FSSA Aged, Blind & Disabled Taskforce

House Enrolled Act 1328

Report to the General Assembly

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Executive Summary

Background

House Enrolled Act 1328 (HEA 1328) passed by the Indiana General Assembly in 2013 tasked the Indiana Family and Social Service Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP) with submission of a report to the Health Finance Committee regarding managing care of the aged, blind and disabled (ABD) Medicaid enrollees. In response, the FSSA convened the ABD Task Force (Task Force) which was comprised of staff from across key FSSA divisions. The Task Force undertook a comprehensive review of the current ABD population, expenditures, programming and nationwide trends. Stakeholder input was garnered through a variety of strategies including public meetings, testimony and a stakeholder survey.

This report does not contain recommendations regarding the care or provision of services to the ABD population; rather, it provides answers to the specific questions outlined in HEA 1328 regarding enrollment of ABD populations in a risk-based managed care (RBMC) program, managed fee-for-service (FFS) program and a home and community based services (HCBS) management program.

Within current Indiana Medicaid programming for the ABD populations, there are various examples of strategies and practices that are aligned with the goals and processes under managed care arrangements. These current strategies span a variety of practices such as prior authorization policies, reimbursement strategies, case management and care coordination efforts. In evaluating the impact of implementing a managed care model for the Indiana ABD populations, it is important to consider what management strategies are already in place and effectively working to manage care and outcomes as these impact the potential savings.

ABD expenditures are a large driver of overall Medicaid costs, accounting for 69% of Indiana Medicaid's healthcare expenditures in SFY 2012.[1] Institutional care accounted for the largest share of ABD expenditures by service type, representing 34% of ABD costs. With the aging baby boomer population, total annual expenditures for the ABD population are projected to increase substantially over the next decade; without any medical inflation, these annual costs are projected to grow by approximately $908 million by the year 2025.

Different managed care models are available and in use by states. Nationwide, states are increasingly enrolling Medicaid recipients, including ABD populations, into managed care arrangements. This is part

[1] Based on Milliman, Inc. forecast for FY 2012 with values on an incurred basis to adjust for timing of payments. Includes Medicaid, HIP & CHIP enrollees.

of a larger trend toward the provision of more integrated and coordinated care and reimbursement reforms which seek to reward quality outcomes versus volume.

Overview of Models

Risk Based Managed Care

Under a RBMC model, the State contracts with managed care entities (MCEs) which receive a per member per month capitation. In turn, the MCEs are at financial risk to provide all services covered under the contract for the assigned population. The contract under a RBMC approach provides many design opportunities for the State and would identify key quality metrics and performance objectives.

Managed FFS

Under a managed FFS approach the State contracts with an external vendor or community-based networks composed of physician's offices, hospitals, health and social service departments. These contracted entities provide services similar to a RBMC model such as care management, disease management and care coordination, but claims are paid by the State on a FFS basis. Unlike RBMC, the contractors are not at financial risk for the overall service costs; however, they could be put at risk for performance outcomes and achievement of savings targets.

HCBS Management Program

In a HCBS management program, the State contracts with an Area Agency on Aging (AAA) or other community-based care coordination organization to provide services to maintain a Medicaid recipient in a home and community-based setting, or to return a recipient to a home and community-based setting. Under this model, eligibility determinations, service authorizations, care plan development, case management and HCBS delivery are provided by the HCBS management entity. Unlike RBMC and managed FFS, this model primarily focuses on home and community based long-term services and supports (LTSS).

Options for Covered Populations & Services

Within each managed care model, the State has significant flexibility in program design. The Task Force studied a variety of available options for covered populations and services and analyzed these options based on the impact to consumers and stakeholders, state costs, supplemental payments and state matching funds. This analysis informed the development of the following four options for exclusion from RBMC and managed FFS: institutional populations[2], individuals with intellectual and developmental disabilities[3], duals[4]

[2] Defined as hospice, nursing facility, group home and intermediate care facilities for the intellectually disabled (ICF/IDs) residents
[3] Defined as those consumers served by the Family Supports and Community Integration and Habilitation Waivers
[4] Refers to an individual enrolled in both Medicare and Medicaid.

and individuals under age 21. Additionally, the option for a Medicaid Rehabilitation Option (MRO) services carve-out is being presented for the RBMC model. Because the HCBS management model primarily addresses home and community based LTSS, the Task Force is not presenting options for population or service carve-outs for this model.

Analysis of Options

Options for Contract Provisions

In accordance with HEA 1328, the Task Force reviewed options for provisions that are likely to ensure enrollees have timely access to efficient and high quality care for each managed care model. Potential strategies are vast, and the State has the option to implement a variety of contract requirements related to provider network and rate setting issues, to promote beneficiary choice of providers and minimize impact during transition. However, there are limited options available to coordinate care for duals as enrollment of this population is projected to result in a financial loss to the State, as described further below. Table 1 provides a summary overview of options for provisions, by managed care model, as outlined in HEA 1328. CMS approval of all contracts would be required as well as development and approval of waivers or State Plan Amendment (SPA), dependent on the populations to be included and other program design elements.

Table 1: Options for Contract Provisions by Model

	Contract Options	Model(s) to Which Option Applies		
		RMBC	**Managed FFS**	**HCBS Management**
Beneficiary Choice of Network & Non-Network Providers	Require out-of-network care	X	X	X
	Neutral third parties for level of care determinations, options counseling & pre-admission screenings	X	X	n/a
	Mandatory vs. voluntary enrollment	X	X	X
Impact to Enrollees During Transition	Phased-in approach	X	X	X
	Continuity of care requirements	X	X	X
	Stakeholder engagement strategy	X	X	X
Provider Network & Rate Setting	Setting reimbursement floor tied to current rates	X	n/a	n/a
	State maintenance of rate-setting functions	X	n/a	n/a
	Any-willing provider provisions	X	X	X
	Standards on timely claims processing	X	n/a	n/a
	Network access requirements	X	X	X

Core Principles

In reviewing the three models, the Task Force also developed a set of core principles on which to evaluate the models against, based on common themes which emerged from stakeholder feedback, research and discussions. Table 2 outlines these principles and an assessment of each model's potential to achieve these principles. If the State were to pursue any of the options, these principles could be integrated into the contract to assure these parameters are achieved.

Table 2: Assessment of Managed Care Models against Task Force Principles

Principle	Description	RBMC	Managed FFS	Managed HCBS
Potential to Improve Quality Outcomes & Consistency of Care Across the Delivery System	• Establishment of quality objectives with stakeholder input. • Provides consistent quality of care regardless of geographic location. • Provides incentives, including financial incentives, to improve quality versus restrict access to needed services. • Creates incentives and rewards for providers for quality outcomes rather than volume of services. • Aligns financial incentives and quality outcomes across the service delivery system to align providers with common goals. • Establishes quality measures that include, but are not limited to: clinical outcomes, patient satisfaction, quality of life and social determinants, functional outcomes, health and safety assurances, community integration and access to care, and measures that consider different population needs. • Establishes process measures that include, but are not limited to: claims payment timeliness, network adequacy, timeliness of assessments and service plans, member call center performance, fraud and abuse, appeals, utilization management processing times and approval rates.	X	X	

Principle	Description	RBMC	Managed FFS	Managed HCBS
Enrollee Choice, Protections & Access	• Clearly establishes participant rights and responsibilities. • Preserves and promotes consumer choice and autonomy. • Provides neutral third parties to ensure participant's rights are upheld and enrollees understand their options for care. • Provides conflict free services such that entities conducting assessment and eligibility determination are separated from service providers. • Assures person-centered service planning which includes the enhanced provision of local home and community based services versus institutional care when appropriate for the individual's needs. • Provides local, face-to-face case managers where appropriate. • Preserves existing provider infrastructure to ensure longstanding relationships are not disrupted.	X	X	
Potential to Coordinate Care Across the Delivery System & Care Continuum	• Strategy acknowledges the whole person's diverse medical and social needs which span primary and acute medical care, behavioral health and long-term services and supports. • Provides coordination through the continuum of care from medical services, both physical and behavioral health, along with non-medical and throughout different disease phases and stages. • Assures quality and reduces duplication of services while considering the comprehensive needs of the individual. • Avoids multiple layers of uncoordinated care managers. • Provides a system and leverages technology to provide real-time, accessible client information across the delivery system to promote high quality, coordinated care.	X	X	

Principle	Description	RBMC	Managed FFS	Managed HCBS
Flexible Person Centered Care	• Promotes flexible care plans that avoid a "one-size fits all" approach. • Understands unique client needs and develops individualized service plans. • Recognizes high prevalence of comorbidities and creates care plans that address the whole person.	X	X	X
Transition Planning, Contract Oversight & Implementation Issues	• Assures adequate reimbursement rates, sufficient provider networks, state oversight of contractors, and continuity of care. • Develops a transition plan to minimize issues for clients. • Assures accountability through identification of incentives and penalties that are tied to performance requirements and outcomes.	X	X	X

Potential for Cost Savings

Tables 3 – 5 provide a high level overview of the key benefits and disadvantages of each model and the potential costs savings. The impact of the optional population and service exclusions are also analyzed. The savings estimates were developed by the State's actuary. The actuary applied an algorithm that identifies "potentially avoidable costs" to the Indiana Medicaid experience data. Cost savings may be generated under managed care by reducing avoidable costs through better care management practices. In analyzing the fiscal impact of implementation of a managed care model, administrative costs must also be considered. These include factors such as the cost of managing healthcare, claims adjudication and a contribution to the contracted entity's surplus or profit. Additionally, the Affordable Care Act (ACA) implemented a new health insurer fee. As a result of this new federally mandated fee, administrative costs under RBMC will increase by 2.5%. In order to produce net savings from transitioning the ABD population to a managed care model the estimated claims cost savings must be greater than the increase in administrative costs and fees.

Actuarial projections provided in Tables 3 – 5 illustrate the best estimate of the expected net savings after administrative costs from the implementation of a RBMC program and managed FFS program. Savings estimates illustrated are best estimates and include a degree of uncertainty. Actual results are expected to deviate from those illustrated. Additionally, estimates reflect expected annual savings achievable in three to five years and savings in the initial years of implementing a managed care program are expected to be less than the ultimate amount.

Under a managed FFS model, estimated claims savings assumptions are reduced from RBMC estimates because managed care programs that are not risk-based generally result in less claims savings. However, the 2.5% health insurer fee would not apply in this model so administrative costs are lower.

The estimated net savings for the RBMC and managed FFS models varies significantly by population and enrolling some populations is estimated to result in a financial loss to the State. The variance in potential savings among the populations for whom savings may be achievable is attributed to each population's cost profile and current strategies in place to manage their care. For example, the populations with higher inpatient claims costs have a higher potential for savings with implementation of a managed care strategy as cost savings may be generated by reducing avoidable admissions through better care management practices. Populations which are currently managed, such as the Care Select enrollees, will have less opportunity for additional savings.

The estimated **negative** net savings (i.e., **additional** costs to the State) for some populations is attributed to multiple factors. For all dual populations, estimated claims savings is significantly less than for non-duals because any savings for the dual populations would be shared with Medicare; additionally, the fixed administrative costs of a managed care program are spread over a higher per member cost for non-dual populations. For the HCBS waiver populations, with the exception of the Aged & Disabled Waiver, the majority of claims cost is attributable to waiver services. No claims cost savings were estimated to be attainable for waiver services; under the current delivery system, these services are already managed through strategies such as case management, budget caps and service authorizations through budget allocation processes. Furthermore, the State's attempt to impose service limits in the past has been struck down by the courts. Additionally, for the institutional populations, claims costs are largely attributable to the cost of institutional services; no claims cost savings were estimated to be attainable for these services. Institutional costs are typically managed by diverting less medically needy individuals to a home and community based setting. The State already has waiver programs in place designed to move suitable individuals to a home and community based setting.

The HCBS management program is not projected to result in savings to the State. As previously described, for all models, actuarial projections have illustrated a 0% savings for home and community based LTSS because of current management strategies. In presentations to the Task Force, the AAAs projected savings for the HCBS management program model. However, these were projections based off a pilot serving only 30 individuals.[i] Therefore, further analysis of the potential for savings would be necessary.

Impact to Supplemental Payments, Assessment Fees & MRO Match

Indiana collects assessment fees from hospitals, nursing homes and intermediate care facilities for the intellectually disabled (ICF/IDs) to help fund the State's share of Medicaid program costs. The State makes supplemental payments to nursing homes through which the State share of these payments is contributed by nursing facility providers. Additionally, MRO services are funded through a unique partnership with community mental health centers (CMHCs) which allows the State to offer MRO services without additional state dollars to fund the match; this arrangement limits the network to only the CMHCs.

A managed FFS or HCBS management program would not impact any of these arrangements. Under RBMC, the collection of assessment fees would not be impacted; however, there is a potential impact to upper payment limit (UPL) payments and enhanced quality assessment fee (QAF) reimbursement. One concern would be if the nursing homes making such contributions are not in the network of each MCE. Additionally, UPL payments are generally only available under FFS arrangements as they are calculated based only on FFS days in an institutional setting; therefore transitioning enrollees from FFS to managed care translates into fewer FFS days and lower potential UPL payments.

A managed FFS or HCBS management program would not impact the current arrangement for match funds for MRO services. However, If MRO services were included in a RBMC contract, strategies would need to be implemented to ensure this arrangement was not disrupted. At minimum, contract provisions would need to be implemented to require MCEs to contract with all CMHCs as the exclusive provider of MRO services. Alternatively, a MRO carve-out would ensure maintenance of the current arrangement.

Summary Analysis of Managed Care Options

Tables 3 – 5 provide a high level overview of the key benefits and disadvantages of each model and the potential costs savings. The impact of the optional population and service exclusions are also analyzed. Note that a negative number in the Estimated State Savings column represents an additional cost to the State, not a savings.

