Medicaid Advisory Committee

August 21, 2024

Healthy Indiana Plan Annual Update

1115 Demonstration Waiver Post Award Forum

Lynne Mong, HIP and Hoosier Healthwise Director

August 21, 2024

Agenda

HIP Operations
- Delivery System
- Eligibility
- July 2023 – June 2024 Updates

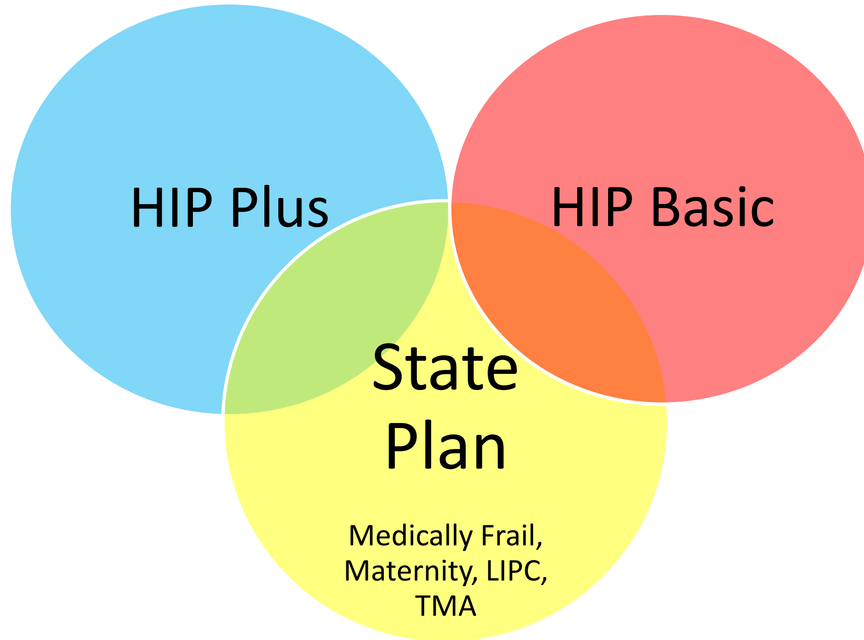
HIP Reporting
- Federal
- Enrollment
- Utilization

Comments

Managed Care Delivery System

- Four managed care entities (MCEs), or health plans, provide coverage through HIP: Anthem, Caresource, Managed Health Services (MHS), MDwise
- Plan selection
  - At the time of application
  - During the HIP Annual Plan Selection Period, November 1st to December 15th of each year
  - At any time for Just Cause
- Enrollment Broker, Maximus, provides unbiased information and assistance with plan selection
- MCEs offer Enhanced Benefits to their HIP members

HIP Eligibility Overview



Who is eligible?

Indiana residents

Ages 19-64

Household income under 138% of the federal poverty level (FPL)

Not eligible for Medicare or any other Medicaid category

Eligibility Populations

- Newly Eligible Population
- Maternity
- Low-Income Parent Caretakers (LIPC)
- Transitional Medical Assistance (TMA)
- Medically Frail

HIP – Notable Updates July 2023 - June 2024

Rate Equalization

- The Rate Equalization project aligned provider reimbursement across all Indiana Medicaid managed care programs as of January 1, 2024, per federal regulation
  - Physician, Lab, and Durable Medical Equipment (DME) rates are now reimbursed at 100% of previous year's Medicare rates
  - Dental and Non-Emergency Medical Transportation rates were also developed and implemented

PHE Unwind

- Close collaboration with MCEs for redetermination and closure outreach
- Frequent stakeholder meetings
- Significant systems testing
- Dashboard development and implementation
- Efforts to aid recipients in maintaining their coverage

HIP Federal Reporting Requirements

Waiver approval granted in October 2020 runs through Dec. 31, 2030

INDEPENDENT EVALUATIONS

Interim Evaluation Reports

- Years 2021 – 2023 due December 31, 2024
- Years 2021 – 2025 due June 30, 2027
- Years 2021 – 2028 due December 31, 2029

Summative Evaluation Report

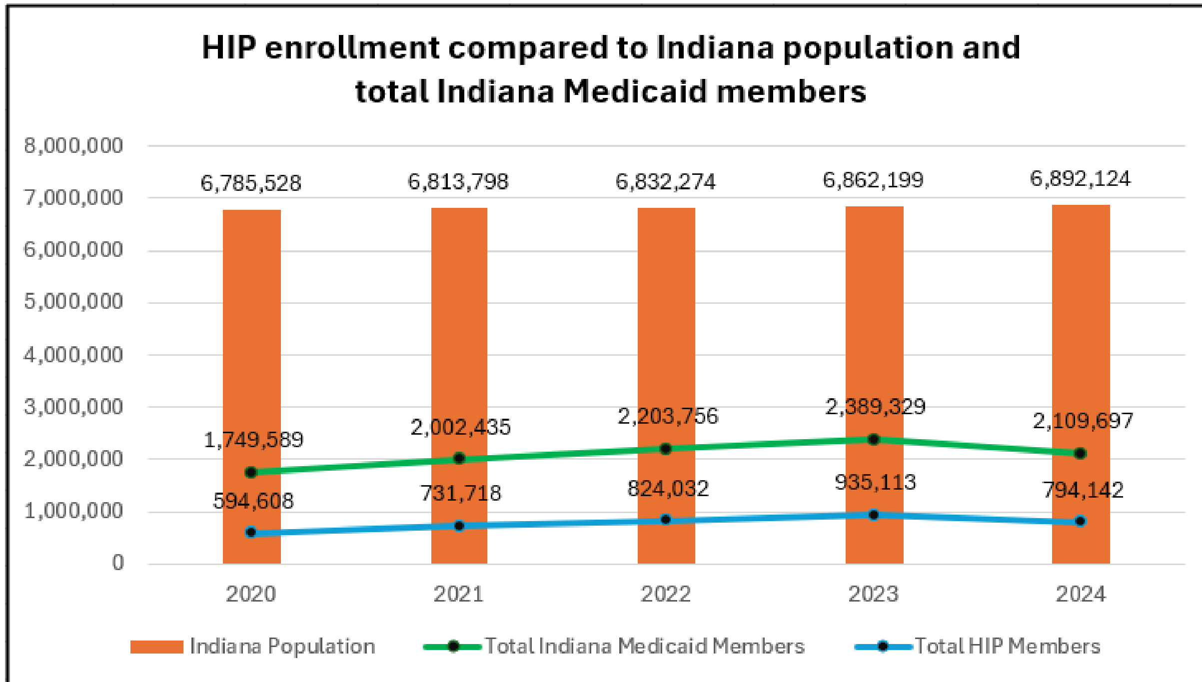
- Years 2021 – 2030 due June 30, 2032

QUARTERLY/ANNUAL MONITORING REPORTS

- Three quarterly monitoring reports and one annual monitoring reports each year
- Focus on progress toward meeting the milestones identified in CMS's framework
- Document key challenges and how those challenges are being addressed
- Summary of public comments received during the annual post award forum and any other forums held
- Budget neutrality and financial reporting requirements

HIP enrollment as a % of total Indiana Medicaid enrollment and Indiana Population

In 2020, HIP members were 34% of Indiana Medicaid's members and 9% of Indiana's population.
In 2021, HIP members were 37% of Indiana Medicaid's members and 11% of Indiana's population.
In 2022, HIP members were 37% of Indiana Medicaid's members and 12% of Indiana's population.
In 2023, HIP members were 39% of Indiana Medicaid's members and 14% of Indiana's population.
For 2024 (to date), HIP members are 37.6% of Indiana Medicaid's members and 11.5% of Indiana's population.

