MLTSS Quality

November 30, 2022

Agenda For Meeting

WELCOME AND INTRODUCTION

CHANGES TO THE MEDICAID SYSTEM

MCE QUALITY PROCESSES

QUESTIONS

Today's Speaker – Camille Dobson

Camille Dobson
Deputy Executive Director

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

Delivery System Changes for Older Hoosiers

Why Reform Indiana's LTSS System?

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

Choice: Hoosiers want to age at home

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

Cost: Developing long-term sustainability

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

Quality: Hoosiers deserve the best care

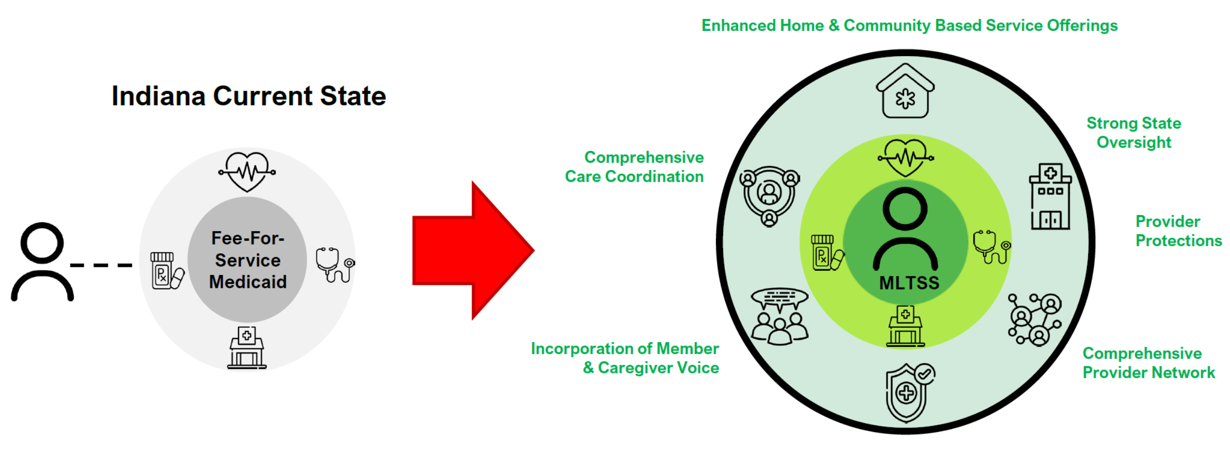
- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

*Accurate as of January 2020

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

Our Objective

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



The Basics

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

Some are already in managed care

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

Most are in FFS

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

The Basics

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

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

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

Each MCE will be responsible for ensuring delivery of high-quality services to their enrollees

Overview of MLTSS Quality Management

MCE Accreditation

- All MCEs must be accredited by the National Committee on Quality Assurance (NCQA)
  - The ‘gold standard’ for assessing health plan performance (https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/)
- NCQA health plan standards provide a current, rigorous and comprehensive framework for essential quality improvement and measurement.
- NCQA standards are a roadmap for improvement—organizations use them to perform a gap analysis and align improvement activities with areas that are most important to states such as network adequacy and member rights.

MCE Accreditation

- Health plans' policies and procedures (and compliance with them) are assessed in the following areas:
  - Quality Management and Improvement.
  - Population Health Management.
  - Network Management.
  - Utilization Management.
  - Credentialing and Recredentialing.
  - Members' Rights and Responsibilities.
  - Member Connections.
  - Medicaid Benefits and Services.
- Provides states with an independent assessment of health plan performance

External Quality Review

- In addition to NCQA accreditation, Federal regulations require states to conduct an annual, external independent review of each MCE's quality of, timeliness of and access to health care services.
- Any findings from the EQR must be addressed by the MCE through a corrective action plan.
- NCQA accreditation findings and EQR findings paint a fairly complete picture of how the MCE is performing.