Table 3: Option 1 - RBMC Analysis

Option 1: RBMC Analysis	Advantages	Disadvantages	Estimated State Savings
Option 1: Include All Populations	• High potential for improved care coordination. • Potential to improve quality & consistency across the delivery system. • Ability for MCEs to provide enhanced services & negotiate higher rates to meet network access requirements. • Enrollee linkage to PMPs. • Budget predictability.	• Administrative costs, including 2.5% ACA health insurer fee. • Financial loss projected. • Potential risk to nursing home supplemental payments. • Potential risk to match funding for MRO program. • Potential for duplication with current case management; can be mitigated through MCE conducting all case management or required contracting with current entities.	-$49,600,000
Option 1a: Exclude Only Institutional Populations	• Ensures no disruption to nursing home supplemental payments. • Prevents projected financial loss attributed to including this population.[5]	• Reduced incentive for MCE to prevent institutionalization; but contract requirements, performance standards & neutral third party entities available to mitigate this disadvantage.	-$15,400,000
Option 1b: Exclude Only Individuals with Intellectual & Developmental Disabilities	• Prevents projected financial loss attributed to including this population. • Waiver services already managed and limited potential for further management. • Prevents potential duplication with current waiver case management; though this could be mitigated under carve-in by having MCE provide case management or require contract with current waiver case managers.	• The ID/DD population does not benefit from potential care coordination services.	-$36,700,000
Option 1c: Exclude Only Individuals under 21	• Prevents projected financial loss attributed to including this population.	• The under 21 population does not benefit from potential care coordination services.	-$43,100,000

[5] With exception of nursing home non-dual for whom a 4.1% net savings is projected

Option 1: RBMC Analysis			
	Advantages	**Disadvantages**	**Estimated State Savings**
Option 1d: Exclude Only Duals	• Prevents projected financial loss attributed to including this population.	• Spending on duals represents a high-cost area for the State and beneficiaries could benefit from more coordinated care. Until federal rules change to allow States to glean from savings, inclusion of duals will not financially benefit the State.	$4,200,000
Option 1e: Exclude Only MRO	• Prevents disruption to current program which manages MRO services. • Avoids additional management layer; though this could be mitigated under carve-in by having MCE provide case management or require contract with CMHC for this function. • Ensures no risk to match funding.	• Potential reduction in integrated care; though this could be mitigated through contract parameters for coordination.	-$45,600,000
Option 1f: Exclude Institutional Populations, Individuals with Intellectual & Developmental Disabilities, Individuals under 21, Duals & MRO	• Prevents projected financial loss attributed to RBMC when all ABD populations are included.	• Projected enrollment reduced to 49,400. In accordance with federal regulations State must contract with at least 2 MCEs; potential concern there is low enrollment to spread out over 2 MCEs.	$14,100,000

Table 4: Option 2 - Managed FFS Analysis

Option 2: Managed FFS Analysis			
	Advantages	**Disadvantages**	**Estimated State Savings**
Option 2: Include All Populations	• Potential for improved care coordination; additional incentive at provider level through PMPM management fee. • Potential to improve quality & consistency across the delivery system. • Enrollees linked to primary medical provider. • No risk to nursing home QAF & UPL payments or MRO match.	• Less financial incentive for contracted entities to manage risk. • Less opportunity than RBMC for flexibility in authorization of services. • Potential for duplication with current case management; can be mitigated through having contracted entity take on all case management functions or require contracting with current entities. • Budget predictability not achieved as in RBMC model. • No opportunity for negotiation of higher rate with providers to meet network requirements. • Less financial incentive for prevention of institutionalization and increased care coordination; can be mitigated through pay-for-performance or shared savings.	-$800,000
Option 2a: Exclude Only Institutional Populations	• Prevents projected financial loss attributed to including dual institutionalized populations.	• Lose potential for coordinated care.	-$100,000

Option 2: Managed FFS Analysis			
	Advantages	**Disadvantages**	**Estimated State Savings**
Option 2b: Exclude Only Individuals with Intellectual & Developmental Disabilities	• Prevents projected financial loss attributed to including this population.[6] • Waiver services already managed. • Prevents potential duplication with current waiver case management; though this could be mitigated under carve-in by having managed FFS contracted entity provide case management or require contract with current waiver case managers.	• The ID/DD population does not benefit from potential care coordination services.	$100,000
Option 2c: Exclude Only Individuals under 21	• Prevents projected financial loss attributed to including this population.	• The under 21 population does not benefit from potential care coordination services.	$700,000
Option 2d: Exclude Only Duals	• Prevents projected financial loss attributed to including this population.	• Spending on duals represents a high-cost area for the State and beneficiaries could benefit from more coordinated care. Until federal rules change to allow States to glean from savings, inclusion of duals will not financially benefit the State.	$9,900,000
Option 2e: Exclude Institutional Populations, Individuals with Intellectual & Developmental Disabilities, Individuals under 21 & Duals	• Prevents projected financial loss attributed to managed FFS when all ABD populations are included.	-	$8,900,000

[6] Except for non-dual Community Integration & Habilitation Waiver enrollees for which a 0.2% savings estimate was projected

Table 5: Option 3 - HCBS Management Program Analysis

Option 3: HCBS Management Program Analysis			
	Advantages	**Disadvantages**	**Estimated State Savings**
Include all Populations Requiring Home & Community Based LTSS	• Applies person-centered approach. • Services provided locally and in-person. • No risk to nursing home QAF & UPL payments or MRO match.	• The model is not conflict free as one entity is responsible for eligibility determination, service authorization and service delivery. • No single entity responsible for overall care & outcomes across the delivery system. • Does not fully integrate primary and acute medical care and behavioral health with long-term services and supports. • Less financial incentive for prevention of institutionalization and increased care coordination; can be mitigated through pay-for-performance or shared savings. • Individuals not linked to primary medical provider.	$0

Background

House Enrolled Act 1328 (HEA 1328) passed by the Indiana General Assembly in 2013 tasked the Indiana Family and Social Service Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP) with submission of a report to the Health Finance Committee regarding the following:

- Estimate of the cost savings to Indiana if aged, blind and disabled (ABD) Medicaid enrollees are enrolled in a risk-based managed care program, managed fee-for-service program, or a home and community based services management program;
- A description of the provisions of a risk-based managed care program, managed fee-for-service program, or a home and community based services management program that are likely to ensure that enrollees have timely access to efficient and high quality care, including:
    - Beneficiary choice of network and non-network providers
    - Impact to enrollees during transition to the program
    - Provider network and rate setting processes
    - Coordination of care for dually eligible enrollees;
- Whether all ABD Medicaid enrollees should be enrolled in a risk-based managed care program, managed fee-for-service program, or home and community based management program and a description of any group that should be excluded;
- Whether participation of ABD Medicaid enrollees in a risk-based managed care program, managed fee-for-service program, or a home and community based services management program would:
    - Reduce or eliminate supplemental payments under the Medicaid program that are received by non-state governmental entities
    - Affect the collection and use of the health facility quality assessment fee, the hospital assessment fee, or any other provider assessment fee.

This report does not contain recommendations regarding the care or provision of services to the ABD population; rather, it provides answers to the specific questions outlined above. In response to HEA 1328, the FSSA convened the Aged, Blind and Disabled Task Force (Task Force) which was comprised of staff from the various FSSA divisions as outlined in Table 6.

Table 6: Task Force Membership

Member	Role
Paul Bowling	FSSA CFO
Dawn Downer	Chief of Staff of the Division of Disability & Rehabilitative Services (DDRS)
Christina Hage	FSSA Senior Policy Director
Debra Herrmann	Deputy Director of the Division of Mental Health and Addiction (DMHA)
Marni Lemons	FSSA Deputy Director of Communications & Media
Susan Waschevski	Deputy Director of the Division of Aging (DA)
Ann Zerr	FSSA Medical Director (OMPP)

The Task Force undertook a comprehensive analysis of current Indiana Medicaid ABD enrollment, expenditures and programming. Additionally, it reviewed nationwide trends and Medicaid managed care strategies for the ABD population. Throughout this process, stakeholder feedback was garnered through a variety of strategies. A series of public meetings were convened as outlined in Table 7. Stakeholders were invited to provide proposals or ideas to the Task Force and present those either through presentation or written comments. A stakeholder survey was also developed and distributed. A total of 143 surveys were returned, representing providers, consumers, advocates and other stakeholders. All presentation materials, recordings, written testimony and survey results were made publically available via the internet at http://www.in.gov/fssa/4828.htm , a website developed specifically to provide information to the public on all Task Force activities.

Table 7: Task Force Public Meetings

Date	Agenda
July 12, 2013	ABD Study Kick Off Meeting • Welcome by FSSA team • Description of populations, ABD study requirements and timeline • Survey development tool and feedback • Discussion and questions • Next Steps
August 15, 2013	Stakeholder Presentations • Indiana Council of Community Mental Health Centers • The Arc of Indiana and Self Advocates • Indiana Association of Rehabilitation Facilities • Indiana University School of Medicine • Indiana Association of Home and Hospice Care • Anthem Indiana Medicaid
August 16, 2013	Stakeholder Presentations • Lifetime Resources • MHS • Indiana Health Care Association • Community Hospital Network, Indianapolis • Leading Age Indiana • Indiana's Area Agencies on Aging
August 19, 2013	Public Input

This report provides an overview of the Task Force findings with respect to managing care of Indiana Medicaid ABD enrollees.

Medicaid Managed Care

Medicaid managed care encompasses a variety of strategies for the delivery and financing of Medicaid services. In the commercial market, the term managed care is typically associated with a health maintenance organization (HMO) model in which a closed network of providers delivers services to an enrolled population for a monthly premium. In Medicaid, managed care models are more varied. Common among the models as described by the Centers for Medicare and Medicaid Services (CMS), "in a managed care delivery system, people get most or all of their Medicaid services from an organization under contract with the state.[ii]"

Under managed care, state Medicaid agencies contract with health plans or providers who are responsible for managing and coordinating the care of their assigned members. This differs from traditional fee-for-service (FFS) under which enrollees must seek out providers accepting Medicaid patients and there is no

entity ultimately responsible for coordinating all of their care. Under a traditional FFS model, providers are reimbursed for each service rendered; this can incentivize volume versus outcomes and does not tie service delivery to quality measures or clinical outcomes. Furthermore, unmanaged FFS models lack integration and care coordination among delivery system providers. Nationwide, states are increasingly shifting away from pure FFS models. States are increasingly experimenting with strategies to increase quality outcomes and provider accountability.

Different managed care models are available and in use by states. There are three basic models of Medicaid managed care recognized by federal law and regulations. These include risk-based managed care entities (MCEs), non-comprehensive prepaid health plans (PHPs) and primary care case management (PCCM).

Within these different models, states have a variety of policy and program options available. For example, the State may exclude certain populations from mandatory enrollment and carve-out specific covered services. States can also incorporate reimbursement strategies which tie financial incentives to quality outcomes such as pay-for-performance, shared savings, capitation withholds and bonuses.

While the reimbursement mechanism and contracting methodologies differ between the models, managed care is intended to achieve a variety of quality goals such as improved coordination of care, reduction in the duplication of services and increased access to care. Managed care is also utilized to achieve cost-savings goals and provide more budget predictability for states. Savings from managed care may be generated by reducing "potentially avoidable costs" through better care management practices. These include acute services for conditions that potentially could be avoided via appropriate ambulatory care such as inpatient admissions and ER visits for conditions such as chronic obstructive pulmonary disease (COPD), congestive heart failure, pneumonia and septicemia. Potentially avoidable costs are generally represented by inpatient hospital and emergency room service categories. Other service categories such as office visits have very limited potential savings, and costs for some of these service categories may actually increase when transitioning from a traditional FFS program to a managed care environment; for example, increased office visit utilization with the shift from avoidable ER visits. The degree of healthcare management will influence the amount of savings that is achievable. Generally, a program with less rigorous management, such as a managed FFS program, will achieve lower savings than a program with more rigorous management, such as a full risk-based program.[iii]

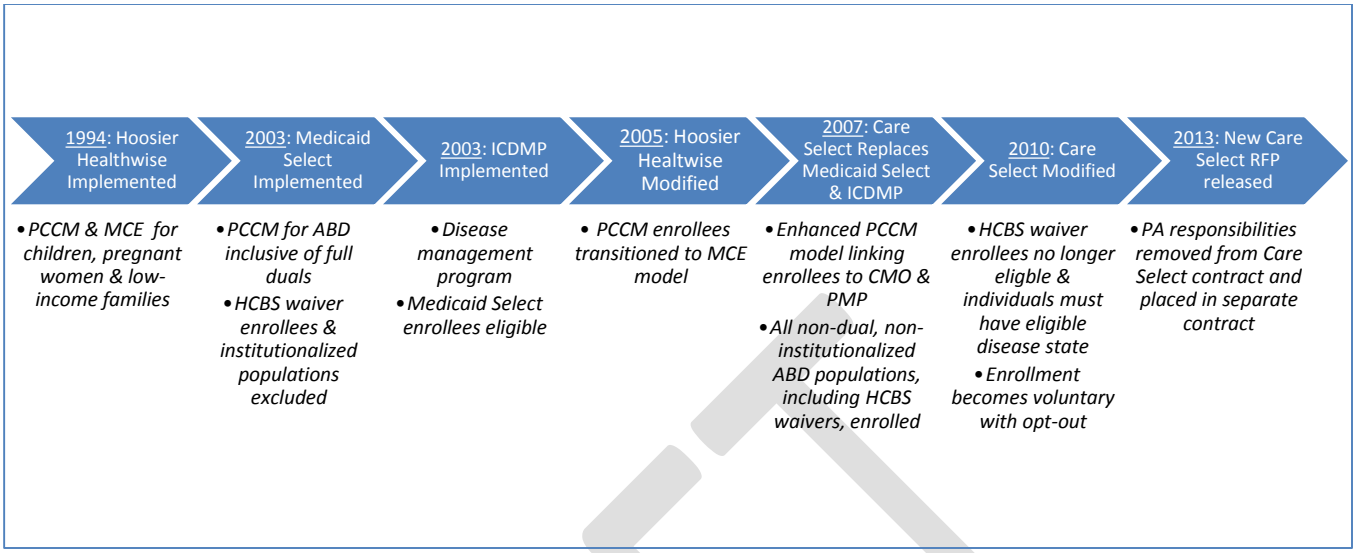
Additionally, managed care provides a mechanism to hold providers, MCEs and other contracted entities accountable through contract and performance requirements. This differs from a FFS delivery model under which enrollees do not receive covered services through a single entity or provider and providers

are paid for each service rendered. This can contribute to budget unpredictability, duplication of services and a lack of accountability for health outcomes as there is no established entity through which care is coordinated.

Managed Care in Indiana

Managed care in the Medicaid program has been in existence since the early 1980's. In Indiana, Medicaid managed care has been in existence for nearly two decades. The Hoosier Healthwise program, Indiana's risk-based managed care program for children, pregnant women and low income families was established in 1994. When first established, Hoosier Healthwise utilized both an MCE and PCCM model; in 2005 the program transitioned all enrollees to an MCE model. The State began enrolling ABD populations in managed care arrangements beginning in 2003; over the past decade these strategies have undergone several modifications as outlined in Figure 1. In January 2003 the State first began implementing managed care for the ABD population, in the form of a PCCM program called Medicaid Select. Under Medicaid Select, ABD enrollees, including full duals, were connected with a primary medical provider (PMP); however, home and community based services (HCBS) waiver enrollees were excluded from participation. PMPs were paid a $4 per member per month administrative fee in addition to fee-for-service reimbursement for services rendered. A large proportion of Medicaid Select enrollees were also enrolled in the Indiana Chronic Disease Management Program (ICDMP), a disease management program launched in July 2003 for Medicaid members with congestive heart failure, diabetes, asthma and other state defined conditions. The ICDMP included features such as risk stratification, nurse care management for high-risk participants and telephonic interventions for all enrollees. In 2007, the Care Select Program, an enhanced PCCM program, replaced Medicaid Select and the ICDMP was rolled-in to the Care Select contracts. Care Select originally included all non-dual, non-institutionalized ABD enrollees, including HCBS waiver recipients. Under Care Select, enrollees are assigned to both a PMP and Care Management Organization (CMO). CMOs in the original program design were responsible for functions such as care management and coordination, prior authorization (PA), network development and disease management. PMPs began receiving a higher per member per month administrative fee of $15 and an additional covered service was made available to Care Select PMPs, a care coordination conference to review member's progress and care management plan. In 2010, Care Select was modified to focus only on members with certain chronic conditions. To be eligible, enrollees had to have one of the chronic conditions identified by the State and HCBS waiver enrollees became ineligible. Enrollment became voluntary with opt-out provisions.

Figure 1: History of Medicaid Managed Care in Indiana



National Trends in Medicaid Managed Care

Nationwide, enrollment in Medicaid managed care has increased each year. Historically, Medicaid managed care was utilized primarily to manage the care of children, pregnant women and non-disabled parents and caretakers. Over time, states have expanded managed care enrollment for the aged and disabled. The majority of states now provide at least one managed care program for disabled children and aged and disabled adults who are not eligible for both Medicare and Medicaid.[iv] As the aged, blind and disabled account for a disproportionate share of costs in comparison to their enrollment share, states continue to explore strategies to better manage their care and manage costs.

Recently there has been a surge in state activities surrounding movement of Medicaid populations into a managed care arrangement. States such as Louisiana and New Hampshire with low managed care enrollment are moving toward the adoption of statewide managed care. Additionally, states with experience in managed care, concentrated particularly in urban areas, such as New York, Texas and California announced the adoption of statewide enrollment across all populations. The shift toward increased managed care in the Medicaid program is part of a larger trend toward the provision of more integrated and coordinated care and reimbursement reforms which seek to reward quality and outcomes versus volume.

