House Enrolled Act 1001- 2021

Managed Long-Term Services and Supports (MLTSS) Report

February 1, 2022

Introduction

Over the past year, FSSA has engaged with stakeholders in an intensive co-design process leveraging over 200 stakeholder meetings and 20,000 State staff hours into a well-formulated design for a Managed Long-Term Services and Supports (MLTSS) program. The program which will serve over 120,000 Hoosiers in the early years and 165,000 Hoosiers by 2029 is now in the final stages of development. MLTSS, a proven model across the country, was selected because it builds on FSSA's current successful managed care models of care and will afford the opportunity for more Hoosiers to age at home, enhance quality of care and life wherever each individual chooses to age, and bring much needed fiscal sustainability to a program that will grow due to the wave of aging baby boomers. These outcomes will be achieved through rebalancing community and institutional care.

During the 2021 session, the Indiana General Assembly removed the moratorium that prohibited the Indiana Family and Social Services Administration (FSSA) from pursuing risk-based managed care for the aging population, enabling the opportunity for FSSA to move forward with designing its MLTSS program. House Enrolled Act 1001 – 2021 required FSSA to submit a report on the Agency's planned implementation of MLTSS. This document provides an update on FSSA's progress to date on the four key report requirements. FSSA spent the last twelve (12) months dedicated to developing this MLTSS program in strong collaboration with stakeholders. It has been the agency's top priority, and FSSA staff have committed extensive time and resources to this initiative.

The timing of rebalancing community and institutional care is critical as the State expects to see the first baby-boomers reach eighty (80) years old in 2027 – this is when stress on the LTSS system will be at an all-time high and will last for several years as baby boomers continue to reach advanced age. The time for Indiana to comprehensively and boldly reform the current system is now – with the new MLTSS program coming into operation in the first quarter of 2024 and hitting a 3-year post-implementation stability mark around 2027. This timeline is intentional and essential to meeting the growth in Indiana's older adult population that lies ahead with the important, critical, and agreed-upon priorities of choice, quality, and sustainability.

As the State plans for this growing need, it is also critically important to do so in a way that improves upon the current LTSS system. First, the current system overly incentivizes institutional care. While 77% of individuals say they want to age at home (AARP[1]), only 45% of people who qualify for Indiana Medicaid are doing so today. Further, the pandemic highlighted concerns about poor quality care in nursing facilities. In a national poll, 71% of people say they are unwilling to live in a nursing facility, and 90% say changes are needed to make nursing facilities appealing to them.[2] Second, the current system does not incentivize quality care. In

[1] AARP 2021 Home and Community Preferences Survey
[2] John A. Hartford Foundation Age-Friendly Insights Poll December 2021

AARP's 2020 LTSS scorecard, Indiana ranked 44th overall in the nation and 48th for choice of setting and provider for LTSS.[3] Third, Indiana's Medicaid spending is imbalanced: 19% of LTSS funding is for home and community-based services (HCBS), while 81% goes to institutional/nursing facility care. This trajectory of institutional spend is not sustainable, and continued institutional growth depresses the growth of HCBS. Maintaining the status quo is not acceptable, and there is no time for incremental or small gains.

Due to the pressing need, FSSA's LTSS reform effort contains five crucial and interdependent objectives, one of which is the implementation of MLTSS detailed in this report, all tied to an overall rebalancing goal of ensuring 75% of *new* LTSS recipients have an opportunity to age in their community. The five objectives are centered around the values of Choice, Quality, and Cost/Sustainability and address deficits in the current system that impede timely, quality, and person-centered care:

- Choice: Respect individuals' personal choice and dignity
- Quality: Achieve good health outcomes and accountability
- Cost and Sustainability: Steward taxpayer dollars with excellence

These centering values inform the overall rebalancing goal and all five key objectives:

1. Ensure Hoosiers have access to home and community-based services within 72 hours
2. Move LTSS into a risk-based managed care model
3. Link provider payments to member outcomes
4. Create an integrated data system linking individuals, providers, facilities, and the State
5. Recruit, retain, and train the direct service workforce

While all of these objectives are essential to FSSA's comprehensive reform, the agency's effectiveness in reaching a rebalanced LTSS system is strongly tied to the nationally proven MLTSS model. MLTSS has shown it can be a strong driver of rebalancing and aligning incentives for quality care. In fact, with 24 existing MLTSS programs across the country, the evidence shows a bending of the cost curve associated with respecting individual choices to age at home. This affords Indiana a unique opportunity to achieve all three values of the reform effort: choice, quality, and fiscal sustainability. With a 2024 MLTSS implementation, FSSA estimates it will bend the cost curve resulting in $2.4B savings State and federal by 2029 with an MLTSS model as compared to if the status quo were maintained. As noted below, this bending of the cost curve is achieved through increasing the number of individuals who choose to be served in the community, not through reduction of provider rates.

