MLTSS 101

October 12, 2022

Advancing States

Leadership, innovation, collaboration
for state Aging and Disability agencies

Agenda For Meeting

WELCOME AND INTRODUCTION

TODAY'S SPEAKER

FSSA VISION FOR LTSS REFORM

THE BASICS OF MLTSS

QUESTIONS

FUTURE EDUCATION TOPICS

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Today's Speaker – Camille Dobson

Camille Dobson
Deputy Executive
Director

- Currently provide intensive TA to states operating MLTSS programs
  - Develop and manage semi-annual full day conferences on MLTSS
  - Co-author of eight MLTSS Institute papers

- Senior Policy Advisor on Medicaid Managed Care at CMS
  - Primary author of CMS MLTSS guidance and MLTSS sections of Medicaid managed care regulations

- 20 years experience in Medicaid managed care policy and operations

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FSSA Vision for LTSS Reform

Why Reform Indiana's LTSS System?

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

Choice: Hoosiers want to age at home
- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home*
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing long-term sustainability
- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

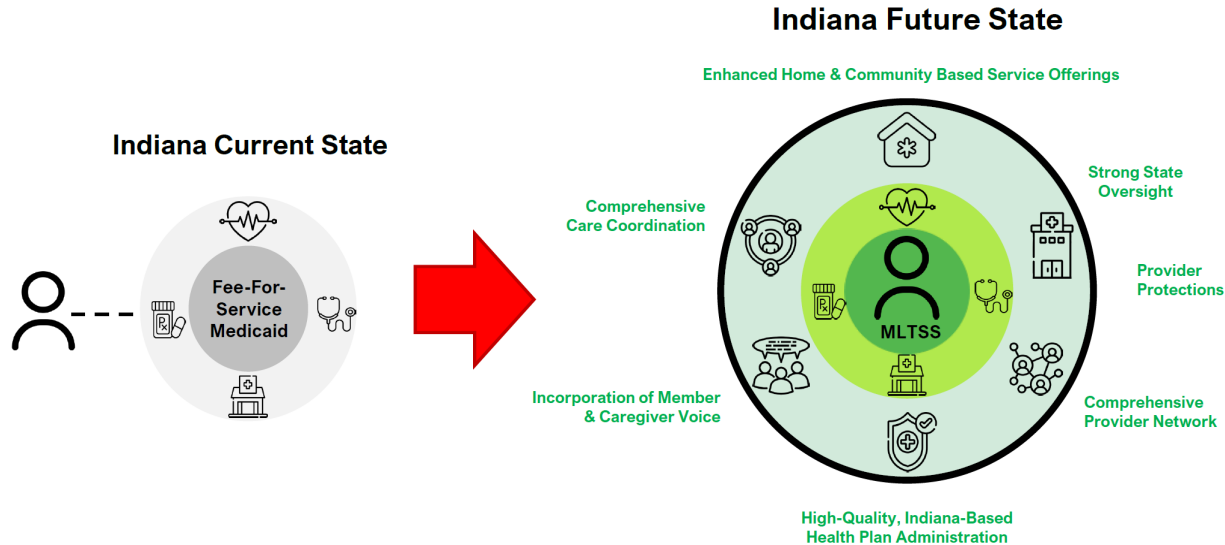### Quality: Hoosiers deserve the best care
- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

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Indiana's Path to Long-term Services and Supports Reform

Our Objective

1) 75% of new LTSS members will live and receive services in a home and community-based setting
2) 50% of LTSS spend will be on home- and community-based services