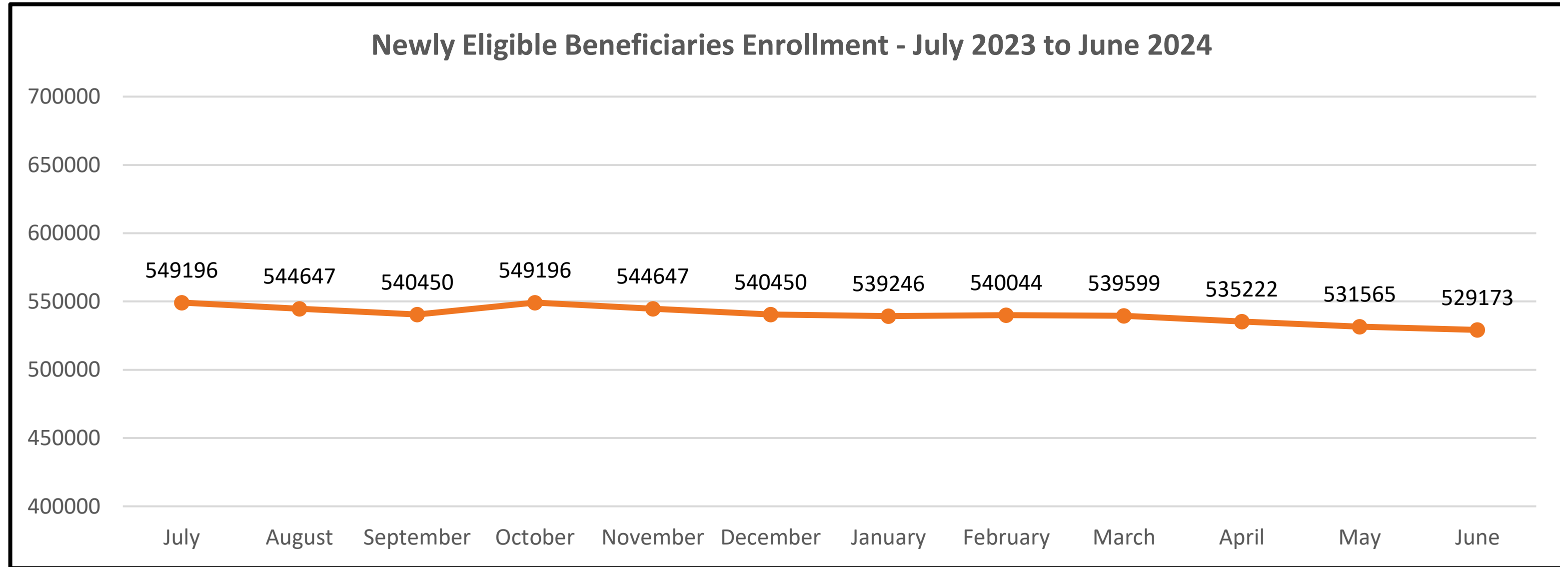


Bar graph shows HIP enrollment data since January 2023, with growth from Jan 2023 through May 2023 and unwind-related decreases beginning in June 2023. As of June 30, 2024, there were 696,430 HIP members.

HIP ENROLLMENT

Month	Number of HIP Enrollees
Jan-23	799,691
Feb-23	805,243
Mar-23	811,367
Apr-23	815,793
May-23	815,562
Jun-23	793,334
Jul-23	774,520
Aug-23	764,617
Sep-23	753,757
Oct-23	746,961
Nov-23	740,372
Dec-23	731,899
Jan-24	728,858
Feb-24	721,323
Mar-24	717,922
Apr-24	709,706
May-24	702,650
Jun-24	696,430

Newly Eligible* Population HIP Enrollment, July 2023 to June 2024



*The newly eligible population, also sometimes referred to as the "expansion population" or the "new adult group", is comprised of individuals who would not have been eligible or qualified for full benefits, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009.

HIP Kept Hoosiers Healthy by Covering…

Period	Preventive Care	Inpatient Admissions	Emergency Department	Prescription Drug Fills
2023 Q3	879,816	14,307	160,251	3,890,397
2023 Q4	820,922	13,561	147,884	3,745,619
2024 Q1	859,290	12,824	142,410	3,720,918

Thank You

Indiana 1115 Demonstration Substance Use Disorder (SUD)/Serious Mental Illness (SMI) Waivers

Post-Award Forum: Waiver and Data Updates

Presenter:

Andrew Sekeres III – Policy Developer, Coverage and Benefits Unit

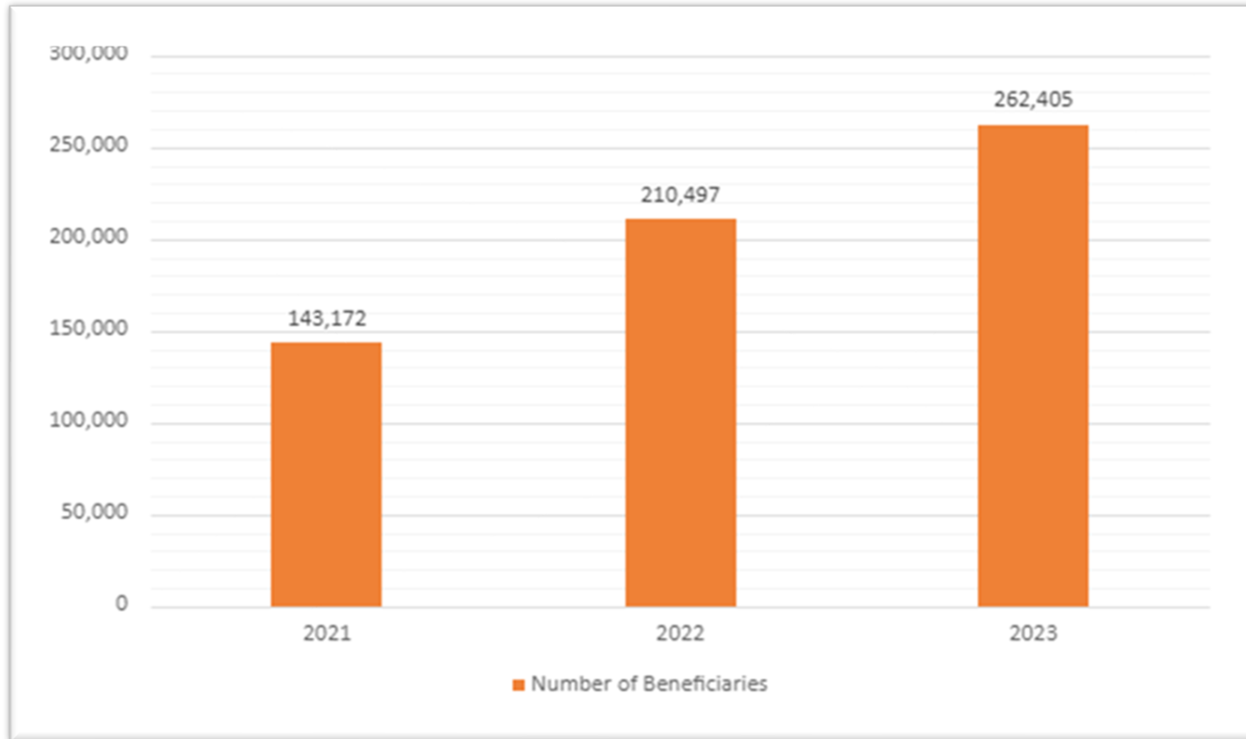
Office of Medicaid Policy and Planning

Agenda

1. Substance Use Disorder (SUD) Waiver Overview
   - Goals/Milestones
   - Monitoring Report Metrics
     - 2020 to 2024
2. Serious Mental Illness (SMI) Waiver Overview
   - Goals/Milestones
   - Monitoring Report Metrics
     - 2020 to 2024