Further, to inform the reform objectives, particularly the design of this MLTSS program, FSSA has engaged in substantial stakeholder engagement over the past year. FSSA staff have spent over 20,000 hours planning and preparing this initiative. Stakeholders spent over 1,700 hours with FSSA in co-design and workgroup sessions. In a first of its kind effort, FSSA stakeholders contributed 75% of a Request for Information (RFI) released to managed care entities (MCEs) in the summer of 2021. This RFI - along with continued stakeholder engagement and peer-state

[3] AARP Long-Term Services and Supports State Scorecard

best practices - are informing the Request for Proposals (RFP) to select MCE partners, in the next stage of MLTSS implementation.

Finally, in developing the program described in this report, FSSA is committed to the following:

- Ensuring an engaged, accountable, and thoughtful runway and implementation of MLTSS. FSSA has procured and launched risk-based managed care for over 1.6 million members, the most recent re-procurement and onboarding of a new MCE occurring smoothly for 90,000 aged, blind and disabled Hoosiers in April 2021 during the pandemic. FSSA prepared for over a year and the implementation went well. FSSA intends to use the same intentional and thoughtful readiness methods with MLTSS. FSSA's risk-based managed care implementations are further described in a later section.
- Ensuring a person-centered approach throughout the program through three core MLTSS goals: 1) person-centered services and supports, 2) ensuring smooth transitions, and 3) access to services (participant choice).
- Aligning MLTSS incentives with what Hoosiers value: Managed care plans are financially incentivized to provide comprehensive and high-quality care at home or in the community in keeping with each member's unique needs, which is lacking in today's fee-for-service (FFS) system where there are few incentives for the system to prevent costly institutional care or to help a member find the care they most need or want in their desired setting.
- Providing care coordination to members through a single-point-of-access approach: The MLTSS program will introduce enhanced care coordination that brings together the member, their providers and caregivers, and, if applicable, their Medicare plan, to help members get the care they want in the right place and the right time.
- Maintaining aggregate provider spending and member access to services: Managed care plans offer program enhancements, value-added services, and local investment. In FSSA's financial projections, which are detailed in this report, the enhanced services provided through MLTSS are funded through helping more Hoosiers get the more affordable care they want at home. Managed care is not financed through a reduction in provider spending, and FSSA is committed to maintaining aggregate provider spending to ensure FSSA members have access to needed services across the continuum. More details regarding program financing are located in Sections III-IV of this report.
- Protecting valued members and provider partners: FSSA's federal regulating body, the Centers for Medicare and Medicaid Services (CMS), has comprehensive rules and regulations regarding MLTSS. In addition to federal rules and regulations, FSSA plans to exceed minimum standards in order to build an Indiana program that ensures member choice, network adequacy, timely provider credentialing and payments, and many more standards. These topics have been a focus of discussion throughout the 2021 stakeholder engagement. For instance, as of January 2022, FSSA had reached consensus on 32 of 36 requests by the nursing facility industry and is having similar conversations with other stakeholder groups. Additional details are located in Sections I-II of this report.
- Building on FSSA's long-standing experience with managed care: Over 80% of Indiana's Medicaid members, 1.6 million enrollees, are currently served in FSSA's successful

Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW), and Hoosier Care Connect (HCC) risk-based managed care programs. Over the past 30 years, FSSA has built a mature and successful managed care program that serves babies and children, pregnant women, and the aged, blind, and disabled, creating a strong foundation for serving additional recipients through managed care.

- Leveraging one-time, immediate federal investment: As part of the American Rescue Act, FSSA received enhanced Federal Medicaid Assistance Percentage (FMAP) Funds of approximately $800M to invest in HCBS through March of 2024. The investment of these dollars will ensure ample supports for Medicaid members and providers for the transition to MLTSS. Slowing or altering the approach would fail to best utilize this opportunity for federal investment and coordination of funding.