Indiana Current State

Fee-For-Service Medicaid

Indiana Future State

Enhanced Home & Community Based Service Offerings

Comprehensive Care Coordination

Strong State Oversight

Provider Protections

MLTSS

Incorporation of Member & Caregiver Voice

Comprehensive Provider Network

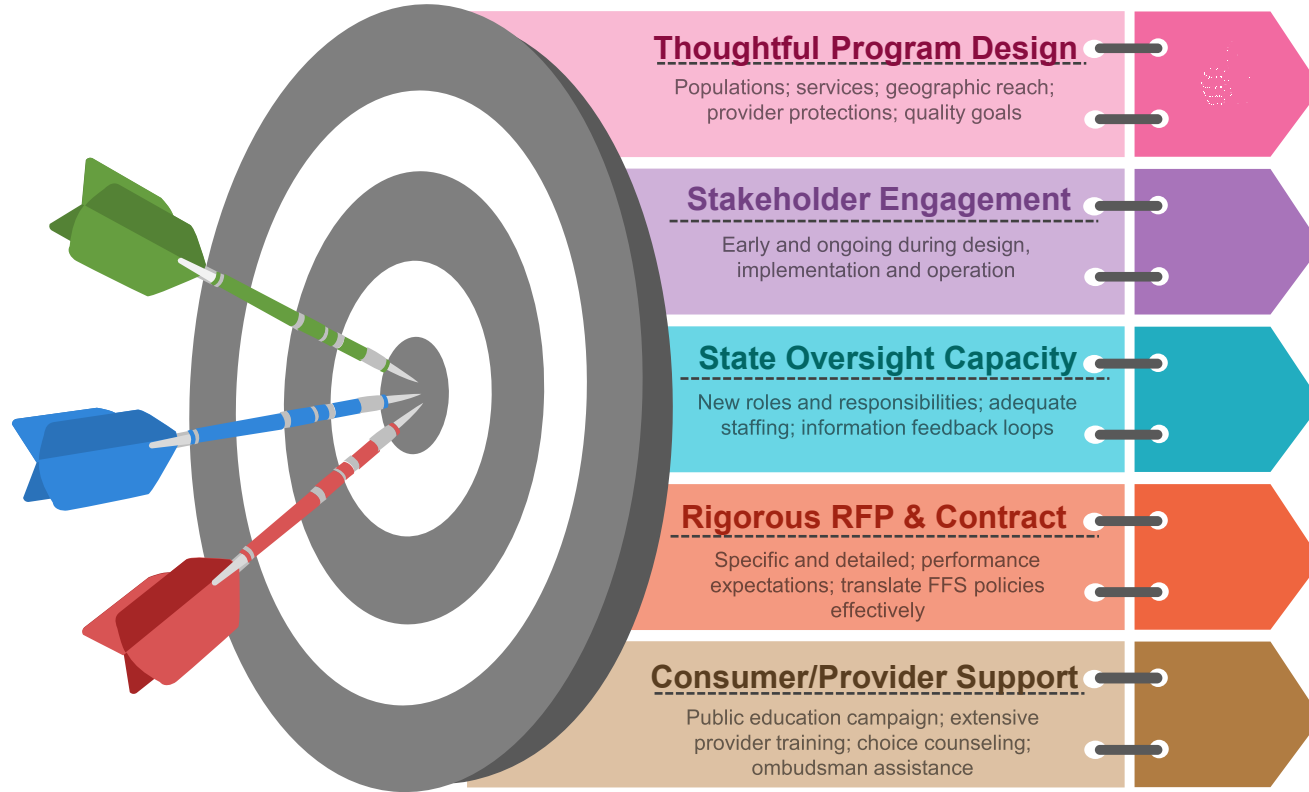High-Quality, Indiana-Based Health Plan Administration

The Basics of MLTSS

Managed Long-Term Services and Supports

- MLTSS is a delivery system that uses managed care entities (MCEs) to coordinate long-term services and supports (LTSS) to enrolled Medicaid beneficiaries

- The state decides which LTSS services the MCEs will be responsible for delivering

- Indiana's mLTSS program will have MCEs deliver acute and preventive care services as well as waiver and NF services

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Key Elements for a Successful MLTSS Program

Thoughtful Program Design
Populations; services; geographic reach; provider protections; quality goals

Stakeholder Engagement
Early and ongoing during design, implementation and operation

State Oversight Capacity
New roles and responsibilities; adequate staffing; information feedback loops

Rigorous RFP & Contract
Specific and detailed; performance expectations; translate FFS policies effectively

Consumer/Provider Support
Public education campaign; extensive provider training; choice counseling; ombudsman assistance

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Typical State Goals for MLTSS Programs

