

Rate Setting Overview

Long Term Supports and Services Stakeholder Finance Work Group

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
March 18, 2021



Why Reform Indiana's LTSS System?

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%. Indiana's disjointed system must be reformed to meet growing demand and to ensure Choice, drive Quality and manage Cost.

Choice: Hoosiers Want to Age at Home



- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing Long-term Sustainability



- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers Deserve the Best Care



- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

Indiana's Path to LTSS Reform

Our Objective

- 1) 75% of new LTSS members will live and receive services in a home and community-based setting
- 2) 50% of LTSS spend will be on home and community-based services

Key Results (KR*) to Reform LTSS

- 1 Ensure Hoosiers have access to HCBS within 72 hours
- 2 Move LTSS into an mLTSS model
- 3 Link provider payments to member outcomes (value-based purchasing)
- 4 Create an integrated LTSS data system linking individuals, providers, facilities, and the State

*All KR work will be coordinated with Medicaid supplemental payment reform and depends upon finalization of federal guidelines

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Rate Methodology Goals and Objectives

To develop rate methodologies that comply with Centers for Medicare and Medicaid Services (CMS) rules and achieve the following:

- 1. Alignment and Transparency** - bring continuity and alignment across the rate methodologies and rates for all programs, providing a consistent framework
- 2. Sustainability** - facilitate adequate participant access to services and be sustainable under the FSSA budget and operations
- 3. Promotion of Person-Centeredness and Value-Based Purchasing** - striving to align provider and participant incentives to achieve access to person-centered services, encourage appropriate utilization, and drive healthy outcomes for all Hoosiers that we serve



Agenda

- Introduction / Rating Anomalies
- Provider Rate Setting
 - Base Rates
 - Supplemental Programs
- Capitation Rate Setting
- Rating Issue Examples
- Next Steps

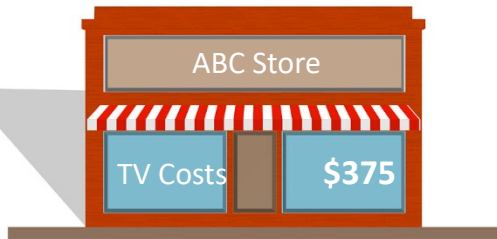


Actuarial Concept : Rating Anomaly

a-nom-a-ly – something that deviates from what is standard, normal, or expected

Rating Anomaly – Examples

Unexpected Pricing Combinations



Rating Anomaly – Examples

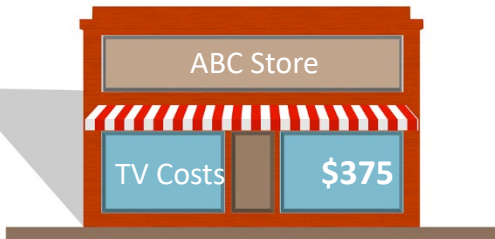
Unexpected Pricing Combinations



3 Ounces for
\$0.95



9 Ounces
for \$3.00



Rating Anomaly – Examples

Unexpected Pricing Combinations



3 Ounces for
\$0.95



20 Ounces
for \$1.64



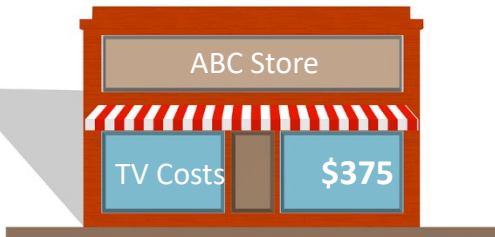
30 Ounces
for \$1.95



40 Ounces
for \$2.05



9 Ounces
for \$3.00



Home and Community-Based Services 2019 Rate Setting – Rating Anomalies

	Adult Day Service		
	Level 1	Level 2	Level 3
Current Rate (15 minutes)	\$3.06	\$3.06	\$3.06

	Case Management	
	A&D Waiver	TBI Waiver
Current Monthly Rate	\$150.00	\$100.00

Rating Anomaly #1

Same rate is paid for members that require different levels of service

Rating Anomaly #2

Different Rate is paid for same service

Rating Anomalies can result in some Medicaid enrollees experiencing additional challenges in accessing needed services.

Provider Rates

- Base Rates
- Supplemental Payments

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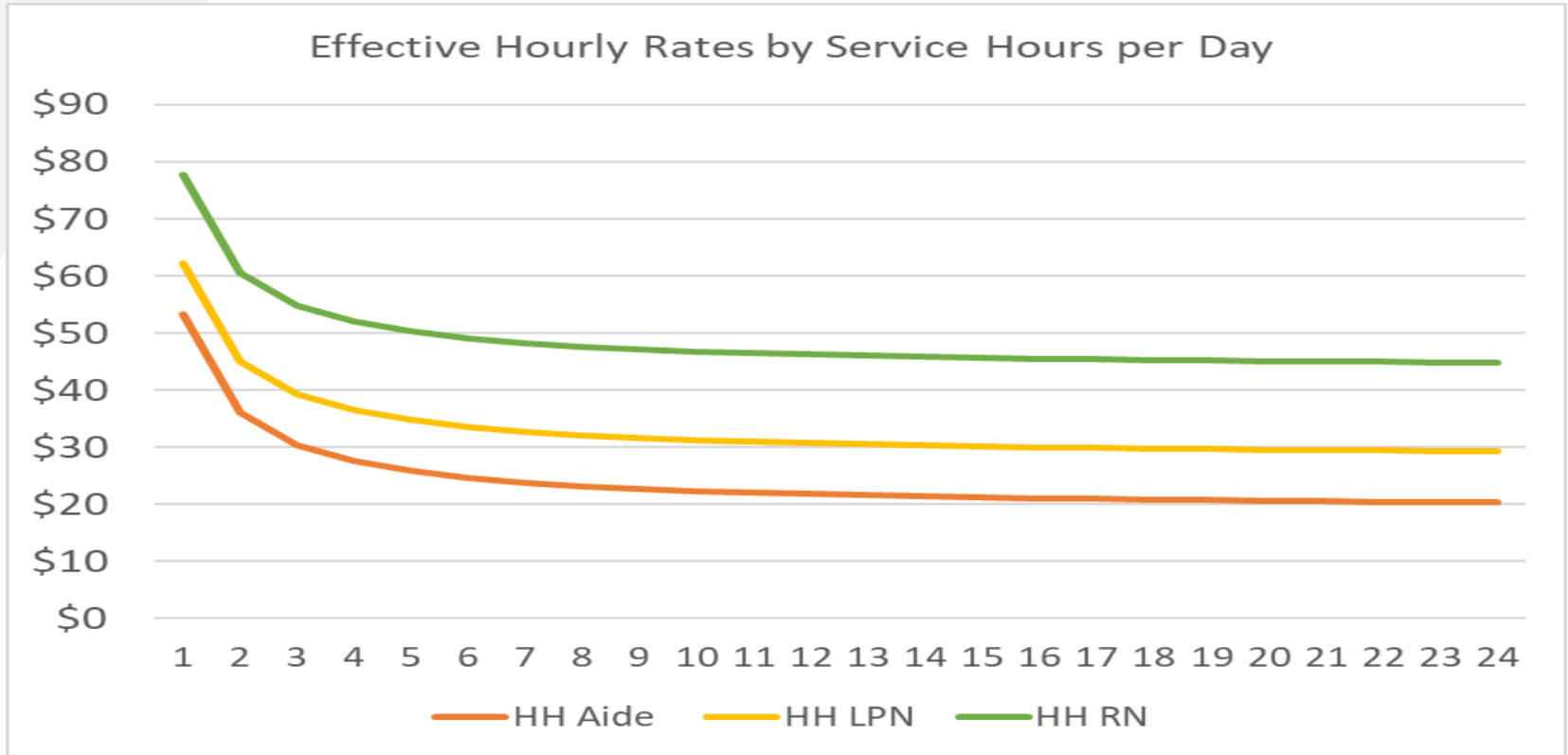