While the work and stakeholder engagement are ongoing, FSSA is pleased to provide this update on the collaborative effort and remains committed to a strong, smooth, and data-informed implementation and transition where members, providers, legislators, and other partners are informed and supported through the whole process. This reform effort will position Indiana to be ready when the baby boomer population grows and reaches a critical mass before the end of the decade.

Legislation

The Office of the Secretary of the Indiana Family and Social Services Administration respectfully submits this report pursuant to IC 12-15-5-17.5 (b). It prescribes:

Not later than February 1, 2022, the office shall report the following information and analysis to the legislative council and budget committee (in an electronic format under IC 5-14-6) regarding the implementation of a risk based managed care program or capitated managed care program for Medicaid recipients who are eligible to participate in the Medicare program (42 U.S.C. 1395 et seq.) and receive nursing facility services, as follows:

(1) The projected utilization of home and community-based services and institutional services for the four (4) years following implementation, and including, but not limited to, information on:

(A) provider network adequacy;

(B) family caregiver programming; and

(C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.

(2) How administrative processes, including service approval and billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.

(3) Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.

(4) The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality

assessment fee and supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.

I. IC 12-15-5-17.5 (a)(1)

The projected utilization of home and community-based services and institutional services for the four (4) years following implementation, and including, but not limited to, information on: (A) provider network adequacy; (B) family caregiver programming; and (C) costs and funding sources associated with creating and maintaining adequate provider networks and family caregiving programming.

(A) Projected Utilization and Provider Network Adequacy:

The MLTSS program will include primarily three populations:

- Nursing facility residents, aged 60 or older
- A&D Waiver recipients, aged 60 or older
- Aged, blind, or disabled members, aged 60 or older, who do not require long term services and supports

Many of these aging Hoosiers have complex care needs, multiple conditions, physical disabilities and receive disjoined and inefficient care. They likely have multiple physicians and need the services of varied specialists, pharmacy, durable medical equipment providers, etc. The majority of these Hoosiers are eligible for Medicare and Medicaid (dually eligible). Medicaid and Medicare were not designed to work together and as a result, while individuals typically have greater health care needs who are dually eligible, they must navigate two disjointed systems and report worse health status than Medicare-only individuals. The MLTSS program will provide these Hoosiers with one single point of contact to navigate the disjointed system and to help Hoosiers bring together their chosen care team, a care coordinator, and supports to improve their health and wellbeing and delay nursing home institutionalization.

Notably, in the current Medicaid system, aged, blind and disabled enrollees are served in the risk-based managed care program called Hoosier Care Connect (HCC). When HCC members become eligible for Medicare, they are **disenrolled** from risk-based managed care (HCC) and put into FFS. Similarly, because of historical program constraints, HCC members who become eligible for long-term institutional care or HCBS waiver services are **disenrolled** from risk based managed care (HCC) and put into FFS. This disenrollment is significant in that it thrusts people into a confusing and uncoordinated system at a time where having a high degree of coordination and alignment between Medicaid and Medicare is most critical.

Figure 1 illustrates average monthly enrollment for each of the above populations during the first six years of the proposed MLTSS program, CY 2024 through CY 2029. For comparison, a status quo projection is included. The status quo projection is an extension of the current Medicaid

forecast, assuming continuation of current trends. The main distinction between the two projections is the assumption that risk-based managed care (RBMC) and the expedited waiver eligibility program are able to accelerate the pace of rebalancing. Baseline enrollment projections are consistent with the most recent Medicaid forecast, presented on December 16, 2021, but with an extended time frame.