Total Medicaid Members with Substance Use Diagnosis

(SUD diagnosed Medicaid members who received medication assisted treatment or a related treatment from 2021 – 2023)



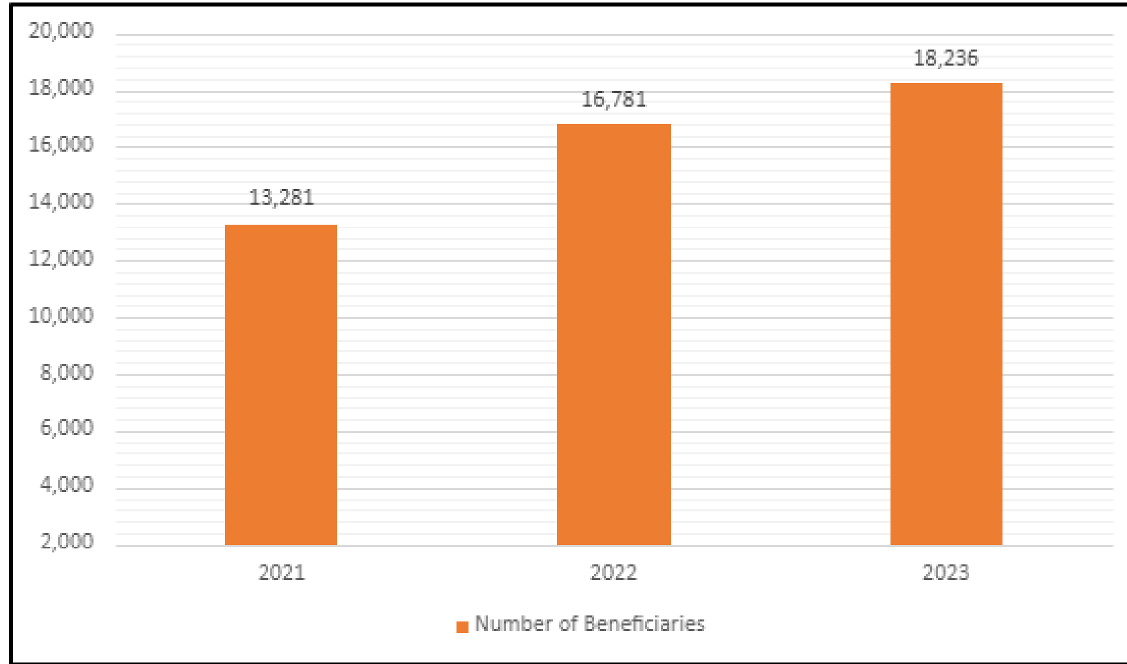
Substance Use Disorder Residential Treatment Growth

ASAM Level	Facilities	Beds
Low-Intensity Residential Services (ASAM 3.1)	13	232
High-Intensity Residential Services (ASAM Leve 3.5)	64	2904
Low and High-Intensity Residential Services (ASAM 3.1 and 3.5)	10	311

Year	Total Facilities	Total Beds
2022 (June)	68	2509
2023 (December)	79	2997
2024 (August)	87	3447

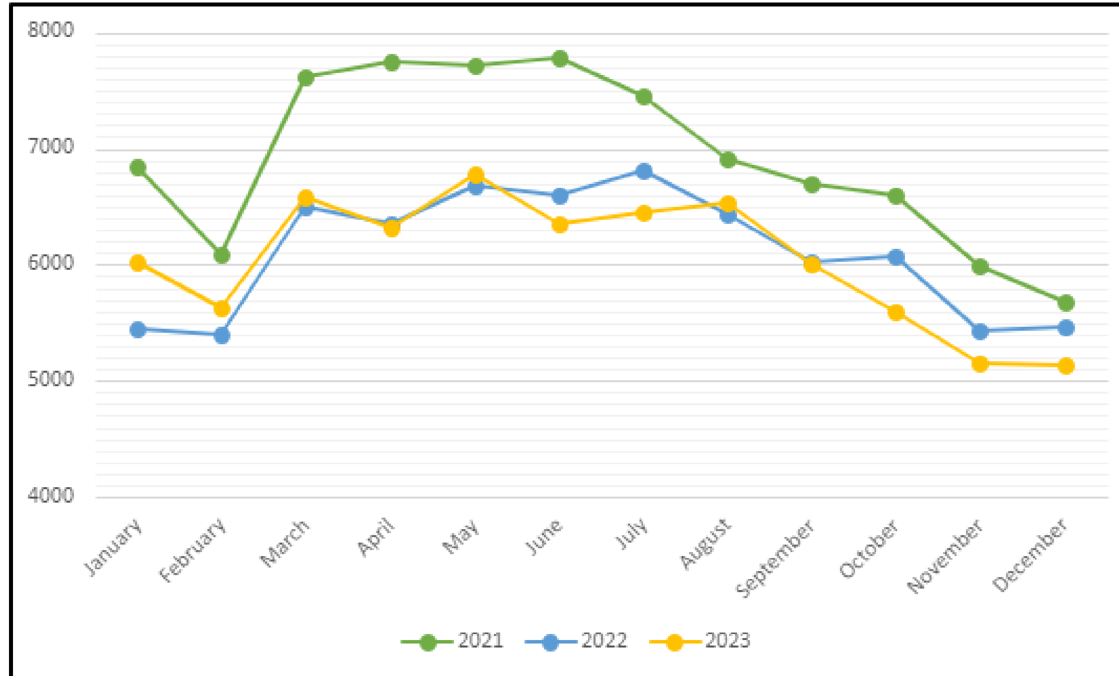
- American Society of Addiction Medicine (ASAM) established treatment criteria for addictive, substance-related, and co-occurring conditions.
- Within this criteria, individuals are assessed for their level of care at their initial intake.
- Access to SUD treatment continues to improve through year-over-year increases in facilities and beds.

Medicaid Members Treated in Inpatient and Residential Institutes of Mental Disease for Substance Use Disorder



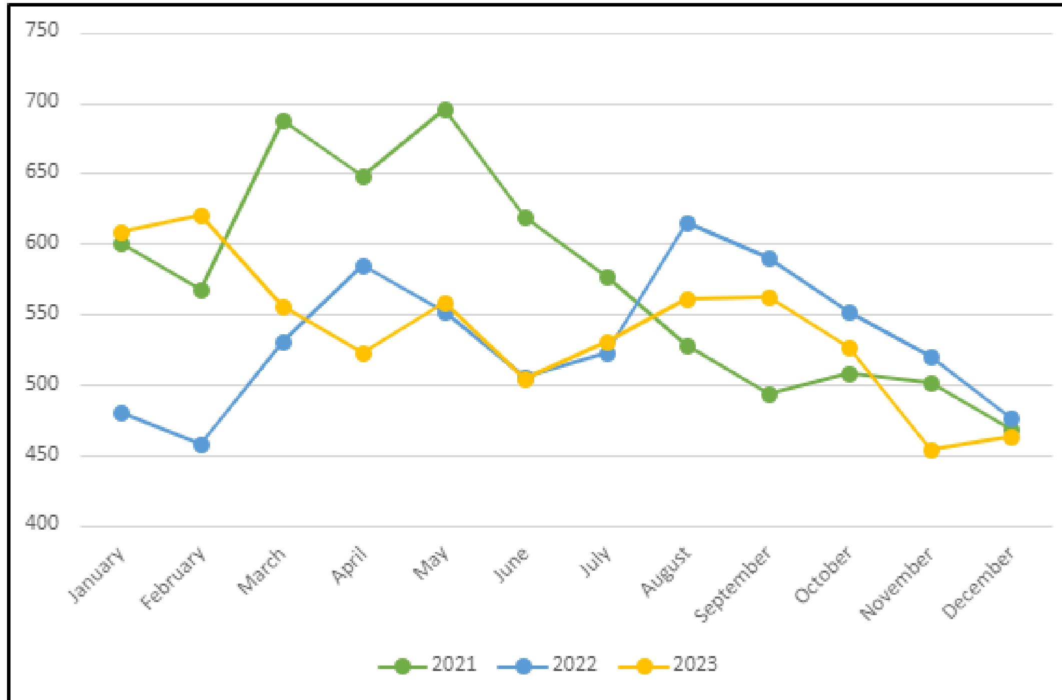
Number of Emergency Department Visits for Substance Use Disorder