Risk Based Managed Care

Under risk-based managed care (RBMC), States contract with Managed Care Entities (MCEs) which receive a per member per month capitation. In turn, the MCEs are at risk to provide all services covered under the contract for the assigned population. This shifts financial risk from the State to the MCE.

RBMC can include contracts with MCEs which provide a comprehensive set of benefits or with non-comprehensive prepaid health plans (PHPs).

States have flexibility, within federal parameters, to establish contract provisions to hold MCEs accountable for outcomes. Contract requirements can address a variety of issues such as network access requirements, enrollee protections, quality outcomes and reimbursement mechanisms. States are increasingly utilizing RBMC strategies to manage the care of ABD Medicaid enrollees.

Managed Long-Term Services and Supports (MLTSS)

More recently, the nationwide trend indicates States are increasingly exploring the delivery of long-term services and supports through RBMC. This strategy is referred to as Managed Long-Term Services and Supports (MLTSS). Long-term services and supports include long-term care provided in institutional settings as well as community based services and supports to assist with activities of daily living. MLTSS is being utilized by states as a strategy to improve access to home and community based services and increase coordination of care.[v]

As of 2012 sixteen states were operating MLTSS programs. This number is projected to grow to twenty-six by 2014.[vi] MLTSS strives to better integrate long-term services and supports with the provision of primary, acute and behavioral health care.[vii] MLTSS program design across the nation varies significantly in terms of enrollment policies, covered populations and benefits [viii].

Because MLTSS programs are continuing to evolve and remain in their infancy, long-term studies on outcomes are limited at this time. Findings indicate that in comparison to fee-for-service strategies, these programs may provide increased access to home and community based services and reduced institutional service usage. These outcomes, in addition to evidence of avoidable emergency room visits and reduced hospital length of stay, point to the potential for MLTSS to result in cost savings; however, other studies have been inconclusive.[ix]

PACE

The Program of All-Inclusive Care for the Elderly (PACE) is another form of RBMC used to manage care of Medicaid enrollees; however, it is targeted to only a subset of the ABD population. PACE provides services primarily in an adult day health center, supplemented by in-home and referral services. The program is for frail elderly enrollees and fully integrates Medicare and Medicaid services. Individuals who are 55 or older, meet nursing home level of care (LOC), can live safely in the community and live in the service area of a PACE organization are eligible. PACE organizations receive prospective monthly Medicare and Medicaid capitation payments for each enrollee and assume full financial risk for all needed health care services.

PACE is currently offered in twenty-nine states. Indiana received approval of a State Plan Amendment (SPA) in February 2013 to operate PACE. The program is not yet operational but St. Francis is in the process of obtaining CMS approval to operate as a PACE provider.

Primary Care Case Management

Under primary care case management (PCCM) states contract directly with primary care providers who are responsible for management of beneficiaries assigned to their panel. Under this model providers are typically paid a small per member per month fee in addition to fee-for-service payments for services rendered. The primary care provider serves as the enrollee's medical home and authorizes referrals to any needed specialists.

States have also developed enhanced PCCM (EPCCM) programs. As of September 2011, nine states reported they were operating EPCCM programs.[x] Under EPCCM, states utilize strategies to advance quality outcomes and coordinated care. Enhancements may include features such as case management, disease management, care coordination, medical home initiatives, the use of performance and quality metrics and financial incentives tied to quality outcomes.

EPCCM programs are intended to supplement and support physician's practices which typically do not have the resources to completely manage and coordinate patient care or provide linkage to community and social support systems, especially for high-needs patients. Studies have suggested care management and care coordination are the most important enhancements that can be provided in a PCCM program.[xi] Indiana's Care Select program described in further detail in the Indiana Medicaid for the Aged, Blind and Disabled Section is an example of an EPCCM program.

The structure of EPCCM programs varies across states utilizing this strategy. For example, states utilize different resources and staffing models for care coordination and case management; state models include use of state staff, community-based networks and separate vendors. Additionally, states have varied care coordination methods such as focusing on specific disease states or individuals with co-morbidities.[xii]

PCCM models do not always include explicit contract mechanisms designed to manage costs. Under PCCM models, the contractor is not at risk for the overall service costs as in RBMC. Therefore, it is important for states to consider strategies to align incentives and increase accountability for outcomes.[xiii] For example, states can implement mechanisms and contracting strategies to implement risk for performance measures and outcomes. Louisiana has implemented such a strategy; the State operates an EPCCM program with limited risk tied to savings targets. Entities are paid a per member per month EPCCM fee. Savings targets are established and the entities share in any savings achieved with the

providers. When savings are not realized, a percentage of the monthly care management payment made for each member must be returned.

Indiana Medicaid for the Aged, Blind and Disabled

Eligibility Criteria

To be eligible for Indiana Medicaid on the basis of blindness or disability, an individual must meet the State's financial criteria and be determined blind or disabled through a disability review. Eligibility for the aged is for individuals over the age of 65 who meet the State's financial criteria.[7] ABD enrollees include both children and adults and enrollees reside in both community and institutional settings[8].

A portion of Indiana's ABD population is enrolled in a HCBS waiver, a program designed to provide an array of services to enrollees to prevent institutionalization. To be eligible for a HCBS waiver, an individual must meet the Level of Care (LOC) for the waiver as well as diagnostic and/or functional criteria. Indiana currently offers the five waivers outlined in Table 8.

[7] Indiana currently operates as a 209(b) state under which the State uses more restrictive eligibility criteria than the Supplemental Security Income (SSI) program. In 2014, upon approval from CMS, the State will be transitioning to 1634 status under which SSI recipients will be automatically eligible for Medicaid and the State will no longer operate a spend-down program. Additionally, Medicaid will be available to aged and disabled individuals under 100% of the federal poverty level (FPL).

[8] The State also operates the M.E.D. Works program for the working disabled who fall below 350% of the FPL.

Table 8: Indiana HCBS Waivers

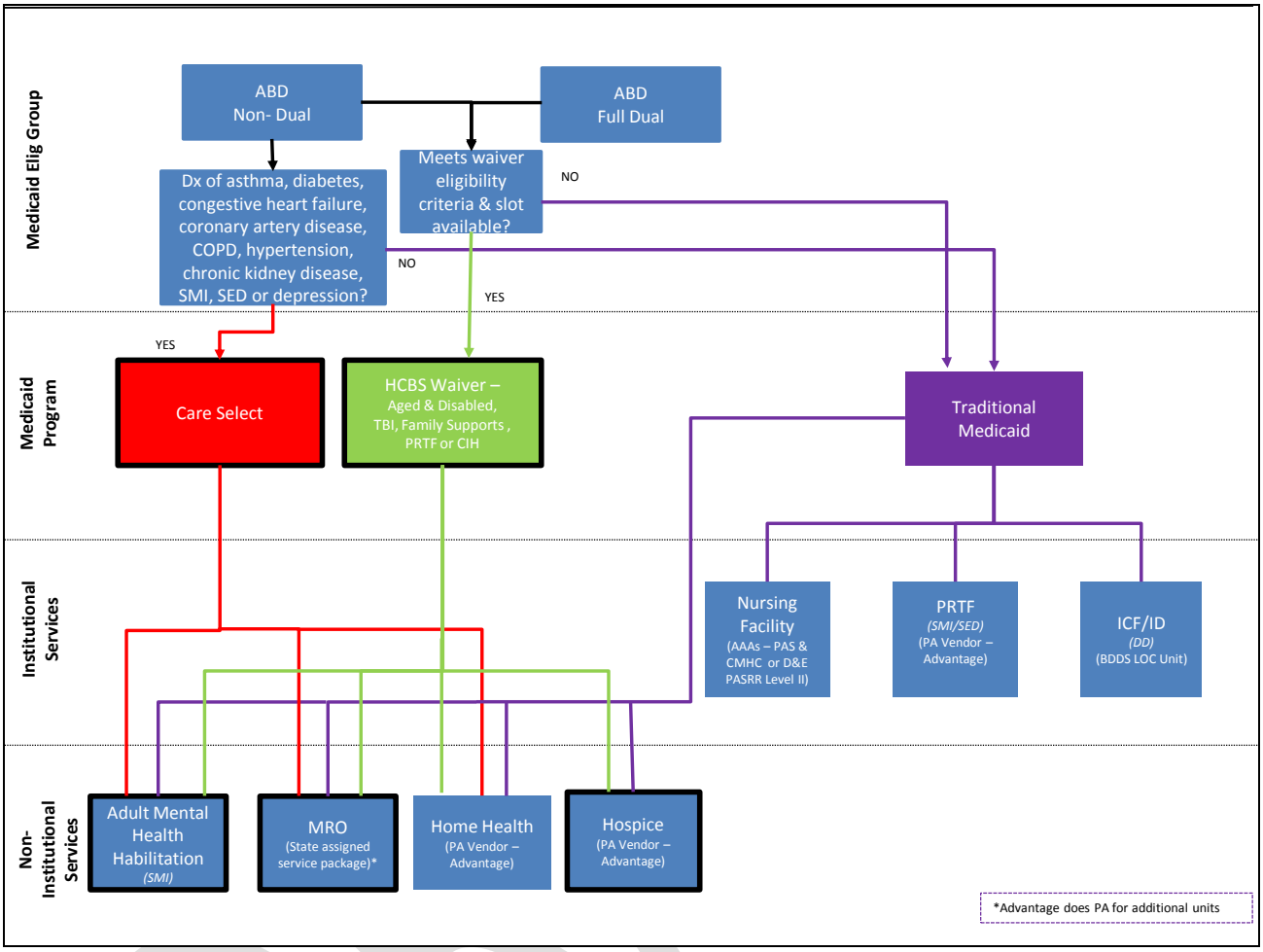
Waiver	Description
Aged & Disabled Waiver	For children & adults who meet nursing facility level of care. Assists the person to be as independent as possible and live in the least restrictive home environment possible.
Traumatic Brain Injury Waiver	
Community Integration & Habilitation Waiver	For children & adults with intellectual disabilities. The waivers assist a person to: • Become involved in the community where he or she lives or works • Develop social relationships in the home and work communities • Develop skills to make decisions about how and where he/she wants to live • Be as independent as possible
Family Supports Waiver	
Psychiatric Residential Treatment Transition Waiver	For children with serious emotional disturbances and youth with serious mental illness who transitioned from the prior Community Alternative to PRTF Grant for continuing intensive community-based interventions and supports to become as independent as possible.

Some Medicaid enrollees are also enrolled in Medicare. These individuals are referred to as "duals." Duals who receive full Medicaid benefits as well as assistance in paying for Medicare cost-sharing are referred to as "full duals." Medicaid is the payer of last resort; therefore, the State pays for any covered services up to the Medicaid allowable amount after Medicare has paid their required portion.

Current ABD Programs & Services

Figure 2 provides a snapshot of the current eligibility groups, associated programs and services available to Indiana ABD enrollees. Any applicable entities responsible for authorizing services or placement in a facility are noted in parentheses on the chart, any service or program which provides care coordination services are outlined in bold.

Figure 2: Current Programming & Services for ABD Enrollees



Current Indiana ABD Management Strategies & Opportunities

Indiana's ABD eligibility groups are excluded from managed care and are served under the FFS program, referred to as Traditional Medicaid. However, non-duals and non-HCBS waiver enrollees with specified disease states may voluntarily enroll in the State's PCCM program, Care Select, described in further detail below. In general, Traditional Medicaid enrollees do not receive Medicaid funded assistance in accessing or coordinating services or in the overall management of their healthcare needs. However, within current Indiana Medicaid programming for these populations there are various examples of strategies and practices that are aligned with the goals and processes under managed care arrangements. These current strategies span a variety of practices such as prior authorization (PA) policies, reimbursement strategies, case management and care coordination efforts. In evaluating the impact of implementing a managed care model for the Indiana ABD populations per legislation, it is important to consider what management strategies are already in place and effectively working to manage care and

outcomes. In some areas, the effectiveness of these current strategies may limit the potential for additional cost savings.

While there are a variety of ABD management examples currently in place, these strategies are available at different points throughout an individual's Medicaid eligibility cycle and engagement with the healthcare system and are not coordinated by an overarching entity or provider responsible for enrollee's health outcomes. Additionally, the current processes do not have overarching quality metrics and financial incentives tied to performance and health outcomes. The following sections provide a brief description of current "managed care like" arrangements within Indiana Medicaid for the ABD and more detailed descriptions of many of the processes described above in Figure 2. A summary description of these strategies is provided in Table 9.

Table 9: Current Indiana ABD Management Strategies

Strategy	Examples
Processes to Facilitate Community vs. Institutional Placement	• AAA Options Counseling • Pre-Admission Screenings • Money Follows the Person
Service Authorization	• Prior authorization for acute care services • Waiver service authorizations • MRO service package assignment
Care Coordination	• Care Select • HCBS waivers • MRO • 1915(i) programs
Quality	• Care Select pay-for-performance • HCBS waiver monitoring • Nursing Home Quality Assessment Fee • DMHA performance-based contracting
Financing & Reimbursement Strategies	• PACE • HCBS waivers – annual service caps • Per diem rates

Processes to Facilitate Community vs. Institutional Placement

Current processes are in place to evaluate the appropriateness of institutional placement and ensure the exploration of community-based alternatives, depending on the type of patient and institutional setting. For example, Options Counseling is provided by the Indiana Area Agencies on Aging (AAAs) to promote informed decision-making about long-term care needs and supports. Additionally, as illustrated in Figure 2 above, any person seeking nursing facility placement in Indiana must complete the pre-admission screening (PAS) process. The goal of the PAS process is to prevent premature or unnecessary placements

for those who have long-term care needs but do not require a nursing facility level of care and to ensure that nursing facility alternatives have been explored. The AAAs complete the PAS and receive Medicaid reimbursement for each application received and screening conducted. If during the PAS a mental health or intellectual/developmental disability is identified, the consumer receives an additional evaluation, referred to as a Level II screening. Individuals with a potential mental health issue have the Level II screening conducted by a Community Mental Health Center (CMHC) and individuals with an identified intellectual/developmental disability have the additional screening conducted by a diagnostic and evaluation team with the FSSA Bureau of Developmental Disabilities Services (BDDS).

Admissions to psychiatric residential treatment facilities (PRTF) are also reviewed for appropriateness by the State's prior authorization (PA) vendor, Advantage Health Solutions. Admissions to intermediate care facilities for the Intellectually Disabled (ICF/IDs) are authorized based on determination of an individual's Level of Care by service coordinators within DDRS.

Services are also available to assist individuals in transitioning out of institutional settings. For example, the Money Follows the Person (MFP) program is available for Medicaid eligible individuals who meet specific target criteria for the program, have been institutionalized for ninety consecutive days or more and have needs that can be safely met in the community. Through the MFP program, a transition nurse and specialist work with the participant to identify needs and available supports and services. Participants are assisted in tasks such as finding housing and services. Each MFP participant has a case manager that coordinates and manages the variety of services and supports the participant receives. After a year of receiving MFP services, individuals are transitioned to another Medicaid funded service such as the Aged and Disabled or TBI Waiver, clinic option services, Children's Mental Health Wrap-around (CMHW) or Medicaid Rehabilitation Option (MRO).

Overall, these current efforts provide critical assistance to ensure individuals are receiving care in the appropriate setting and are aimed at increasing community versus institutional care, but these programs do not include financial and other incentives for the responsible entities to actively transition enrollees to community-based care.

Service Authorization

Service authorization practices are also in place to ensure Medicaid covered services are authorized and provided in the appropriate amount, duration and scope. Some Medicaid covered acute care services require prior authorization (PA), a process by which the medical necessity of a requested service is reviewed. When a service requires PA, if it is rendered without PA being secured, reimbursement is not

available. All PA functions for acute care services for ABD enrollees are currently handled through a contract with Advantage Health Solutions.

The process for authorization of waiver services varies based on the HCBS waiver as outlined in Table 10. Overall, waiver services are authorized based on an approved care plan after an individual has been determined eligible for a HCBS waiver; this process is based on the enrollee's individual needs and required supports.