Provider Base Rates

Examples of Current Rating Methodologies

Less Complex		Moderate Complexity		More Complex
Hospice	Home Health	Adult Day Care	Assisted Living	Nursing Facility
Medicaid Rates aligned with Medicare Rates	Rates had been set using cost reports, are now frozen pending new methodology	Rates set using combination of provider surveys and data from US Bureau of Labor Statistics	Rates set as a composite of rates for similar HCBS services	Rates set individually for each of 500+ facilities based on cost report data

Provider Base Rates Home Health Services



	HH Aide	LPN	RN
Hourly Rate :	\$18.88	\$27.82	\$43.34
Plus Overhead			
Daily Rate:		\$34.50	



Provider Base Rates

Adult Day Service - Moderate Rating Complexity

Rate Component	Level 1	Level 2	Level 3	Note
Direct care worker wage	\$11.80	\$11.80	\$11.80	Default wage with 4% inflation
Staffing ratio	3.5:1	3.25:1	3:1	Informed by waiver requirements
Supervisor wages	\$15.75- \$31.16	\$15.75- \$31.16	\$13.49- \$31.16	Mix of BLS Indiana median wage for RNs, LPNs, Psychiatric Aides and Healthcare Support Workers with 4% inflation
Supervisor span of control	10:1-4:1	10:1-4:1	10:1-4:1	Mix of ratios by supervisor type
Labor cost	\$ 1.75	\$ 2.16	\$ 2.53	Default 19% benefits, 6% productivity and 3% PTO
Administration	\$ 0.44	\$ 0.54	\$ 0.63	Default 25% administration
Program support	\$ 0.10	\$ 0.13	\$ 0.15	Default 6% program support
Food cost	\$ 0.35	\$ 0.35	\$ 0.35	Based on \$12 per day
Proposed rate (15 minutes)	\$ 2.64	\$ 3.18	\$3.66	
Current A&D rate	\$ 3.06	\$ 3.06	\$ 3.06	
A&D rate Change	-13.6%	+4.1%	+19.6%	



Provider Base Rates

Assisted Living Rate Composite – Moderate Complexity

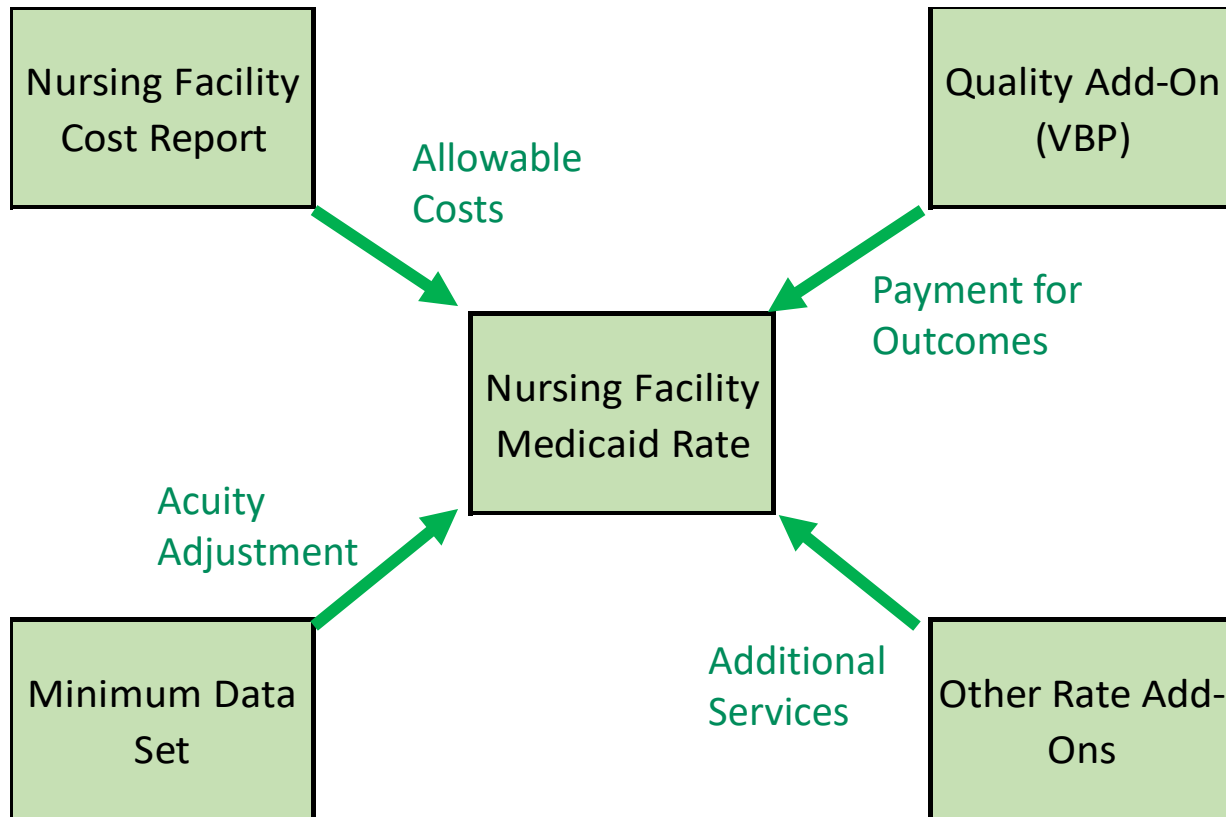
Attendant Care		Home Maker		Assisted Living (Level 2)	
Labor Cost: \$4.40	Administration: \$1.10	Labor Cost: \$3.66	Administration: \$0.92	Attendant Care – Agency (4 units)	\$23.28
Program Support: \$0.26	EVV ⁽¹⁾ : \$0.05	Program Support: \$0.37	EVV ⁽¹⁾ : \$0.05	Home Maker – Agency (4 units)	\$19.96
Total: \$5.82 (15 minutes)		Total: \$4.99 (15 minutes)		Skilled Nursing (1.5 units, mix of LPN and RN)	\$16.41
				Adult Day Service – Commercial (3 units)	\$10.20
				Meals (2 meals)	\$6.00
				Emergency Response (0.03 monthly units)	\$1.83
				Non Medical Transportation (0.3 trips, 2 miles per trip)	\$2.53
				Proposed Daily Rate	\$80.21
				Proposed Monthly Rate (29.7 days)	\$2,382.24