Continued decrease of Medicaid members with a substance use disorder who utilized the emergency department for an acute crisis



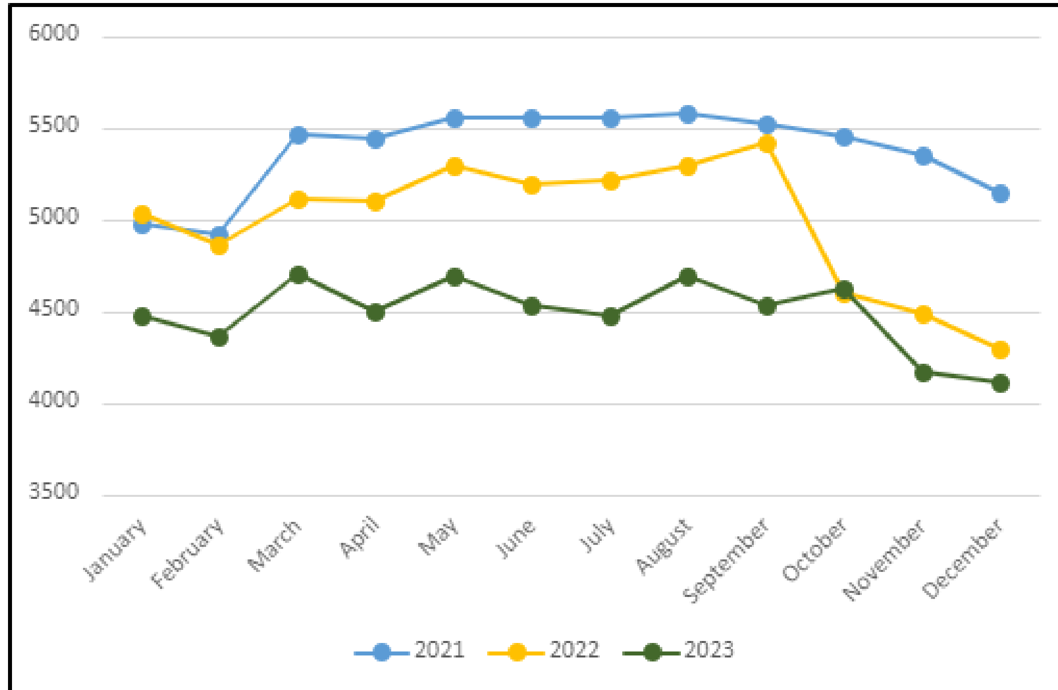
Number of Emergency Department Visits for Serious Mental Illness

Decreasing number of Medicaid members with a serious mental illness/serious emotional disturbance who have been utilizing the emergency department for an acute crisis



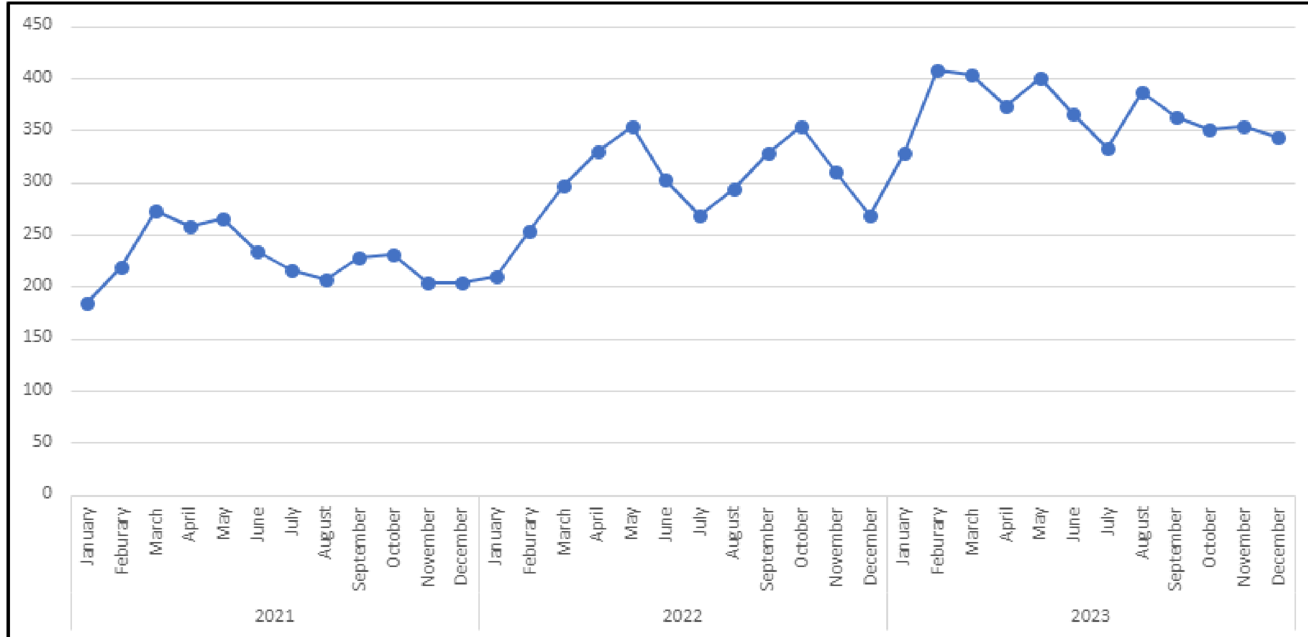
Utilization of Inpatient Services

Continued decrease of Medicaid members with a serious mental illness who are utilizing inpatient services