Table 10: HCBS Waiver Service Authorization Process

Waiver	Process
Aged & Disabled & TBI	• State contracts with AAAs to facilitate the waiver eligibility process • An individualized plan of care is developed by case manager, subject to the approval of DA and OMPP • After completion of eligibility determination and care plan development, enrollee can retain AAA case manager or independent case manager
Community Integration & Habilitation	• Participant selects case management company (CMCO) approved by Bureau of Developmental Disabilities Services (BDDS) • Individual's budget allocation determined by State staff during intake based on an assessment of the member's functional ability based on health and behavioral factors combined with age, employment and living arrangement • Support plan is developed
Family Supports Waiver	• Services are subject to an annual waiver services budget currently set at $16,250 • Waiver participant develops Individual Service Plan (ISP) guided by an Individual Support Team (IST) composed of the participant, case manager and other individuals of the enrollee's choosing
PRTF	• Services are authorized by the Division of Mental Health and Addiction (DMHA) • Plan of care based on an individualized assessment is the vehicle for service authorization

Additionally, Medicaid enrollees requiring MRO services are assigned a service package based on level of need (LON), as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be authorized when they are determined to be medically necessary.

Care Coordination

Care coordination services are also provided through a variety of current programs for the ABD. The Care Select program is an optional program available to non-dual ABD members. Spend-down enrollees,

individuals receiving HCBS waivers, M.E.D. Works Participants and institutionalized populations are not eligible for Care Select.

Care Select is designed to improve a member's health status, enhance quality of life, and improve client safety, client autonomy and adherence to treatment plans. To be eligible for Care Select, an enrollee must have one of the following conditions:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease[9]
- Hypertension
- Chronic Kidney Disease without dialysis
- Severe Mental Illness
- Serious Emotional Disturbance
- Depression
- The co-morbidity of diabetes and hypertension
- The co-morbidities and or/combinations of any of these disease states
- Other serious or chronic medical condition, as approved by OMPP

The State will continue to contract with two Care Select vendors in a new contract starting January 1, 2014. The vendors will provide disease management, care management and complex case management services to Care Select enrollees based on an individualized assessment and risk stratification. Additionally, enrollees have a designated primary medical provider (PMP) who receives a monthly administrative fee to manage the care of their enrollees.

Case management and care coordination services are also available to other categories of ABD enrollees. For example, HCBS waiver enrollees have a case manager of their choosing. However, waiver case managers are primarily charged with assisting with waiver supports and services versus a targeted focus on the overall medical needs of the enrollee. One exception is within the Community Integration and Habilitation waiver, aimed at individuals with intellectual and developmental diagnoses. Wellness coordination services are currently under development for inclusion as a covered service and will provide

[9] COPD is a new addition for the contract effective January 1, 2014.

an increased focus on coordinating medical services. Through wellness coordination services, waiver enrollees with an identified need for assistance in coordination of medical needs will receive services from a registered nurse (RN) or licensed practical nurse (LPN).

MRO recipients are also eligible to receive case management services as part of their assigned service package though case management is primarily related to mental health and social supports and does not fully link physical health services and providers. Additionally, the State recently received approval from CMS on two 1915(i) State Plan Amendments (SPAs). The Child Mental Health Wraparound (CMHW) 1915(i) allows the State to provide intensive home and community based wraparound services to eligible individuals. The Adult Mental Health Habilitation (AMHH) 1915(i) allows the State to provide a variety of habilitative services including care coordination to eligible individuals.

In sum, while there are numerous examples of care coordination and case management activities within current ABD programs, they are not coordinated by an overarching entity or provider responsible for enrollees' health outcomes and they do not span the social, medical and behavioral health needs of enrollees.

Current Quality Initiatives

As previously discussed, one of the reasons states implement a managed care model is to improve quality while simultaneously managing costs. Within Indiana Medicaid programs for the ABD, there are a variety of quality efforts and initiatives in place, but not all current ABD programs and services have quality metrics by which performance and outcomes are measured. Following are some examples of current performance initiatives within Indiana Medicaid ABD programs.

In the Care Select program, CMOs participate in a pay-for-performance program. At various times during the history of the program, a portion of the CMO's payment has been withheld; the CMO is eligible for payment of the withhold based on performance on quality measures such as HEDIS Ambulatory Care, rates on follow-up after hospitalization for mental illness and rates related to access to preventive care. Fifty percent of these performance related delayed payments must in turn be reinvested in incentive payments to providers and/or members.

There are a variety of monitoring tools and quality indicators for HCBS waivers as well, including but not limited to, provider reviews, surveys of participant experiences and ongoing monitoring reports.

Quality outcomes for individuals in nursing homes are also rewarded through the Quality Assessment Fee (QAF). Nursing facilities in Indiana are required to pay a QAF. A portion of the QAF is used to increase

nursing facility reimbursement for initiatives that promote the enhancement of quality of care to nursing facility residents. This increased reimbursement is based on each nursing facility's total quality score, a score which will be calculated based on performance on the quality measures described in Table 11 following approval of the SPA by CMS retroactive to July 1, 2013. Facilities with a higher total quality score receive a higher quality rate add-on.

Table 11: Nursing Quality Measures Tied to Nursing Facility Quality Add-On

Component of Total Quality Score	Description
Nursing Home Report Card Score	• A numerical score developed and published by the Indiana State Department of Health (ISDH). • Quantifies each facility's survey results on categories including administration, care and services, resident rights, dietary and environment. • The scoring system evaluates 45 requirements of compliance[xiv].
Normalized Weighted Average Nursing Hours Per Resident Day	• Each nursing facility's normalized weighted average of nursing hours per resident day is calculated based on the facility's annual financial report.
Staff Retention	• Registered Nurse (RN) & Licensed Practical Nurse (LPN) retention rates • Certified Nursing Assistant (CNA) retention rates
Staff Turnover	• RN/LPN turnover rates • CNA turnover rates • Administrative turnover rates • Director of Nursing turnover rates

Plans are underway to incorporate resident, family and staff satisfaction and specific clinical outcome measures into the QAF methodology.

Additionally, DMHA maintains performance-based contracting with organizations, such as CMHCs, responsible for ensuring a community-based continuum of care for adults and youth with mental illnesses and/or addiction. These organizations "earn" a portion of their allocated funds based on degree to which performance measure targets are met. Performance measures are grouped into three funding pools: Seriously Mentally Ill (SMI) Performance Measures, Chronically Addicted (CA) Performance Measures and Seriously Emotionally Disturbed (SED) Performance Measures. One-fourth of the performance funds plus any funds not earned in previous quarters are available each quarter. The amount of payment each quarter is based on the overall percentage of targets met for SMI, for CA, and for SED funding pools. Providers are paid up to 100% of dollars available for the fiscal quarter. If the provider meets the established target, they will receive 100% of the dollars allocated toward that funding pool. If the

performance is less than the established target, providers receive a reduced percentage of funds related to the level of performance. If any allocated dollars are not paid out due to under performance, those dollars will be shifted to a bonus pool. When a provider exceeds 100% of a designated performance target, they are eligible for participation in receiving funds as available from a bonus pool.

Collection of enrollee satisfaction information is limited with some exceptions such as within the Care Select Program where CMOs are responsible for completing an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, a standardized patient survey designed to allow consumers to report on and evaluate their experiences with the healthcare system. Financial incentives for quality outcomes are not widely utilized.

Financing & Reimbursement Strategies

Within current Indiana Medicaid programs for the ABD, there are also some examples of reimbursement mechanisms which are similar in nature to managed care financing strategies. These current models are important to consider when evaluating the impact of implementing an ABD managed care model in the State. Overall, these reimbursement strategies do not span the healthcare delivery system for ABD enrollees and are instead isolated to unique services. The majority of ABD services are reimbursed in a traditional fee-for-service payment model under which services are unbundled and payment is provided for each service rendered.

As previously discussed, once PACE is fully implemented in Indiana, capitation payments will be made to PACE organizations; in turn these organizations will be at risk for all Medicaid and Medicare services for their enrolled population. Additionally, within the Family Supports Waiver, HCBS have a budget cap. Other examples of reimbursement methodologies that mimic managed care financing strategies include all-inclusive per diem rates which are rates paid on a daily basis for all services rendered. Per diem rates are in use in institutional settings such as ICF/IDs, nursing facilities and PRTFs. As illustrated in Table 12, there are also incentives built into the rate setting-methodology for ICF/IDs and nursing facilities to operate efficiently as there is a profit add-on available for facilities with costs lower than the median.

Table 12: Facility Per Diem Methodologies

Facility Type	Overview of Per Diem Methodology

ICF/ID	• All inclusive per diem including:
	  ○ Durable Medical Equipment
	  ○ Customized equipment
	  ○ Medical and non-medical supplies
	  ○ Nursing care
	  ○ Room and board
	  ○ Therapy services
	  ○ Transportation
	  ○ Habilitation
	  ○ Day habilitation (small ICF/IDs only)
	• Allowable costs per day subject to minimum occupancy levels
	• Profit add-on may also be included; facilities with costs that are less than the median patient day receive an add-on proportional to the cost differential up to state cap
	• Capital return factor incorporated
	• Rates are in effect for two years and rebased; adjusted for inflation in non-rebasing year
	• Non-state owned facilities pay an assessment fee based on annual facility revenue

Nursing Facility	• Per diem rate updated quarterly
	• Case mix methodology utilized to reimburse providers based on resident's clinical acuity
	• Five separate cost-based components:
	  ○ Direct care
	  ○ Indirect care
	  ○ Administrative
	  ○ Capital
	  ○ Therapy
	• Direct care, indirect care and capital costs calculated based on minimum occupancy standards
	• Profit add-on may also be included for facilities whose costs are less than the median across facilities
	• Additional add-ons:
	  ○ Special care unit add-on
	  ○ Ventilator unit add-on
	  ○ Quality assessment fee add-on

PRTFs	• Statewide prospective per diem rate based on lower of:
	  ○ Statewide PRTF prospective per diem rate calculated by State –or-
	  ○ Usual and customary daily charges billed
	• Per diem includes all Medicaid covered services provided in facility except pharmacy and physician services

The Role of AAAs

The AAAs currently play a key role in the delivery of care to Indiana ABD enrollees. This was a theme heard consistently through stakeholder feedback and one to be considered when evaluating the potential impact of implementation of a managed care model. There are sixteen AAAs located in communities throughout the state, and they serve a variety of community functions. As the Aging and Disability Resource Centers (ADRC), AAAs serve as a single entry point for information and assistance on issues affecting the aged and disabled. AAAs connect individuals with community programs and services. Additionally, as previously discussed they play a key role in ensuring institutional placements are appropriate through both the PAS process and Options Counseling. Furthermore, they play a role in the HCBS waiver eligibility and case management processes for the Aged and Disabled and TBI waivers. Outside of Medicaid funded services, the AAAs also provide eligibility determination, service authorization, care plan development, case management and HCBS service delivery for the CHOICE, Title III and Social Service Block Grant funded supports. Overall, the AAAs play an important role in serving as a local neutral third party resource.

Indiana Financing Considerations

When evaluating the potential impact of implementation of a managed care model, it is important to consider the impact to supplemental payments, quality assessment fees (QAF), the hospital assessment fee and MRO funding. In Indiana, non-state government owned nursing homes receive supplemental payments through Upper Payment Limit (UPL) payments. Under the UPL, federal regulations prohibit federal matching funds for Medicaid payments that exceed what Medicare pays. Because the nursing home reimbursement under Medicaid is below that which would be paid by Medicare, the State can make supplemental payments beyond the regular Medicaid rate, up to the UPL and receive Federal funding for the supplemental payments.

Additionally, as previously discussed, nursing homes pay a QAF through which a portion is used to increase reimbursement for initiatives linked to improvement in quality. In-State acute care hospitals and freestanding psychiatric hospitals also pay an assessment fee that is used in part to increase reimbursement to eligible hospitals for services provided in both FFS and managed care programs, and as the state share of disproportionate share hospital (DSH) payments. Non-state owned ICF/IDs are also required to pay an assessment fee that is based on the total annual facility revenue. These assessment fees help fund the state's share of Medicaid program costs.

Finally, MRO services are funded through a unique partnership. CMHCs have been granted status as governmental entities to allow them to certify both county and state funds for federal matching purposes. CMHCs may use their DMHA allocated state dollars as the matching funds for Medicaid programs like

MRO which require state match. CMHCs are the exclusive providers of MRO services. CMHCs may also use their county funds for any match required beyond their DMHA state allocated funding. This arrangement allows the State to offer MRO services without additional state dollars to fund the match.

An analysis of the impact of each potential managed care option on the assessment fees, supplemental payments and MRO match is provided in the Managed Care Options Sections.

ABD Enrollment & Expenditures

Current Enrollment and Expenditures

Indiana Medicaid's ABD enrollees accounted for 69% of all Medicaid healthcare expenditures in SFY 2012, despite only representing 25% of the Medicaid population.[10] State Fiscal Year (SFY) 2012 average monthly enrollment for Indiana's ABD population was 273,957. A breakdown by population is provided in Table 13.

Table 13: SFY 2012 Indiana Medicaid Average Monthly Enrollment– Disabled Universe - June 2013 Data

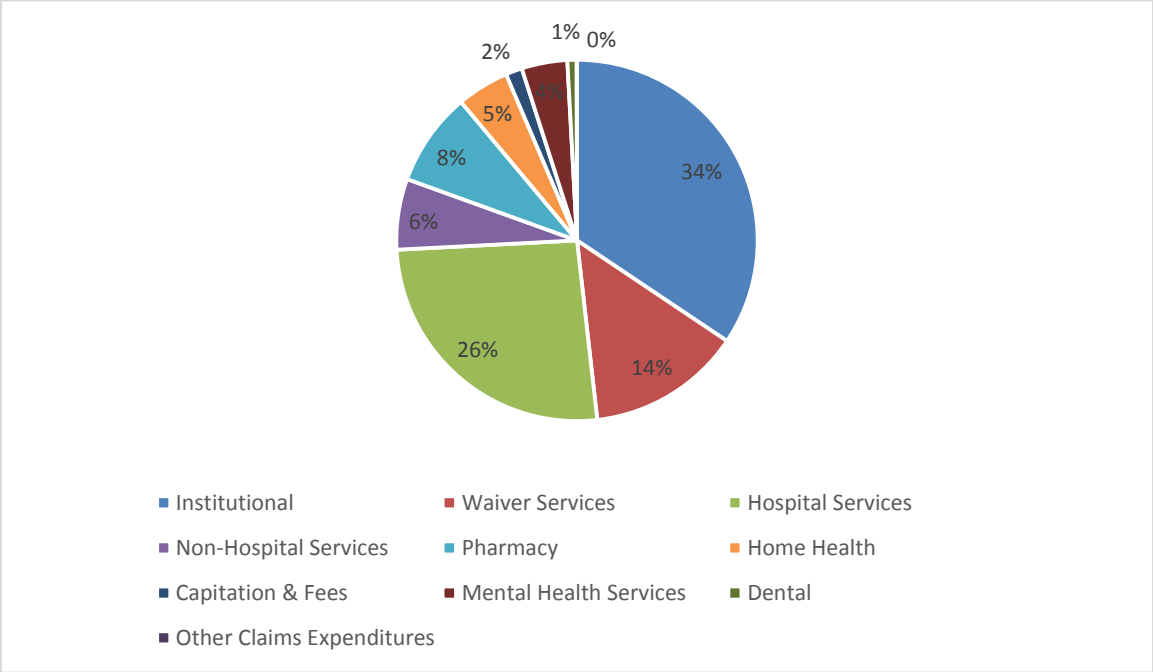
POPULATION	Dual	Non-Dual	Partial Dual	Total
Institutionalized				
Nursing Home	26,436	2,183	171	**28,790**
Other Institutionalized	4,411	1,754	2	**6,167**
Waiver				
Aging Waiver	6,045	2,436	7	**8,489**
DDRS Waiver	7,275	5,218	7	**12,499**
DMHA Waiver	-	546	-	**546**
Care Select	438[11]	34,024	0	**34,462**
ESP	39	1,303	-	**1,342**
MA-U	468	17,415	-	**17,883**
M.E.D. Works	1,879	1,733	-	**3,612**
Spend Down	53,954	8,695	-	**62,649**
Other Disabled	34,325	31,260	31,934	**97,519**
Total Disabled	**135,270**	**106,567**	**32,121**	**273,957**

[10] Based on Milliman, Inc. forecast for FY 2012 with values on an incurred basis to adjust for timing of payments. Includes Medicaid, HIP & CHIP enrollees.

