Public Health Emergency (PHE) Unwinding & Cost-Share Restart

Office of Medicaid Policy & Planning

Medicaid Advisory Committee
May 22, 2024

Unwinding Renewal Activities

- First post-PHE renewals were due in **April 2023**
- 12 months to finish, with two months for any remaining activities
- Final PHE-related renewals were due in **March 2023**

We have processed renewals for **1,785,104** members
over the last 12 months

Unwinding Renewal Activities

- Each month, an average of 148,759 members were due for renewal; of those, an average of:
  - 77,967 (**52%**) had their coverage successfully renewed
    - Of those renewed 61,096 **(78%)** were auto-renewed with no action required from the member
    - Of *all members due for renewal*, an average of **41%** were auto-renewed

Unwinding Renewal Activities

An average of 32,101 (**22%** of the total due for renewal) were disenrolled from Medicaid each month

- An average of 5,146 each month (**3%** of total due) were determined ineligible based on information they provided; most of these would have qualified to have their account transferred to the Federal Marketplace (Healthcare.gov) so that they could apply for coverage there

Reminder: Through November 2024, individuals who lost Medicaid for <u>any reason</u> can apply on the Marketplace; Annual Open Enrollment begins in November

Unwinding Renewal Activities

- 26,955 (**18%** of total due) were disenrolled due to procedural reasons (i.e., failure to respond)
  - 7% of all those due for renewal were closed for failure to respond; 4% were suspected to be ineligible (for example, our data showed they were over the income limit) and they did not respond; and 2% provided incomplete information or were known to be ineligible (for example, deceased or moved out of Indiana)

- Of those who failed to respond, our records show that **21% have regained their eligibility** by submitting their missing verifications during the 90-day reconsideration period

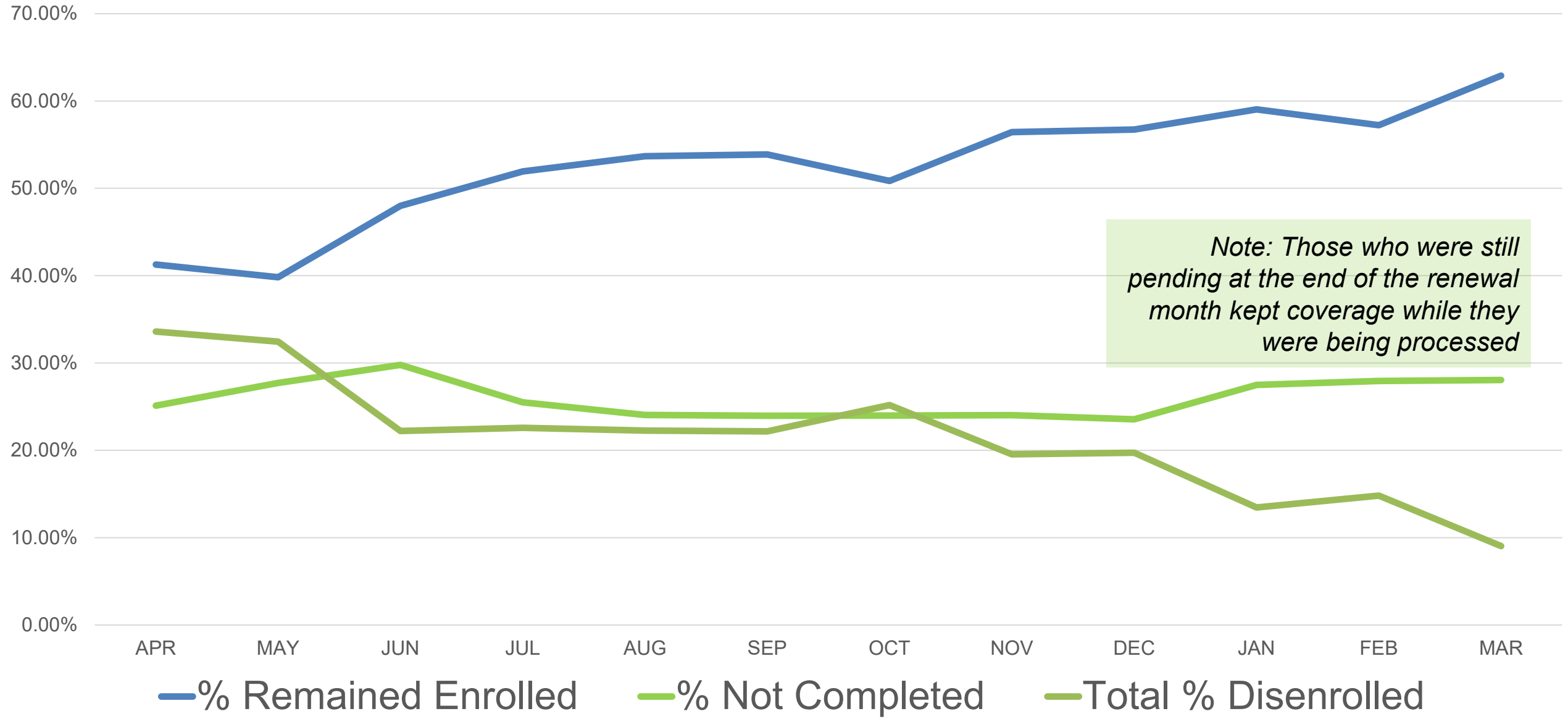
- The reconsideration period is still active for those who were due in February or March

Unwinding Renewal Activities

- Of those disenrolled for procedural reasons, our data shows that an average of 35% were known to have other insurance coverage