Respite - LPN		Adult Day Service (Level 2)	
Labor Cost: \$8.03	Administration: \$2.01	Labor Cost: \$2.16	Administration: \$0.54
Program Support: \$0.48	EVV ⁽¹⁾ : \$0.05	Program Support: \$0.35	Food: \$0.35
Total: \$10.57 (15 minutes)		Total: \$3.40 (15 minutes)	



Provider Base Rates

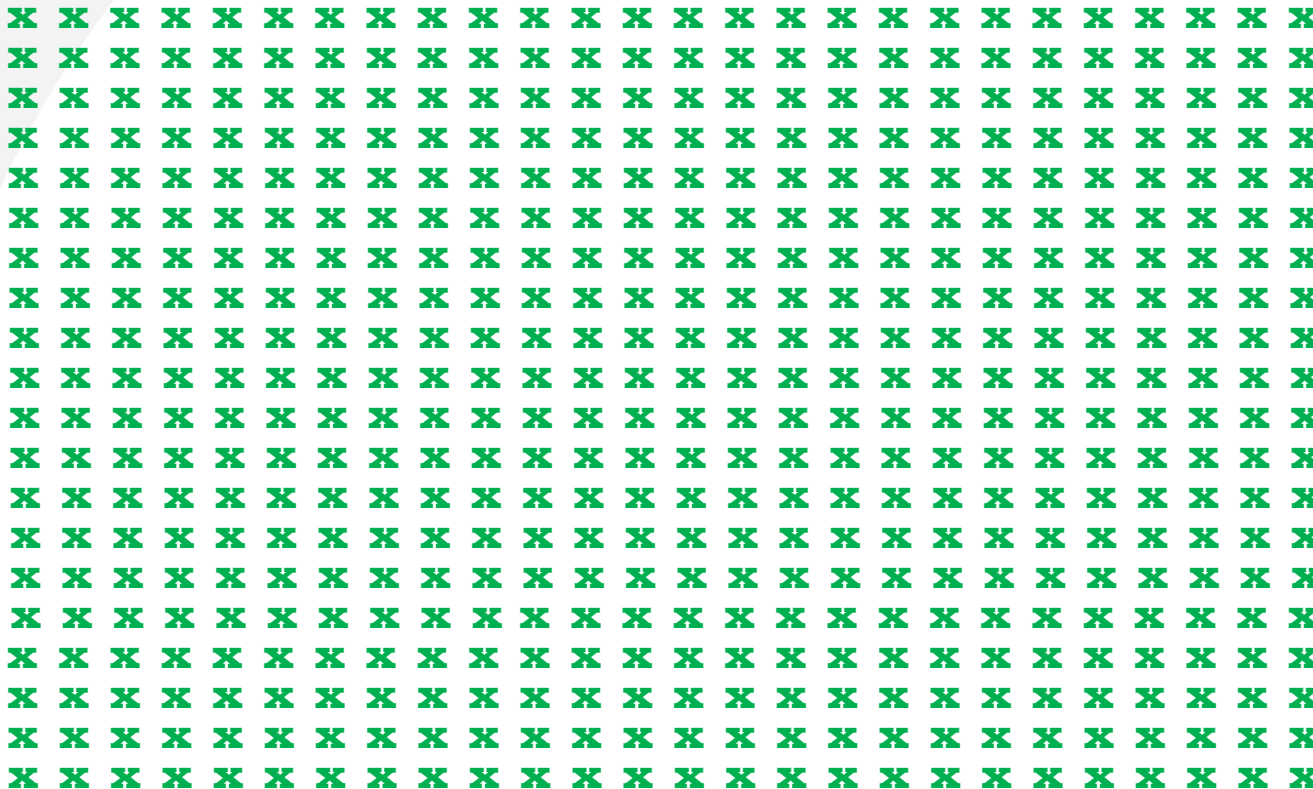
Nursing Facility – Most Complex



Provider Base Rates

Nursing Facility – Most Complex – Most Labor Intensive

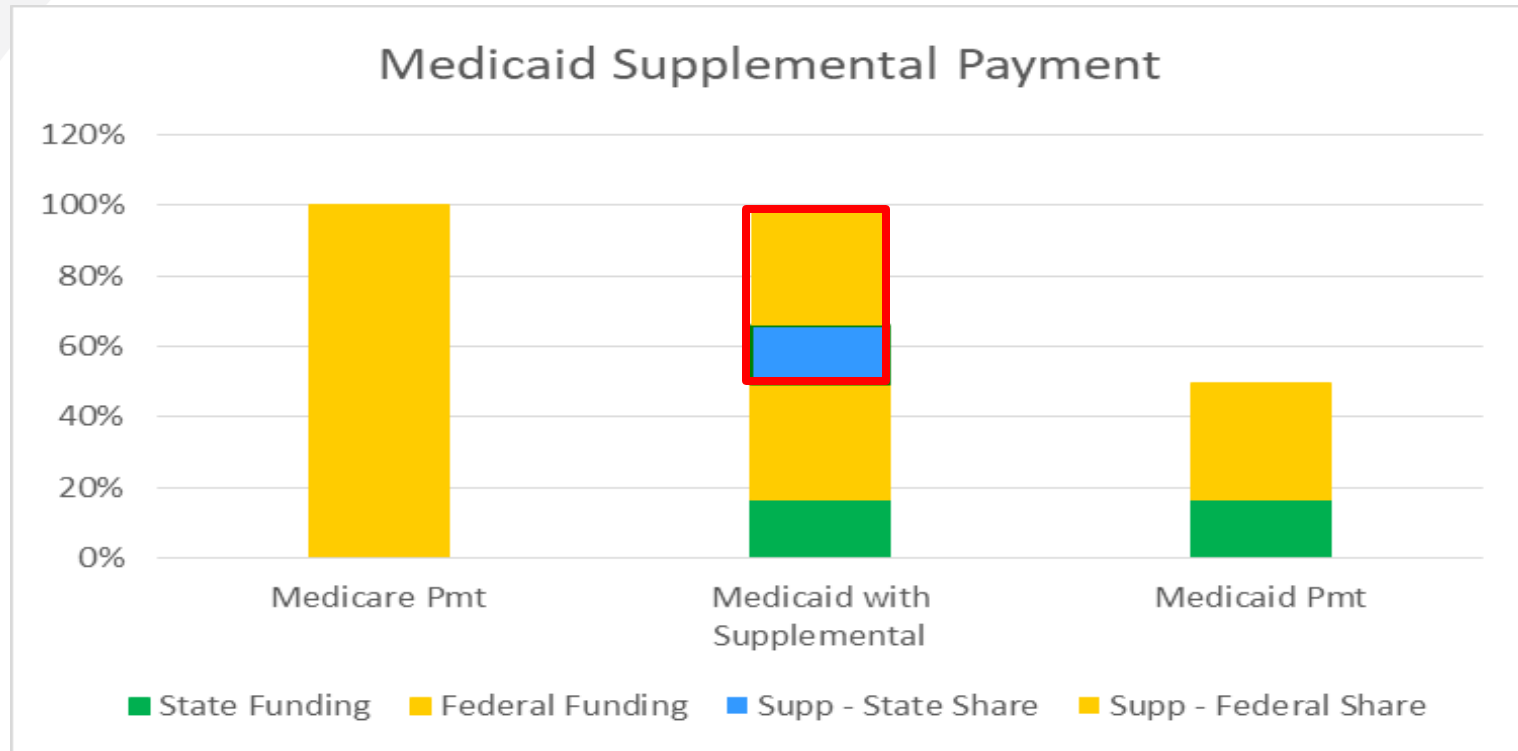
520 Rate Calculations:



- Complex rating calculation is performed for each of **520 nursing facilities**
- Rates are set annually and undated quarterly for acuity changes
- Retro adjustments may be made based on audit findings



Provider Rates Supplemental Payments



- Supplemental payments are used to close the gap between Medicaid and Medicare reimbursement levels