Compliance with Federal HCBS Requirements

- Each MCE must have processes and procedures to be able to report the necessary data to FSSA in order to comply with 1915(c) waiver assurances and subassurances.
- Each MCE must ensure that all staff and providers report critical incidents to FSSA consistent with waiver requirements
  - Tracking of reported critical incidents is required to identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents

Quality Provisions in MLTSS SOW

Program Quality Goals *

- Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses SDOH.
- Ensure continuity of care and seamless experiences for members during transitions
- Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7, page 196

Required MCE Quality Activities *

1. Measure and report to the State on its performance to determine the quality and appropriateness of care and services furnished to all enrollees.
2. Complete up to 3 State-specified quality improvement projects each year.
3. Implement up to 3 State-defined initiatives or interventions annually, in support of the program's quality goals.
4. Design and implement at least one specific and measurable initiative to support each of program's quality goals, including one to address equity.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7.1, page 197

Required MCE Quality Activities *

5. Actively participate in and contribute to program-wide quality improvement activities;

6. Design improvement activities to support the quality of program, services, using input from members, informal caregivers and providers.

7. Create a Member and Informal Caregiver Advocacy Committee.

8. Produce quality of care reports as required by FSSA.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7.1, page 197

Required MCE Quality Activities *

- Each MCE must submit a Quality Plan to FSSA each year that tells FSSA how the MCE is going to address quality throughout the organization.

- It will include:
  - Detailed work plan
  - How the MCE will get feedback on quality from members and providers
  - How the MCE will look at quality of care and utilization of services and supports
  - How the MCE will collect data and use that to address quality issues
  - How the MCE will actually implement changes to improve the quality of care they deliver activities

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7.1.2, page 199

Required MCE Quality Activities *

- The MCE is also required to perform annual surveys including member, informal caregiver, and provider surveys.
  - Required member-focused surveys:
    - CAHPS (health plan satisfaction survey – https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html)
    - HCBS CAHPS (HCBS satisfaction survey – https://www.ahrq.gov/cahps/surveys-guidance/hcbs/index.html)
    - NCI-AD (HCBS quality of life survey - (https://nci-ad.org/)
  - Caregiver and provider surveys not specified
- Information and findings from those surveys can be used to assess quality of care and identify areas for improvement

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7.2, page 209

FSSA Monitoring Activities

- FSSA will conduct ongoing monitoring of the MCE, which could include:
  - Performance and findings related to quality measures and audits
  - Member enrollment, disenrollment, satisfaction, appeals
- FSSA may publish provider-level quality performance data and information
- Beginning in year two, FSSA may utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of an MCE *

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 10, page 248

Pay for Outcomes Structure *

- FSSA has established a pay for outcomes (P4O) quality incentive program for MCEs
- At the start of each contract year, FSSA will withhold (keep) a specified percentage of the MCE's monthly capitation payment, called a performance withhold
  - For contract year 1, the percentage is 1.85%
  - For an MCE with an average monthly enrollment of 40,000 members, that amount is roughly equivalent to $1.8 million/month

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-O-Exhibit-2-Compliance-and-P4O.pdf , Section B, page 10

Pay for Outcomes Structure *

- The MCE can ‘earn’ back part of the total performance withhold amount by meeting the below standards (as well as others identified by FSSA):
  - Having a specified percentage of Service Coordinators completing training modules annually with demonstrated person-centered planning competencies, as defined as a score of 85% or higher for each module.
  - Completing a specific percentage of health needs screening (including SDOH screen) for enrollees within 90 days of enrollment,
  - Ensuring that a specified percentage of members receive their personal care services on time, based on EVV data.

* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-O-Exhibit-2-Compliance-and-P4O.pdf , Section B, page 10

Value–Based Payment Program

Value-Based Payment (VBP)

- FSSA will develop a VBP program for MCEs to implement with their network providers *
  - MCEs are permitted to create their own VBP program to supplement the state program

- VBP is defined as 'linking provider payment to improved performance by health care providers'

- VBP programs use alternative payment models, which changes the way Medicaid providers are paid, moving away from FFS (rewarding volume), to methods of payment that incentivize value.