[11] Duals are not included in the Care Select program; however, some individuals receive dual eligibility on a retroactive basis, causing the presence of duals in the enrollment data. Additionally there may be some minor overlap as individuals that are non-dual become dual eligible and disenroll from Care Select.

Figure 3 illustrates the distribution of expenditures for the ABD populations by service type. 34% of expenditures for the ABD populations were associated with institutional care while institutional populations accounted for only 13% of the total ABD enrollment.

Figure 3: ABD SFY 2012 Incurred Expenditures by Service Type



Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Table 13 and Figure 3 illustrated the SFY 2012 enrollment and expenditures without any adjustments in order to provide a complete profile of the ABD population. The remaining tables in the report outlining enrollment and fiscal projections for each managed care model option will reflect the following adjustments:

- ABD individuals under the age of 21, regardless of initial population, were assigned to the under 21 population. This population was not further stratified.
- Individuals with a partial Medicare status are excluded; partial duals do not receive full Medicaid coverage and only receive Medicaid-funded assistance in paying Medicare premiums and cost-sharing. They are excluded due to a lack of ability to manage their costs.
- Individuals in the MA-U eligibility category are excluded; MA-U refers to Indiana's eligibility category for individuals who are receiving SSI and who would meet Temporary Aid to Needy Families (TANF) eligibility requirements were they not receiving SSI. These individuals are currently enrolled in Hoosier Healthwise and are therefore excluded as they are already managed.

- Individuals in the Enhanced Services Program (ESP) are excluded as they are already managed by the Healthy Indiana Plan.
- The spend down program will be eliminated with conversion to 1634 status in 2014, but some of the current spend down individuals are expected to transition to the "community population." For purposes of this report, the community population refers to non-institutionalized ABD enrollees over age 21 who are not in Care Select, a HCBS waiver or M.E.D. Works. 22% of non-dual spend down individuals were assumed to transition to the non-dual community population in the 2015 enrollment estimate, and 38% of the dual spend down individuals were assumed to transition to the dual community population in the 2015 enrollment estimate. Spend down individuals were excluded from any PMPM estimates in the actuarial analysis because of an incomplete cost profile.
- The first three months of Medicaid eligibility and claims for individuals not enrolled in a Care Select population were removed from the data. These months usually include retroactive eligibility and are not manageable.

For the remainder of the report, the populations described in the Rolled-Up Population column in Table 14 will be used to describe the ABD populations when delineating the potential cost impact of each managed care model option.

Table 14: ABD Population Descriptions

Detailed Population	Rolled-Up Population
Under 21	Under 21[12]
Nursing Home	Nursing Home
Hospice	Other Institutional
ICF/ID	Other Institutional
Aged & Disabled	Aged & Disabled Waiver
Money Follows the Person	Aged & Disabled Waiver
Traumatic Brain Injury	Aged & Disabled Waiver
CIH	CIH Waiver
Family Supports	Family Supports Waiver
Care Select	Care Select
Other Disabled	Community
M.E.D. Works	M.E.D. Works
Spend Down	Community
MA-U[13]	Excluded
ESP	Excluded

The remainder of the report will use the above stated population definitions and methodology. Table 15 illustrates the effect of the above population adjustments and will be used as the baseline for enrollment and expenditures; this table reconciles the difference for SFY 2012 enrollment and expenditures. Differences between totals displayed in Table 15 and other tables throughout the report are attributable to the rest of the report using combined SFY 2011 and 2012 enrollment and expenditures.

[12] Any individual under 21 is included in the population.
[13] MA-U refers to Indiana's eligibility category for individuals who would meet Temporary Aid to Needy Families (TANF) eligibility requirements were they not receiving Supplemental Security Income (SSI).

Table 15: Adjustments to ABD Expenditures and Enrollment
SFY 2011 & 2012 Combined

	SFY12 Expenditures	Average Monthly Enrollment
Non-Adjusted ABD Enrollment & Expenditures[14]	$5,203,015,726	273,957
Less Non-Claims Expenditures[15]		
Pharmacy Rebates	(169,266,165)	
M.E.D. Works Premiums	(1,794,069)	
Medicare Buy-Ins	213,626,754	
Clawback Payments	95,143,585	
DSH (Incurred)	225,800,000	
UPL (Incurred – non- Hospital)	200,305,942	
PCCM Admin Fees	68,000,369	
Subtotal	$4,571,199,311	273,957
Less Population Exclusions		
Partials	$12,884,412	31,888
Spend-Downs	311,479,503	62,620
MA-U	87,328,496	17,878
ESP	15,699,338	1,347
Subtotal	$4,143,807,562	160,224
Other Adjustments		
1st 3 Months of Eligibility	170,379,370	6,303
Spend Down to Community	(23,422,919)	(22,305)
SFY 12 Total	**$3,996,851,112**	**176,226**

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Enrollment & Expenditure Projections for Indiana to 2025

With the aging baby boomer population, ABD individuals in a nursing home or other institutional setting may increase by more than 25% from SFY 2012 to 2025. However, the increased enrollment in

[14] Refers to expenditures associated with enrollees outlined in Table 13. Of the $5.2 billion in associated ABD expenditures, $4.6 billion was summarized from the claims data and identified as corresponding to an ABD enrollee. The remaining $0.6 billion corresponds to non-claims expenditures. The allocation methodology for non-claims expenditures are detailed in the Milliman, Aged & Disabled Report prepared for the State of Indiana Family and Social Services Administration, November 18, 2013.

[15] The allocation methodology for these non-claims expenditures is detailed in the Milliman, Aged & Disabled Report prepared for the State of Indiana Family and Social Services Administration, November 18, 2013.

institutional settings may be dampened to the extent that medical advances, societal changes, or other factors cause less Indiana residents to need institutional care in the future. Enrollment estimates were created by the State's actuary by projecting SFY 2012 ABD enrollment using population growth estimates from STATS Indiana.[16] Total annual expenditures for the ABD populations described in Table 16 are projected to increase by approximately $908 million by the year 2025 without any medical inflation.[xv]

Table 16: Indiana ABD Estimated Average Monthly Enrollment by SFY[17]

Population	2012	2015	2020	2025
Nursing Home	28,600	30,300	33,000	36,700
Other Institutional	5,800	5,900	6,200	6,400
Aged & Disabled Waiver	7,200	11,500	12,400	13,300
CIH Waiver	6,800	7,500	7,600	7,700
Family Supports Waiver	3,800	7,000	7,000	7,000
Care Select	22,800	23,100	23,200	22,900
Community	62,100	87,300	91,200	94,600
M.E.D. Works	3,600	3,600	3,600	3,500
Under 21	19,500	19,600	19,800	20,000
Total	**160,200**	**195,800**	**204,000**	**212,100**

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Managed Care Options

The remainder of the report focuses on the three models identified in HEA 1328 to manage the care of Indiana ABD enrollees. This includes a RBMC program, managed FFS program and HCBS management program. The Task Force mission was not to make a specific recommendation on any particular model, but rather to analyze the potential options and the issues surrounding each option.

Overarching Program Goals & Key Principles

Across each potential ABD management strategy, there is significant state flexibility in program design. However, regardless of the model, there were common themes and goals that emerged from stakeholder

[16] Information on STATS Indiana is available at http://www.stats.indiana.edu/index.asp

[17] The effect of spend down individuals transitioning to the community population is illustrated beginning in SFY 2015. Spend down individuals are not included in the SFY 2012 enrollment. Additionally, the first three months of enrollment were not excluded from this table.

feedback and Task Force research and discussions. In outlining the different State options, the Task Force assessed the potential impact of each model against the core principles outlined in Table 17.

Table 17: Core Principles

Principle	Description	RBMC	Managed FFS	Managed HCBS
Potential to Improve Quality Outcomes & Consistency of Care Across the Delivery System	• Establishment of quality objectives with stakeholder input. • Provides consistent quality of care regardless of geographic location. • Provides incentives, including financial incentives, to improve quality versus restrict access to needed services. • Creates incentives and rewards for providers for quality outcomes rather than volume of services. • Aligns financial incentives and quality outcomes across the service delivery system to align providers with common goals. • Establishes quality measures that include, but are not limited to: clinical outcomes, patient satisfaction, quality of life and social determinants, functional outcomes, health and safety assurances, community integration and access to care, and measures that consider different population needs. • Establishes process measures that include, but are not limited to: claims payment timeliness, network adequacy, timeliness of assessments and service plans, member call center performance, fraud and abuse, appeals, utilization management processing times and approval rates.	X	X	

Principle	Description	RBMC	Managed FFS	Managed HCBS
Enrollee Choice, Protections & Access	• Clearly establishes participant rights and responsibilities. • Preserves and promotes consumer choice and autonomy. • Provides neutral third parties to ensure participant's rights are upheld and enrollees understand their options for care. • Provides conflict free services such that entities conducting assessment and eligibility determination are separated from service providers. • Assures person-centered service planning which includes the enhanced provision of local home and community based services versus institutional care when appropriate for the individual's needs. • Provides local, face-to-face case managers where appropriate. • Preserves existing provider infrastructure to ensure longstanding relationships are not disrupted.	X	X	
Potential to Coordinate Care Across the Delivery System & Care Continuum	• Strategy acknowledges the whole person's diverse medical and social needs which span primary and acute medical care, behavioral health and long-term services and supports. • Provides coordination through the continuum of care from medical services, both physical and behavioral health, along with non-medical and throughout different disease phases and stages. • Assures quality and reduces duplication of services while considering the comprehensive needs of the individual. • Avoids multiple layers of uncoordinated care managers. • Provides a system and leverages technology to provide real-time, accessible client information across the delivery system to promote high quality, coordinated care.	X	X	

Principle	Description	RBMC	Managed FFS	Managed HCBS
Flexible Person Centered Care	• Promotes flexible care plans that avoid a "one-size fits all" approach. • Understands unique client needs and develops individualized service plans. • Recognizes high prevalence of comorbidities and creates care plans that address the whole person.	X	X	X
Transition Planning, Contract Oversight & Implementation Issues	• Assures adequate reimbursement rates, sufficient provider networks, state oversight of contractors, and continuity of care. • Develops a transition plan to minimize issues for clients. • Assures accountability through identification of incentives and penalties that are tied to performance requirements and outcomes.	X	X	X
Cost Impact	• Assures prudent use of taxpayer dollars. • Maximizes federal funding to the State and does not impede existing federal funding streams, such as quality assessment fees, supplemental payments. • Considers source of State Medicaid matching funds and preserves existing funding streams.	X *Some populations*	X *Some populations*	

Option #1: Risk-Based Managed Care

Under a risk-based managed care (RBMC) model, the State would contract with Managed Care Entities (MCEs). The MCEs would be paid a per member per month capitation rate and would be at risk to provide all services covered under the contract. Through the contract with the State, the MCEs would be responsible for a variety of functions such as those outlined in Table 18. The State would define specific quality goals and outcomes the contractors would be required to meet and could develop financial incentives such as capitation withholds, bonuses or shared savings tied to the achievement of state-defined performance metrics. The contract under a RBMC approach provides many design opportunities for the State and would identify key requirements and performance objectives for the MCEs.

Table 18: Overview of Potential MCE Contract Requirements

Function	Potential MCE Requirements
Quality Improvement	• MCE to meet State-defined quality metrics • Development of quality improvement strategy • Participation in state-driven quality initiatives • Development of provider performance incentive programs • Requirements for meeting key process measures
Member Services	• Provision of care coordination, case management and disease management • Operation of customer service number & 24 hour nurse hotline • Processing grievances and appeals
Utilization Management	• Operation of utilization management program to evaluate the appropriateness and medical necessity of healthcare services and procedures (prior authorization, concurrent review, etc.)
Provider Network	• Development of provider network within state-defined access and availability requirements • Contracting and credentialing providers
Information Systems	• Processing provider claims • Submitting data to the state • Developing health information technology programs
Administrative Requirements	• Development of infrastructure and staffing • Meeting Department of Insurance requirements for solvency and financial stability

RBMC Potential for Cost Savings

In developing estimated savings for implementation of a managed care program, an algorithm that identifies avoidable costs was applied to the Indiana Medicaid experience data by the State's actuary. The algorithm is based on Milliman's internal and published clinical research and identifies services that are "potentially avoidable." These are acute services for conditions that potentially could have been avoided via appropriate ambulatory care. Cost savings may be generated under managed care by reducing avoidable costs through better care management practices.

In analyzing the fiscal impact of implementation of RBMC, administrative costs must also be considered; these include factors such as the cost of managing healthcare, claims adjudication and a contribution to the MCE's surplus or profit. Additionally, the ACA implemented a new health insurer fee. As a result of this new federally mandated fee, administrative costs under RBMC will increase by 2.5%. In order to produce net savings from transitioning the ABD population to RBMC, the estimated claims cost savings must be greater than the increase in administrative costs and fees.

Actuarial projections provided in Table 19 illustrate the best estimate of the expected net savings after administrative costs from the implementation of a RBMC program for each individual ABD population. Savings estimates illustrated are best estimates and include a degree of uncertainty. Actual results are expected to deviate from those illustrated. Additionally, estimates reflect expected annual savings achievable in three to five years. Savings from a managed care program may take multiple years to materialize, and therefore savings in the initial years of implementing a managed care program are expected to be less than the ultimate amount.

The expected net savings varies significantly by population. This variance is attributed to each population's cost profile and current strategies in place to manage their care. The Care Select, community non-dual, M.E.D. Works non-dual, Aged and Disabled Waiver non-dual and nursing home non-dual populations have a potential for net savings ranging from 1.5% to 5.6%. The remaining populations have an estimated negative net savings; this means the State's costs are projected to increase by enrolling these populations in RBMC. Each population should be reviewed individually when determining whether or not to implement a managed care program.

The Care Select population has a lower range of estimated claims savings relative to the community non-dual population because they are already in a managed FFS program. The community non-dual population offers the most potential for savings on a percentage basis. This population is currently not managed and may experience reduced claims costs under RBMC. The savings estimates for the M.E.D. Works non-dual population is lower than the community non-dual population's best estimate, which is attributable to the different cost profiles of the populations; the M.E.D. Works non-dual population experiences approximately $225 PMPM less in inpatient claims, where the majority of potential cost savings is estimated. Relative to the other HCBS waivers, the Aged and Disabled Waiver offers the most potential for claims savings due to the high inpatient costs ($1,117 PMPM), which offer opportunity for management.

The actuarial projections illustrate that the remaining populations have an estimated negative net savings under RBMC; this is due to multiple factors. For all dual populations, estimated claims savings is significantly less than for non-duals because the claims costs savings for the dual populations would be shared with Medicare, and the fixed administrative costs are spread over a higher per member cost for non-dual populations. Claims data limitations with the dual population also create more uncertainty regarding potential managed care savings from this population.

