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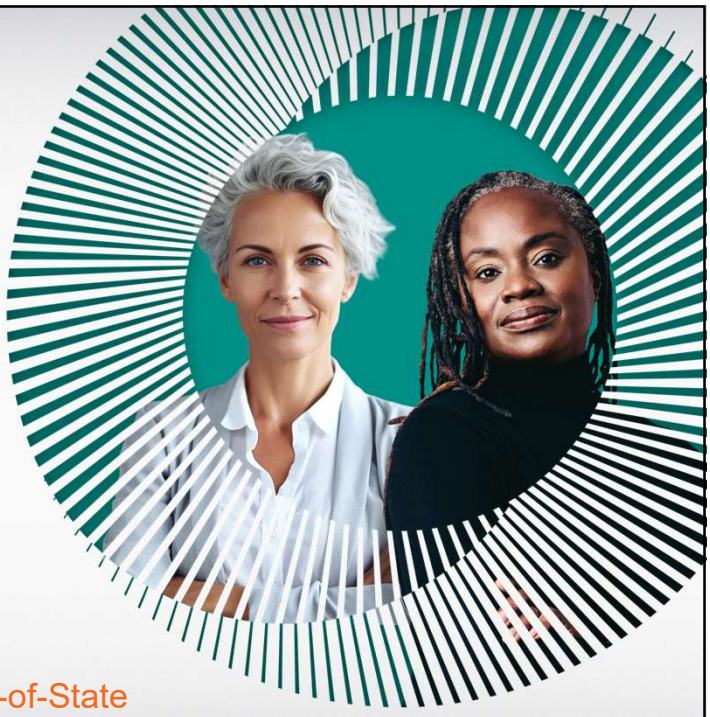

COURAGE IGNITED

Session 2D: Managed Care Update with Eric Essley and Panel Discussion with Out-of-State Providers

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PathWays FOR AGING

Basic MLTSS information / Resident Enrollment / MCE Selection

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Goals of this presentation

- Answer basic MLTSS questions
  - What is it?
  - When is it happening?
  - How do I contact and contract with the MCEs/health plans?
- Assist residents and their families with MCE selection.
- Answer basic enrollment questions.
- Provide resource information for future questions and answers
  - Pathways for Aging website - https://www.in.gov/pathways/
  - LeadingAge Indiana website dedicated to the Pathways program - https://www.leadingageindiana.org/aws/LAIN/pt/sp/mmc.

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MLTSS Basics - Key terms

- **MLTSS** – Indiana's transition to Managed Long-Term Services & Supports, also known as Pathways for Aging (or PathWays). The PathWays transition is set to go-live July 1, 2024.
  - The "managed" part means that claims for services rendered will be submitted to MCEs in the future – not just to the state's fee for service claims payer – Gainwell – as is done currently.
- **MCE / or MCO** - Managed Care Entity / Organization (insurance company / health plan)
  - Three MCEs to choose from: Anthem, Humana, United HealthCare.
- **Providers** - Nursing Homes and other care and service providers.
  - HCBS – home and community-based service providers (which will include AL waiver facilities)
- **PathWays Members / Covered Persons / Enrollees** – Medicaid eligible individuals (aka residents) 60 years of age and over attached to one of the MCEs.
  - Recall – individuals under 60 will remain in the current fee for service Medicaid program and will not transition to the Pathways program until they are 60.
- **Enrollment Broker** – an FSSA (or likely, Maximus) employee designated to assist potential Pathways enrollees with transition to PathWays, initial enrollment matters, or their MCE selection.
  - Enrollees or their representatives can contact 87-PATHWAY-4 (1-877-284-9294) for additional questions at any time.

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MLTSS Basics - Key terms, Cont'd

- **MCE Selection** – the process by which an eligible enrollee chooses one of the three MCEs in the PathWays program.
  - An enrollee will have roughly 60 days after receiving their initial notification letter to select an MCE.
- **Assignment** – if an enrollee does not select an MCE, FSSA will match the enrollee with their current Medicare D-SNP plan if they have one. If such a relationship does not exist, the enrollee will be placed into a round-robin auto-assignment queue.
- **Dually Eligible (or Duals) –** Individuals who qualify for both Medicare and Medicaid at the same time.
  - Most Duals will already be enrolled in a Medicare Part-D special needs plan (D-SNP) with Anthem, Humana, or United HealthCare.
  - FSSA prefers that Pathways enrollees are aligned with their D-SNP whenever possible (e.g. - an Anthem D-SNP enrollee will select Anthem as their PathWays MCE, etc. – but alignment is not required).