Figure 1: Preliminary population projections, CY 2024 through CY 2029 (Member Months)

FIGURE 1: PRELIMINARY POPULATION PROJECTIONS, CY 2024 THROUGH CY 2029 (AVERAGE MONTHLY ENROLLMENT)						
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	CY 2029
Under Managed Care						
Nursing Facility	23,499	23,616	23,735	23,853	23,972	24,092
HCBS	31,327	36,328	41,805	47,805	54,239	60,671
Non-LTSS	74,982	76,106	77,248	78,407	79,583	80,776
Total Enrollment	**129,808**	**136,050**	**142,788**	**150,065**	**157,794**	**165,539**
Percentage of LTSS In HCBS	**57.1%**	**60.6%**	**63.8%**	**66.7%**	**69.3%**	**71.6%**
Status Quo						
Nursing Facility	27,195	28,878	30,725	32,694	34,758	36,809
HCBS	27,631	31,066	34,815	38,965	43,454	47,954
Non-LTSS	74,982	76,106	77,248	78,407	79,583	80,776
Total Enrollment	**129,808**	**136,050**	**142,788**	**150,065**	**157,794**	**165,539**
Percentage of LTSS In HCBS	**50.4%**	**51.8%**	**53.1%**	**54.4%**	**55.6%**	**56.6%**

Under the status quo projection, natural rebalancing is expected to occur at a pace of approximately 1% to 1.5% per year, while under risk-based managed care, the percentage of LTSS population members in community settings is projected to increase by approximately 3% per year (on average, or between 2% and 4% per year), slowing gradually over the six-year projection period. However, rebalancing outcomes will depend on State efforts to support HCBS, grow the HBCS provider workforce, and on the effectiveness of contracted risk-based managed care entities. These projections are in line with states who have recently moved to MLTSS. For instance, in the first three years of its program, Florida saw a 12% decrease in the number of Medicaid members receiving care in a nursing facility, and Tennessee saw their HCBS enrollment increase from 17% to 44% (ADvancing States).[4]

A benefit of risk-based managed care is MCEs must meet State defined requirements for network adequacy. MCEs will have the ability to negotiate higher rates with providers to meet network adequacy requirements – this is a feature not available in FFS models. Further, when an MCE establishes a provider network, an individual is no longer responsible for seeking out a Medicaid provider, but rather the MCE is responsible for linking individuals to providers to help oversee and coordinate care. In the LTSS environment where the provider service array is vast and disjointed, having an accessible network will be helpful for Hoosiers.

As Indiana transitions the long-term services population to risk-based managed care, FSSA will establish many protections to ensure a seamless process and member experience. FSSA will require a three year "any willing provider" period for HCBS providers and skilled nursing facilities who meet the program requirements. This means that MCEs will be required to contract

[4] NASUAD [ADvancing States] and Center for Health Care Strategies Demonstrating the Value of Medicaid MLTSS Programs, 2017

with any interested providers for the first three years of the program which allows members and providers to maintain continuity of care. Also, consistent with FSSA's focus on person-centeredness, contract requirements will be put in place to ensure that anyone who resides in a nursing facility when MLTSS is implemented will be supported to remain there, if they desire to do so and if they remain eligible for the support. This recognizes that some individuals consider the nursing facility to be their "home." And, lastly, it is important to note while covering this topic, FSSA will mandate the MCEs pay at least the State's fee schedule for skilled nursing facilities and HCBS providers. However, it is important for this "any willing provider" period to end, as quality of care and performance must be a factor in determining whether a provider or facility may stay in the network and serve Hoosiers. Quality must be a factor in determining the network, centering efforts on each member's experience.

When the "any willing provider" period expires, Indiana will have robust network adequacy standards in place that reflect the expected volume of providers and services required under risk-based managed care. FSSA will include requirements for MCEs to meet provider time and distance standards, member to provider ratios, care wait times, and contracting thresholds (e.g., requiring the MCEs to contract with a high percentage of hospitals in the state). FSSA will evaluate the network capacity in the state and the needs of the members to determine network adequacy requirements.

(B) Family Caregiver Programming:

Nationally, 41.8 million adults in the U.S. act as a caregiver for an adult over age 50.[5] Only three-in-ten of those individuals who have an unpaid caregiver also have paid support.[6] When caregivers experience high levels of stress, it significantly impacts the likelihood the individual for which they are providing care will be admitted to a nursing facility.[7]

With this as a backdrop, the emerging MLTSS program seeks to build on FSSA's current caregiver support activities. These include Aged & Disabled waiver services like adult day care, respite, structured family caregiving, and self-direction that provide direct support to family caregiver often providing a brief hiatus from caregiving responsibilities that allow them to work, go to school, attend to other responsibilities, or just get a break from the day-to-day demands of providing care to their loved one. FSSA also provides indirect services that may yield similar support for caregivers including State Plan home health, as well as attendant care, homemaker services, home delivered meals, case management, home modifications, transportation, and specialized medical equipment under the A&D waiver.

