Medicaid	• Inclusion will not financially benefit the State until federal rules change to allow states to share in savings achieved by managed care for duals
Institutionalized Enrollees	• Prevents disruption in nursing home supplemental payments
HCBS Waiver Enrollees	• Prevents duplication and disruption to current waiver case management
Money Follows the Person Grant Enrollees	• Prevents duplication and disruption to current case management

Other Excluded Populations

- Undocumented persons eligible for emergency services only
- Wards, foster children and former foster children
- Children receiving adoption assistance
- Individuals enrolled in Hoosier Healthwise or Healthy Indiana Plan
- Individuals enrolled in the Family Planning Eligibility Program
- Breast and Cervical Cancer Program enrollees
- Medicare Savings Program enrollees

Overview of the Eligible Population

This list represents the top diagnoses/conditions of the eligible population.

Adults

- Cardiovascular
- Psychiatric
- Skeletal and Connective
- Gastrointestinal
- Pulmonary
- Diabetes

Children

- Psychiatric
- Hearing
- Pulmonary
- Nervous System
- Skeletal and Connective
- Metabolic

Covered Benefits

While MCEs are not financially responsible for carved-out services, they must ensure coordination of all Medicaid covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

Included Benefits

- Primary care
- Acute care
- Prescription drugs
- Behavioral health
- Emergency services
- Transportation

Carve-Outs

- Medicaid Rehabilitation Option Services (MRO)
- 1915(i) State Plan Home and Community Based Services
- Dental
- FirstSteps
- Individualized education plans

Excluded Services

Individuals enrolled with a MCE who become eligible for an excluded service will be transitioned to fee-for-service

- Nursing home care
- State psychiatric hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- HCBS waivers

Role of Area Agencies on Aging (AAAs)

HCBS Waivers

- Will continue current functions
  - Level of care determinations
  - Needs assessment
  - Case management processes

Pre-Admission Screening (PAS)

- Individuals enrolled with a MCE who are admitted to a nursing facility for long-term care will continue to have PAS conducted by AAA
- MCEs will be required to coordinate with nursing facility to ensure timely submission

Program Goals

Strategies to Improve Quality Outcomes and Consistency of Care Across the Delivery System

Quality Management and Improvement

- MCEs required to have ongoing quality assessment and performance improvement activities
- Participation in State's quality strategy processes and development of MCE internal quality management and improvement committee required
- Required reporting on clinical outcomes, patient satisfaction and quality of life indicators
  - Examples: Engagement in workforce or volunteer activities, inpatient readmission rates, emergency room utilization rates, rates of outpatient visit following inpatient stay, etc.

Strategies to Improve Quality Outcomes and Consistency of Care Across the Delivery System - Continued

Pay for Performance and Penalties

- MCE payments tied to outcomes
  - Withholds and bonuses which can be earned only by achieving outcomes
  - Must demonstrate both attainment of goals and maintenance or improvement from previous years
- Liquidated damages assessed when metrics not achieved
  - Ex: Timely claims payment, timely prior authorization processing, member call center performance
- MCEs required to establish physician pay-for-performance program

Strategies to Improve Quality Outcomes and Consistency of Care Across the Delivery System - Continued

National Committee for Quality Assurance (NCQA) Accreditation

- Standardized survey process which evaluates the insurers on areas such as:
  - Quality management and improvement
  - Utilization management
  - Credentialing and re-credentialing
  - Members' rights and responsibilities
  - Compliance with federal Medicaid requirements

Strategies to Coordinate Care Across the Delivery System and Care Continuum

Requirements for Care Coordination

- Option for MCEs to utilize primary medical provider (PMP) model
  - Must demonstrate how care coordination and continuity of care is achieved if PMP model is not proposed
- Contract requirements surrounding follow-up care requirements after inpatient hospitalization and contact if enrollee misses follow-up appointment
- Health screening required for all enrollees and case management services based on assessed need

Strategies to Coordinate Care Across the Delivery System and Care Continuum - Continued

Behavioral Health Integration

- Strategies to ensure collaboration between behavioral and physical health providers
  - Examples:
    - Profiles shared among providers detailing physical and behavioral health utilization and treatment plans
    - Notification required when behavioral health treatment initiated
    - MCEs required to propose other coordination efforts and strategies

Strategies to Coordinate Care Across the Delivery System and Care Continuum - Continued

Covered Benefits

- Contract covers most Medicaid covered services to ensure single entity responsible for coordination across the delivery system
- Where services are carved-out, MCEs must demonstrate coordination and strategies to prevent duplication and fragmentation

After-Hours Access to Services

- MCEs required to operate 24 hour nurse line

Strategies to Ensure Enrollee Choice, Protections and Access

MCE Choice

- State will contract with a minimum of two MCEs
- Enrollees select MCE
- Enrollment Broker as neutral third party to assist in MCE selection

Network Adequacy Requirements

- MCE required to meet State defined network requirements
- Out-of-network care required when access standards are not met

Strategies to Ensure Enrollee Choice, Protections and Access - Continued

Strategies to Promote Enrollee Rights

- Access to Independent Review Organization and State Fair Hearing process for medical necessity appeals
- MCE required to have dedicated Member Advocate/Non-Discrimination Coordinator
- MCEs required to convene Member Advisory Committee to engage consumers and stakeholders
- Maintenance of current processes to ensure appropriateness of institutional placements
  - AAA will continue to provide Options Counseling and preadmission screenings
- Access to Enrollment Broker for review of "just cause" disenrollments after first 90 days of enrollment with MCE