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PathWays – what is it …

Eligible populations:

- PathWays will target three populations of Medicaid-eligible seniors who receive services in nursing facilities or through the HCBS Aged & Disabled waiver programs:
  - Nursing facility residents, aged 60 or older
  - A&D Waiver recipients, aged 60 or older
  - Aged, blind, or disabled members, aged 60 or older, who do not require long term services and supports.
  - Note - LTC resident populations under 60 will not move to managed care but will remain in the state's current fee for service programs.

Rebalancing Indiana's LTC population:

- FSSA intends to encourage at least 75% of all new LTSS entrants into HCBS care settings (and away from skilled nursing care) – also starting in July 2024. This is known as rebalancing.
  - FSSA will not force current residents who wish to stay in their current placements to rebalance out of skilled care.
- FSSA believes the PathWays program will lead to better quality outcomes, more choice for senior Hoosiers, and significant cost savings over time.

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PathWays – when will things happen …

Full Program Timeline:

- Kickoff, Request for Information (RFI), Steering Committee/ Workgroup meetings: Jan. 2021 - present;
- RFI Release to the public: July 2021;
- Request for Proposal (RFP) Release: June 2022;
- RFP Award to four (4) MCEs; three ultimately selected (Anthem, UHC, Humana): March 2023;
- Contracting/Readiness/Implementation: All of 2023 – 2024;
  - MCE-provider contracting Jan. 2024 – July 2024
  - Initial FSSA outreach to residents about enrollment and plan selection – Feb. 2024 – March 2024
  - Plan selection / assignment – by end of April 2024
  - Enrollee receives 60-day notice(s) (final details of Pathways program) from FSSA – May 2024
  - Welcome packet sent to enrollee by selected /assigned MCE – June 2024
- Go-live Date: July 1, 2024.
- Post Go-live period … Important first 180 days – July 1-Dec. 31, 2024

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PathWays - who do I contact …

- If you have not yet heard from an MCE about contracting, you can contact each directly as follows:
  - UnitedHealthcare: IN_providerservices@uhc.com
  - Humana: Denise Watson - DWatson31@humana.com; Terry King - TKing58@humana.com;
    - For those already contracted with Humana, but have not received any outreach - INProviderUpdates@humana.com
    - For additional general inquires at Humana - https://humana-6853.quickbase.com/db/btnam42he - Humana Healthy Horizons.
  - Anthem: INMLTSSProviderRelations@anthem.com; Emma Badgley - emma.badgley@anthem.com; Taylor Blake - taylor.blake@anthem.com.
  - IHSN members: As an IHSN member, IHSN will assist with MCE contracting and credentialing. Please contact Dawn Miller (dawn.miller@shcare.net) if you haven't heard from the MCEs noted above or if you have any questions.

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Who do I contact, cont'd …

- MCE Provider Manuals are available online and listed below:
  - Anthem Provider Manual
  - Humana Provider Manual
  - UnitedHealthcare Provider Manual
- Enrollees or their representatives can contact 87-PATHWAY-4 (1-877-284-9294) for additional questions at any time.
- Care and service coordinators – these individuals assist with the range of services offered to members, help schedule regular assessments for members in a facility, and facilitate clinical support services.
  - Coordinators will be a great resource for facilities, members and their representatives for a variety of issues under the Pathways program and will have a consistent presence in buildings post go-live.

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Initial PathWays enrollment contact

- Initial contact notices should have come in the form of an "enrollment letter" from FSSA in February and March 2024. Here is an example, and here is where you can find all notice letters that FSSA might send out to different enrollees.
- Contact was to be made in batches of thousands of potential enrollees by Zip Code.
- Contact was to be made to the individual(s) (up to three) who are already the authorized contact(s) in the FSSA-CORE system. This could be the resident and / or multiple other authorized persons.
- Initial contact should not be from an MCE – either via phone call or letter
  - No MCE should contact a potential enrollee until June 2024 – after they have been selected by the enrollee or after auto-assignment to one of the 3 MCEs has occurred.
  - This contact should include a Welcome Packet – and new Medicaid Card.

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MCE Selection

- **How does an enrollee choose between the three MCEs?**
  - FSSA prefers alignment with an existing Medicare D-SNP plan. This should encourage easier coordination of care and more efficient EMR management. If no alignment exists, an enrollee can choose a particular MCE for any reason or defer to the auto-assignment process.
  - These two resources contain information that can assist in choosing between MCEs (by design, there are very few substantive differences between the Plans: http://www.advancingstates.org/mcehcbs-provider-roundtable-events; https://www.in.gov/pathways/providers/ ("Pathways Providers" - then "Plan Comparison").
    - Due to different individual needs, not all of the Enhanced Benefits of a particular MCE will apply to all of its covered persons; please review carefully.
- **What can a Provider do in assisting an enrollee in choosing between the three MCEs?**
  - A provider can offer education and consultation. FSSA cautions providers to remain impartial and not attempt to influence MCE selections.
  - A provider who is listed as the Authorized Representative of a resident can directly assist the member in selecting an MCE. If the member has a designated health care representative or a court appointed power of attorney or guardian, MCE selection decisions are made by these individuals.
  - As detailed in the Notice letter an enrollee will receive, when the MCE selection decision is ready to be made, the enrollee (or representative) should call 87-PATHWAY-4 (877- 284-9294).