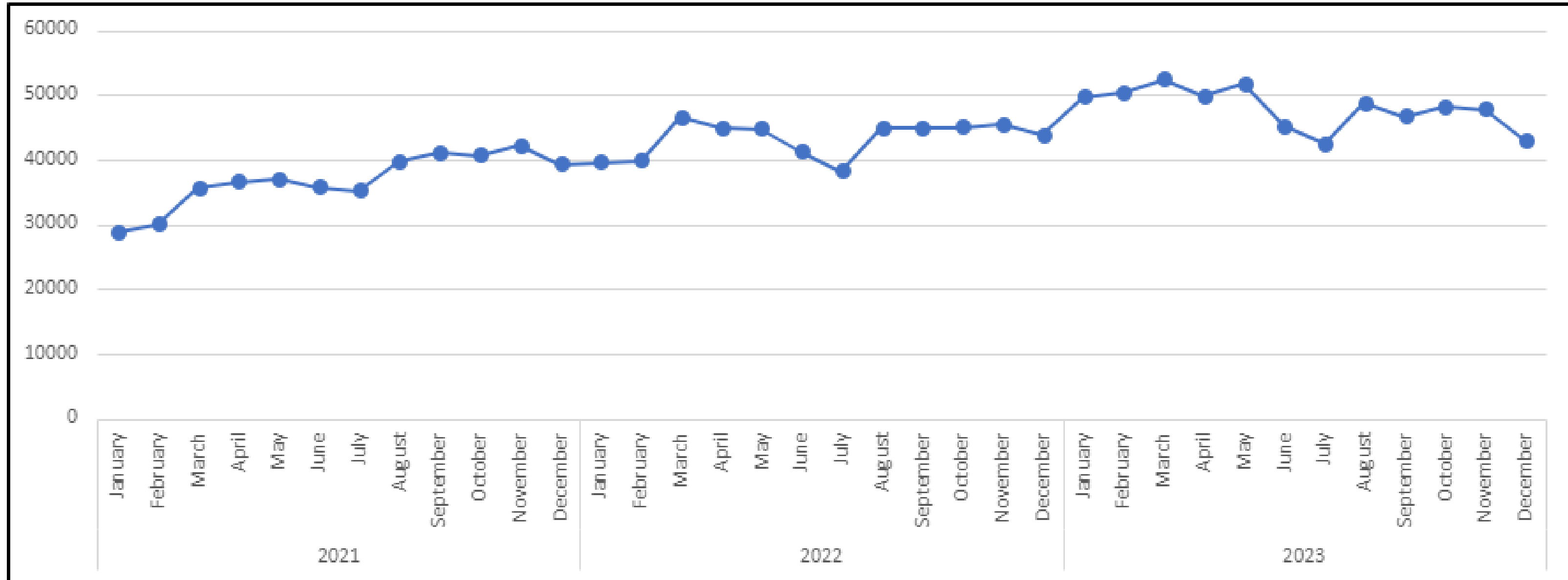
Intensive Outpatient and/or Partial Hospitalization

Continued increased utilization of intensive outpatient and/or partial hospitalization services for Medicaid members with a serious mental illness/serious emotional disturbance



Outpatient Services

Increasing number of Medicaid members with a serious mental illness/serious emotional disturbance who have been accessing outpatient members



Conclusion

- Increases in the number of substance use disorder (SUD) residential facilities have led to decreases in emergency department stays for SUD acute crises.
- Increased access to outpatient clinics and stays in partial hospitalization facilities for individuals with a serious mental illness (SMI) and serious emotional disturbance (SED) have led to decreases in emergency department stays that exceed 24 hours.
- Additional conversations around behavioral health and SUD coupled with increased access to Institutions for Mental Disease (IMDs) and residential facilities accessible through the 1115 Demonstration Waiver have helped to decrease stigma and improve options for those seeking assistance in recovery and behavioral health treatment.

1115 Waiver Annual Update: How to Comment in Writing

Via email:

INMedicaidGA@fssa.in.gov

Please include “COMMENTS FOR HIP ANNUAL UPDATE” in the subject line

Via post:

Office of Medicaid Policy and Planning, FSSA

C/O Lynne Mong, HIP and HHW Director

402 W. Washington St., Room W374, MS07

Indianapolis, IN 46204

PathWays Overview and Post-Implementation Work

Managed Long-Term Services and Supports (MLTSS) Launched July 1, 2024

- MLTSS is a delivery system that uses managed care entities (MCEs) to coordinate medical care and long-term services and supports (LTSS) to enrolled Medicaid beneficiaries
- Indiana has introduced an MLTSS program for Medicaid-eligible Hoosiers 60+ called **Indiana PathWays for Aging**
- Members are now enrolled in a PathWays health plan (Anthem, Humana, and UnitedHealthcare) and receiving health coverage
- MCEs participating in PathWays provide health coverage for acute and preventive care services as well as Home and Community-Based Services (HCBS) and Nursing Facility (NF) services

Managed Care Entity Plan Changes

PathWays members may change plans at following times:

- Within 90 days of starting coverage
- Once per calendar year
- During Medicare Annual Enrollment Period (Mid-Oct to Dec)
- When Medicare and Medicaid plans become unaligned
- For Just Cause (ex. poor quality of care, significant language or cultural barriers)

Members and their Authorized Representatives may call the Enrollment Broker to change MCEs:

- 87-PATHWAY-4 (877-284-9294)
- The helpline is open M-F 8am-7pm ET

PathWays Post-Implementation Monitoring

- Like readiness review before program launch, OMPP has developed topics and a schedule for the post go-live monitoring of the PathWays program that will take place over the next year and beyond
- OMPP has also implemented "secret shopper" calls to the Member Support Services (MSS) vendor as well as the managed care entities (MCE) call centers to gain a better sense for how calls are being addressed
- Member and provider call information is a helpful tool for OMPP to identify recurring themes and proactively address concerns
- Additionally, MCEs and MSS are subject to robust reporting requirements

Member Support Services Overview

- Members, member advocates, and caregivers have access to the independent Member Supports Services (MSS)
- MSS provides direct assistance in navigating PathWays coverage and helps to resolve any issues that members may experience
    - Educating members on managed care and how to access services
    - Assisting members experiencing issues accessing care
    - Ensuring member voice is being upheld in person-centered planning, and care and service coordination
    - Support navigating issues with MCEs or providers
    - Education on Grievance and Appeals processes
- Members may reach the MSS by calling 877-738-3511 or emailing indianapathwaysmss@maximus.com
    - Phone line operates Monday-Friday from 8 am – 8 pm ET
    - Indianapathwaysmss.com

Member Support Services Information

Top call reasons in the first 45+ days include:

- Care and service coordination contact information
- Requests for medical supplies, transportation, and/or meals
- Home health care prior authorization questions
- Pharmacy inquiries

MSS resolution involves an escalation process with MCEs when issues are received. Most escalations are resolved within 2-3 days, and MSS follows up directly with all members to ensure the MCE responses align with member expectations.

MSS and the MCEs have regular touchpoints and required reporting under OMPP oversight.

PathWays Managed Care Oversight

Onsite and Desk Review Audits

- Onsite audits with MCEs and ongoing review of policies and procedures
- Review of service authorizations
- Continuity of Care
- MCE systems monitoring
- Secret shopper calls to MCE

Go-Live Reporting

- Claims Production
- MCE Call Center
- Prior Authorization Denial
- Completion of Health Needs Screening, Comprehensive Health Assessment, and Informal Caregiver Assessment
- Monthly Regulatory Reports

PathWays Success

Continued MCE Interaction and Oversight

- Daily stand-up meetings
- Weekly clinical implementation meetings
- Weekly quality meetings
- Monthly provider network meetings
- Continued interaction and feedback from stakeholders

MCE Member Helpline Call Data (Jul. 1 – Aug. 17)

Top member call reasons:

- Care Coordination and clinical support needs
- Questions regarding Benefits and Covered Services
- Provider search information
- Eligibility and ID card requests

Measure	Anthem	Humana	UHC
Number of Member Calls Received	15,602	24,251	16,774
Number of Member Calls Answered	15,527	24,175	16,745
Number of Member Calls Answered Live within 30 Seconds	15,039	24,103	16,745
Percent of Calls Answered Live within 30 Seconds (calculated)	96.39%	99.39%	99.83%
Assess Calls Answered Performance Metric (85% or greater)	Target Met	Target Met	Target Met
Number of Abandoned Calls	75	74	29
Percent of Calls Abandoned (calculated)	0.48%	0.31%	0.17%
Assess Abandonment Rate Performance Metric (<5%)	Target Met	Target Met	Target Met
Number of Calls Received after Hours	64	4	5

MCE Provider Helpline Call Data (Jul. 1 – Aug. 17)

Top provider call reasons:

- Claims inquiry and claims status
- Authorization status
- Benefits and coverage questions
- Member eligibility verification

Measure	Anthem	Humana	UHC
Number of Provider Calls Received	2,348	7,261	7,803
Number of Provider Calls Answered	2,321	7,237	7,735
Number of Provider Calls Answered Live within 30 Seconds	2,247	7,228	6,939
Percent of Calls Answered Live within 30 Seconds (calculated)	95.70%	99.55%	88.93%
Assess Calls Answered Performance Metric (85% or greater)	Target Met	Target Met	Target Met
Number of Abandoned Calls	27	24	68
Percent of Calls Abandoned (calculated)	1.15%	0.33%	0.87%
Assess Abandonment Rate Performance Metric (<5%)	Target Met	Target Met	Target Met
Number of Calls Received after Hours	3	2	0

PathWays Issue Resolution

- PathWays provider associations are encouraged to submit issues through a centralized issues resolution log so OMPP can collect and track systemic issues in a single location
- Individual provider issues should be routed directly to the appropriate MCE(s) as a first step in order to mitigate issue(s)
  - Anthem: 833-569-4739, INmltssproviderrelations@anthem.com
    Humana: 866-274-5888, InMedicaidProviderRelations@humana.com
    UnitedHealthcare: 877-610-9785, in_providerservices@uhc.com
- Provider issues may also be shared with the INPathWays@fssa.in.gov inbox

PathWays Claims Monitoring

OMPP reviews on a weekly basis claims information by both claim count and dollar amount:

- Clean claims received (by electronic and paper)
- Clean claims adjudicated
  - % paid
  - % denied
- Claims paid with interest
- % of claims adjudicated within 21 days of receipt
- Top 20 denial codes by institutional and professional claim categories

PathWays Claims Workgroup Overview

- As a result of legislation passed in collaboration with the General Assembly, FSSA, and providers, OMPP leads a provider-based claims workgroup that began meetin in April and continues to meet biweekly with the State and MCEs to:
  - Refine the uniform billing format used by the Pathways MCEs
  - Receive feedback on claims submission
  - Advise OMPP and MCEs on education and training needs of providers participating in the PathWays program

Claims Issues – Flexibilities and Remaining Common Denial Reasons

- OMPP directed MCEs to reconfigure systems or otherwise address a number of top denial reasons that has greatly improved payment percentages
  - "Type of Bill" issues for nursing facility providers
  - Missing National Provider ID when Medicaid ID was present for waiver providers
  - Certain Medicare Explanation of Benefits (crossover) issues for home health providers
  - Certain Electronic Visit Verification (EVV) system matching issues (*note, though, that EVV compliance remains a top denial reason*)
- Denials for Institutional / UB billing have decreased significantly in the last 2-3 weeks
- Professional / 1500 billing issues are informing additional provider education
  - Billing Provider ID is not registered with the state
  - Duplicate claim submission
  - No Electronic Visit Verification (EVV) match
  - Service is a non-covered service

PathWays Claims Payment Data (Aug. 11 –Aug. 17)

Measure	Anthem		Humana		UHC	
	Institutional	Professional	Institutional	Professional	Institutional	Professional
Clean Claims Received						
Electronic	2,290	7,598	1,910	5,968	7,268	14,162
Paper	1,856	4,116	17	232	2	454
Total Received	4,146	11,714	1,927	6,200	7,270	14,616
Clean Claims Adjudicated						
Paid	5,578	15,785	1,762	4,767	5,872	13,109
Denied	681	3,198	165	1,433	520	473
Total Adjudicated	6,259	18,983	1,927	6,200	6,392	13,582
Percent of Adjudicated Claims Paid	89.12%	83.15%	91.44%	76.89%	91.86%	96.52%
Claims Paid With Interest						
Total Number of Claims Paid With Interest	2	45	6	380	255	627
Total Dollar Amount of Interest Paid	$13.41	$26.88	$12.50	$46.78	$2,560.81	$930.38
% of Claims Adjudicated within 21 days	99.84%	99.92%	99.90%	100.00%	99.26%	99.70%

Temporary Emergency Financial Assistance Program

- Requirements of the Temporary Emergency Financial Assistance Program (TEFAP) are outlined in state law at Ind. Code § 12-15-13-1.8
- A provider is only eligible for Temporary Emergency Financial Assistance from an MCE with which the provider successfully completed the PathWays claims testing process
- Over 2,500 providers successfully participated in claims testing with Anthem, Humana, and/or UnitedHealthcare from April through June. The list of providers can be found online here.
    - If a provider believes they completed claims testing but is not listed for one or more MCEs, we request the provider submit their emailed confirmation from the MCEs
- The application can be accessed on the PathWays stakeholder webpage. Applications will be accepted through January 31, 2025.
- OMPP and MCEs are actively reviewing and issuing approvals and denials to 165 provider applicants who have applied for TEFAP

FAQs on the PathWays Website

- General Program Overview
- Eligibility, Enrollment, and Plan Selection
- Coverage and Benefits
- Service Plans/Processes
- Care and Service Coordination
- Claims/Contracts/Authorizations
- Other Services/Service Change Questions
- AAA and Case Manager Questions
- Medicare/Duals/D-SNP

Medicaid Advisory Committee

Certified Community Behavioral Health Clinic (CCBHC) Update

Lindsay Potts, Director of System Transformation
Division of Mental Health & Addiction

What is CCBHC?

As directed by SEA1, DMHA is expanding the Certified Community Behavioral Health Clinic (CCBHC) model statewide to transform the current behavioral health system. CCBHCs are specially-designated clinics that provide a comprehensive range of mental health & substance use services.

National Council for Mental Wellbeing

The CCBHC model is a proven outpatient model that:

- **Ensures access to integrated services** including 24/7 crisis response and medication-assisted treatment
- **Meets strict criteria** regarding access, quality reporting, staffing, and coordination with social services, justice, and education systems
- **Receives funding** to support the real costs of expanding services to fully meet the need for care in communities

WHO can access CCBHC services?

- Anyone who requests care for mental health or substance use
- Accessible regardless of one's ability to pay, place of residence, or age
  - Includes developmentally appropriate care for children and youth

Nine Core Services

Crisis Services

Screening, Diagnosis, & Risk Assessment

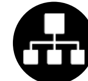
Psychiatric Rehabilitation Services

Outpatient Primary Care Screening & Monitoring

Targeted Case Management

Peer, Family Support, & Counselor Services

Community-Based Mental Health Care for Veterans


Person- & Family- Centered Treatment Planning

Outpatient Mental Health & Substance Use Services

Current BH System ➡ Future CCBHC State

Indiana's Behavioral Health system is ready to **transform to the future state, with the CCBHC framework as the backbone.**

Structural barriers and practices keep care siloed and leads to disparate service provision

Established standards for integrated and coordinated care

Fee-for service drives quantity, so programs are designed by what is billable

Prospective payments can be tied to outcomes & quality, so programs are designed to meet needs