For the HCBS waiver populations, claims cost is largely attributable to the cost of waiver services, and no claims cost savings were estimated to be attainable for the waiver services. This is because under the

current delivery system, waiver services are already managed through strategies such as case management, capped limits in the Family Supports Waiver and individualized budget allocations in the Community Integration and Habilitation Waiver. Although waiver services are already managed, case managers normally focus more heavily on waiver services rather than on the full spectrum of Medicaid services a participant receives, including hospital, physician, pharmacy and home health services. It is possible that by increasing the case manager's responsibility, or replacing case management with a more comprehensive management service, would lead to better managed care. However, any savings would probably have to be approached in an oblique manner, not directly through limitations or service restrictions. There is the potential for legal issues arising from state policy which would limit services by population without specific consideration of an individual's needs. Relative to the Aged and Disabled Waiver non-duals, for which potential savings under RBMC were projected, the Family Supports Waiver and Community Integration and Habilitation Waiver non-dual populations are characterized by lower inpatient and emergency room costs; this results in less opportunity to reduce claims costs through managed care. Actual waiver expenses for the non-duals, are approximately 60% (Family Supports Waiver) and 80% (Community Integration and Habilitation Waiver) of costs for these populations.

For the institutional populations, claims costs are largely attributable to the cost of institutional services, and no claims cost savings were estimated to be attainable for the institutional services. Institutions are already paid a per diem rate. Furthermore, institutional costs are typically managed by diverting less medically needy individuals to a home and community based setting. The State already has programs in place designed to move suitable individuals to a home and community based setting. It is not clear whether a RBMC approach would be able to achieve any additional claims cost savings with an institution diversion program. Relative to the other institutional populations, the nursing home non-dual population offers the most potential for claims savings due to their high inpatient costs ($2,275 PMPM) which indicate an opportunity for management.

Finally, for the under 21 populations, many are already managed in the Care Select program, so there may be less opportunity for additional claims savings from managing these individuals. Additionally, the non-duals under 21 have relatively low inpatient ($198 PMPM) and emergency room ($23 PMPM) costs, resulting in limited opportunity for care management.

Table 19: Estimated Aggregate Net Savings by Population under RBMC Model
SFY 2011 & 2012 Estimated Aggregate Annual Expenditures

Population	Estimated Enrollment	Annual Claim Expenditures	Best Estimate	
			Net Savings	% Net Savings
Care Select	24,200	$506,600,000	$9,900,000	2.0%
Community Non-Dual	22,900	481,100,000	26,900,000	5.6%
Community Dual	52,300	158,900,000	-11,500,000	-7.2%
M.E.D. Works Non-Dual	1,300	28,000,000	600,000	2.1%
M.E.D. Works Dual	1,700	6,500,000	-700,000	-10.8%
Aged & Disabled Waiver Non-Dual	1,000	68,400,000	1,000,000	1.5%
Aged & Disabled Waiver Dual	6,000	181,600,000	-13,700,000	-7.5%
Family Supports Non-Dual	1,300	18,000,000	-900,000	-5.0%
Family Supports Dual	2,200	21,700,000	-1,800,000	-8.3%
CIH Waiver Non-Dual	1,600	131,100,000	-9,200,000	-7.0%
CIH Waiver Dual	4,900	320,000,000	-26,900,000	-8.4%
Other Institutional Non-Dual	1,200	115,300,000	-3,800,000	-3.3%
Other Institutional Dual	4,400	261,700,000	-21,500,000	-8.2%
Nursing Home Non-Dual	1,800	176,300,000	7,200,000	4.1%
Nursing Home Dual	24,500	1,049,700,000	-84,300,000	-8.0%
Under 21 Non-Dual	19,700	361,300,000	-19,400,000	-5.4%
Under 21 Dual	200	4,600,000	-400,000	-8.7%
TOTAL (State & Federal)	171,200	$3,890,800,000	-$148,500,000	-3.8%
TOTAL (State Dollar)	**171,200**	**$1,302,700,000**	**-$49,600,000**	**-3.8%**

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

RBMC Provisions to Ensure Enrollee Access to Efficient & High Quality Care

HEA 1328 called for a description of provisions of a RBMC program that are likely to ensure that enrollees have timely access to efficient and high quality care. The following sections detail State options for such approaches within a RBMC model as outlined in the legislation.

Beneficiary Choice of Network & Non-Network Providers

A RBMC model would provide the State with flexibility to design contract parameters regarding enrollee choice of providers. For example, the State could implement any-willing provider provisions through which MCEs would be required to contract with any provider entity that meets the network requirements and is interested in participating. Additionally, the State could either permit or require the continued

provision of services by an out-of-network provider through a single case agreement or out-of-network agreement when a consumer is receiving ongoing care from a provider that is not in the MCE network.

Under RBMC, neutral third party entities could be maintained in areas such as providing counseling on options for institutional versus community-based care and having a separate entity responsible for level of care (LOC) eligibility determinations and the provision of services. For example, current functions such as the AAAs role in providing Options Counseling and the PAS for institutional placements, and State staff LOC determinations for DDRS waivers, could be considered for remaining intact. Alternatively, other States have delegated authority for LOC determinations to MCEs through the use of a State designed tool, have had the initial LOC conducted by a third party entity with subsequent reviews conducted by the MCE, or have allowed the MCE to conduct the LOC with final review by a third party entity. If such functions were delegated to a MCE, these changes would require CMS approval through amendment of the waivers, and specific safeguards would continue to be federally required such as consumer choice and conflict free case management.

The State also has the option to either mandate enrollment in a RBMC program or implement voluntary enrollment policies. Mandatory enrollment would require CMS approval through a waiver. Medicare enrollees have the option to choose FFS for Medicare covered services, so mandatory enrollment for duals would only be permissible for Medicaid covered services. Under a voluntary enrollment arrangement, individuals could either be automatically enrolled with the ability to opt-out or they could be given instructions on how to opt-in. Feedback from the stakeholder survey pointed to strong support for a voluntary enrollment policy with only 4.2% indicating participation should be mandatory. However, with voluntary enrollment policies there is the potential concern that there will not be sufficient enrollment figures to attract competitive MCEs to the market and to ensure the long-term financial stability of the program. While enrollee choice and flexibility are critical components of any managed care program, to promote the sustainability of a RBMC model, this needs to be carefully balanced. Alternative approaches may better safeguard program sustainability while simultaneously supporting enrollee choice; for example, allowing out-of-network care and implementing robust contract requirements to encourage adequate provider networks and quality outcomes. Additionally, in accordance with federal requirements, individuals would have the choice of at least two MCEs under a RBMC model.

Impact to Enrollees during Transition to Program

Multiple strategies are available to minimize impact to enrollees during a transition to a RBMC model and to mitigate any potential disruptions to care. For example, a phased-in approach would allow the State and MCEs to ensure implementation is proceeding smoothly prior to enrolling additional individuals. Phase-in could occur by regions or types of populations that are included in managed care.

The MCE contract could also include parameters surrounding continuity of care. Available options during a transition period could include requiring all outstanding authorizations be honored, requiring out-of-network care or mandating that a needs assessment and care plan be completed prior to any changes in authorized services. Furthermore, a robust stakeholder engagement and consumer outreach strategy would be critical to assist in transitioning enrollees to a RBMC program.

Provider Network & Rate-Setting Process

Under a RBMC model, the State could implement a variety of contract provisions related to the provider network and rate-setting process. For example, the State could consider mandating providers be paid, at minimum, at current rates during a transition period or require an ongoing payment floor, tied to current rates. The State could maintain ultimate responsibility for setting rates, either by limiting to certain provider types or for all providers. For example, due to the current complex rate-setting methodology for institutional settings such as ICF/IDs and nursing facilities, the State could maintain authority for continuing to develop those rates and mandate payment at those rates. Additionally, the State could implement any-willing provider provisions through which the MCE would be required to extend a contract to all providers meeting the State's requirements and require the MCE to tender a minimum number of contract offers at the FFS rate or above. If the provider did not contract with the MCE after these minimum number of contract offers were extended, the provider could receive reimbursement at a set percent of the FFS rate. These any willing provider provisions could either be extended indefinitely or the MCE could be permitted after a defined time period to evaluate provider's continued network enrollment based on an assessment of quality and performance outcomes as approved by the State. Furthermore, the State could develop contract parameters related to individuals who are under the care of a current provider who is not in the network, such as requiring the MCE to authorize the out-of-network care or enter into a single case agreement. Additionally, to promote prompt and accurate payment to providers, contract standards would be set regarding timely claims processing.

In accordance with federal regulations, the MCE would be required to assure an adequate network was in place to serve the enrolled population. The State would develop contract parameters related to the number and type of providers, considering distance and travel time within specified mileage requirements and require an open network when the standards were not met. The MCE would also be required to arrange for specialized services outside of the provider network when one is not available in-network. Other standards related to access to care could be set such as minimum standards for appointment and waiting times by provider type and patient acuity.

Coordination of Care for Duals

Medicaid is the payer of last resort; therefore, Medicaid spending on duals is limited to payment of services up to the Medicaid allowable amount or payment for services covered by Medicaid and not Medicare. As described previously, a RBMC model for managing the care of duals is projected to result in a financial loss to the State. This is because any claim costs savings achieved through RBMC would be shared with Medicare and the fixed administrative costs under a RBMC model are applied to a lower per member cost than the non-dual populations.

To address the financial misalignment between Medicare and Medicaid, CMS is testing new strategies, such as the Financial Alignment Initiative, to provide financial incentives to states to coordinate care for duals. Under this initiative, the state, CMS and a MCE would enter into a three-way contract with the MCE paid a monthly capitation and the state receiving a share of any anticipated Medicare savings. Following the outcomes of this initiative, in the future there may be additional opportunities for the State to consider a RBMC model for duals which would not result in an estimated financial loss. Until then, due to this projected loss, the State may opt to exclude duals from a RBMC model. Should the State still opt to include duals in a RBMC program, there are different potential options for coordinating their care as outlined in Table 20.[xvi]

Table 20: Options to Coordinate Care for Duals under RBMC

Strategy	Description	Potential Impact
Full Integration – MCE Required to be Medicare Advantage Special Needs Plan (SNP)	• MCEs receive both Medicaid & Medicare capitation rate & duals enroll in same plan to receive both Medicare & Medicaid benefits • MCE responsible for covering both Medicaid & Medicare services	Aligns financial incentives across programs & provides incentive to coordinate care among providers; however Medicare rules require voluntary enrollment in a SNP so reach may be limited
Require MCE to also Offer Companion SNP	• MCE required to coordinate with Medicare & to offer Medicare Advantage SNP product	Financial incentives may not be aligned as the funding streams for Medicaid & Medicare are not fully integrated but better care coordination may be promoted
Require Medicare Coordination	• MCEs required through contract provisions to coordinate Medicare & Medicaid services	Financial incentives may not be aligned as the funding streams for Medicaid & Medicare are not fully integrated but better care coordination may be promoted

Options for Population & Service Exclusions

Under RBMC the State has the option to exclude certain services or populations. The Task Force explored different potential options for covered populations. These options were informed by factors such as stakeholder feedback, cost and enrollment data and impact to supplemental payments and the QAF. In considering carve-outs, it is important to note that CMS has established key elements that are expected to be incorporated into a MLTSS program. One such element is the requirement to provide a comprehensive integrated service package through which the MCE provides or coordinates all physical and behavioral health services. States seeking approval for a MLTSS program will be required to justify all carve outs and explain how goals such as integration, efficiency, improved health and quality outcomes and appropriate incentives are maintained. Therefore, if the State were to implement a RBMC model for ABD populations with carve-outs, care must be taken to ensure these goals are maintained and there is a focus on ensuring community-based versus institutional care.

Option 1a: Exclude Institutional Populations

The State could opt to exclude institutional populations from a RBMC model. For purposes of this analysis, institutional populations are defined as hospice, nursing facility, group home and ICF/ID residents. The Task Force is presenting this as an option for multiple reasons. Specifically, as previously illustrated, cost savings are not projected for these populations under a RBMC model, with the exception of non-dual nursing home residents. Additionally, exclusion of nursing facility residents would ensure no disruption to supplemental payments.

However, excluding institutionalized populations could impact the potential for a RBMC model to coordinate care. Specifically, with the exclusion of nursing facility services, this would reduce a MCE's incentive to prevent institutionalization. However, the State could implement contract requirements and performance standards to mitigate this impact. For example, pay for performance requirements linked to institutionalization rates could be considered with incentives for increased HCBS and decreased institutional rates. Furthermore, as previously described, if the State maintained current methods related to institutional placements such as the AAA role in providing Options Counseling and the PAS, there would be neutral third parties in place to assist in mitigating the concern that institutional placements were being encouraged when community-based alternatives were available.

If the State were to implement RBMC with the exclusion of institutional populations, as depicted in Table 21, the number of projected enrollees would be reduced to 139,300 and the projected fiscal loss would also be reduced.

Table 21: RBMC Model – Impact of Institutional Population Exclusion on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$49,600,000	-3.8%
Institutional Population Exclusion	139,300	-$15,400,000	-2.0%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 1b: Exclude Individuals with Intellectual and Developmental Disabilities

The State could also opt to exclude individuals with intellectual and developmental disabilities from a RBMC model. For purposes of this analysis, these populations are defined to include enrollees in both the Family Supports and Community Integration and Habilitation waivers. The Task Force is presenting this population exclusion as an option due to existing mechanisms in the waivers which are already managing care of these populations and the lack of projected cost savings for enrolling these populations in a RBMC model.

As previously discussed, a RBMC model has the potential to improve the coordination of services across the delivery system. However, Family Supports and Community Integration and Habilitation waiver recipients are already receiving case management services through their waiver case manager. While waiver case management services tend to focus more heavily on coordinating waiver services, wellness coordination services are currently under development for the Community Integration and Habilitation waiver and will provide an increased focus on coordinating medical services. Through wellness coordination services, waiver enrollees with an identified need for assistance in coordination of medical needs will receive services from a registered nurse (RN) or licensed practical nurse (LPN) such as development of a wellness coordination plan and consultation with health care providers.

If the State were to implement RBMC with the exclusion of individuals with intellectual and developmental disabilities, as depicted in Table 22, the number of projected enrollees would be reduced to 161,200 and the projected fiscal loss would also be reduced.

Table 22: RBMC Model – Impact of Exclusion of Individuals with Intellectual & Developmental Disabilities on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$49,600,000	-3.8%
Exclusion of Individuals with Intellectual & Developmental Disabilities	161,200	-$36,700,000	-3.2%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 1c: Exclude Individuals under 21

No savings are estimated for inclusion of individuals under age 21 in a RBMC model. The State could opt to exclude this population. As depicted in Table 23, the projected enrollment would be reduced to 151,300 and the estimated net loss would also be reduced.

Table 23: RBMC Model – Impact of Exclusion of Individuals under 21 on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$49,600,000	-3.8%
Exclusion of Individuals under 21	151,300	-$43,100,000	-3.7%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 1d: Exclude all Duals

As previously discussed, no savings are estimated for implementation of a RBMC model for duals. Table 24 demonstrates the impact to estimated net savings by implementing a RBMC model with exclusion of all duals. By excluding duals from a RBMC model a $4.2 million savings is estimated.

Table 24: RBMC Model – Impact of Exclusion of Duals on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$49,600,000	-3.8%
Exclusion of Duals	75,000	$4,200,000	0.7%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 1e: MRO Carve-Out

Under the MRO carve-out option, individuals utilizing MRO services would be included in the RBMC enrolled populations, but MRO services would be carved-out. Other mental health services such as clinic option and psychiatric hospitalizations would be provided under the MCE and would be coordinated with

physical health services. The State would continue to pay MRO claims FFS and the CMHCs would continue to manage and deliver MRO services.

The MRO carve-out is being outlined as an option for consideration due to the current management strategies that are in place in the MRO program. Specifically, as previously discussed, MRO service packages are assigned based on level of need (LON) as determined by an individualized assessment. Additionally, current funding mechanisms allow the State to offer MRO services without additional state dollars to fund the match. A MRO carve-out would ensure the current funding arrangement was not put at risk.