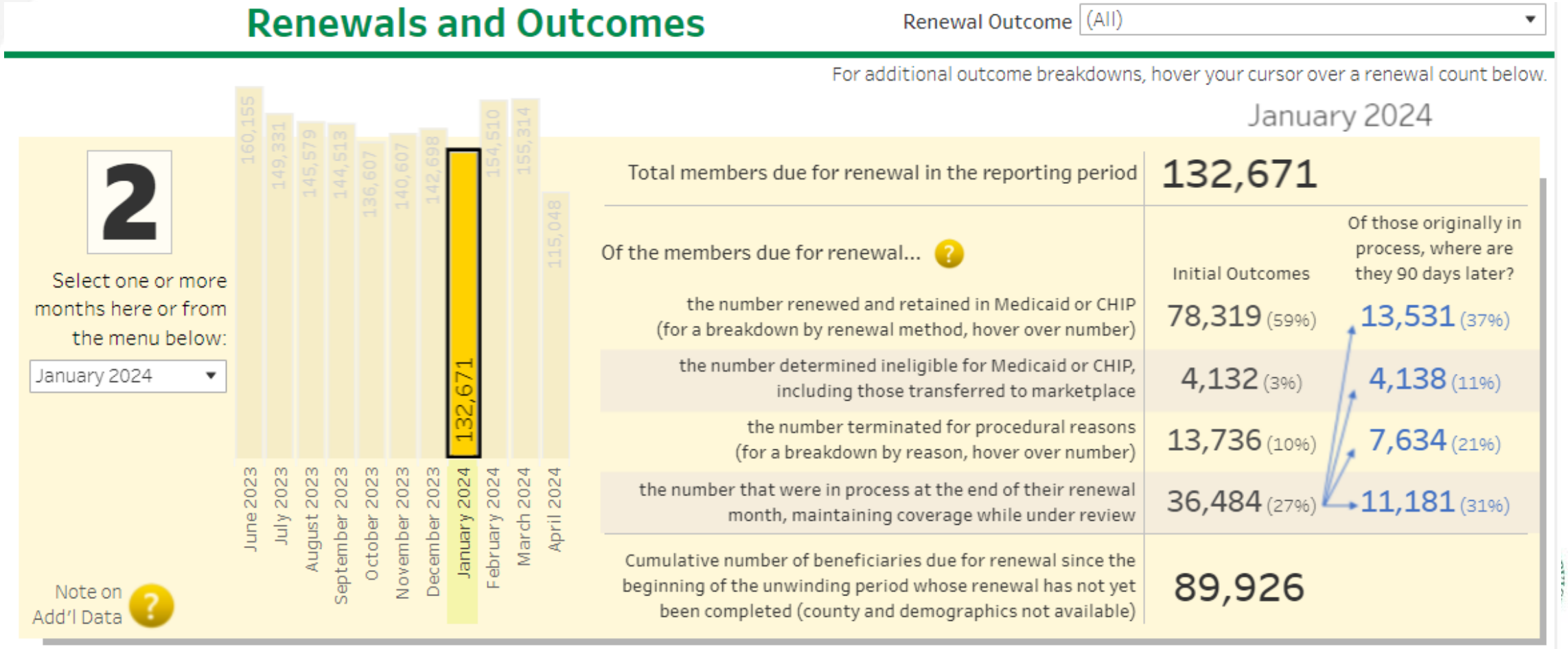
- Indiana (along with Tennessee) adopted the highest number of 1902(e)(14)(A) Unwinding waivers among all states and territories
  - We adopted 15 waivers/flexibilities to increase successful renewals and decrease procedural terminations