Strategies to Provide Flexible Person Centered Care

Health Screening and Assessment Requirements

- Health screening required for all enrollees
- Initial screening to be followed with detailed assessment by healthcare professional when screening indicates clinical needs

Case Management/Care Management Requirements

- Individualized care plans developed based on assessed needs by individual with clinical training
  - Care plan development process incorporates individuals of client's choosing
- Face-to-face contact required where indicated

Strategies to Provide Flexible Person Centered Care - Continued

Enhanced Benefits

- MCEs required to propose enhanced services
- Flexibility of MCEs to authorize care in more flexible manner versus being tied to State Plan limits on benefits
- Inherent incentive for MCEs to invest in services which lead to long-term savings from declines in health status
  - Example: home modifications

Strategies to Address Transition Planning, Contract Oversight and Implementation Issues

Readiness Review

- Prior to receiving enrollment MCEs required to demonstrate readiness
- Includes both onsite and desk reviews
- MCEs failing to demonstrate readiness do not receive enrollment until compliance demonstrated

Ongoing Monitoring Strategies

- Regular reporting of operational, fiscal and quality measures
- Monthly onsite visits
- Policy and procedure review
- Unannounced site visits
- Review of all communication materials prior to distribution

Strategies to Address Transition Planning, Contract Oversight and Implementation Issues - Continued

Contract Penalties and Incentives

- Liquidated damages for failure to meet contract requirements
- Pay for performance tied to quality outcomes

External Quality Review

- Annual review of performance and compliance conducted by neutral third party

Medical Loss Ratio (MLR)

- MCEs must meet MLR requirement to ensure that state dollars are spent on service provision

Strategies to Address Transition Planning, Contract Oversight and Implementation Issues - Continued

Continuity of Care Provisions

- Requirement to honor previously authorized services
  - 90 days during 1st year of contract
  - 30 days during 2nd year and beyond
- For enrollees transitioning from Care Select, MCE must maintain case management stratification and services until new assessment completed
- During first 90 days of contract, even if network access requirements are met, MCE to permit ongoing care from current non-network provider
- Require MCEs to designate Transition Coordinator to oversee all member transitions
- MCEs to develop procedures for identifying outstanding authorizations at time of enrollment

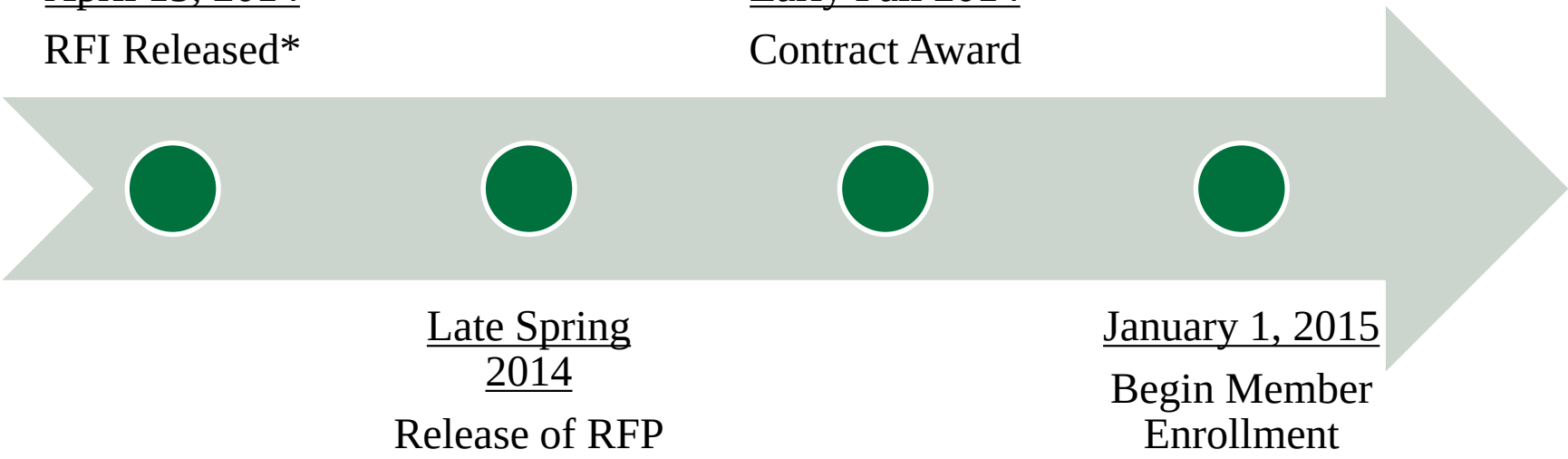
Strategies to Address Transition Planning, Contract Oversight and Implementation Issues - Continued

Provider Payment and Contracting Issues

- Requirements for claims payment timeliness
- Require payment for EMTALA screening exam, at minimum, when prudent layperson standard for an emergency is not met
- Minimum payment requirements for authorized out-of-network services
- State review of model provider contracts and requirements for provisions to be included in provider contracts

Next Steps

Timeline



All dates are estimated

*The RFI is available at www.in.gov/idoa/ under the "Current State of Indiana Opportunities" in the "Procurement" section

Additional Next Steps

- Contest to name the program
  - Email your entry to ABDTaskforce@fssa.IN.gov
  - Deadline: 6/1/14
- Additional meetings to be held on program implementation issues

For More Information

- Updates will be made available via:
  - http://www.fssa.in.gov
    - Under “Resources”
    - Under “Aged, Blind and Disabled Task Force”
- Questions and comments can be submitted to ABDTaskforce@fssa.IN.gov

Reminder: Please be sure to include your name and email address on the sign-in sheet so we can add you to our distribution list

Questions?