- Supplemental programs are often referred to as Upper Payment Limit (UPL) programs

Provider Rates Supplemental Payments

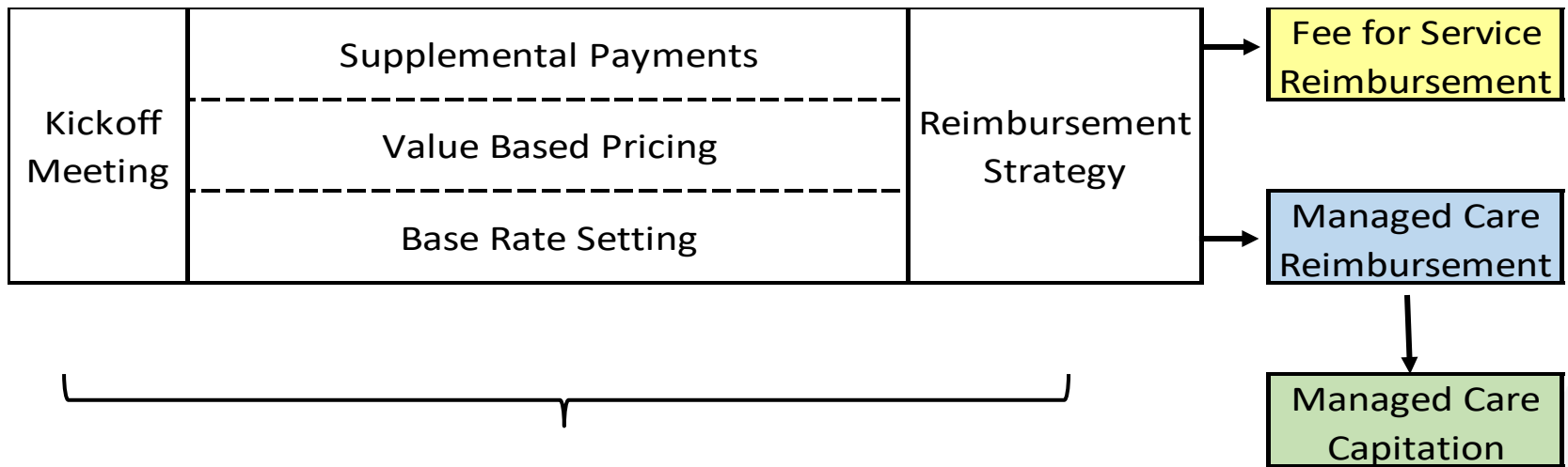
- Supplemental payments have received significant focus in recent years from CMS / Federal government due to acceleration of supplemental expenditures
- Proposed regulatory changes (Medicaid Fiscal Accountability Regulations or MFAR) were not finalized, but have highlighted areas of concern that will need to be addressed for current programs
- CMS recently released a “preprint” application for directed payment arrangements which calls for more reporting around quality measures and provider contributions
- In the near future, FSSA will be focusing on modifications needed to retain existing supplemental programs and is not planning to add any new supplemental programs