Unwinding Renewals

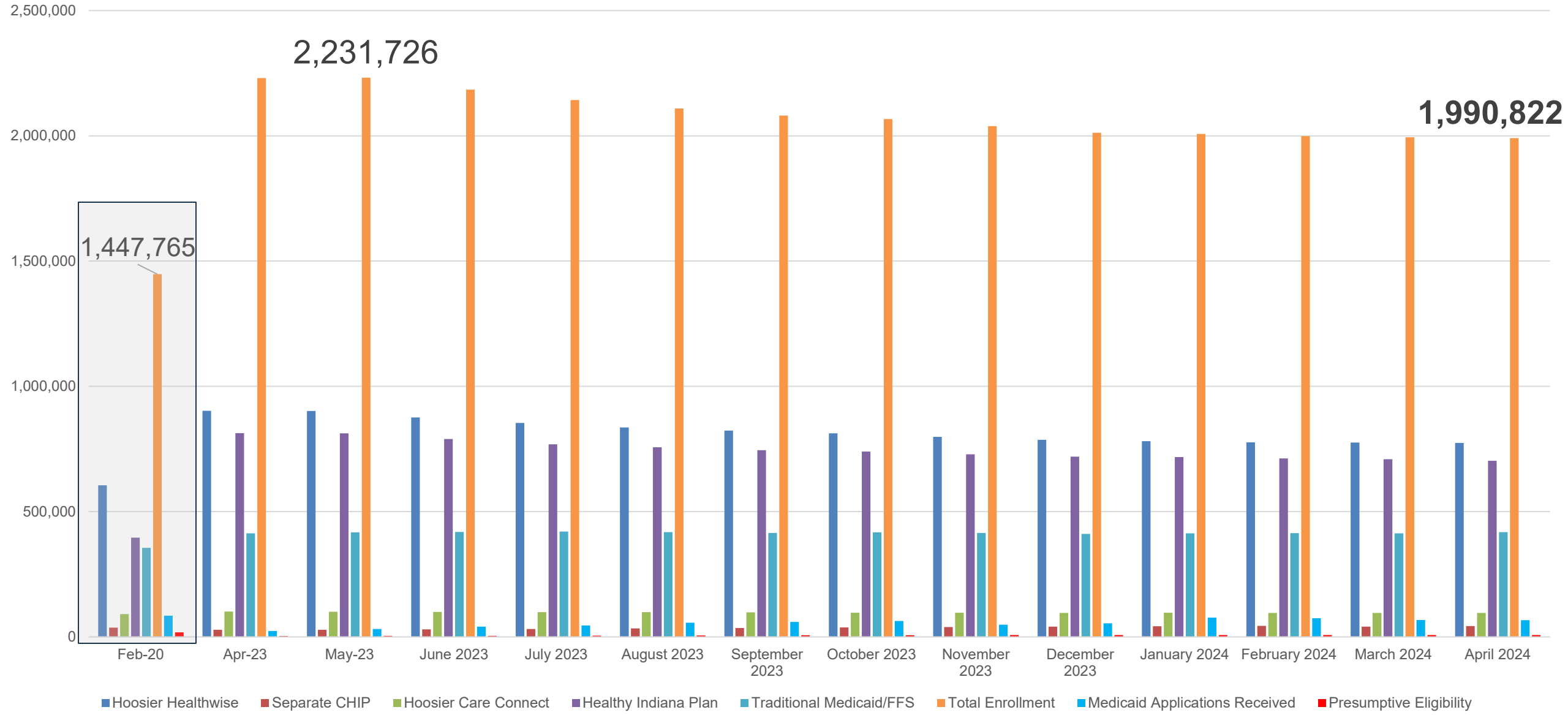


Note: Those who were still pending at the end of the renewal month kept coverage while they were being processed

New: We are now also reporting to CMS on the outcomes (90 days later) for those who were still pending at the end of their renewal month. You can find this information for applicable months on our Renewals and Outcomes dashboard.



Medicaid Enrollment Change during Unwinding



Outreach Efforts: April 2023 - March 2024

FSSA made 5 to 7 contact attempts to individuals due for redetermination who did not qualify for auto-renewal

	Outreach Method	Items Sent
Advanced Outreach	Postcard	700,000
	211 Outbound Call	49,357
Total Outreach	Warning Letter	535,347
	Renewal Packet (households / members)	900,168 / 1,206,266
	Text Message	323,997
	DFR Outbound Call	169,628
	Email	141,759
	Postcards Utilizing BMV Data	80,242

Data Notes:

- Postcards were sent to all PHE-protected members, who would have lost coverage during the PHE except for the special PHE flexibilities, and 211 Outbound Calls were made to all PHE-protected Fee-for-Service members
- Warning letters are sent to PHE-protected members two months before their redetermination paperwork is due
- Renewal Packets are sent to households (members) who do not qualify for ex parte (auto) renewal over a month before their redetermination paperwork is due
- Text Messages are sent to all members who must return their renewal packets, a month before their packets are due
- Outbound Calls are made and Emails sent to members who have not returned their renewal packets after the official redetermination due date but prior to the end of the renewal month
- Postcards Utilizing BMV Data were sent to members in July 2023 to confirm the address information obtained from the Indiana Bureau of Motor Vehicles (BMV)
- The tables above do not include manage d care entity (MCE) outreach, except for the postcards. In January 2023, MCEs sent postcards to PHE-protected members to prompt them to update their contact information. MCEs are also doing monthly outreach to those who receive renewal packets and those who no longer have coverage
- FSSA is also providing hospitals, nursing facilities, and other health care providers with a list of PHE-protected patients/ residents to aid in further targeted outreach efforts

Take action now to keep health care coverage!

What should you do? Anyone who is currently in one of Indiana Medicaid's health coverage programs, including the Healthy Indiana Plan, Hoosier Healthwise or Hoosier Care Connect, **should take action now to help stay covered**. Update your contact information!

- Go to **FSSABenefits.IN.gov**
- Scroll to "Manage Your Benefits" section
- Click on either "Sign in to my account" or "Create account"

Watch your mail! Be sure to respond with any info you're asked for. Need help updating your address? Call 800-403-0864.

HIP HEALTHY INDIANA PLAN

Hoosier Healthwise

Hoosier CARE CONNECT

WHAT TO DO IF YOU'VE LOST MEDICAID COVERAGE

- Call the Indiana Division of Family Resources at **800-403-0864**. If you lost coverage in the last 90 days because you didn't receive or respond to requests for information, we may be able to restart coverage without you having to re-apply.
  - » Children may remain eligible, even if parents are not, so check on your children's coverage and redetermination dates.
- If you have a medical emergency and need coverage, ask your doctor or hospital about Presumptive Eligibility, which can provide temporary Medicaid, if eligible.

  SCAN HERE FOR THE IHCP PROVIDER LOCATOR
- Check the federal marketplace at www.healthcare.gov to see if you qualify for low-cost health insurance.
- If it has been more than 90 days since you lost your coverage, reapply at https://fssabenefits.in.gov/bp.

  SCAN HERE FOR THE FSSA BENEFITS PORTAL
- If you are 65 or soon will be, you may be eligible for Medicare. Find out more at www.medicare.gov/basics/get-started-with-medicare or contact SHIP at **800-452-4800**.
- If you are employed, check with your employer about whether you are eligible for health insurance through the workplace.