As Indiana moves to MLTSS, FSSA is including several features to enhance focus on family caregiver support. One of these features will be to add two new services to the A&D waiver that focus on caregivers. The first of these services is Caregiving Coaching and Behavioral Management which helps to address root causes of burnout by offering tools and guidance to

[5] Caregiving in the U.S. 2020 Report, AARP, ES-1 Caregiving in the U.S. 2020 Executive Summary - AARP Research Report.
[6] Caregiving in the U.S. 2020 Report, AARP, ES-1 Caregiving in the U.S. 2020 Executive Summary - AARP Research Report.
[7] Does High Caregiver Stress Lead to Nursing Home Entry? 2007, HHS & ASPE, p. vi.

unpaid caregivers to support a loved one experiencing dementia or a serious mental health condition. The second service, fashioned after successful national models such as the CAPABLE program, focuses on making small home adjustments with the guidance of a nurse and occupational therapist that address safety concerns and decrease the need for nursing facility admission. In addition to adding these services, FSSA will be seeking to expand use of self-direction to allow more members to select a caregiver of their choosing from their own community.

Additionally, FSSA will require all selected MCEs to include a caregiver assessment in their care planning process for members. This approach recognizes the vital role unpaid caregivers play in supporting older adults to remain in their home. The assessment will identify issues which impact the caregiver's ability to support the member, and the MCEs will be expected to identify appropriate resources to support the caregiver. The assessment will also identify when there is a change in caregiver or the status of a caregiver (e.g., decline in health) and trigger the MCE to modify the member's or the caregiver's supports, as needed.

(C) Costs and Funding Sources Associated with Creating and Maintaining Adequate Provider Networks and Family Caregiving Programming:

As with the current service delivery system, the costs associated with maintaining adequate provider networks and family caregiving programming will be funded through Medicaid. The current fiscal effort under FSSA's FFS structure is included in the baseline utilized in the forecast detailed below. This forecast also includes the costs associated with utilizing a State fee schedule for skilled nursing facilities and HCBS providers, which is expected to encourage contracting and reduce the need for significant MCE effort to attract providers. MCE investments to ensure assessment, engagement, and support of caregivers, along with building a robust provider network will be funded through the administrative portion of the MCE's capitation rate. This cost is reflected in the overall financial projections below. It is the expectation that MCEs will utilize these financial resources to build their network.

II. IC 12-15-5-17.5 (a)(2)

How administrative processes, including service approval and billing processes, between managed care entities and providers of services will be addressed or streamlined in a risk based managed care program or capitated managed care program, with specific discussion of uniform provider credentialing, the potential of a single claims processing portal, and prior authorization processes.

Before any administrative processes begin, FSSA will undergo a thorough readiness review to ensure a smooth managed care transition. This readiness review will consist of a large-scale systematic review of MCE staffing, policies, processes, documents, subcontracts, system capabilities, and provider network to ensure the MCE is prepared in advance of the transition to MLTSS. FSSA has conducted numerous readiness reviews over the past decades for its existing managed care programs and will leverage that experience for this program transition. During readiness review, FSSA will ensure the MCE is 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. FSSA will provide updates to providers, stakeholders, and legislators throughout this readiness check process and will also be supporting providers with training and technical assistance. This will ensure all stakeholders have a good sense of the MLTSS administrative processes well in advance of program transition.

To ensure services are authorized in a consistent, efficient, and timely manner, FSSA's current MCEs are required to meet standard authorization timeframes and process requirements. In the new MLTSS model, these requirements will be more stringent and require MCEs to process urgent authorizations in 48 hours and non-urgent authorizations in seven days. Further, as is true today, MCEs cannot require authorization for emergency services. It is important to note authorizations are a key tool for MCEs to be notified of a health care event, so the MCE can assist with the member with the supports needed for the individual's next care steps.

Beyond the standard processes noted above, FSSA is adding a host of standardization and streamlined processes to improve provider experience. For instance, FSSA will be requiring a standard authorization form and limiting variability in medical necessity criteria. For example, in the current Medicaid risk-based managed care model, FSSA has been implementing standard aligned medical necessity criteria for services like applied behavior analysis and urine drug screening and limit MCEs to use either MCG or InterQual standardized guidelines (the same that hospitals use) for inpatient services. Additionally, FSSA will prohibit MCEs from subcontracting their utilization management functions to other vendors.