Capitation Rates

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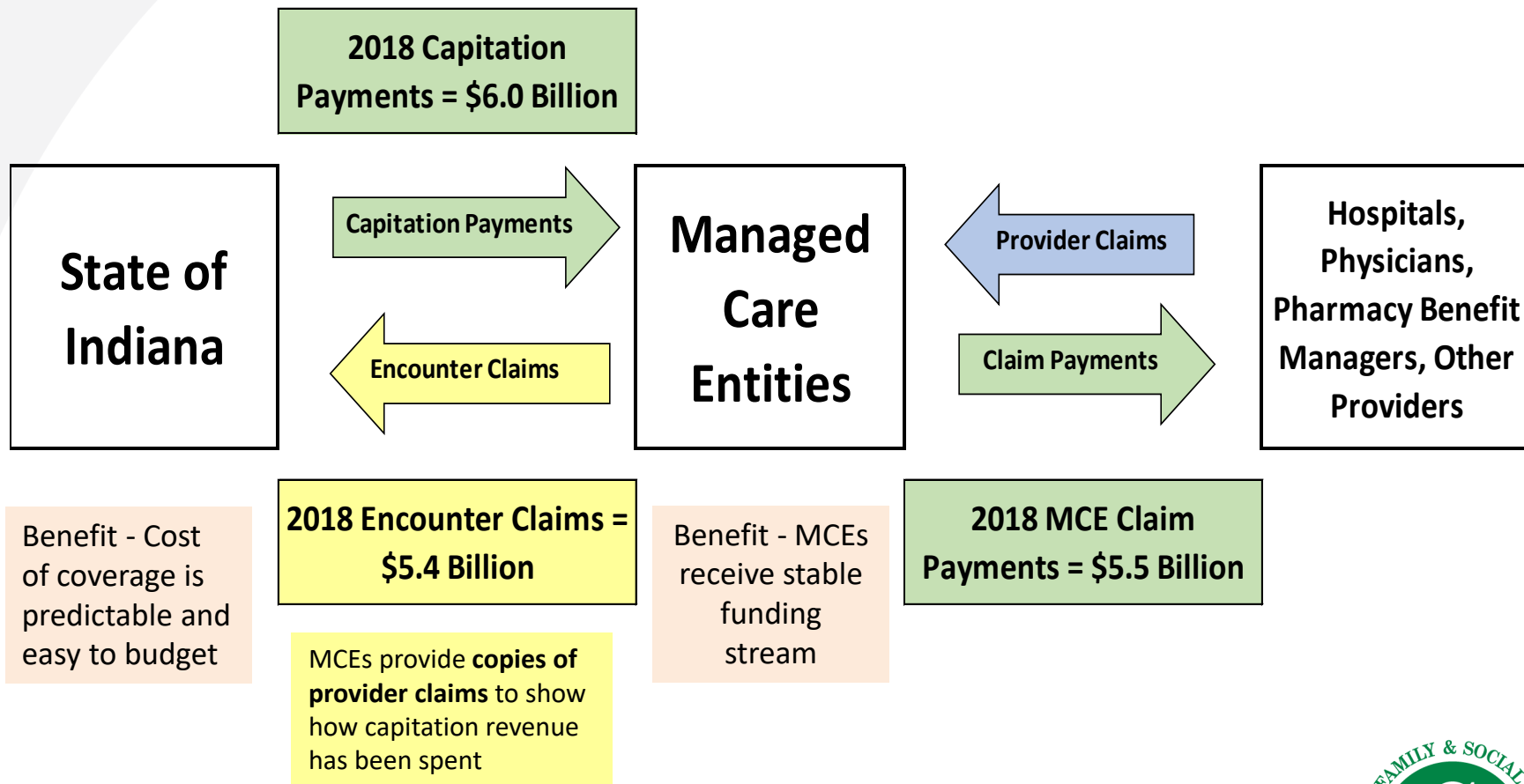
LTSS Reimbursement Review