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How can an enrollee change MCEs?

The Basics –

- Within 60 days of starting coverage
  - Within 60 days of go-live (~ 7/1/24) and/or when the potential member enters the Pathways managed care system.
- At anytime the member's Medicare and Medicaid plans become unaligned;
- Once per calendar year for any reason.
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.
- At anytime the "just cause" process applies (described below).

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Changing an MCE, cont'd

Just-cause reasons include, but not are limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the MCE to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the MCE by the state's Medicaid office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the MCE's contract with the state;
- A service is not covered by the MCE for moral or religious objections, as described in Section 7.8.2 of the Pathways scope of work;
- Related services are required to be performed at the same time and not all related services are available within the MCE's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
- Other circumstances determined by the state's Medicaid office or its designee to constitute poor quality of health care coverage.

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Who makes the initial (and ongoing) Medicaid eligibility determinations?

Quick answer – the state / FSSA … never an MCE

- Every 12 months, members (or their representative(s)) are required to complete the Medicaid eligibility redetermination process. This includes financial and medical eligibility. If something changes with a member's information, FSSA may send a request that requires a response (and this might include another request for medical or financial information) to continue eligibility before the 12-month period ends.
- All such determinations will be effective on the first of the following month (e.g. an April 17 eligibility determination will trigger coverage with an assigned/selected MCE starting May 1).
- Generally speaking, claims for services rendered between the determination date and the first of the following month will be submitted to the current fee-for-service claims payment portal.
    - Note – some coordination of benefits (with other payers or programs – HCC, the Veterans Administration, Medicare, etc.) concerns are still being worked out by FSSA and the MCEs.

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Should we contract with all 3 MCEs?

- Yes! There is no reason not to – and every reason to do so.
- FSSA's Pathways administration contract requires each MCE to offer an in-network contract to any/every willing LTC provider (AWP) who wants one for a period of three (3) years post go-live.
  - MCEs cannot restrict (or narrow) their provider network based on quality outcomes or star ratings, geographic saturation, or other similar reasons.
  - The AWP rules might be limited if a provider does not meet certain conditions of an MCE that would apply to all providers in its network (debarment, failure to comply with credentialing requirements, etc.)
- **Temporary emergency fund assistance program** – this program, which was passed as part of SB 132, with limitations, generally provides a fund to pay providers 75% of their monthly average of Medicaid claims (above $25,000) – in the event that significant claims payment delays arise from one or more of the MCEs.
  - BUT – providers must participate in the claims submission and testing program (that is being rolled out now) first. Contracting and participating with all three MCEs appears to be a condition precedent.
  - Document all efforts to participate in the claims testing program and every step thereafter.

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Claims Testing Program

- See IHCP Bulletin 202451 (BT 202451) – April 25, 2024.
- Two claims submission testing periods will be held.
  - The first testing window will take place April 29 through May 10, 2024.
  - The second testing window will take place May 20 through May 31, 2024.
  - Providers should register for claims testing with each MCE as follows:
    - **Anthem:** Register with Anthem using the online Anthem Claims Testing Registration Form at s-us.chkmkt.com.. Providers will receive instructions for claims testing upon registration. For questions: INLTSSClaimsTesting@anthem.com
    - **Humana:** Email - HumanaHealthyHorizonsIndianaClaimsTesting@humana.com. Providers will receive a response requesting specific information for registration. When registered, a provider will receive claims testing instructions based on their provider type and testing needs. For questions, use the same email address.
    - **UnitedHealthcare:** Email UnitedHealthcare at inclaimstesting@uhc.com. Providers will receive a response requesting specific information for registration. When registered, a provider will receive claims testing instructions based on their provider type and testing needs. For questions, use the same email address.