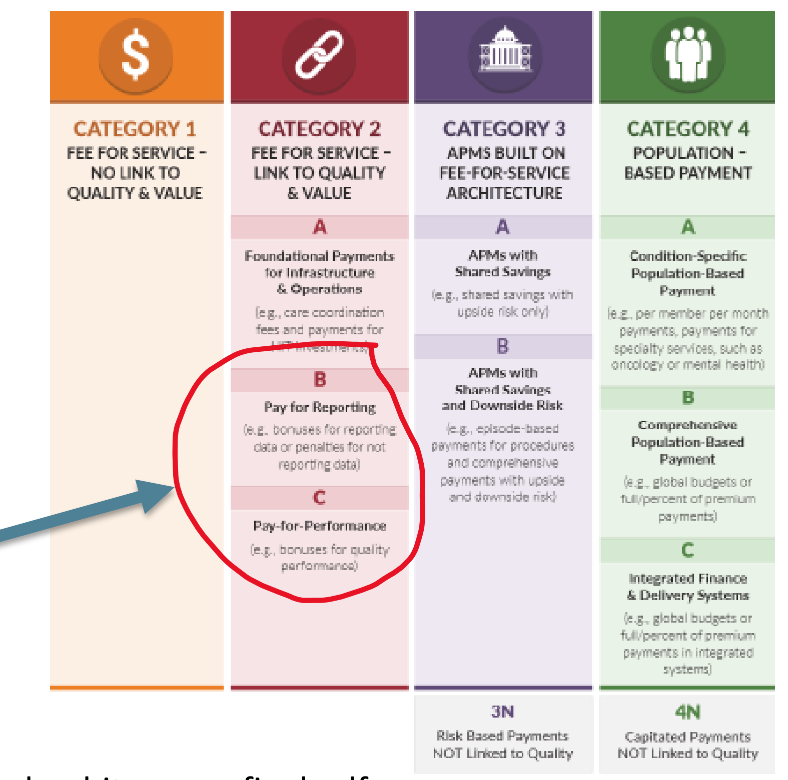
* https://www.in.gov/fssa/long-term-services-and-supports-reform/files/RFP-23-72118-Att-N-Exhibit-1-Scope-of-Work.pdf, Section 7.3, page 211

Value-Based Payment (VBP)

Alternate Payment Model Framework

(defined by CMS) *

HCBS providers will likely start here



* http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Value-Based Payment (VBP)

- Providers may be paid the state fee schedule rate, but also may be eligible for a incentive payment (or VBP) from the MCE based on an event or performance measurement:
  - Milestone
  - Outcome
  - Quality-related performance
  - Other specified criteria

- Building a VBP program is complex and takes time

VBP Program Elements

Plan
- Set Policy Objectives
- Engage Stakeholders

Develop
- Develop Measurement System
- Collect Data

Assess
- Develop Financial Model
- Measure Performance

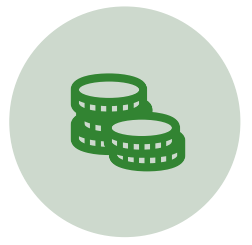
* https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/program-areas/vbp-hcbs-strat-prog-accom-webinar.pdf

VBP Challenges

IDENTIFYING THE VALUE PROPOSITION

AVAILABILITY OF DATA THAT CAN MEASURE PROGRESS TOWARD VALUE PROPOSITION

CLEAR COMMUNICATION TO AND EDUCATION OF PROVIDERS



BUILDING A FINANCIAL MODEL THAT PROVIDES ENOUGH FUNDING TO DRIVE BEHAVIOR CHANGE

Questions

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

Recordings of prior webinars and associated materials can be found at http://www.advancingstates.org/long-term-services-and-supports-provider-training

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