Inclusion of MRO services in a RBMC model would disrupt a system that has already been established to link service authorizations to assessed level of need. Exclusion of MRO services has the potential to eliminate another administrative layer and potential duplication of case management and care coordination, unless the State opted under a carve-in scenario to have the MCE take on all case management functions or require contracting with MRO providers. However, carve-outs also have the potential to reduce coordination of care as the MCE has reduced incentive to manage the carved-out service and coordinate care. Given the critical linkage between physical and behavioral health and the need for integrated services, there is the potential concern that the provision of integrated care would be reduced under a MRO carve-out. However, contracting strategies could be implemented to mitigate such as required contact and communications among the MCE and MRO service providers at predetermined frequencies. Additionally, a current gap in the system is CMHC's lack of access to enrollee medical data. Even with a MRO carve-out, MCEs could be required to implement strategies to bridge the link between physical and behavioral health providers and serve as the single entity responsible for the coordination across the healthcare delivery system.

Table 25 illustrates a RBMC model with all ABD populations enrolled under a MRO carve-out scenario as projected by the State's actuary. No claims savings were assumed to apply to MRO services under a carve-in scenario; however, net savings estimates are higher when MRO is carved out because the ACA health insurer fee and administrative costs would be applied to MRO services when carved-in.

Table 25: RBMC Model – Impact of MRO Carve-Out on Projected Enrollment & Savings

	Best Estimate	
	Net State Savings	% Net State Savings
MRO Carve-In	-$49,600,000	-3.8%
MRO Carve-Out	-$45,600,000	-3.6%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Impact to Supplemental Payments, Assessment Fees & MRO Match

As discussed in the Indiana Financing Considerations Section, Indiana collects assessment fees from hospitals, nursing homes and ICF/IDs to help fund the State's share of Medicaid program costs. The State makes supplemental payments to nursing homes through which the State share of these payments is contributed by nursing facility providers. Implementation of RBMC would not impact the State's collection of assessment fees; however, supplemental payments would potentially be at risk if nursing home enrollees were enrolled in a RBMC program.

Nursing homes currently receive revenue of three types: regular Medicaid reimbursement, enhanced QAF reimbursement, and UPL reimbursement. For services provided during SFY 2013, regular Medicaid reimbursement to the nursing homes was $879.2 million, QAF reimbursement was $315.7 million, and UPL was $381.6 million.[xvii] The federal government funds all three income streams at the standard FMAP (67.16% during FFY 2013), but the State only contributes to the regular Medicaid reimbursement payment. The State share of the QAF and UPL payments is contributed by nursing facility providers. This type of payment arrangement would be difficult to duplicate under risk-based managed care. One concern would be if the nursing homes making such contributions are not in the network of each MCE. Additionally, UPL payments are generally only available under FFS arrangements as they are calculated based only on FFS days in an institutional setting; therefore transitioning enrollees from FFS to managed care translates into fewer FFS days and lower potential UPL payments. Provider contributions under QAF arrangements are limited to 6% of provider net revenue, so the amounts currently being paid in Indiana are already near the maximum allowed. Under RBMC it would be difficult to maintain the current level of payments to nursing homes without increasing the cost to the State.

Additionally, as previously discussed, MRO services are funded through a unique partnership which allows the State to offer these services without additional state dollars to fund the match. If MRO services were included in a RBMC contract, strategies would need to be implemented to ensure this arrangement was not disrupted. As the State's share of MRO funding was not provided by the State general fund, it is unclear what parties would need to approve a transition to managed care contracting. At minimum, contract provisions would need to be implemented to require MCEs to contract with all CMHCs as the exclusive provider of MRO services.

Assessment of RBMC Model

Advantages

A RBMC model provides a high potential for improved care coordination by providing a single entity responsible for an enrollee's care across the delivery system versus the current FFS model in which care is managed and coordinated only at certain points. This model also reinforces treatment of the whole

person, addressing needs ranging from physical health to social supports and behavioral health. This model has the potential to reduce duplication of services and improve communication across the delivery system.

Implementation of a RBMC model provides the opportunity to improve quality and consistency of care across the healthcare delivery system through the implementation of a quality assessment and performance improvement strategy incorporating input of key stakeholders. This model also has the potential to incorporate incentives for improved quality such as pay-for-performance, payment withholds, shared savings and penalties based on identified priority areas.

Under traditional FFS models, the State is required to provide covered benefits and services within the limits and framework of the State Plan, the contract between the State and Federal government describing how the State administers the Medicaid program. RBMC provides the ability for services to be provided in a more flexible manner versus being tied to State Plan limits on benefits. The State could set contract parameters to allow MCEs to provide enhanced services and create a benefit package based on the assessed needs of an individual. In addition to having the flexibility to provide such services, MCEs have financial incentives to invest in services which lead to long-term savings from avoided institutionalizations and declines in health status.

In order to meet State defined requirements for network adequacy, MCEs have the ability to negotiate higher rates with providers, a feature not present in FFS models. Furthermore, under RBMC, when a MCE establishes a provider network and patient panels, an enrollee is no longer responsible for seeking out a provider accepting Medicaid enrollees, but rather has the benefit of linkage to a provider responsible for overseeing his care. Finally, RBMC would provide budget predictability to the State.

Disadvantages

Due to the federally mandated health insurer fee imposed by the ACA, states will begin paying 2.5% more in administrative costs to operate a RBMC program. Additionally, as previously discussed, there is a potential risk to nursing home UPL payments and match funding for the MRO program unless this population or service is excluded. Furthermore, there is the potential for overlap and duplication between case managers and care coordinators and the addition of another management layer.

Option #2: Managed FFS

Under a managed FFS model, the State could implement an EPCCM program, either leveraging the current Care Select program or developing an alternative strategy. Under the managed FFS model, the State would continue to pay providers on a FFS basis. Enrollees would be linked to a primary medical provider (PMP) responsible for managing the beneficiaries assigned to their panel. PMPs would receive a

per member, per month management fee in addition to the FFS payments for services rendered. As is seen in EPCCM programs, as described in further detail in the Primary Care Case Management Section, supplements and supports would be provided to physician's practices which typically don't necessarily have the resources to completely manage and coordinate patient care or link patients to community resources. Enhancements could include features present today in the Care Select program such as case management, disease management, care coordination, care management and medical home initiatives. The State could contract with an external vendor as in Care Select, or alternatively, community-based networks composed of physician's offices, hospitals, health and social service departments. These contracted entities would provide services such as care management, disease management and technical support to physician offices. These contracted entities would receive a monthly fee, in addition to the management fee received by the PMP.

Under a managed FFS model, the contractor is not at risk for the overall service costs as under RBMC, but the State could put the entity at risk for performance measures and outcomes. For example, the State could build upon the current pay-for-performance program in the Care Select program in which a portion of the CMO payment is withheld and at the end of each quarter the entity is eligible to receive payment of the withhold proportionate to performance on metrics such as HEDIS rates for ambulatory care, rates for follow-up after hospitalization for mental illness and completion of health risk assessments. The State could incorporate additional reimbursement methodologies linked to performance and outcomes at both the provider and contracted entity level. For example, implementation of a shared savings model with incorporation of upside and/or downside risk could be considered. Under such a model the State could opt to share in any savings gained with the entity, and could also put the entity at risk when savings targets are not reached.

The State could also opt to expand the populations eligible for a managed Fee for Service program. Currently in Care Select, HCBS waiver enrollees and duals are excluded from enrollment; additionally, individuals are only eligible if they have a specified disease state. Enrollment in the program could become mandatory versus the current voluntary, passive enrollment process. However, as discussed earlier, this approach was previously taken in the Care Select program and the State moved away from this approach when the program was modified in 2010 to focus on members with certain chronic conditions. At that time, the State shifted to a voluntary enrollment process with exclusion of HCBS waiver enrollees.

Alternatively, in place of leveraging the Care Select and CMO model, the State could contract directly with patient-centered medical homes or community-based networks which would receive a per member per month fee to hire case managers and medical management staff.

Under a managed FFS model, the State would develop a contract similar in nature to the contract with MCEs in a RBMC model. The primary difference is that the managed FFS entity would not reimburse providers and claims would continue to be paid directly by the State.

Managed FFS Potential for Cost Savings

Table 26 illustrates the estimated savings under a managed FFS model as provided by the State's actuary. As described in the RBMC model, savings estimates illustrated are best estimates and include a degree of uncertainty; estimates reflect expected annual savings achievable in three to five years. Under a managed FFS model, estimated claims savings assumptions are reduced from RBMC estimates because managed care programs that are not risk-based generally result in less claims savings. However, the 2.5% health insurer fee would not apply in this model so administrative costs are lower.

As in the RBMC projections, there is variation in the expected net savings by population due to each population's cost profile and current strategies in place to manage their care. Savings are estimated for the same populations as in RBMC and range from 0.2% to 3.7%. Additionally, under Managed FFS, there is a 0.2% savings estimate for the Community Integration & Habilitation Waiver and a 0.9% savings estimate for the other institutional non-duals; inclusion of these groups in a RBMC model was projected to result in State loss due to administrative costs under RBMC.

The remaining populations have an estimated negative net savings; this means the State's costs are projected to increase by enrolling these populations in a managed FFS program. This projected loss is attributed to the factors discussed under the RBMC model. For example, Medicare would be the primary beneficiary of any claims savings associated with implementation of a managed care model for duals. Furthermore, no claims costs savings were attributed to waiver or institutional LTSS.

Table 26: Estimated Aggregate Net Savings by Population under Managed FFS Model

Population	Estimated Enrollment	Annual Claim Expenditures	Best Estimate	
			Net Savings	% Net Savings
Care Select	24,200	$506,600,000	$6,000,000	1.2%
Community Non-Dual	22,900	481,100,000	18,000,000	3.7%
Community Dual	52,300	158,900,000	-17,500,000	-11.0%
M.E.D. Works Non-Dual	1,300	28,000,000	800,000	2.9%
M.E.D. Works Dual	1,700	6,500,000	-600,000	-9.2%
Aged & Disabled Waiver Non-Dual	1,000	68,400,000	1,800,000	2.6%
Aged & Disabled Waiver Dual	6,000	181,600,000	-1,700,000	-0.9%
Family Supports Non-Dual	1,300	18,000,000	-200,000	-1.1%
Family Supports Dual	2,200	21,700,000	-800,000	-3.7%
CIH Waiver Non-Dual	1,600	131,100,000	200,000	0.2%
CIH Waiver Dual	4,900	320,000,000	-1,800,000	-0.6%
Other Institutional Non-Dual	1,200	115,300,000	1,000,000	0.9%
Other Institutional Dual	4,400	261,700,000	-1,500,000	-0.6%
Nursing Home Non-Dual	1,800	176,300,000	6,200,000	3.5%
Nursing Home Dual	24,500	1,049,700,000	-7,900,000	-0.8%
Under 21 Non-Dual	19,700	361,300,000	-4,300,000	-1.2%
Under 21 Dual	200	4,600,000	-100,000	-2.2%
TOTAL (State & Federal)	171,200	$3,890,800,000	-$2,400,000	-0.1%
TOTAL (State Dollar)	**171,200**	**$1,302,700,000**	**-$800,000**	**-0.1%**

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Managed FFS Provisions to Ensure Enrollee Access to Efficient & High Quality Care

HEA 1328 called for a description of provisions of a managed FFS program that are likely to ensure that enrollees have timely access to efficient and high quality care. The following sections detail State options for such approaches as outlined in the legislation.

Beneficiary Choice of Network & Non-Network Providers

A managed FFS model would provide the State with the same options for contract parameters to encourage beneficiary choice of network and non-network providers. A full description of such strategies is provided in the RBMC Provisions to Ensure Enrollee Access to Efficient & High Quality Care Section. For example, the State could implement any-willing provider provisions and permit or require the continued provision of services by out-of-network providers. Current third party entities which conduct

level of care determinations could also be considered for remaining intact. The State also has the option to either mandate enrollment in the program for all eligible populations or continue voluntary enrollment policies as is currently the process in Care Select. Mandatory enrollment would require CMS approval through a waiver.

Impact to Enrollees during Transition to Program

The options discussed in the RBMC model to minimize impact to enrollee's during program transition are also available in a managed FFS model. These include strategies such as a phased-in approach and contract parameters to promote continuity of care including requiring all outstanding authorizations be honored, requiring out-of-network care or mandating that a needs assessment and care plan be completed prior to any changes in authorized services. Furthermore, a robust stakeholder engagement and consumer outreach strategy would be critical to assist in transitioning enrollees to a managed FFS program.

Provider Network & Rate-Setting Process

Under a managed FFS model, the State would continue to pay claims and set rates. Regarding provider network contract parameters, strategies would be the same as those described in the RBMC section. For example, the State could implement any-willing provider provisions and require out-of-network care when an individual is under the care of a non-network provider. The contracted entity would be required to assure an adequate network was in place to serve the enrolled population with the State developing contract parameters related to the number and type of providers and require an open network when the standards were not met. The contractor would also be required to arrange for specialized services outside of the provider network when one is not available in-network. Other standards related to access to care could be set such as minimum standards for appointment and waiting times by provider type and patient acuity.

Coordination of Care for Duals

As seen under the RBMC model, a managed FFS model is projected to result in a financial loss to the State for the dual population because Medicaid is the secondary payer and Medicare would be the primary beneficiary of any savings attributed to a healthcare management program. Currently there are no mechanisms for Medicaid to share in any potential Medicare savings achieved by better management of the dual population. The CMS Financial Alignment Initiative described in the RBMC section is also testing managed FFS models to better coordinate care for duals and address the financial misalignment between Medicare and Medicaid. Under these pilots, States and CMS are entering into agreements by which States will be eligible to share in any savings resulting from the tested initiatives. Following the outcomes of this federal initiative, in the future there may be additional opportunities for the State to

consider a managed FFS model for duals without seeing a net loss. Until then, due to this projected loss, the State may opt to exclude duals from a managed FFS model.

Options for Population Exclusions

The Task Force explored different potential options for covered populations in the managed FFS model. These options were informed by factors such as stakeholder feedback and cost and enrollment data. Because all services would continue to be paid FFS under this model, the group did not explore service carve-outs. While a MRO carve-out is not being presented as an option as it was in RBMC, there is the potential for an increase in administrative costs associated with a carve-in; however, these administrative costs are anticipated to be lower than under RBMC because there is no ACA health insurer fee applied in this model.

Option 2a: Exclude Institutional Populations

As in the RBMC model, the State could opt to exclude institutional populations from a managed FFS model. There would be no impact to supplemental payments under this model with the inclusion of this population; however, this option is being presented as cost savings were not projected by the State's actuary when institutionalized populations are enrolled, with the exception of the non-duals. Table 27 illustrates the impact of an institutional population exclusion on projected enrollment and savings.

Table 27: Managed FFS Model –Impact of Institutional Population Exclusion on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$800,000	-0.1%
Institutional Population Exclusion	139,300	-$100,000	0.0%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 2b: Exclude Individuals with Intellectual and Developmental Disabilities

The State could also opt to exclude individuals with intellectual and developmental disabilities from a managed FFS model, including enrollees in both the Family Supports and Community Integration and Habilitation waivers. The Task Force is presenting this population carve-out as an option due to existing mechanisms in the waivers which are already managing care of these populations and the lack of projected cost savings for enrolling these populations, with the exception of the non-dual Community Integration and Habilitation enrollees, for whom only a 0.2% savings was projected.

If the State were to implement managed FFS with the exclusion of individuals with intellectual and developmental disabilities, as depicted in Table 28, the number of projected enrollees would be reduced

to 161,200 and the state would no longer be projected to experience a loss though estimated net savings would be negligible.

