

LeadingAge Indiana involvement

LeadingAge Indiana (LAIN) has been deeply involved in the mLTSS project since the FSSA announcement on December 29, 2020. LAIN has attended hundreds of virtual and in-person meetings since then and currently sit on the mLTSS steering committee which meets with FSSA and other stakeholder groups roughly every week. This group includes the other two LTC trade associations, the two hospital trade associations, the state’s actuaries and accountants and representatives from FSSA. LAIN has also provided pubic testimony, written letters to regulators, and have spoken to legislators on this and related topics. All trade associations have, at one point or another, have been joined by individual provider representatives to provide anecdotal expertise to the discussions. We have made a lot of progress trying to shape the best path forward but there is still a fair amount of work to be done and details to be fleshed out.

Medicaid Managed Care of Long-Term Services and Supports (mLTSS)

* Program Timeline
	+ For the full RFP see [Risk-Based Managed Care LT Services and Supports](https://www.in.gov/idoa/proc/solicitations/files/0000072118.zip) zip file;
	+ RFI Co-Design and Finance Workgroups: January 2021 through the present;
	+ RFI Release: July 2021;
	+ RFP Release: June 2022;
	+ RFP Award to four (4) MCEs (Anthem, UHC, Humana): March 2023;
	+ Contracting/Readiness/Implementation: Throughout 2023 – 2024;
	+ Tentative Implementation Date: July 1, 2024.
* Program Design:
	+ The mLTSS program will include primarily three populations of Medicaid-eligible seniors who receive services in nursing facilities or through home and community-based services (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.
		- LTC resident populations under 60 will not move to managed care but will remain in the state’s current fee for service programs. FSSA intends to implement insurance contracts for managed long-term services and supports (LTSS) in the first quarter of 2024. This move will apply to most Medicaid-eligible seniors who receive services in nursing facilities or through home and community-based services (HCBS) Aged & Disabled waiver programs.
	+ FSSA also intends to push at least 75% of all new LTSS entrants into HCBS providers (and away from skilled nursing care) – also starting in July 2024. This is known as rebalancing. FSSA will not be forcing current residents who wish to stay in their current placements to rebalance out of skilled care.
	+ FSSA/the state has stated in public documents that this effort will lead to better quality outcomes, more choice for senior Hoosiers, and significant cost savings over time.
		- FSSA has also struggled to answer capacity (number of available providers and workforce concerns) and access (same) questions from industry stakeholders. They seem to believe that those issues will be resolved through the application of marketplace principles over time.
* Program Financing:
	+ FSSA’s reimbursement proposal is described in the following text and the [attachment from FORVIS](file:///H%3A%5CForvis%20MLTSS%20rate%20change%20summary%20%28March%202023%29.pdf).
		- To some degree (hopefully limited), there will be winners and losers. It is unclear who these folks are at present..
			* FSSA has also promised to conduct a number of regional training sessions through or the state in 2023 and 2024 to better answer individual questions.
	+ Rate change basics.
		- Current - Cost-based system/ resident focused
		- Old (current) rate =

Direct care (using RUGS IV for staffing [adjusted for CMI quarterly]) +

Indirect care (Plant op., maint., housekeeping, social services, etc.) +

Administrative +

Therapy costs +

Capital costs +

Any add-ons (ventilator units & dementia/memory care units.) +

Quality add-on(s) earned by providers via QM achievements +

Guaranteed IGT payment (payed quarterly as a function of a Medicare – Medicaid supplemental payment program)

* + - Future – more price based and facility specific rates
		- New (future) rate =

Bucket 1 … Direct care floor (will continue to use RUGS IV (no moving to PDPM for now) staffing – 95% of direct care cost floor) +

* Base rate will be adjusted every 6 months

Indirect care +

Administration +

Therapy costs +

Capital costs +

Any add-ons (ventilator units & special care unit billed with a separate modifier.) +

Bucket 2 … a % of the guaranteed IGT payment (payed q’ly as a function of a Medicare – Medicaid supplemental payment program) +

Bucket 3 … an “at risk” IGT payment based on earned by providers via new VBP/QM achievements (payment frequency is still TBD).

Buckets 2 and 3 will shift in percentages over time with year 1 being a small percentage of “at-risk” IGT dollars (10%) and over time (5 years), the percentage will be 20%. That is, each of the new 5 VBP metrics (Hospital readmissions, ER visits, Falls, Pressure Ulcers [80%] + a Staffing Metric based on retention of w-2 employees [20%]).

* For all QMs, there will be a floor where a provider might not qualify in that category.
* Providers should be advised to focus on these metrics as they will drive future IGT / UPL payments.
	+ Other notable items:
		- Provider tax (QAF) – no change from today.
		- All available IGT dollars will be paid out to providers (no reversion to state general fund).
		- Quality committee will be established to periodically review (and possibly alter) individual QMs.
	+ Steering Committee meetings are ongoing on the overall reimbursement proposal and related details.
* Foreseeable mLTSS challenges:
	+ All transitions are hard and messy. This will be no different.
	+ FSSA’s rebalancing target percentages and implementation timelines still feel very aggressive.
	+ Staffing challenges and disruptions related to this sort of systemic upheaval have not been adequately addressed by FSSA. HCBS providers report that the system is already extremely understaffed.
	+ Administrative burdens of dealing with 3 different Medicaid MCEs + FSSA (for those LTC residents who are under 60) will be unavoidable and potentially dramatic. Think – prior authorization, claims payment and processing, and other differences.
	+ Resident enrollment changes might be disruptive to cash flow concerns.
	+ Census – although it would appear to have stabilized a bit (certainly from 2020), attracting rehabilitation and long-stay residents remains a challenge;
	+ Appropriate Medicare / Medicaid patient mix – always a challenge;

**Industry Future:**

CMS and Indiana (via mLTSS) are pushing care away from congregate care settings into more HCBS – or home-based care settings. Congregate care settings will not be going away, however. Still, given the push to HCBS care, providers would be well advised to engage in revenue diversification and other financial decisions. Options:

* Look into expanding existing AL portfolio;
* Consider expanding memory care space – but only if there is regional market demand and staffing to support it. Data suggests for profits are aggressively pursuing this area.
* Look into creating IL portfolio;
* Consider CCRC status / take advantage of CCRC tax treatment;
* Create a home care or similar ADL services line/subsidiary if possible;
	+ Might include a hospice subsidiary and/or other non-bricks and mortar service entities
* Consider joint ventures with other AL, HCBS, SNF entities;
* Consider intergenerational partnerships.