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

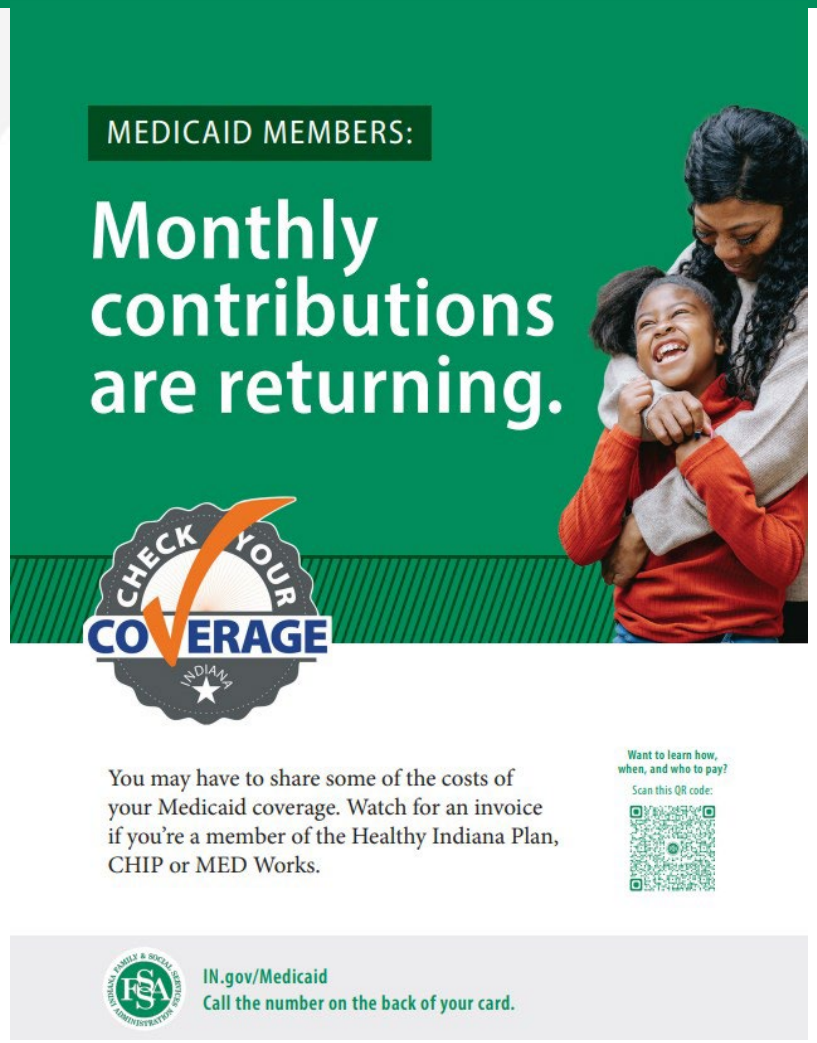
IN.gov/Medicaid

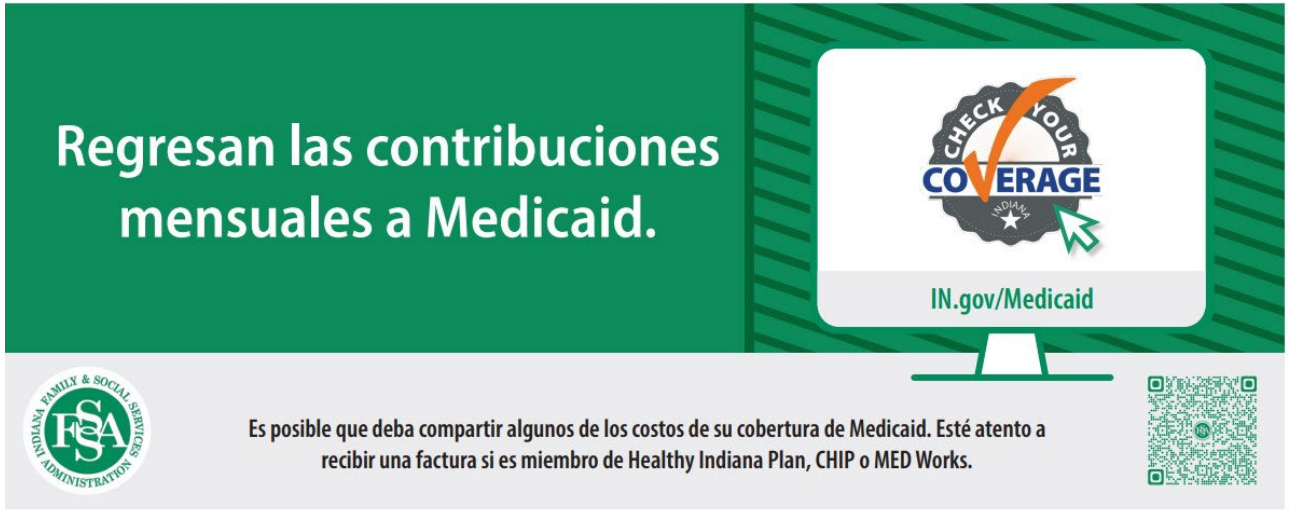
Cost-share Restart

Key dates

- **February 2024:** An updated insert was included in eligibility notices
- **April/May:** 60-day notification of cost share restart sent to members
- **June:** MCEs send notice alerting HIP members to watch for invoice arriving in early July
- **July:** Invoices will be sent in the first half of July for HIP, CHIP and MEDWorks for the month of August
- **July:** Co-pays active in HIP and CHIP

Cost-share Restart





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Indiana Health Coverage Programs (IHCP) Medicaid and CHIP Managed Care Quality Strategy

Medicaid Advisory Committee (MAC) Meeting

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
May 22, 2024

Medicaid Managed Care Quality Strategy Plan (QSP) Background

Federal regulations require State Medicaid agencies that contract with managed care entities (MCEs) to develop and maintain a quality strategy to assess and improve the quality of health care and services provided.

- The quality strategy is a **roadmap** to articulate the state's quality priorities
- The QSP directs the MCEs' **goals, objectives, and targets** for quality improvement to **support achievement of lower costs and better outcomes**