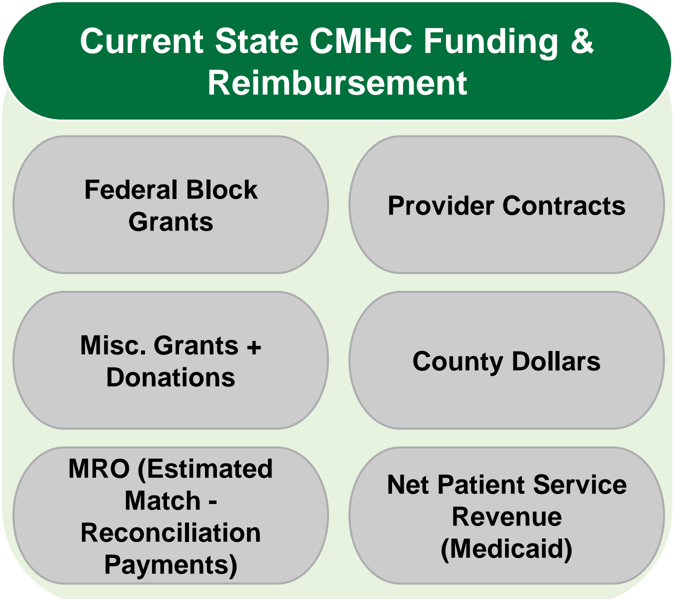
Staff turnover is high due to low pay

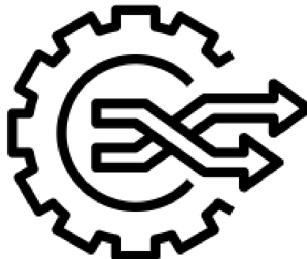
Better salaries achievable through prospective payment system (PPS)

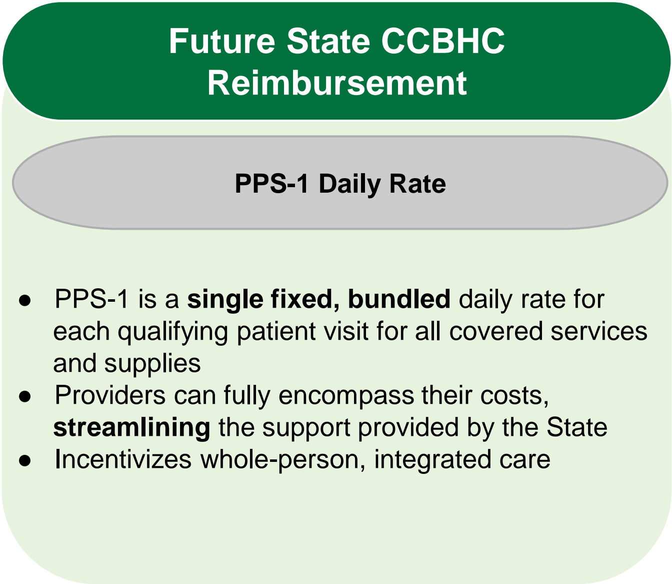
INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

Transforming Reimbursement Structure

The current CMHC system is funded through many siloed sources, resulting in an rigid system that is confusing to navigate. The CCBHC model streamlines the reimbursement structure with a clinic-specific Medicaid Prospective Payment System (PPS) Rate.

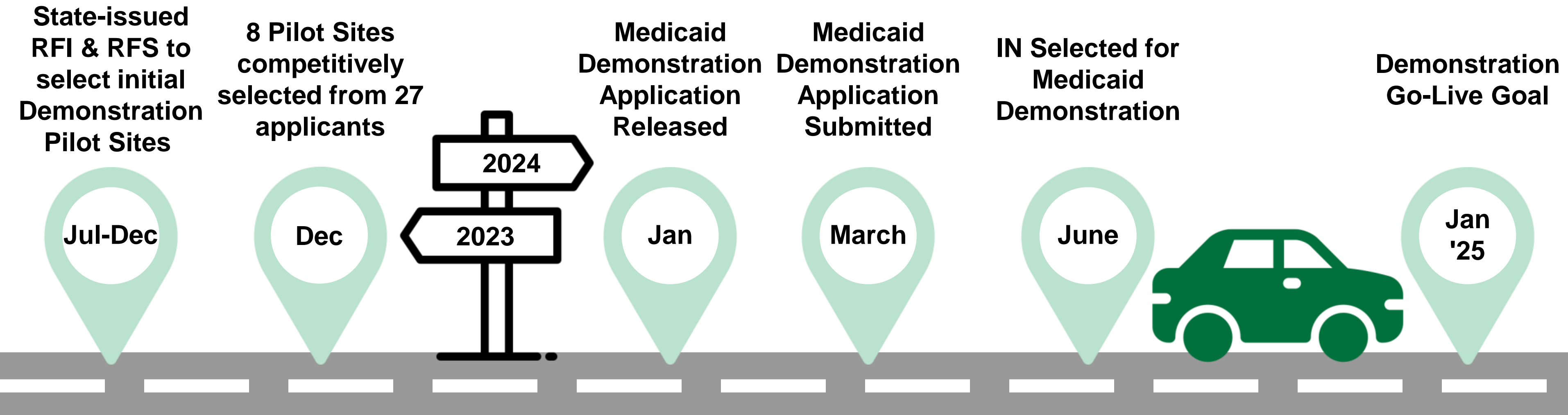






- PPS-1 is a **single fixed, bundled** daily rate for each qualifying patient visit for all covered services and supplies
- Providers can fully encompass their costs, **streamlining** the support provided by the State
- Incentivizes whole-person, integrated care

Road to the Medicaid Demonstration Program



The Medicaid Demonstration Application was released on January 11th, 2024 and due on March 20th, 2024. Results were announced on June 4th, 2024.

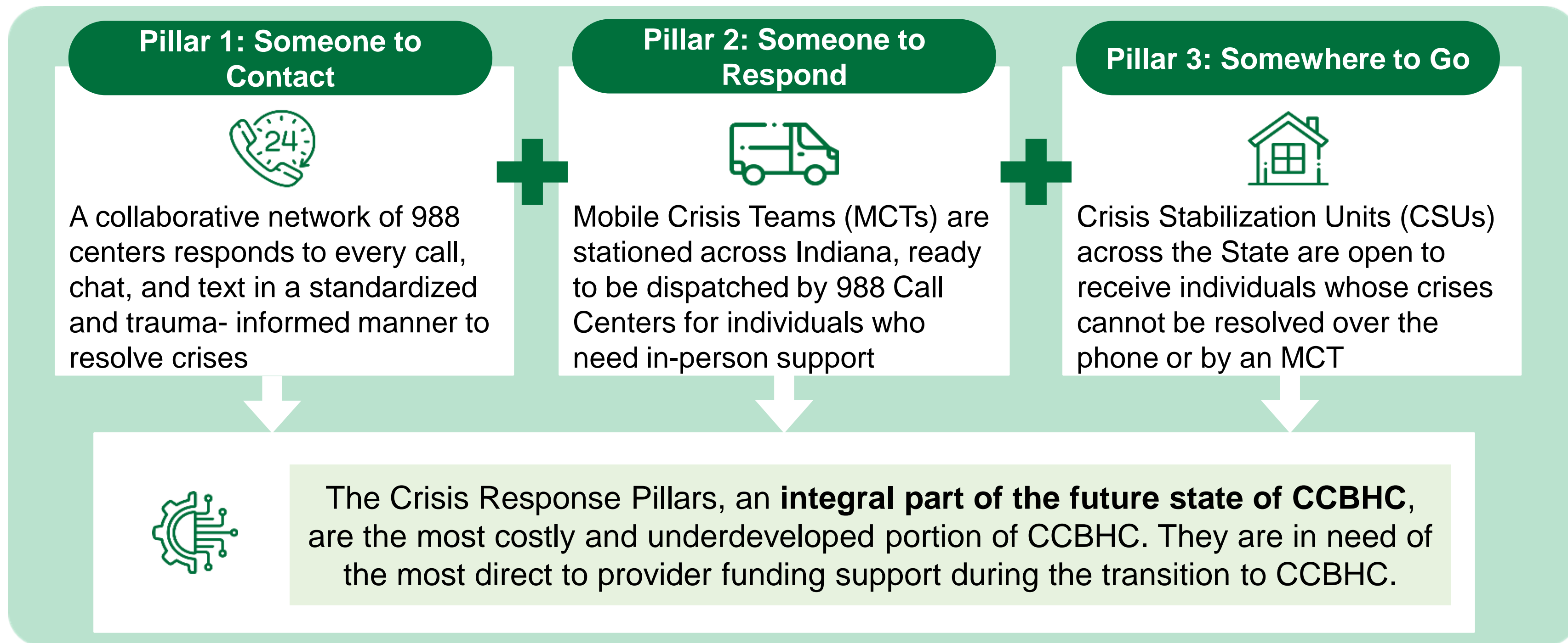
CCBHC Demonstration

Competitively Selected Demonstration Pilot CCBHC Service Areas

- Southwestern
- Eskenazi Health
- Centerstone
- Oaklawn
- Grant Blackford/ Radiant Health
- Adult and Child
- 4C Health
- Hamilton Center

Indiana's Crisis Response System

988 is the national three-digit dialing code for reaching The Suicide & Crisis Lifeline. Since going live in July 2022, Indiana has made significant progress in using 988 to develop a **comprehensive 988 Crisis Response System**.

