Update on FSSA Aged, Blind, & Disabled Task Force Report to the Indiana General Assembly

ICCMHC Learning, Discussing, and Preparing Webinar Series

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Overview of Study Development

Under HEA 1328, the Indiana General Assembly mandated that before December 15, 2013, FSSA prepare and submit a written report to the health finance commission regarding Medicaid risk based managed care, fee for service programs, and home and community based services management programs.

The original language developed under this legislation would have mandated the establishment of a Medicaid risk-based managed care program for any individual currently receiving Medicaid services with a corresponding SSI disability determination.

Under HEA 1328, risk-based managed care program means "a program where a managed care entity or an accountable care organization receives capitated payments from the office of Medicaid policy and planning to cover designated health and social support services provided to Medicaid recipients."

The specific language under HEA 1328 read as follows:

Overview of Study Development

The purpose of the study was to undertake the following analysis:

(1) An estimate of the cost savings to Indiana if Medicaid recipients who are eligible for Medicaid based on the individual's aged, blind, or disabled status are enrolled in a risk-based managed care program, a managed fee-for-service program, or a home and community based services management program.

(2) A description of provisions of a risk-based managed care program, a managed fee-for-service program, and a home and community based services management program that are likely to ensure that enrollees who are aged, blind, or disabled have timely access to efficient and high quality care, including:

(A) beneficiary choice of network and non-network providers;
(B) impact to enrollees during transition to the program;
(C) provider network and rate setting processes; and
(D) coordination of care for dually eligible enrollees.

(3) Whether all Medicaid recipients within the aged, blind, and disabled category should be enrolled in a risk-based managed care program, managed fee-for-service program, or a home and community based services management program and a description of any group that should be excluded.

(4) Whether participation of the aged, blind, or disabled Medicaid recipients in a risk-based managed care program, a managed fee-for-service program, or a home and community based services management program would do the following:

(A) Reduce or eliminate supplemental payments under the Medicaid program that are received by non-state governmental entities.

(B) Affect the collection and use of the health facility quality assessment fee, the hospital assessment fee, or any other provider assessment fee.

Overview of Study Development

In order to develop the research study, FSSA formed a task force made up of various divisions including DMHA, DDRS, OMPP, and Division of Aging.

FSSA has undertaken the research study development in a very transparent process. Specific information on this research analysis may be found on the following website:

http://www.in.gov/fssa/4828.htm

Throughout the process, the FSSA Task Force invited impacted providers and consumer organizations the opportunity to provide input in the study development, including a statewide survey that was disseminated through impacted organizations.

The ICCMHC provided both written and oral remarks regarding our concerns and considerations related to this process.

The study did not provide specific recommendations with respect to a preferred approach, but rather responded to the questions and strategies as posed under HEA 1328.

ABD Drivers of Cost

As discussed in the study, Aged, Blind, and Disabled (ABD) populations are some of the largest drivers of Medicaid costs, which in 2012 accounted for 69% of all of Indiana's Medicaid healthcare expenditures.

By service type (ie, long term care, mental health, developmental disability), institutional care is the largest driver of cost at 34% of all ABD costs.

Based on state estimates, ABD population Medicaid costs are expected to increase by $908 million through the year 2025.

The managed care models being utilized by states with respect to ABD populations vary dramatically, with varying degrees of success related to the program's implementation.

An overview of the models being examined as a part of this research study are as follows:

Managed Care Payment Model Overview

Risk Based Managed Care	• State contracts with managed care entities (MCEs) which receive a per month capitation • MCEs are at a financial risk to provide all services under that contract for an assigned population • Provides many design opportunities, and would identify key quality metrics and performance objectives
Managed FFS	• The State contracts with an external vendor or community-based networks composed of physician offices, hospitals, health and social service departments. Claims are paid by the state on a FFS basis. • Contractors not put at financial risk for overall service costs, but put at risk for performance outcomes and achievement of savings targets
HCBS Management Program	• The State contracts with the Area Agency on Aging (AAA) or other community-based care coordination organization to provide services to either maintain or return a Medicaid recipient to a home and community-based setting • HCBS Management Entity provides eligibility determination, service authorizations, care plan development, case management and HCBS delivery

ABD Options for Contract Provisions

FSSA established options for contract provisions by model. The analysis includes:

1) Beneficiary Choice of Network & Non-Network Providers

- neutral third party for determinations
- counseling options, pre-admission screenings

2) Impact on Enrollees during Transition

- phased-in approach
- continuity of care requirements
- stakeholder engagement strategies

3) Provider Network and Rate Setting

- reimbursement floor tied to current rates
- state rate setting processes
- any-willing provider considerations
- network access requirements

ABD Core Principles

FSSA established a set of core principles on which to evaluate the models against. A summary of the core principles includes:

1) Potential to Improve Quality Outcomes and Consistency of Care across the Delivery System

Established quality measures regardless of location, creating awards and incentives, using parameters such as clinical outcomes, patient satisfaction, quality of life issues, claims processing, etc.