Accountability	• State can drive performance through contracting with few entities • Eliminates state-run insurance company
Access	• Reduce HCBS waiting lists • Increased use of primary and preventive care
System Balance	• Increase HCBS options (consistent with consumer desire) • MCEs have incentive to maximize aging at home opportunities
Innovation and Quality	• MCEs have more flexibility in service array than the state • Focus on integrated care and services • Can better measure health and quality of life outcomes
Budget Predictability	• Capitation minimizes unanticipated spending • May slow growth in per-person costs

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Indiana's Goals for mLTSS

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

CHOICE

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

QUALITY

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

COST

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

MLTSS Across the Country – April 2022

Legend:
- Current MLTSS program (regional **)
- Duals demonstration program only
- MLTSS in active development
- MLTSS under consideration

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Key Characteristics of MLTSS

Capitated Payment

MCEs are paid a monthly fee for each enrollee ('capitation')

MCE is responsible for coordinating and ensuring receipt of all authorized and covered services.

MCE is 'at risk' in this arrangement:
- ➢ if costs exceed payment, MCE loses money
- ➢ if payment exceeds costs, MCE makes money

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Capitated Payment

- States need to guard against underutilization
  - encounter data analysis; medical/loss ratio reports; case audits; complaint data

- Rates must be actuarially sound

- States may pay differential rates per enrollee (rate cells) to MCEs based on enrollee's health status

- States may require or recommend Value-Added Services (VAS)

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Accreditation

- Indiana will require MCEs to be NCQA-accredited

- NCQA imposes strict requirements in all the following areas:

Quality Management	Population Health Management
Network Management	Utilization Management
Credentialing	Member Experience

- MCE is expected to ensure that requirements flow down to providers (where appropriate)
  - Specific quality measures are required (HEDIS)

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Member Services

- Staff available at 800 # to help find provider, answer benefits and other questions

- 24- hour nurse call line to minimize non-urgent use of ED

- Required to provide interpreters (for any member-facing activity)

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Provider Network Management

- Detailed provider contract
  - separate from Medicaid provider enrollment process

- Network adequacy & accessibility standards for LTSS providers

- Credentialing process – consistent with state/waiver requirements

- More reporting requirements than FFS

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Provider Network Management

- Payment
  - State may mandate payment floors as well as move from fee-for-service to Value-Based Payment arrangements

- Special Investigative Unit (provider fraud)

- Formal compliance program to regulate internal processes and external partners and ensure consistency with state/federal requirements

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Claims Payment

- Training on each MCE's system

- Timeliness of billing submissions from providers as well as payment to providers
    - Process is typically electronic, although states may require acceptance of paper claims
    - Service authorization needs to match
    - Provider billing info needs to match

- Appeals process

- Basis of encounter data reported to state

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MCE Case Management/Service Coordination

☑ Will be responsible for coordinating full suite of member benefits – both Medicaid and Medicare	☑ Provide a designated Service Coordinator (point of contact) for enrollees getting LTSS
☑ Perform regular assessments, LTSS service planning, and medical care planning	☑ Will have mandatory caseload sizes and requirements surrounding frequency of visits
☑ Communicate regularly with member and providers	☑ Will be required to have 50% of enrollees served by existing waiver care management entities

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MCE Care/Service Coordination

1 — Promote navigation of service options and benefits (medical, transportation, pharmacy, dental, etc.)

2 — Perform population health interventions (risk stratification/disease management programs)

3 — Support enrollees during transitions between settings

4 — Provide education to individual, families, caregivers (anyone in the circle of support)

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Quality

Formal structure

- Template/process to document processes and outcomes

HEDIS

- Medical as well as LTSS metrics

Member experience/satisfaction surveys

- Examples include NCI-AD and CAHPS

Annual external quality review and performance improvement projects (PIPs)

- Outcome improvement and risk reduction

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Questions

Future Education Topics

HCBS Provider Virtual Sessions

October 19	MCE Contracting
October 26	MLTSS Implementation: Provider Success Stories
November 9	MCE Claims Payment
November 16	Care and Service Coordination
November 30	Quality and Managed Care Oversight

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Resources/Contacts

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

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Thank you!

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Leadership, innovation, collaboration
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