As members will be moving from Medicaid fee-for-service, commercial insurance, or self-pay into the new MLTSS program, it is paramount the program enables continuity of care. As such, FSSA is proposing a requirement of 120 days of continuity of care in the first year for members who join or change plans within the program. This continuity of care requirement would apply to providers and authorizations. Members may receive out of network care from a provider with whom the member has an established relationship with for their first 120 days with the new plan. This time period gives a member time to transition their care to an in-network provider or set up a long-term authorization for out-of-network care with their MCE. In terms of authorizations, the member's existing authorizations (from another plan or program) would be honored by the member's new MCE for 120 days or until the authorization's units or days are used, whichever happens first. This gives the member and their provider time to set up a new authorization with the MCE. After the first year of the program, MCEs are required to honor 90 days of continuity of care for both providers and authorizations when a member joins the program or changes plans. For skilled nursing facilities, because the facility serves as a home for members, FSSA is requiring a lifetime continuity of care requirement for the duration of the program. Under this lifetime continuity of care requirement, if a member joins the MLTSS program or changes plans while on the MLTSS program and is in a skilled nursing facility, the MCE must allow the member to remain with that skilled nursing facility for the entirety of the time the member needs care in a facility, even if out-of-network.

If members are dissatisfied with their MCE in MLTSS, they can change plans during the annual plan selection period, at any time for just cause reasons (including if the member's MCE is not

contracted with the provider of their choice) and an additional time once per year for any reason (no just cause needed). This ultimately provides members the opportunity to change plans several times a year. An enrollment broker will be available to assist the member or their caregiver in picking an MCE that suits the member. The enrollment broker assists with decision making by checking the member's providers against the MCE's network and considering the enhanced benefits each MCE offers. FSSA recognizes contracting with MCEs may be seen by providers as burdensome and simply new for HCBS providers, in particular. To address these concerns, FSSA is taking a multi-faceted approach. First, FSSA partnered with ADvancing States – a national leader in supporting states with MLTSS development and implementation – to support LTSS providers with education, training, and technical assistance. The purpose of this assistance is to prepare providers who are less familiar with risk-based managed care for the program's transition. ADvancing States will also support providers with risk-based managed care contracting in 2023.

Second, FSSA is pursuing systemic solutions identified through a year-long review and alignment project for MCE network credentialing and contracting processes. FSSA implemented a multi-dimensional alignment initiative after completing the review in November 2021. This work included standardizing forms, standardizing timelines for provider enrollment and credentialing, standardizing documentation submission requirements, standardizing notices, and working with each MCE to revise or create provider education documents that are easily followed and easy to find. As a part of normal operations, FSSA reviews and approves all MCE provider contracts and provider materials to ensure they are compliant with State law and the expectations of FSSA.

Additionally, there is a strong Medicare Advantage presence in the state. FSSA will require any MCE to have a companion Dual Eligible Special Needs Plan or D-SNP (a type of Medicare Advantage plan). In consequence, the MCEs will have existing contract relationships with Indiana providers that serve older adults which will improve network contracting and credentialing in the MLTSS program.

Lastly, FSSA continues to investigate the possibility of a uniform portal for claims. Currently, FSSA is unaware of any state that has successfully implemented such a portal. FSSA is aware Ohio is attempting to procure a solution and is evaluating closely.

With or without a single portal for claims, FSSA will require strong standards for claims payment to ensure timely and accurate payment. FSSA contracted MCEs are already required to pay claims within the same timeframe as fee-for service, and all MCEs issue provider payments at least weekly. Pursuant to IC 12-15-21-3, the MCEs must pay a provider interest if the MCE fails to pay claims timely. MCEs must adhere to the same requirements all Health Maintenance Organizations adhere to for claims payment disputes. Additionally, providers can escalate their complaints to FSSA when an MCE fails to resolve their claims disputes appropriately. FSSA has also implemented required timeframes for MCEs to load updated fee schedules into their claims systems.