2) Enrollee Choice, Protections, and Access

Preserve consumer choice, neutral third parties, conflict free services, eligibility determinations separate from providers, person centered, using face-to-face where appropriate, enhanced home and community based services versus institutional care.

3) Potential to Coordinate Care Across Delivery System & Care Continuum

Strategies using the whole person, including social needs, including both primary and behavioral healthcare, reducing duplication, avoid multiple layers of uncoordinated care managers, provide real-time consumer information using technology across delivery systems.

ABD Core Principles

4) Flexible Person Centered Care

Promotes flexible care plans, understand unique client needs, individualized service plans that focus on the whole person.

5) Transition Planning, Contract, Oversight, and Implementation Issues

Assures adequate reimbursement rates, sufficient provider network, state oversight processes, transition planning for consumers, accountability tied to performance and outcomes.

Risk based Managed Care Cost Analysis

The study examined the various managed care model to determine the key benefits of each model and the potential cost savings.

The financial analysis was undertaken for the study by Milliman, the state's contracted actuarial firm.

The state had to consider a number of factors in determining net savings under a risk based managed care program, such as the following: Cost of managing healthcare, claims adjudication, implementation of a new health insurer fee under a risk based model (the administrative increase is 2.5% under the ACA).

As the study suggests, in order to produce net savings by transitioning to a managed care model, the estimated claims savings must be greater than the increase in administrative costs and fees.

The analysis was based on expected annual savings achievable in three to five years. Savings in the initial years are expected to be less than the ultimate amount.

Based on the analysis, the following expected net savings (or loss) under a risk-based managed care program:

Risk based Managed Care Cost Analysis

Under the proposed risk based managed care program, including all ABD populations into the program would result in a **loss of $49,600,000**.

The analysis considered administrative costs, the 2.5% health insurer fee, **the potential risk to match funding for MRO programs**, the potential for duplication of case management, as well as other considerations.

The study also examined net savings to the state if only MRO was excluded. Based on the analysis, the state would still incur a loss of $45.6 million through a risk based managed care program.

Based on the study, if institutional populations, individuals with developmental disabilities, duals, and MRO were excluded from the program, the state would realize a net savings of $14.1 million. Based on this, the projected enrollment would only be 49,400 lives.

The report references, however, that given the need for at least two MCEs to provide services (based on federal regulations), there is concern about spreading this limited population among two MCE's.

FFS Model Managed Care Cost Analysis

Based on the study, even if all ABD populations were included in a FFS model (fee for service, but still at risk for performance outcomes and savings targets) the state would still incur a loss of $800,000.

Using a FFS model, the Milliman financial research reflects a savings to Indiana of $9.9 million if duals are excluded from the model.

MRO Carve Out

The study examines the potential to “carve-out” MRO from any of the designed approaches to a new managed care model.

It appears that based on the research, many of the ICCMHC considerations with respect to the MRO program have been included in the report.

Under this approach, individuals using MRO services would be included in the risk based managed care model, but MRO services would be carved-out of the program.

As expected, other mental health services such as; Medicaid clinic option and psychiatric hospitalizations would be provided through a MCE and would be coordinated with physical health services.

Under the carve-out, the state would continue to pay MRO services under a FFS model, and CMHCs would continue to manage and deliver MRO services.

The study suggests, the MRO carve-out is considered as an option because MRO service needs are determined through a level of need (LON) and service units are assigned as determined through an individual assessment.

As the study suggests, a MRO carve-out would ensure the current funding arrangement is not put at risk.

MRO Carve Out

The study suggests that including MRO into a risk-based program would "disrupt a system that has already been established to link service authorizations to assessed level of need."

The study did suggest that possible care coordination activities could be lost by not utilizing MCEs in the provision of a managed care approach, as MCEs would not be incentivized to work with the carved out population in the provision of coordinated care.

The study suggests, however, that contracting strategies could be implemented to mitigate this risk through required communication and other approaches at required frequencies.

The study highlights the issue of CMHCs having access to enrollee medical information and its further suggested that MCEs could be required to implement strategies to develop linkages between primary and behavioral health providers.

Based on the study, including MRO into a risk-based managed care program would cost the state an additional $4 million.

Summary

The study suggests that the adoption of a managed care model, based upon the three options provided, have the potential to promote high quality, cost effective services for Indiana's ABD populations.

The state may exclude certain populations and services, and also has the flexibility to develop contracted services to promote coordinated and person-centered services.

The state may pursue programs that promote improved clinical outcomes, patient satisfaction, social determinant considerations, community integration, access to care, and other goals to improve health outcomes while bending the Medicaid cost curve.

Based on the study, the ICCMHC is making an assumption that MRO would likely not be carved into the managed care program. We should assume however, that Medicaid clinic option and psychiatric inpatient hospitalization would likely be included under managed care, should the state pursue such a model.

Further, we should assume the state will examine ways to compel MCEs to coordinate with CMHC in the provisions of coordinated care between both primary and behavioral health providers.

Questions

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