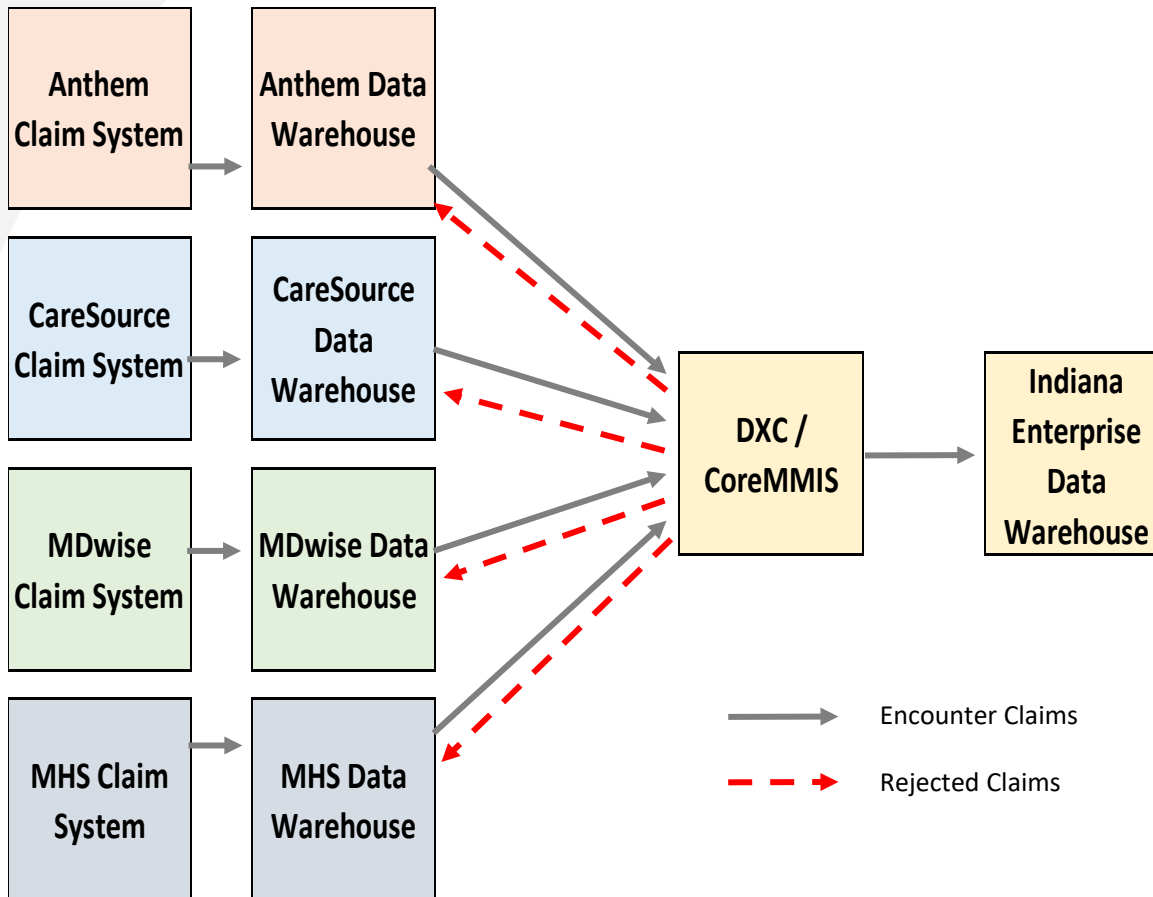
Stakeholder Involvement

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Risk Transfer /Capitated Payment Current Example - Indiana Medicaid - 2018

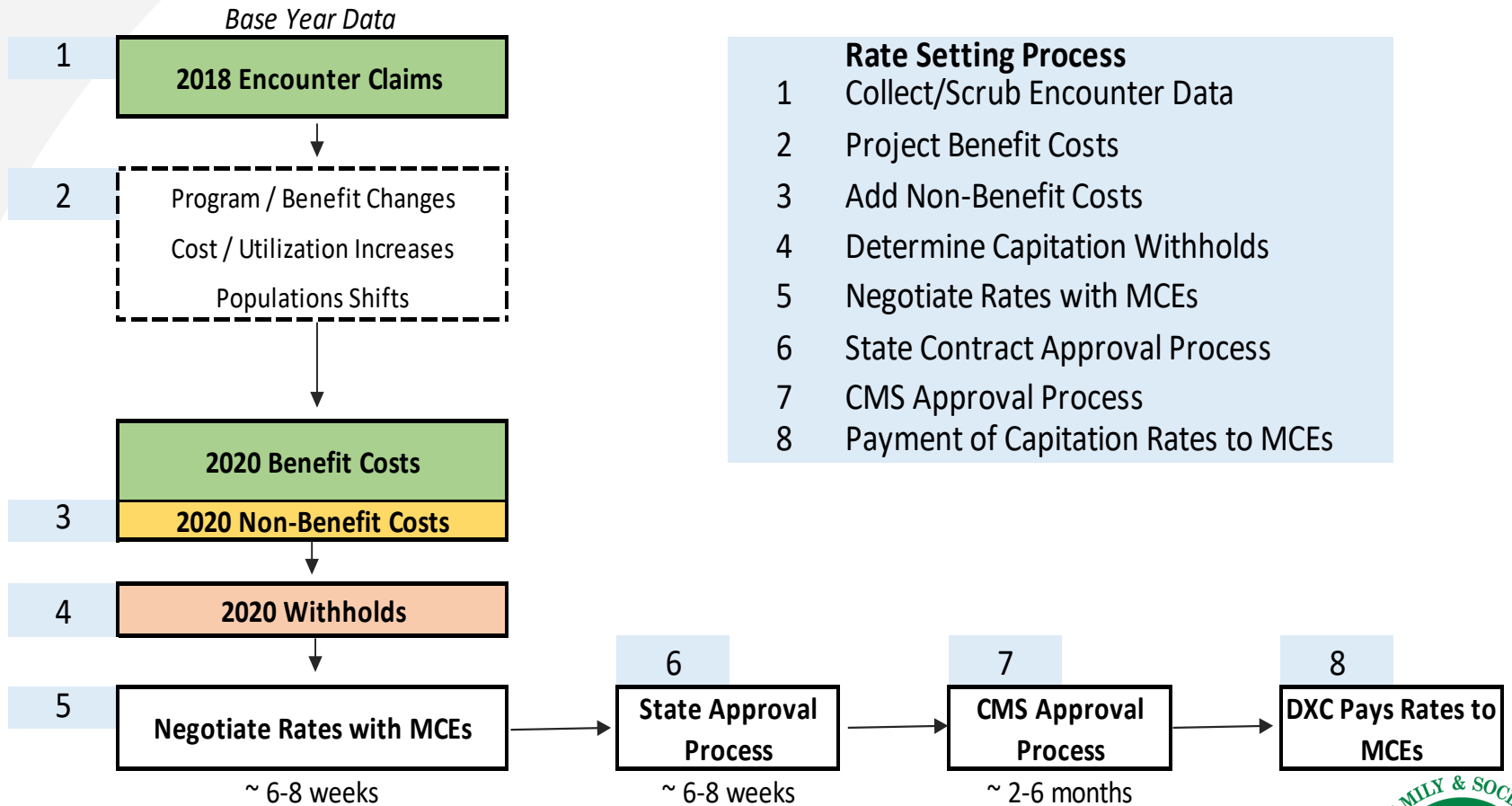


Capitation Rate Setting - Encounter Data Collection Challenges with Validation Process