In the new MLTSS program, FSSA will also implement a minimum fee schedule for a number of years so skilled nursing facilities and HCBS providers will be paid fee-for-service rates, allowing MCEs and providers to establish quality baselines to prepare for pay-for-quality initiatives. As an additional protection for skilled nursing facilities, FSSA will require MCEs in the new MLTSS program to provide coverage for at least five days of services in a skilled nursing facility after the notice of an authorization denial. These five days will allow for the safe transition of members and ensure plans do not notify a skilled nursing facility of the need to transition a member with a single-day notice.

III. IC 12-15-5-17.5 (a)(3)

Projected total spending for a risk based managed care program or capitated managed care program for the four (4) years following implementation. Such information shall include the identification of and impact on each source of state matching funds and overall impact on the state general fund.

As with the population projections provided earlier, baseline expenditure projections are consistent with the most recent Medicaid forecast, presented on December 16, 2021, but with an extended time frame.

Expenditure projections assume there will be no change in reimbursement under risk-based managed care, as MCEs will be directed by the State to reimburse nursing facilities, waiver providers, hospitals, and most other providers at no less that the Medicaid fee schedule, for at least the duration of the projection period. Any savings from the transition to risk-based managed care are derived from rebalancing. Under rebalancing, a greater percentage of members will be able to receive supports needed to stay at home, if that is in accordance with their wishes. Under the current program, although 77% of people express a preference for aging at home, only 45% of members who need LTSS are able to remain out of institutions.[8]

Note, this report does not include risk-based managed care efficiencies in the calculation of savings. Under FFS, enrollees must seek out providers accepting Medicaid, and there is no entity responsible for coordinating care or helping the enrollee to havigte a complex system, particularly for those who receive care through both Medicare and Medicaid. Further, providers are reimbursed for each service rendered, potentially incentivizing volume versus outcomes which does not tie service delivery to quality measures or clinical outcomes. Well-run risk-based managed care programs can result in additional savings through better care management practices. MLTSS programs have potential to reduce duplication of services that occur in FFS or across multiple benefit plans (Medicare and Medicaid) and improve communication across the delivery system. Efficiencies can be particularly evident through care coordination when a member is enrolled with the same plan for Medicare and Medicaid. Further, under risk-based managed care, MCEs are able to provide enhanced services and negotiate higher rates to providers so they meet network adequacy requirements – both of these abilities are unique to risk-based managed care and can result in better care delivery and savings.

[8] AARP 2021 Home and Community Preferences Survey

Preliminary Expenditure Projections:

Figure 2 illustrates projected annual expenditures by population during the first six years of the proposed MLTSS program, CY 2024 through CY 2029. For comparison, FSSA has also provided a status quo projection. The status quo projection is an extension of the current Medicaid forecast, assuming continuation of current trends, and assuming no implementation of risk-based managed care or expedited waiver eligibility. Both projections assume the same reimbursement to providers. The main distinction between the two projections is the assumption risk-based managed care and the expedited waiver eligibility program are able to accelerate the pace of rebalancing.

Figure 2: Preliminary Expenditure projections, CY 2024 through CY 2029[9] ($MILLIONS)

FIGURE 2: PRELIMINARY EXPENDITURE PROJECTIONS, CY 2024 THROUGH CY 2029							
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	CY 2029	ALL YEARS
Under Managed Care							
Nursing Facility	$ 2,683.1	$ 2,762.1	$ 2,843.4	$ 2,927.3	$ 3,013.3	$ 3,101.8	$ 17,331.0
HCBS	1,137.9	1,350.2	1,589.9	1,860.6	2,160.3	2,472.8	10,571.6
Non-LTSS	595.1	619.4	644.6	671.0	697.4	724.1	3,951.7
Total Costs: Under Managed Care	**$ 4,416.2**	**$ 4,731.6**	**$ 5,078.0**	**$ 5,458.8**	**$ 5,871.0**	**$ 6,298.7**	**$ 31,854.4**
Status Quo							
Nursing Facility	$ 3,000.1	$ 3,266.0	$ 3,562.5	$ 3,886.2	$ 4,235.2	$ 4,597.2	$ 22,547.1
HCBS	941.0	1,084.4	1,245.6	1,429.0	1,633.3	1,847.1	8,180.3
Non-LTSS	533.8	556.9	581.0	606.1	631.4	656.9	3,566.2
Total Costs: Status Quo	**$ 4,474.9**	**$ 4,907.3**	**$ 5,389.1**	**$ 5,921.3**	**$ 6,499.8**	**$ 7,101.3**	**$ 34,293.6**
Projected Savings (Best Estimate)	**$ 58.7**	**$ 175.7**	**$ 311.1**	**$ 462.4**	**$ 628.8**	**$ 802.6**	**$ 2,439.2**