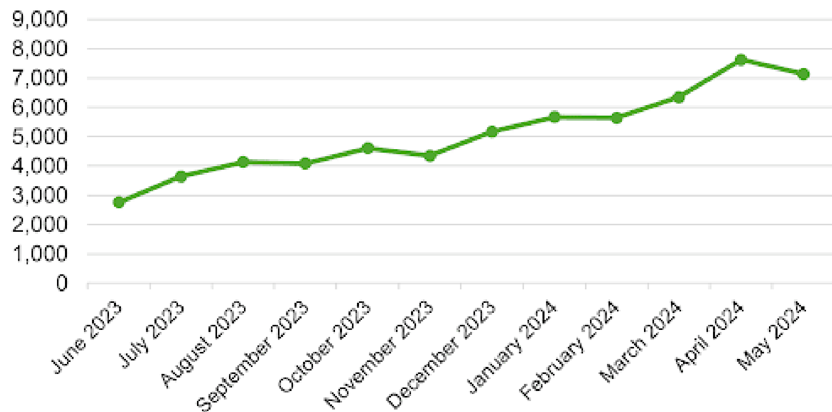


INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

Indiana's Progress on Pillar 1

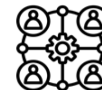
Indiana has worked diligently to become a leader in the crisis space, with the 988 Call Centers boasting an **all-time 95.6% answer rate** in spite of a continuously growing call volume. This answer rate puts Indiana in the **top 10 in the nation.**

Someone to Call Successes



What's next:

Integration with Other Crisis Providers



911 + First Responders

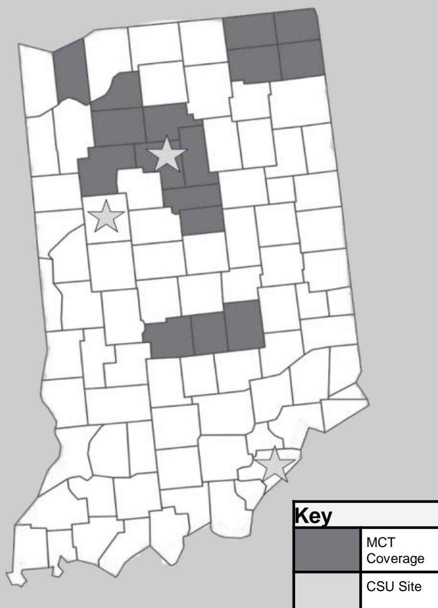
CCBHC

Community Stakeholders

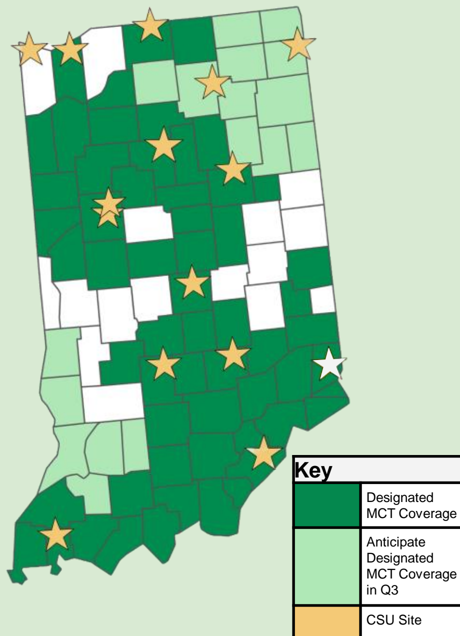
Other Crisis Providers

Indiana's Progress on Pillars 2 and 3

One Year Ago



Present Day



By the Numbers

988 Response Centers

- 4 Call Centers
- 1 Text/Chat Center

Mobile Crisis Teams

- 20 MCTs Funded
- 13 MCTs Designated

Crisis Stabilization Units

- 18 CSUs Funded
- 12 CSUs Open 24/7

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

Future of CCBHC and Crisis Response

The **future state** of the behavioral health landscape connects the 988 and CCBHC systems, to **strengthen and expand services for all Hoosiers.**

Future CCBHC System

- ➔Primary model of behavioral health care statewide
- ➔Majority of MCTs and CRSS (Pillar 2 & 3) will be provided by CCBHCs and paid for by CCBHC Medicaid PPS rates

Future 988 Crisis System

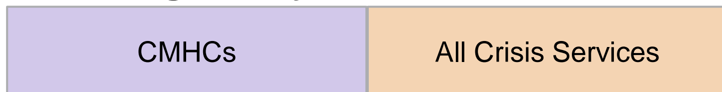
- ➔Integrates with CCBHC and other systems
- ➔Call Centers (Pillar 1) funded via State & federal appropriations
- ➔MCTs and CRSS (Pillar 2 & 3) not affiliated with CCBHCs funded via Medicaid Fee-for-Service or other appropriations

Sustaining funding for CCBHC and 988 is necessary to bridge the gap and connect our systems.

Future of CCBHC & 988 Crisis Funding

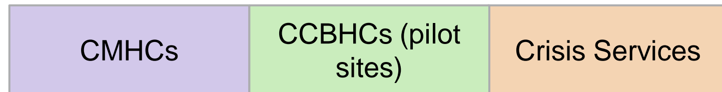
Designated CCBHCs are Medicaid providers, meaning they receive a fixed bundled rate established based on actual costs. As CMHCs are designated as CCBHCs and CCBHC becomes the primary care model, how Crisis Services are funded will also change.

Funding Today



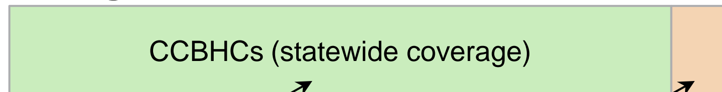
Currently, Crisis Service providers are **one-time funded** providers.

Next Biennium - Transitional Period



The next biennium is a **transitional period** where less federal funding will be available for Crisis Services. This creates the need to backfill for one-time Covid funds until most Crisis Pillar 2 (Someone to Respond) and Crisis Pillar 3 (A Safe Place for Help) providers become CCBHC-affiliated. Crisis Pillar 1 (Someone to Call) providers will remain outside the CCBHC system.

Long-Term



Vast majority of Crisis Pillars 2 & 3 included here

All Crisis Pillar 1 providers and Crisis Pillars 2 & 3 providers that are not CCBHC-affiliated

In the future, the CCBHC system will replace the current CMHC system and include much of the current landscape of Crisis Services. This means Crisis Services will be more **sustainably funded** as they will be included in the CCBHC Medicaid rate.