- MCEs send Encounter Claims to the State: files have ~1,000 fields
- Front end edits may cause claims to be rejected and returned to the MCEs
- Duplicate and replacement claims can be difficult to reconcile
- Each of the MCE's encounter claims in the EDW is compared to that MCE's financial data to determine completeness

Capitation Rate Setting



Capitation Rate Setting - Sample Rates

Hoosier Healthwise	
Newborns	\$ 824.80
Preschool	131.69
Children	146.76
Adolescents/Adults	192.79
Pregnant Women	460.93

Hoosier Care Connect	
Adult	\$ 1,572.14
Child	793.99
Foster	391.94
Dual	480.84

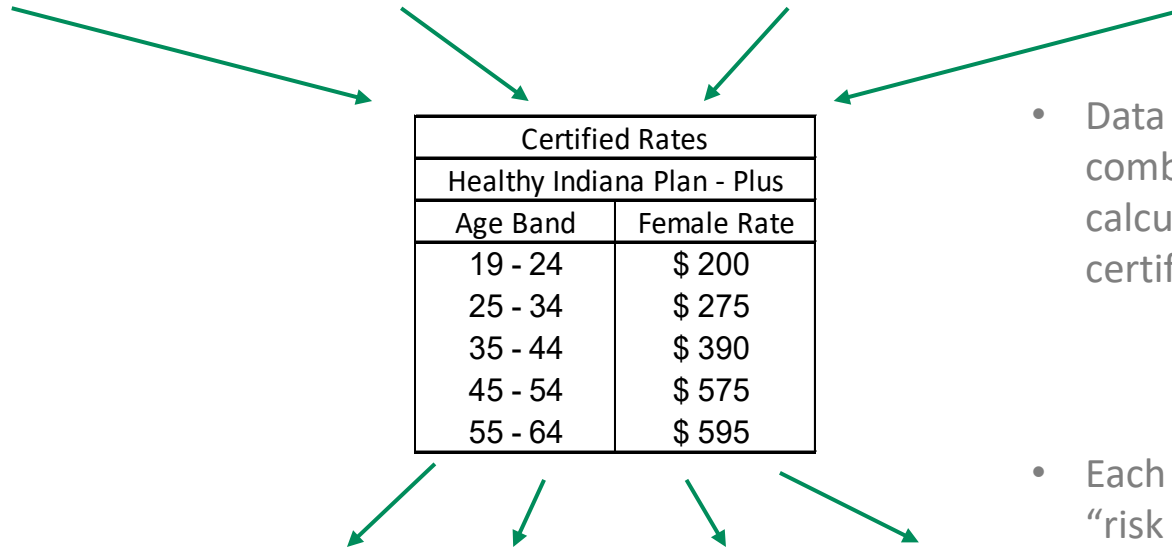
Health Indiana Plan - HIP Plus		
Age	Male	Female
19 - 24	\$ 209.99	\$ 189.92
25 - 34	322.99	265.41
35 - 44	416.45	424.67
45 - 54	628.29	590.09
55 - 64	656.50	595.23

- Rates shown above are examples of “base” 2018 monthly capitation rates
- MCEs are each paid different rates, based on the health status of their covered population
- CMS requires an actuarial certification that **encounter data is the primary data source used for capitation rate setting**
- **2018 Encounter data was used to set 2020 capitation rates**



Capitation Rate Setting - Sample Rates

MCE 1	MCE 2	MCE 3	MCE 4
Encounter Data	Encounter Data	Encounter Data	Encounter Data



- Data from all MCEs is combined to calculate one set of certified rates
- Each MCE is paid a “risk adjusted” rate based on the relative acuity of their members

HIP - Plus	MCE 1	MCE 2	MCE 3	MCE 4
Age Band	Age Band	Female Rate	Age Band	Female Rate
19 - 24	\$218	\$ 180	\$176	\$ 208
25 - 34	\$300	\$248	\$242	\$286
35 - 44	\$425	\$351	\$343	\$406
45 - 54	\$627	\$518	\$506	\$598
55 - 64	\$649	\$536	\$524	\$619