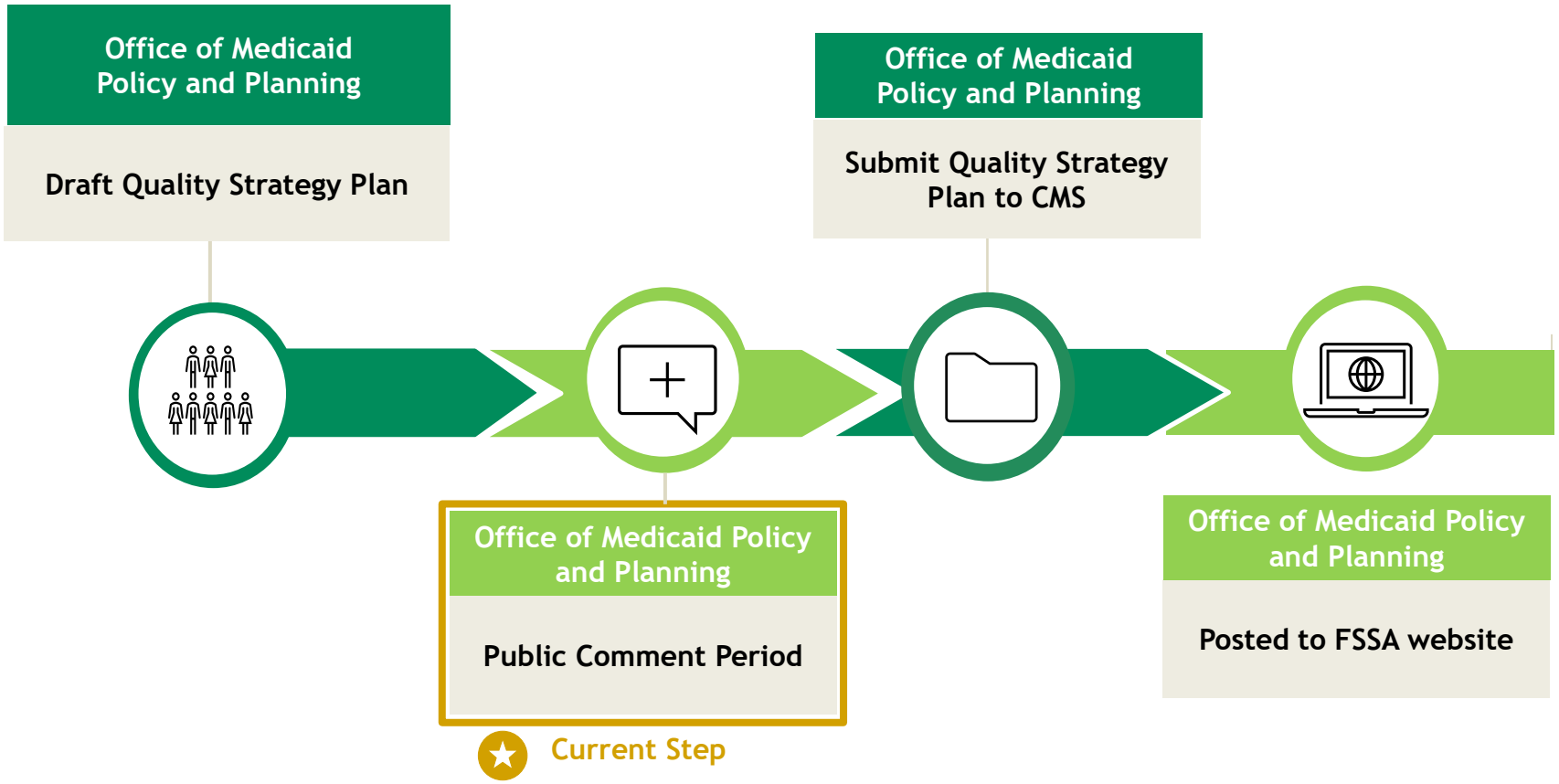
- States must **obtain input on the QSP** from participants and key stakeholders
- States must **post the QSP for public comment** before finalizing and submitting to CMS

- The QSP must be **reviewed at least every three years*** or if there are **significant changes** to the state's managed care program

**OMPP typically reviews the quality strategy every year; the 2024 IHCP Quality Strategy is the state's formal three-year submission to CMS.*

Sources:
42 CFR 438.340 https://www.law.cornell.edu/cfr/text/42/438.340
https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html

Quality Strategy Plan Development Steps



*The 2024 Managed Care Quality Strategy is **currently posted online for public comment (from April 24, 2024 to May 24, 2024)** on the Quality and Outcomes Reporting website: https://www.in.gov/fssa/ompp/quality-and-outcomes-reporting/*

2024 IHCP Quality Strategy: Key Changes

PathWays for Aging Implementation

- Added goals, objectives, and other Quality Strategy requirements related to implementation of the PathWays for Aging program which launches on July 1, 2024

Quality of Care Revisions

- Revised overall goals and objectives for all Indiana Health Coverage Programs
- Outlined new state-directed Performance Improvement Projects (PIPs)
- Outlined Pay for Outcomes (P4O) measures
- Established health priorities for improvement

Quality Management Structure Updates

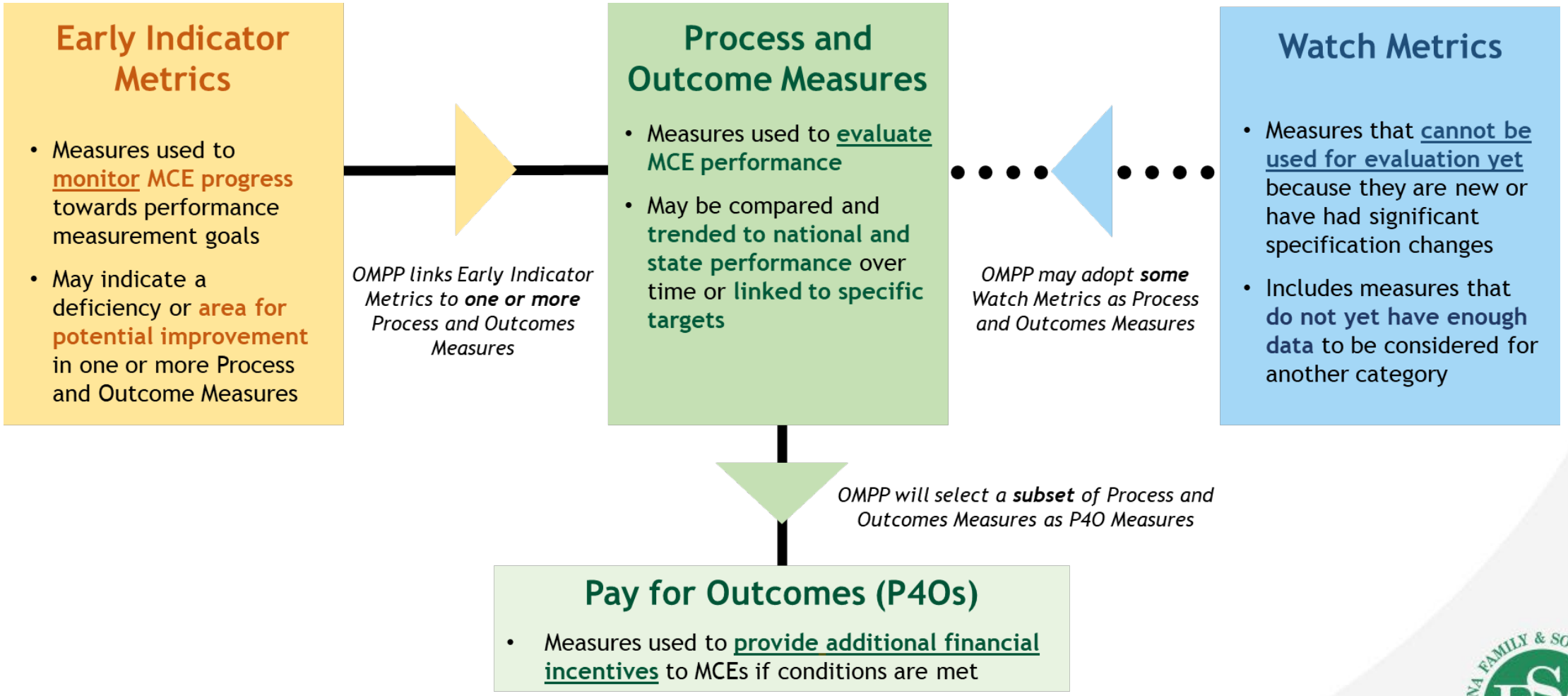
- Enhancements to performance monitoring
- Formed collaborative Interagency Quality Workgroup