Projected savings from rebalancing include savings from implementing risk-based managed care as well as from implementing expedited waiver eligibility. Projections above illustrate a central estimate of savings, which is likely to range between $1.1 billion and $3.4 billion over the first six years of the program.[10] It is important to note FSSA has and will remain committed to maintaining aggregate provider base rate funding, aggregate UPL pools, and aggregate provider payment levels. Funding the program and projected savings will not be funded by reductions to this important funding for service. Savings are driven by serving more individuals in the community and fewer individuals in costly institutions.

IV. IC 12-15-5-17.5 (a)(4)

The expected financial impacts of a risk based managed care program or capitated managed care program on the available amounts and use of the nursing facility quality assessment fee and supplemental payments to nursing facilities that are owned and operated by a governmental entity. Such information shall include an analysis on whether either of these funding streams will be diverted for uses other than the uses prior to implementation of a risk based managed care program or capitated managed care program and the effects on access to acute and post-acute care services due to the expected financial impacts.

[9] The figures shown in the tables include the total projected spend for the population in each category: Nursing Facility, HCBS, and non-LTSS

[10] Rounded values taken from the 2% and 4% rebalancing.

Nursing Facility Quality Assessment Fee:

The projections assume no change in nursing facility quality assessment fees (QAF). The fees allocated to Medicaid under the current program are assumed to continue to be used to support the nursing facility base rates, reducing the Medicaid appropriation cost of base nursing facility expenditures. A pro-rated portion of the fees, corresponding to the percentage of nursing facility expenditures allocated to those aged 60 or older, is utilized to reduce the State share cost of the projections developed for this report.

Nursing Facility Supplemental Payments:

The State share of nursing facility supplemental payments is funded by non-state governmental organization (NSGO) entities, and therefore have no impact on the State Medicaid appropriation. Projections assume no change in reimbursement compared to the current program, in which per average nursing facility per diem are increased to reflect Medicare reimbursement.

Figure 3 provides expenditure projections (State and federal expenditures) stratified by State funding source: nursing facility quality assessment fee, and the State matching funds for nursing facility upper payment limit (UPL) payments, and Medicaid appropriation (general fund) dollars.

Figure 3: Preliminary Expenditure projections, CY 2024 through CY 2029 ($MILIONS)

FIGURE 3: PRELIMINARY EXPENDITURE PROJECTIONS, CY 2024 THROUGH CY 2029							
	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	CY 2029	ALL YEARS
Under Managed Care							
QAF	$ 326.1	$ 327.8	$ 329.4	$ 331.1	$ 332.7	$ 334.4	$ 1,981.4
UPL	711.8	733.4	755.6	778.5	802.0	826.2	4,607.7
Other Funding Sources	3,378.2	3,670.4	3,993.0	4,349.2	4,736.3	5,138.1	25,265.2
Total Costs: Under Managed Care	$ 4,416.2	$ 4,731.6	$ 5,078.0	$ 5,458.8	$ 5,871.0	$ 6,298.7	$ 31,854.4

The projected MLTSS program does not contemplate diversion of either of the above funding sources. It assumes both will continue to be used to support the nursing facility base rates and supplemental payments, respectively, with no changes from the current program.

Conclusion

Most Hoosiers want to age at home. Through MLTSS and its incentivized rebalancing, FSSA plans to give more people on Medicaid this choice by making LTSS more effective, person-centered, and better coordinated. MLTSS, a managed care model implemented by 24 other states, drives rebalancing, provides consumer choice, and enhances quality of care and life wherever an individual chooses to age, in a fiscally responsible and sustainable way. The planned MLTSS program puts the State on solid ground to serve the growing aging population for the decades to come in a manner that aligns Hoosiers' desires with marketplace incentives. FSSA, in collaboration with stakeholders, has laid a foundation for a strong MLTSS program, and is committed to building and implementing a program that meets Hoosiers' needs through the goals and commitments outlined in this report.