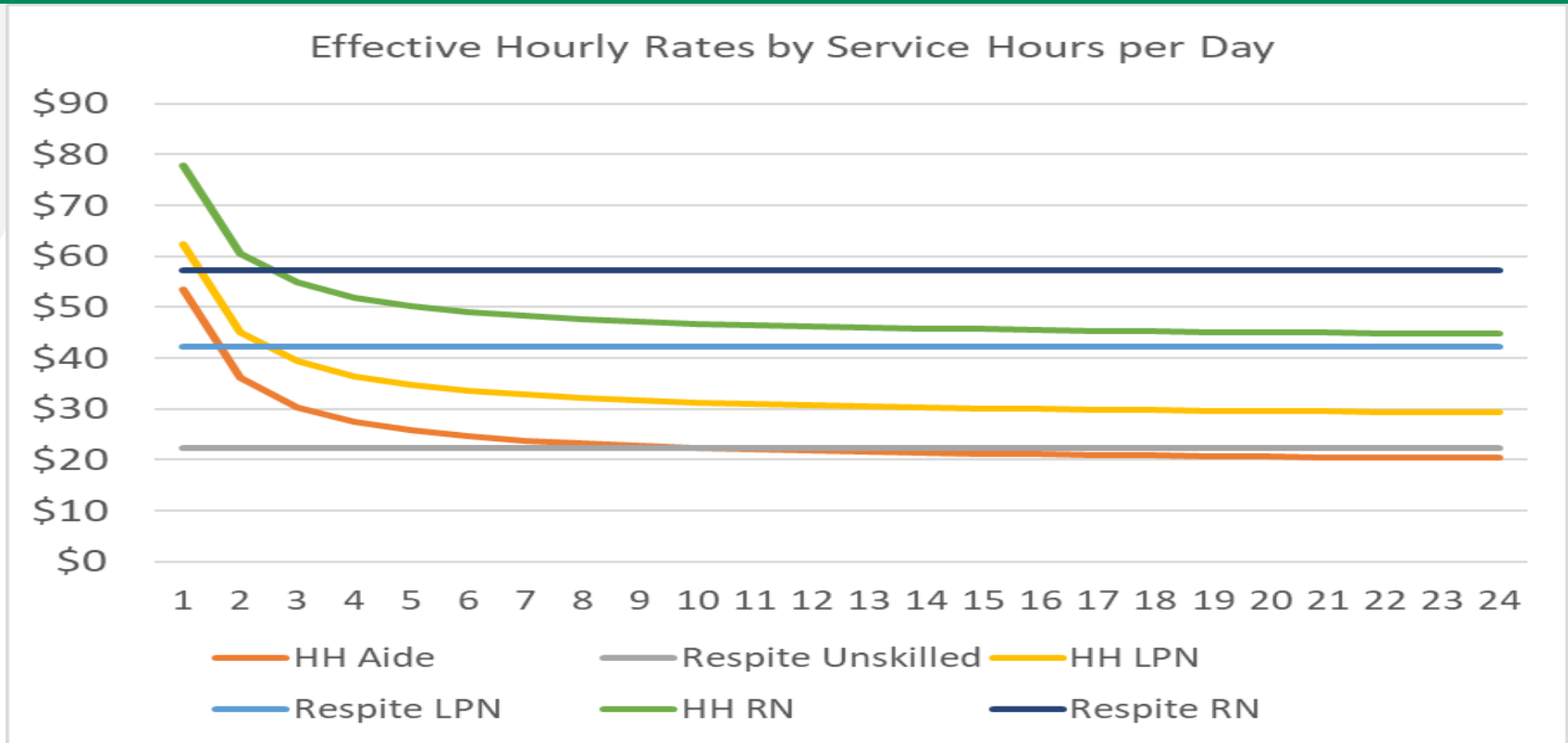


Rating Issue Examples

- Home Health vs. Waiver Rates
- Nursing Facility VBP Add-on vs. UPL Supplemental Payments

Rate Setting Issue

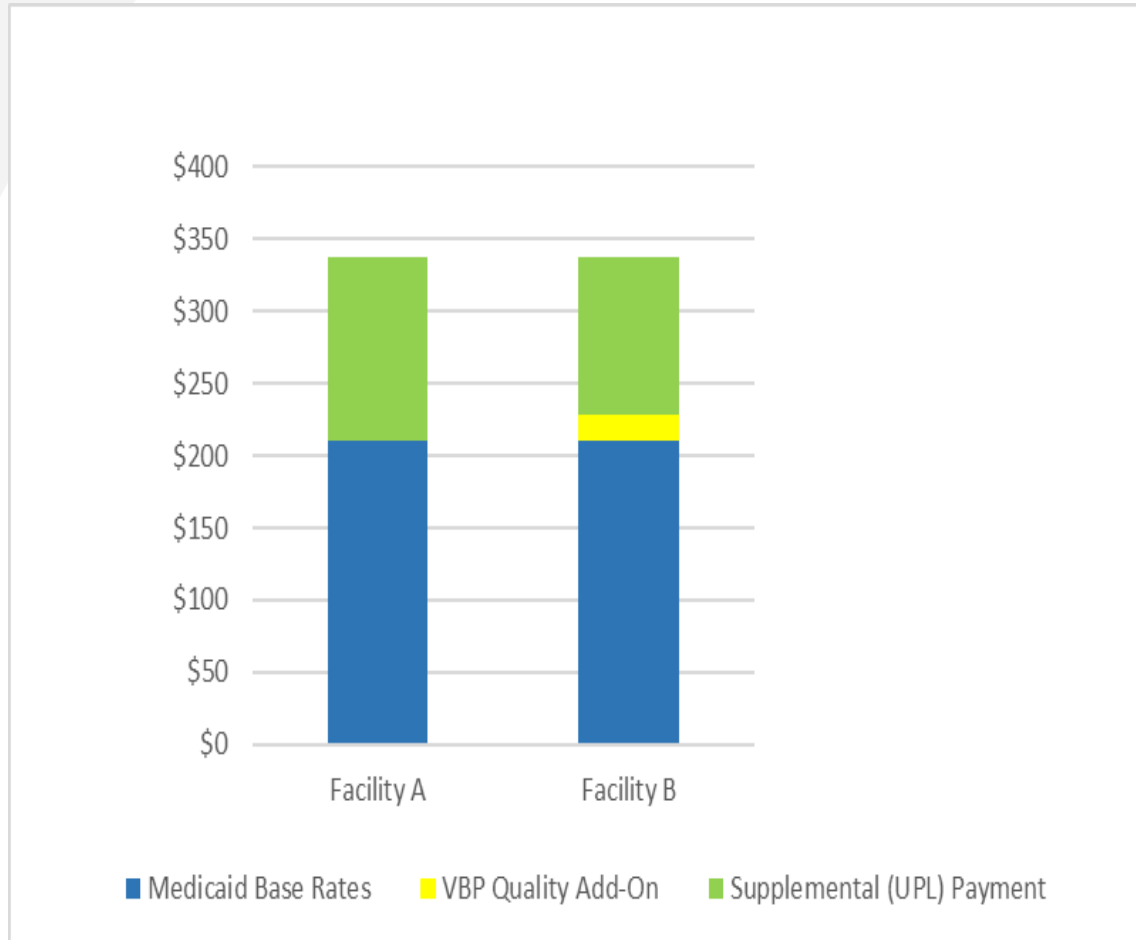
Home Health Rates vs. Waiver Respite Rates



- Home Health Reimbursement features a daily “overhead” payment that results in higher effective rates for shorter visits
- Hourly rates for waiver respite care include overhead costs
- The result is a mismatch for individuals who are eligible for both types of coverage

Rate Setting Issue

Nursing Facility VBP Payments vs. UPL Payments



- Facility A and Facility B have identical populations, but Facility A receives no VBP quality add-on and Facility B receives the maximum quality add-on
- Facility B will receive a smaller UPL payment as both facilities are increased to the same Medicare rate

Next Steps

- *Stakeholder Feedback on Rate Setting*
- *Focused Smaller Group meetings to be scheduled for more detailed discussions*

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