Additional information about quality measure categories on next slide

PIP – A plan to remediate an identified program deficiency in response to a sanction or action by the State involving a process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

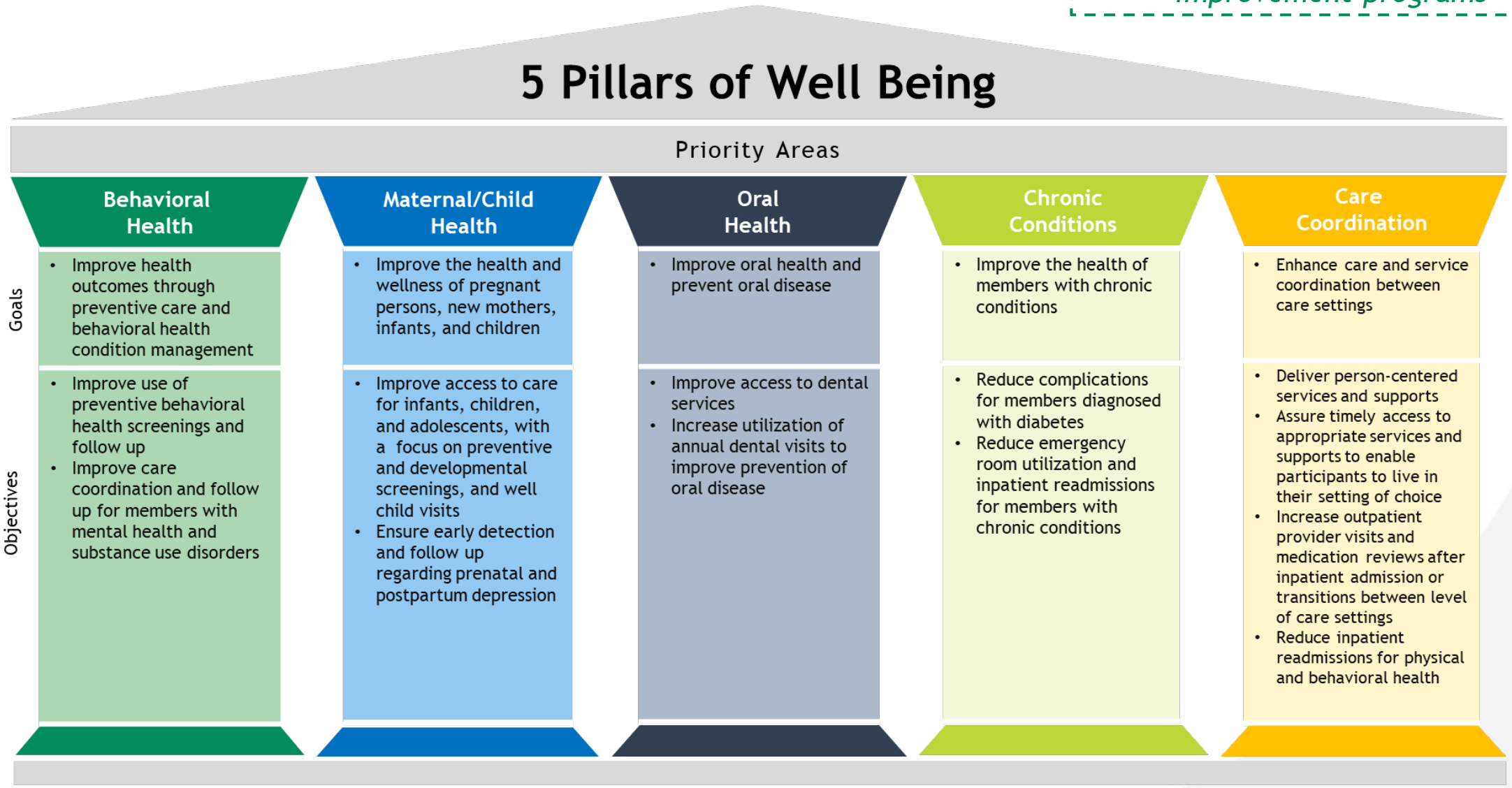
P4O - quality measures that OMPP has determined MCEs may receive additional compensation if certain conditions are met.

