Medicaid Finance Workgroup

Date

Thursday, March 18th 2:30-3:30pm, virtual meeting

Presenters

- Kathy Leonard, Director of Reimbursement and Actuary, Office of Medicaid Policy and Planning

Learning Topics

Rate Setting Overview: Presentation by Kathy Leonard

- Rating Anomalies
- How Different Provider Rates are Set
- Supplemental Payments for Nursing Facilities – Rationale and Considerations
- How Capitation Rates Work

Agenda

1. Introduction
2. Provider Rate Setting: Base Rates and Supplemental Programs
3. Capitation Rate Setting
4. Rating Issue Examples
5. Next Steps

(a copy of the presentation is provided with these minutes)

Summary of important facts from the presentation

- State would like to avoid rating anomalies
- Provider rates can vary in complexity, but extra effort should provide a commensurate benefit
- Capitation rates are set using combined data from all health plans, but may vary based on acuity
- State has identified issues with some rates in advance

Questions/Answers

Indiana Hospital Association: Have you determined which populations this will apply to?

FSSA: The State is near a final recommendation. The groups will probably be individuals over 60, dual eligible beneficiaries, Medicaid only beneficiaries, and individuals over 60 and on waiver. The population can be described generally as individuals over 60. This will be covered at an upcoming RFI Codesign Meeting.

Indiana Association of Area Agencies on Aging: Rate setting happens in negotiation with managed care entities (MCEs), but the State will not select MCEs for at least another year. Regardless, the State needs to get started on rate setting. How does the timeline work?

FSSA: The State will start on provider reimbursement now. This information is needed before the State can do the capitation rates. The State negotiates with MCEs on capitation rates just as they do with other providers.

Indiana Association of Area Agencies on Aging: In home health, things are based on cost reports that are restrained by reimbursement. Some of the rates still have not reached a point where they are competitive enough to ensure a sufficient workforce. How can we push that competition? How can we make the home health agency be the employer of choice to make this system transformation happen?

FSSA: The State heard this concern during the home and community-based services (HCBS) waiver rate-setting process and understands there is a lot of pressure around wages. That is part of what the State will have evaluate. There may be the opportunity to evaluate the issue soon with relief dollars. The State is also concerned about sustainability of the program and workforce. We hope wage pressure will moderate post COVID, but we are setting the rates for further down the road. The labor component is important in all considerations.

AARP: With the conversation around the Upper Payment Limit (UPL) and what the Indianapolis Star has been reporting, can the State help explain how this conversation fits in with that and provide a baseline understanding about what is being discussed in the article?

FSSA: UPL has received scrutiny in the press. We are aware we have issues we need to fix around transparency and ties to quality and were planning to address those before the project started. We would like to address those issues moving forward to make sure the program meets the objectives. The State sees supplemental programs as one component in a larger four-part plan, and we may plan to bring together separate funding streams. There will be a long runway for mLTSS but a quicker route to collaborate with long term care partners and hospitals to move towards transparency and to augment and amplify the work we are doing to drive quality outcomes.

Indiana Health Care Association: The program was always intended to benefit county hospitals and nursing facilities in a dual way. It both backfills funding gaps and keeps critical hospitals open. Nursing facilities are underfunded. Direct care staffing is the most expensive part of costs at 65%. There have been closures in Indiana of hospitals that were part of the supplemental payment

program because it was not enough to keep them going. The supplemental payment is not perfect, but it is a complex issue and there is nothing to be ashamed of. The presentation chart requires additional background. Quality benchmarks and performance benchmarks, negotiated between the hospital and the nursing facility, are used for these payments, so the poor performing facility will generally receive a lower payment. This program has created access in places of Indiana where there may not have been. The State could look at utilizing at a home health supplemental payment such as the one in Colorado.

FSSA: We need to look at our best opportunity to deliver a sustainable program. The State's first priority is to look at existing supplemental programs and get them moved over to managed care. We do not want to give the impression that we currently have the resources to expand supplemental payments to other areas. The State would like to do everything we can to support home health. The mechanism is unlikely to be through a supplemental payment.

Indiana Hospital Association: The county hospitals do use these funds to remain viable. It is important to keep money at the county hospitals.

FSSA: The State understands that many county hospitals may benefit from participation in the UPL program and would like to better understand the potential disruptions related to modifying the program.

Indiana Association for Home and Hospice Care: On the subject of modeling, some criticism of the overhead component of [home health] funding is understandable. I encourage the analysis to be done based on what it looks like for the 60 and over population. Likely, most of the extended hours care is for the younger population. The State will need to dial in on impact to the 60+ population specifically, including any potential negative impact.

FSSA: The State will need to decide if we will rate fee-for-service (FFS) and managed care the same or differently. We agree that the State needs address this and look at linkages between two sets of rates. We are planning to have a session to talk about nursing facility UPL program. The state is seeking interested participants for a brainstorming meeting discussing solutions, direction, and collecting thoughts at a more detailed level.

Closing comments

The State invites participants to join next Lunch and Learn opportunity. The state also asks for interested stakeholders to request an invitation to a future targeted listening session on the UPL. More details about these conversations will be available within the next few weeks.

Follow-up

Stakeholder participants may contact the Back Home Indiana email (backhome.indiana@fssa.in.gov) if they would like to be invited to Medicaid Finance focus group working sessions.

Stakeholder Attendees

- Ambre Marr, AARP Indiana
- Ben Harvey, Indiana Primary Health Care Association (IPHCA)
- Ellen Burton, University of Indianapolis Center for Aging & Community (UIndy CAC)
- Eric Essley, LeadingAge Indiana
- Evan Reinhardt, Indiana Association for Home and Hospice Care (IAHHC)
- JoAnn Burke. Indiana Commission on Aging
- Kelli Tungate, Caregiver Homes
- Kristen LaEace, Indiana Association of Area Agencies on Aging
- Michelle Stein-Ordonez, Indiana Association for Home and Hospice Care (IAHHC)
- Sarah Waddle, AARP
- Tauhric Brown, CICOA Aging & In-Home Solutions
- Teresa Lorenz, Thrive Alliance
- Terry Cole, Indiana Hospital Association
- Terry Miller, Hoosier Owners and Providers for the Elderly (HOPE)
- Zach Cattell, Indiana Health Care Association (IHCA)

FSSA Attendees

Allison Taylor, Andrew Bean, Anne Jacobs, Ben Mori, Cathleen Nine-Altevogt, Christine Mytelka, Dan Rusyniak, Darcy Tower, Derris Harrison, Elizabeth Peyton, Erica Ng, Jen Sullivan, Jesse Wyatt, Jim Pettersson, Kandace Alexander, Maggie Novak, Mary Pat Stemnock, Matt Foster, Natalie Angel, Paul Bowling, Sarah Renner, Shannon Effler, Steve Bordenkecher, Steve Gale, Vanessa Convard-Brinkley