Table 28: Managed FFS Model – Impact of Exclusion of Individuals with Intellectual & Developmental Disabilities on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$800,000	-0.1%
Exclusion of Individuals with Intellectual & Developmental Disabilities	161,200	$100,000	0.0%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 2c: Exclude Individuals under 21

No savings are estimated for inclusion of individuals under age 21 in a Managed FFS model. The State could opt to exclude this population. Table 29 demonstrates the impact to estimated net savings and exclusion of this population.

Table 29: Managed FFS Model – Impact of Exclusion of Individuals under 21 on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$800,000	-0.1%
Exclusion of Individuals under 21	151,300	$700,000	0.1%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Option 2d: Exclude all Duals

As previously discussed, no savings are estimated for including duals in a managed FFS model. By excluding duals a $9.9 million savings is estimated.

Table 30: Managed FFS Model – Impact of Exclusion of Duals on Projected Enrollment & Savings

	Estimated Enrollment	Best Estimate	
		Net State Savings	% Net State Savings
No Population Exclusions	171,200	-$800,000	-0.1%
Exclusion of Duals	75,000	$9,900,000	1.6%

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

Impact to Supplemental Payments, Assessment Fees & MRO Match

Under a managed FFS model, all claims would continue to be paid FFS. Therefore, there would be no impact to supplemental payments, assessment fees or the MRO match.

Assessment of Managed FFS Model

Advantages

A managed FFS model offers similar opportunities to RBMC related to improving quality and consistency across the delivery system. By providing a single entity responsible for an enrollee's care, this provides the potential for increased coordination, improved communication and reduction in duplication of services. Enrollees would have the benefit of linkage to a PMP; furthermore, there would be an incentive at the provider level to coordinate care through the provision of a per member monthly management fee. This feature is not present in traditional FFS or RBMC models.

Disadvantages

Unlike the RBMC model, under a managed FFS model, there is not the potential for the contracted entity to negotiate higher rates with providers in order to meet State mandated access requirements. Additionally, as the contracted entity is not at financial risk, there is less financial incentive in a managed FFS model to prevent institutionalization and ensure care coordination. This could be mitigated through reimbursement strategies such as shared savings or performance withholds.

A managed FFS model would not result in more flexibility in the authorization of services as was discussed in the RBMC model as services would be reimbursed FFS and tied to State Plan services and limits. Additionally, a managed FFS model does not provide inherent financial incentives to authorize flexible services to prevent long-term costs. Budget predictability is not provided through a managed FFS model.

As in the RBMC model, there is the potential for overlap and duplication between case managers and care coordinators and the addition of another management layer. However, this could be mitigated through contract guidelines clearly delineating the role of each entity and requiring coordination without duplication. Alternatively, duplication could be avoided by having the managed FFS entity take on all case management functions or require contracting with current case management entities.

Option #3: Home and Community Based Services Management Program

As outlined in HEA 1328, a HCBS management program is defined as the State contracting with a AAA or other community-based care coordination organization to provide services to maintain a Medicaid recipient in a home and community-based setting, or to return a recipient to a home and community-based setting and may include primary care management, care coordination and integrated delivery of social support services.[18] Under this model, eligibility determinations, service authorizations, care plan

[18] Definition of HCBS Management Program provided by Kristen LaEace, Chief Executive Officer of the Indiana Association of Area Agencies on Aging

development, case management and HCBS service delivery are provided by the HCBS management entity. This model is primarily envisioned for long-term services and supports (LTSS), though there are applications for HCBS LTSS that are currently provided through Medicaid prior authorization such as home health. Traditional utilization management functions for medical services such as prior authorization and concurrent review are not incorporated into this model.

This model is currently administered by the AAAs for the CHOICE, Title III and Social Service Block Grant funded HCBS services. In these programs, the AAAs conduct the eligibility determination, service authorization, care plan development, case management and HCBS service delivery through a AAA-managed provider network. As mission-driven non-profits, the AAAs seek to meet the needs of as many consumers as possible to avoid waiting lists for services. Components of the HCBS management model are in place for the Aged and Disabled Waiver and Traumatic Brain Injury Waiver except that the State makes the final Medicaid eligibility determinations and also issues the final authorization of waiver care plans.

An enhancement to this model called the Community Living Program (CLP) was piloted by the AAAs in two Aging and Disability Resource Centers (ADRC) through the Community Living Program grant. Under the CLP model, the intake and assessment process was modified to target individuals at high risk of nursing facility placement. Individuals with the highest identified need were served first. Needs were defined as a functional deficit impacting an individual's ability to live independently and/or his health and safety. Critical needs in the CLP model are services needed to keep an individual out of a nursing home and ensure safety in the community whereas non-critical needs are services which would enhance an individual's quality of life but are not necessary to keep an individual living independently. When a critical need was identified in the CLP, a plan of care with agreed upon services, vendors and designated hours was authorized as well as an action plan for any non-critical needs identified. The CLP model was intended to offer flexibility to develop a short-term plan of care related to the individual's ability to regain the capacity to care for themselves. Under the CLP model, Resource Counselors determined whether an individual received financial subsidies for care plan services that met critical needs. Service subsidies were not provided if the individual had the ability to pay for the service, had informal supports that could be coordinated to meet the individual's needs or caregivers were managing care safely without unmanageable stress. Additionally, services were authorized in a "fluid" manner. For example, instead of authorizing four hours of care one time per week, two hours of care could be authorized two times per month if the only identified household task the individual couldn't complete was washing floors. Services were reduced when they were no longer critical to keep someone safely in the community. Alternatives in HCBS provider management was also a component of the CLP. For example, bundling of

services for clients living proximate to each other, a reduction in required minimum hours per visit and a reduction in authorized services based on what consumers are able to complete for themselves.

HCBS Management Program Potential for Cost Savings

In the actuarial analysis provided by Milliman, a range of savings estimates has been provided for a RBMC and managed FFS program. However, as previously described, savings illustrated for home and community based long term services and supports (LTSS) has generally been illustrated as 0% due to current management strategies.[xviii]

Although waiver services are already managed, case managers normally focus more heavily on waiver services rather than on the full spectrum of Medicaid services a participant receives, including hospital, physician, pharmacy and home health services. It is possible that by increasing the case manager's responsibility, or replacing case management with a more comprehensive management service, would lead to better managed care. However, any savings would probably have to be approached in an oblique manner, not directly through limitations or service restrictions. There is the potential for legal issues arising from state policy which would limit services by population without specific consideration of an individual's needs.

Immediate savings for LTSS services may be difficult to achieve. As in the other models, one way that a HCBS management program may achieve savings is by either converting or diverting individuals from a nursing home setting to a home and community based setting. Serving more individuals in a home and community based setting may result in lower total expenditures for LTSS services. However, approximately 40% of individuals entering a nursing home were not Medicaid eligible before entry so these individuals may be more difficult to divert from a nursing home due to more extensive healthcare needs.

It is unclear what the administrative cost to the State would be for implementing a HCBS management program as this was not included in the proposed model, based off the Community Living Program described above. In presentations to the Task Force, the AAAs projected savings for the HCBS management program model. However, these were projections based off a pilot serving only 30 individuals.[xix]

HCBS Management Provisions to Ensure Enrollee Access to Efficient & High Quality Care

HEA 1328 called for a description of provisions of a HCBS management program that are likely to ensure that enrollees have timely access to efficient and high quality care. The following sections detail State options for such approaches as outlined in the legislation.

Beneficiary Choice of Network & Non-Network Providers

Under a HCBS management program, the network of providers within the program would consist only of waiver service providers and case managers. The contracted AAA or other community-based care coordination organization would develop a network of such providers. The State would have the flexibility to set contract parameters surrounding network development as seen in the RBMC and Managed FFS models. For example, the State could implement provisions in which the contracted entity would be required to contract with any provider who met the requirements and was interested in participating. Additionally, the State could either permit or require the continued provision of services by an out-of-network provider when a consumer is receiving waiver services from an entity that is not in the network.

Impact to Enrollees during Transition to Program

To minimize impact to enrollee's during a transition to a HCBS management program, the contract would include parameters to promote continuity of care as in the RBMC and managed FFS models. For example, the State could require all current care plans be continued until the next regularly scheduled reassessment; alternatively, the State could require a new needs assessment and care plan be completed prior to any changes in authorized services. Additionally, the State could implement a phased-in approach to allow the State and contracted entities to resolve any implementation issues prior to rolling out to additional regions or populations. As described previously, individuals could also be permitted to continue receiving services from an out-of-network provider.

Provider Network & Rate-Setting

Under a HCBS management program, reimbursement for services would continue to be paid FFS by the State. Therefore, the contracted entity would not have responsibility for developing rates or reimbursing providers.

For provider network development, as in the other models, the State could implement any-willing provider provisions through which the contracted entity would be required to extend a contract to all providers meeting the State's requirements. These provisions could either be extended indefinitely or the contracted entity could be permitted after a defined time period to evaluate provider's continued network enrollment based on an assessment of quality and performance outcomes as approved by the State. Furthermore, the State could develop contract parameters related to individuals who are under the care of a current provider who is not in the network, such as requiring the entity to authorize the out-of-network care. Finally, access requirements based on distance and number of service providers by type could also be developed.

Coordination of Care for Duals

Because the HCBS management program model does not incorporate primary and acute care services as in the other model options, there would likely be less contract requirements surrounding parameters for coordinating care for duals. Additionally, many of the services that would be managed through this model are not covered by Medicare.

Options for Population Exclusions

Because the HCBS management model primarily addresses LTSS, the Task Force is not presenting options for population or service carve-outs as were presented for the RBMC and managed FFS models.

Impact to Supplemental Payments, Assessment Fees & MRO Match

The HCBS management program model would not impact any supplemental payments, assessment fees or MRO funding.

Assessment of HCBS Management Model

Advantages

A HCBS management program would provide local, community-based service delivery through a person-centered approach. There would be no risk to nursing home UPL payments or match funding for the MRO program.

Disadvantages

The HCBS management program model includes one entity responsible for eligibility determinations, service authorizations, care plan development, case management and service delivery. This poses the concern that the model is not conflict-free. Additionally, no single entity is responsible for the overall care and outcomes across the healthcare delivery system. As this model primarily addresses LTSS, though it may include primary care management and care coordination, it does not fully integrate primary and acute medical care and behavioral health. Therefore, this model does not directly address the lack of coordination and fragmentation that is present in the current FFS model. There is mission-driven care to prevent institutionalization; however, there is not an inherent financial incentive built in to prevent institutionalization and ensure care coordination. This could be mitigated through the development of pay-for-performance measure linked to metrics such as institutionalization rates and other performance metrics. Finally, this model does not link enrollees to a primary medical provider.

Implementation Issues

Implementation of any of the three managed care models would require sufficient time, resources and planning. Transition activities would include a variety of tasks such as CMS approvals, contracting activities, technical and operational changes and stakeholder engagement. A RBMC approach would likely require the most lengthy implementation timeline; CMS has recommended a two year timeline for

development of MLTSS programs which includes one year for planning and one year for implementation.[xx]

There would also be an impact to current contracts and State programs. For example, under RBMC the Care Select contract would be eliminated as duplicative and there would be a reduction in claims processed by the State Fiscal Agent. Under all models, there would likely be a reduction in scope of the PA vendor contract.

Providers would also be impacted. Under all three models they would be required to go through the contracting and credentialing process with the entities with whom they chose to contract. Claims submission processes would also be altered under a RBMC model. The State could require implementation of streamlined processes to reduce provider impact.

Conclusion

Within a RBMC, managed FFS and HCBS management program, the State has significant flexibility in developing a program with contract parameters to promote the provision of high quality, cost effective care for Indiana's ABD populations. The State may exclude certain populations and services and can also develop contract parameters to promote coordinated, flexible person centered care while also assuring appropriate client rights, protections and choice. The State may also consider a variety of quality measures for contracts that include, but are not limited to: clinical outcomes, patient satisfaction, quality of life and social determinants, functional outcomes, health and safety assurances, community integration and access to care, and measures that consider different population needs. Incentives can be tied to these outcomes to encourage improved quality and consistency across the delivery system and to promote community-based versus institutional care.

Additionally, the State can establish contract parameters related to beneficiary choice of network and non-network providers. For example, requirements for permitting the provision of out-of-network care, the maintenance of neutral third parties for level of care determinations, options counseling and pre-admission screenings and optional versus mandatory enrollment can all be considered. If a managed care program is implemented, the State may address the impact to enrollees during the transition period through a robust stakeholder engagement strategy, phased-in approach and continuity of care requirements. The State can also establish contract parameters to set provider rates, claims processing and network adequacy standards and allow any willing provider to participate.

Table 31 provides a comparison of estimated savings under RBMC versus managed FFS and the different options for population and service exclusions. Were the State to enroll all ABD populations, a financial

loss is projected under both models. However, if the State were to exclude MRO services from RBMC and institutional enrollees, individuals with intellectual and developmental disabilities, individuals under age 21 and duals from both models, the State is anticipated to realize savings. The projected state savings with these exclusions is $14.1 million in RBMC versus $8.9 million under managed FFS. The HCBS management model does not project savings because waiver services are already managed through a variety of strategies. Accordingly, none of the models were projected to result in savings for home and community based LTSS expenditures.

Table 31: RBMC & Managed FFS Annual Projected State Savings by Enrollment Options

RBMC

Option	Estimated Enrollment	Estimated State Savings
Enroll all ABD Groups	171,200	-$49,600,000
Exclude Institutional	139,300	-$15,400,000
Exclude Individuals with Intellectual & Developmental Disabilities	161,200	-$36,700,000
Exclude Under 21	151,300	-$43,100,000
Exclude Duals	75,000	$4,200,000
Exclude MRO	171,200	-$45,600,000
Exclude Institutional, Individuals with Intellectual & Developmental Disabilities, Duals, Under 21 & MRO	49,400	$14,100,000

Managed FFS

Option	Estimated Enrollment	Estimated State Savings
Enroll all ABD Groups	171,200	-$800,000
Exclude Institutional	139,300	-$100,000
Exclude Individuals with Intellectual & Developmental Disabilities	161,200	$100,000
Exclude Under 21	151,300	$700,000
Exclude Duals	75,000	$9,900,000
Exclude Institutional, Individuals with Intellectual & Developmental Disabilities, Under 21 & Duals	49,400	$8,900,000

Source: Milliman, Aged & Disabled Report prepared for the State of Indiana FSSA, November 18, 2013

While a RBMC model, with the population exclusions described above, provides the most potential savings, prevents impact to nursing home supplemental payments and MRO match funding, and provides budget predictability, as illustrated in Table 31, these exclusions would reduce projected enrollment significantly. This poses the potential concern there would be insufficient enrollment for the minimum of two MCEs the State would be required to contract with under federal regulations. Despite this potential concern, RBMC provides a high potential for improved care coordination and consistency by providing a single entity responsible for an enrollee's care across the delivery system. This model provides the potential availability of enhanced services as service authorizations would not be tied to the limits and framework of the State Plan as they are under FFS models. Additionally, potential concerns regarding

overlap and duplication with current case management services could be mitigated through program design and contract parameters.

A managed FFS model provides similar opportunities to RBMC related to improving quality and consistency across the delivery system by providing a single entity responsible for an enrollee's care. This model also provides an additional incentive at the provider level to coordinate care through a PMPM management fee. There would be no risk to nursing home supplemental payments or MRO match in this model. However, compared to RBMC, there is less financial incentive for contracted entities to manage risk and budget predictability is not achieved.

Finally, a HCBS management program provides local, community-based service delivery through a person-centered approach. There would be no risk to nursing home supplemental payments or match funding for the MRO program. However, this model is not conflict-free as one entity is responsible for eligibility determinations, service authorizations, care plan development, case management and service delivery. This concern is not present in a RBMC or managed FFS model if neutral third parties are maintained in areas such as level of care determinations. Furthermore, unlike the other managed care model options, a HCBS management program does not provide a single entity responsible for overall care and outcomes across the delivery system, does not link enrollees to primary medical providers and does not fully integrate primary and acute medical care and behavioral health with LTSS.

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