Quality Measure Categories



2024-2027 Quality Strategy Priorities

MCEs are expected to incorporate the Five Pillars into their quality improvement programs



Questions and Next Steps

- **Any questions?**
  - Feedback or concerns can be shared with Kathleen.Dillinger@fssa.IN.gov

- **Next Steps:**
  - Public comment period ends May 24, 2024
  - OMPP will review comments and revise QSP as necessary based on feedback
  - QSP will be formally submitted to CMS for review

Medicaid Advisory Committee(MAC) Meeting

May 22, 2024

Contents

- Enrollment
- Readiness Review
- Claims Testing
- Complex Care Transitions & Service Coordination
- Resources and Stakeholder Engagement

PathWays Enrollment

Enrollment Activities

May 2024	June 2024	July 1, 2024
• Members receive 60-day PathWays enrollment notice with plan benefit and contact information.	• Members receive Welcome Packet from assigned health plan.	• PathWays coverage becomes effective (and changes from FFS or HCC).

How to Change MCE Assignments?

Current Medicaid enrollees were sent an enrollment letter in the mail in late February and March with details on how to enroll with a health plan.

60-day go-live letter sent to PathWays members with assigned health plan and details on how to change their health plan.

Letter included the Indiana PathWays for Aging helpline number for the enrollment broker - **87-PATHWAY-4 (1-877-284-9294)** and a health plan comparison chart.

Individuals can call the helpline for assistance enrolling in a health plan OR they can go to the health plan websites to for more information.

Individuals with no health plan by 4/30/2024 were auto assigned to a health plan in May.

Individuals can change their health plan anytime between now and up to 90 days after go-live.

Member Choice

- Member **always** has the right to choose their PathWays health plan.
- If they did not choose by the end of April, FSSA assigned them to an MCE
  - If the member is enrolled in a Dual Special Needs Plan (D-SNP) sponsored by a Pathways MCE or parent company, they will be auto-assigned to an aligned PathWays plan
  - Auto Assignment Logic:

Auto Assign – Default when they do not fall into any of the criteria below
Auto Assigned - Previous RCP
Auto Assignment - DSNP Current or Future Medicare Plan C MCE
Auto Assignment - On Going Managed Care MCE
Auto Assignment – Primary Medical Provider (PMP) selection Last 365 days
Auto Assignment - Prior DSNP Medicare Plan C MCE
Auto Assignment - Prior MCE Last 90 days

Changing MCEs

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)

PathWays Readiness Review

What is Readiness Review

A systematic large-scale review of MCE staffing, policies and procedures, processes, documents, member and provider communication, subcontracts, system capabilities, and provider network to ensure the health plan is prepared in advance of the new contract go live

Safeguards that the selected MCE is ready to accept enrollment, provide the necessary continuity of care, ensure access to the necessary spectrum of providers, and fully meet the diverse needs of the population

Readiness reviews includes both desk review of MCE documentation as well as onsite demonstrations of MCE capabilities

Readiness Overview

As outlined in § 42 CFR 438.66(d), the OMPP MCE readiness review assesses the ability and capacity of the MCE to perform satisfactorily for the following areas:

1. Operations/Administration, including—
   a. *Administrative staffing and resources.*
   b. *Delegation and oversight of MCE, PIHP, PAHP or PCCM entity responsibilities.*
   c. *Enrollee and provider communications.*
   d. *Grievance and appeals.*
   e. *Member services and outreach.*
   f. *Provider Network Management.*
   g. *Program Integrity/Compliance.*

2. Service delivery, including—
   a. *Case management/care coordination/service planning.*
   b. *Quality improvement.*
   c. *Utilization review.*

3. Financial management, including—
   a. *Financial reporting and monitoring.*
   b. *Financial solvency.*

4. Systems management, including—
   a. *Claims management.*
   b. *Encounter data and enrollment information management.*

PathWays Claims Submission Testing

SB 132: Claims Testing Overview

- OMPP and Pathways MCEs are conducting a claims submission testing period before PathWays implementation
- OMPP has convened a workgroup for purposes of this section. Workgroup members include OMPP, representatives of Pathways MCEs, and provider representatives.
- The workgroup is charged with the following:
  - ✓ Developing a uniform billing format to be used by the Pathways MCEs
  - ✓ Seeking and receiving feedback on the claims submission testing period.
  - ✓ Advising OMPP on claims submission education and training needs of providers participating in the PathWays program.
  - ✓ Developing a policy for defining "claims submitted appropriately" for the purposes of emergency financial assistance.

Claims Testing Progress

- The first testing window was April 29 through May 10, 2024.
- A second testing window is underway now through May 31, 2024. Providers should register for claims testing with each MCE as follows:
  - Anthem
    - Register using the online Anthem claims testing registration form available in the Medicaid bulletin. For questions, email INLTSSClaimsTesting@anthem.com
  - Humana
    - To register, email HumanaHealthyHorizonsIndianaClaimsTesting@humana.com
  - UnitedHealthcare
    - To participate, email inclaimstesting@uhc.com
- MCEs will provide support and technical assistance to providers before and during the claim submission testing period. MCEs jointly hosted three webinars to orient providers to the testing process. The link to the recorded version of presentation is available on the PathWays Stakeholder Engagement Website.

PathWays Complex Care Transitions & Service Coordination

How will PathWays support Members?