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Available resources

- General questions
  - PathWays for Aging website - https://www.in.gov/pathways/.
  - LeadingAge Indiana website dedicated to the PathWays program - https://www.leadingageindiana.org/aws/LAIN/pt/sp/mmc.
- MCE contacts (provider relations and contracting)
  - UnitedHealthcare: IN_providerservices@uhc.com
  - Humana: Denise Watson - DWatson31@humana.com; Terry King - TKing58@humana.com
  - Anthem: INMLTSSProviderRelations@anthem.com, Emma Badgley - emma.badgley@anthem.com; Taylor Blake - taylor.blake@anthem.com

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Manage Your Expectations

Grace
/grās/
Oxford Dictionary
Noun
courteous goodwill

Merriam-Webster
Noun
grace implies a benign attitude and a willingness to grant favors or make concessions.

You will experience a significantly higher burden on

- billing,
- clinical,
- medical records and
- marketing

Everyone has to learn new processes and procedures for three companies and form relationships with likely three or more key contacts.

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Manage Your Expectations

Ohio rolled managed Medicaid out by region to help work out the bugs – <u>this is shotgun start</u>!

- Expect some chaos – MCEs and Providers won't get everything right; allow for extra time especially when <u>everyone</u> is still learning.
- Expect and <u>plan for delays</u>
  - What will you do if….???
  - Run through all the ways managed care touches your organization.
  - **What is Plan B?**

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Help your Residents Avoid Auto-enrollment

- Delays the timeframe that MCEs and providers have to prepare for each other.
- Some people proactively chose their provider but late in the process, and were also auto-enrolled.
- Potential conflicts with the person's supplemental Medicaid benefits may have to change dentists or eye doctors who were not providers.

Ohio rolled out Managed Medicaid in 2014.

What percentage proactively enrolled and selected their plans?

A. 8%
B.16%
C.32%
D.64%

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Top issues in Ohio 6 months after rollout:

1. **Patient Liability** – When the amounts change there is often confusion between the SNF, State and MCE. Ohio created a reconciliation form to track differences.
2. **Changes in Medicaid Rates -** were not always passed through timely and caused the need for corrections.
3. **Hospice** pass through for room and board caused issues.
4. **Claims payment** was still an issue. Two MCEs still had significant issues.
5. **Transportation** was an issue and one of the MCEs had already changed transportation providers.
6. **Care Management** - switching levels from AL to SNF delayed approval – involve the care management team up front. Process for notification of ER or hospitalization with Case Manager.

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Steps You Can Take

1. Make sure you are contracted with all three MCEs.
2. Consider having your staff become subcontractors for the MCE transportation companies. Otterbein continues to employ this strategy. Our residents make it to their doctors on time.
3. Understand how timing of billing and receipt of reimbursement will affect your cash flow and effect any loan or bond covenants you might have like Cash to Debt or Days Cash on Hand

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Steps You Can Take

4. **Steps to Offset Squeeze on Cash Flow**
   a) Negotiate a line of credit now if you do not have cash reserves
   b) Participate in beta testing for billing
   c) Consider billing in smaller increments like payroll – every other week; MCEs are paid PMPM upfront monthly – don't let them keep the float; you can bill at anytime.

5. **Be the Best Partner you can be. Form good relationships!** Case managers may cause more documentation, but can also be used as allies with a difficult family or helping deliver difficult news.

6. **Focus on Quality.** Any willing provider only lasts three years. In Ohio this provision is still intact. Relationships and Quality will be your keys to long term success.

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Managed Medicare is Also Coming
Open Enrollment is Just Months Away

- THE MCEs would like to grow their Medicare Advantage business along with their Medicaid business.
- Educate your residents that it is **THEIR CHOICE**.
- This is coming up in October during open enrollment.

YOU CAN KEEP TRADITIONAL MEDICARE **EDUCATE DO NOT STEER**

- Make sure your residents with supplemental policies or third party health benefits are aware they could lose their benefits if they switch.
- Have your residents check now to make sure their doctors, specialists and hospitals have contracts.
- Make sure your Medical directors, medical specialists like podiatrists, specialists that visit your building are contracted.

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Comparing Ohio Duals to Indiana Duals

Indiana

■ Traditional Medicare

March 2020

Ohio

■ Traditional Medicare

https://www.kff.org/other/state-indicator/number-of-dual-eligible-individuals-by-type-of-medicare-coverage/?currentTimeframe=0&selectedDistributions=dual-eligible-individuals-with-traditional-medicare--dual-eligible-individuals-with-any-medicare-advantage-plan&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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Steps You Can Take for a Successful Future

Negotiate Risk Based Contracts especially for Dual Medicaid/Medicare Advantage residents

7. Under these arrangements SNFs can potentially make more money as they are potentially saving Part A admissions to hospitals or preventing ER visits and sharing the savings.

7. **Focus on preventative care:**
   - Residents avoid costly and debilitating hospital stays!
   - Your resident turnover slows.
   - Your staff is more proactive and empowered, leading to more positive feelings about their jobs and in turn slowing turnover.

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