- *<u>Enrollment Broker</u>: To help members choose a managed care entity, just call 877-284-9294*
- *<u>Care Coordinator</u>: To support member health care needs*
- *<u>Service Coordinator</u>: To support member waiver needs*
- *Assistance with navigating both Medicaid and Medicare benefits*
- *<u>Member Support Services Vendor*</u>: Helps members or caregivers resolve issues they may experience while enrolled in PathWays*

* This is in addition to the Long-Term Care Ombudsman

Care Coordination Structure

- All members must be offered person-centered Care Coordination (CC) reflective of their needs to assist them in planning, accessing, and managing their health care and health care-related services
- MCEs must have, at minimum, two levels of CC:
  - Care Management (available to all members); and
  - Complex Case Management (for members with high risk/high needs)
- For members receiving LTSS in NFs or HCBS, MCEs must provide Service Coordination in addition to Care Coordination
  - Members receiving HCBS in the community must be in Complex Case Management as well
- Will ensure that acute/primary AND HCBS needs are addressed and coordinated

Service Coordination

- Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of each member.
- The Service Coordinator is responsible for the development and implementation of the LTSS-specific Service Plan.
- In addition to Care Coordination services, all members who are determined Nursing Facility Level of Care (NFLOC) and receive HCBS or institutional LTSS will receive Service Coordination for their LTSS and related environmental and social services.
- Service Coordination specifically focuses on supporting members in accessing long-term services and support, medical, social, housing, educational, and other services, regardless of the services' funding sources.
- All members receiving Service Coordination will have an assigned Service Coordinator who works with the member's Care Coordinator to ensure cohesive, holistic service delivery

Transition of Care – Continuity of Care

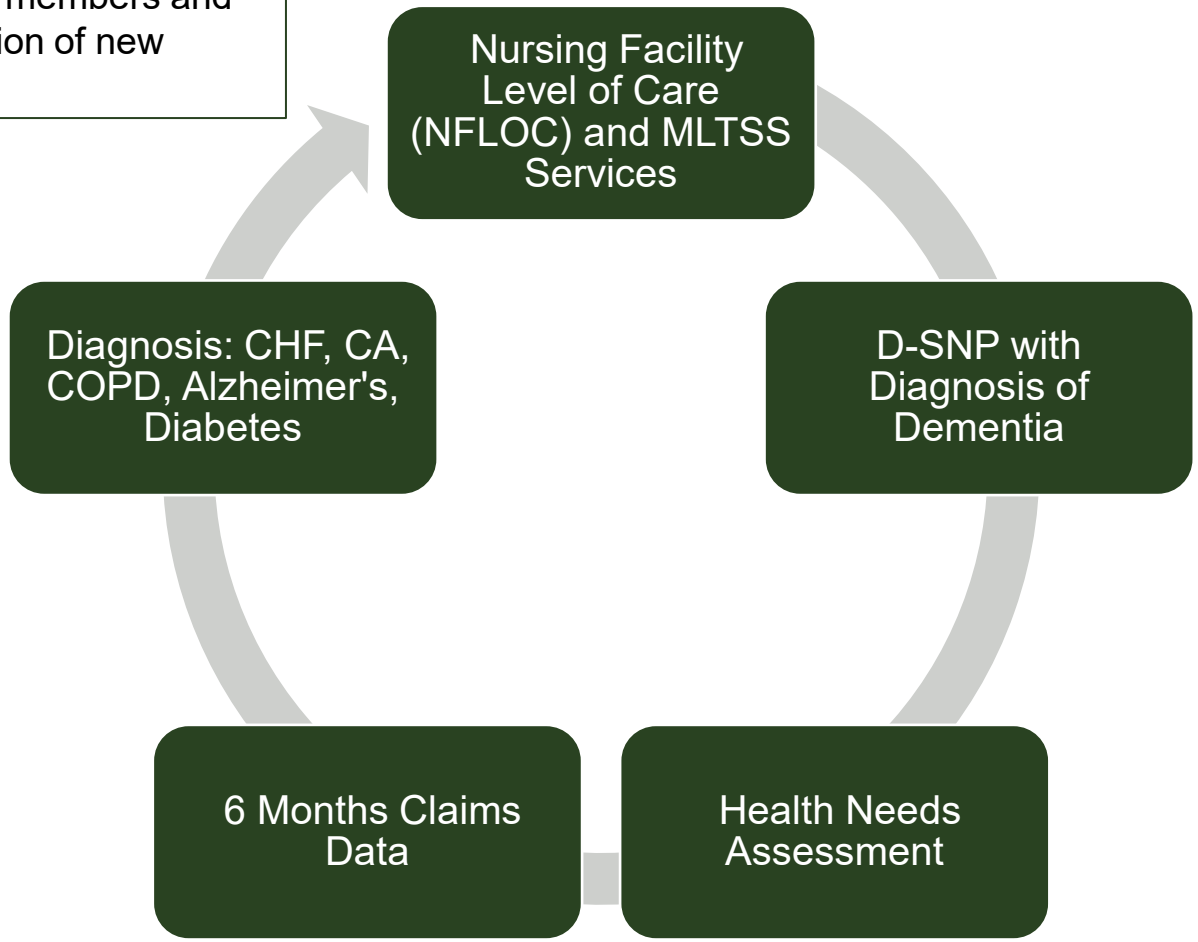
MCEs have received the following data to facilitate a smooth transition of members:

- Member data
  - 6 months of claims data
  - Diagnosis
  - Hospitalizations
  - Emergency room visit history
  - High dollar – over $50k
  - Existing service plan
  - Existing assessment and level of care assessments
  - Existing authorizations – Medical and MLTSS and HCBS

- MCEs are currently initiating the member stratification and engagement process

MCE Identification of Complex Care Members

Transition of existing members and continuous stratification of new eligible members



Resources and Stakeholder Engagement

Member & Provider Engagement

Member	Provider

• Member handbook and welcome packet
• Introduction phone calls
  • Identify language preferences
  • Introduce care team
  • How to reach care or service coordinator
• Reviews service plan
  • Upcoming appointments
  • Medications
  • Member needs and priorities
	• Provide continuity of care authorizations starting 7/1/2024
	• Coordinate care as required by the established service plans
	• Ongoing provider engagement and communication

Upcoming Stakeholder Engagement

Upcoming Stakeholder Engagement				
Event	**When**	**Where**	**Topic(s)**	**Audience**
PathWays Stakeholder Update	June 7	Virtual	PathWays Readiness	Consumers, providers, associations, advocacy orgs, etc.
Provider Education	June	Virtual	Authorizations	Providers

Stakeholder engagement presentations and recordings can be found here: https://www.in.gov/pathways/stakeholder-engagement/

More Information/Resources

- Check out the IN PathWays website at www.IN.gov/Pathways