Members

Sen. Patricia Miller, Chairperson
Sen. Robert Meeks
Sen. Connie Lawson
Sen. Rose Antich-Carr
Sen. Vi Simpson
Sen. Sam Smith
Rep. Charlie Brown
Rep. William Crawford
Rep. Clyde Kersey
Rep. David Frizzell
Rep. Mary Kay Budak
Rep. Tim Brown

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Casey Kline, Attorney for the Commission
Eliza Houston, Attorney for the Commission
Al Gossard, Fiscal Analyst for the Commission

Authority: ***IC 2-5-26***

MEETING MINUTES[1]

Meeting Date:	**August 12, 2003**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Robert Meeks; Sen. Connie Lawson; Sen. Rose Antich-Carr; Sen. Vi Simpson; Rep. Charlie Brown; Rep. William Crawford; Rep. Clyde Kersey; Rep. David Frizzell; Rep. Mary Kay Budak.**

Advisor Present: **Sen. Gary Dillon**

Members Absent: **Sen. Sam Smith; Rep. Tim Brown.**

Senator Miller called the meeting to order at 10:40 a.m. Senator Miller discussed the next meeting date with Commission members and decided that the next meeting would be Sept. 16th at 10:30 a.m. The Commission will also meet on October 15, 2003 at 10:30 a.m.

---

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Nursing Facility Assessment Reimbursement

Ms. Melanie Bella, Assistant Secretary of the Office of Medicaid Policy and Planning (OMPP), informed the Commission that the three nursing home associations and OMPP agreed on a proposal for the nursing facility assessment reimbursement. (See Exhibit 1 for detailed information about the agreement). The four major components of the agreement are: (1) case mix reimbursement changes; (2) quality assessment payment based on the Indiana State Department of Health (ISDH) report card scores; (3) increased reimbursement for residents in Altheimer/dementia special care units; and (4) the creation of a nursing facility conversion/closure fund. (See Exhibit 1). Under this proposal, two nursing facilities would be adversely affected with a net loss. The Commission asked Ms. Bella to continue to work with the nursing facility associates to reduce the adverse effect on any nursing facility.

Mr. Zach Cattell, ISDH, stated that ISDH has initial concerns with using the report cards as a reimbursement mechanism. Mr. Cattell commented that the purpose of the report cards is to provide consumers with a tool and that the use of the report cards in determining reimbursement may make the report card process more adversarial. Mr. Cattell informed the Commission that ISDH is working with OMPP to help alleviate these concerns.

Bob Decker, representing HOPE, stated that he was also testifying on behalf of Jim Leich of IAHSA. Both HOPE and IAHSA endorse the proposal despite the fact that the proposal will adversely affect an IAHSA member. Mr. Decker reminded the Commission that the nursing facility assessment expires after one year.

Steve Albrecht, representing IHCA, reported to the Commission that IHCA supports the proposal which is the result of many meetings between OMPP and the nursing facility associations. Mr. Albrecht stated that work still needs to be done on some of the components such as the nursing facility conversion/closure fund. Mr. Albrecht acknowledged that moving towards quality issues is important.

Rep. Crawford made a motion that the Commission endorses the adoption and implementation of the nursing facility assessment reimbursement proposal set forth in the memo from Melanie Bella dated August 7, 2003 (Exhibit 1). Further, the motion included that the Commission encourages OMPP to work with interested parties to resolve current and future issues associated with the assessment reimbursement. The motion was seconded. During Commission discussion, Sen. Meeks asked that the motion include a request for regular update reporting to the Commission. The Commission agreed to include the update requirement in the motion. The Commission approved the motion by consent. (See Exhibit 2, vote sheet).

EDS Update

Ms. Mary Simpson, EDS, provided the Commission with an updated report on Indiana's Medicaid claims. (See Exhibit 3). Ms. Simpson directed the Commission to a portion of the report indicating that the number of Medicaid enrollees who have been served has increased. In response to a question from the Commission concerning the dramatic reduction in Medicaid providers from 2001 to 2002, Ms. Simpson stated that the decrease is in large part due to duplication in reporting in 2001. Ms. Simpson explained that providers who worked in multiple practices previously used multiple provider numbers and this was changed to only one number per provider in 2002. The Commission requested more information from Ms. Simpson on the exact numbers of the duplication.

In response to a question concerning Medicaid fraud reporting, Ms. Simpson stated that if

EDS identifies a potential fraud case, EDS refers that case to Health Care Excel who has a contract with OMPP.

Medicaid Reimbursement

The Commission requested OMPP to prepare a chart that shows an individual with a particular disease and how the Medicaid reimbursement costs differ depending on the type of care the patient chooses (i.e. home care, hospital care, nursing facility care).

Ms. Bella briefed the Commission on Medicaid reimbursement for hospice care, home health care, and waiver services. (See Exhibit 4.). Hospice reimbursement is based on parameters established by the federal Center for Medicare and Medicaid Services. Four levels of hospice care are provided under Medicaid: routine home care, general inpatient care, continuous care, and respite care. Hospice providers receive a per diem rate based on the level of care. If the recipient is located outside of the recipient's house (i.e. a nursing facility), the hospice receives a room and board per diem payment of 95% of the Medicaid room and board rate that is then passed through the hospice provider to the nursing facility. The hospice negotiates the room and board rate that the hospice will pay with the nursing facility. If the hospice patient resides at home, OMPP pays only the per diem rate and does not make a separate room and board payment.

Home health providers file cost reports with OMPP. The cost reports are used to set reimbursement rates for home health care. A home health provider's total reimbursement includes an overhead cost rate plus a staffing cost rate.

OMPP pays one rate for a particular Medicaid waiver service. The CHOICE program rates differ for a particular service because local Area Agencies of Aging (AAA) negotiate the rates in each region. The CHOICE rates may even vary within a local AAA region. Doug Beebe, Director of the Bureau of Aging and In-Home Services, provided the Commission with the utilization and expenditure amounts for the top ten CHOICE services by AAA region. (See Exhibit 5). In July, 2003, CHOICE expenditures for an individual ranged from $8 to $7500, depending on the services the recipient received. AAA provided the Commission with a statewide range of CHOICE rates for five services. (See Exhibit 6).

Mary Smith Healy, representing VNS Hospice and the Indiana Association for Home & Hospice Care (IAHHC), explained to the Commission the amount of care that hospice patients receive. Stephanie Mayercik, representing Indiana Hospice and Palliative Care, explained that hospice services are voluntary and take place in the home and in nursing facilities. Hospice care is provided to a patient if the patient's doctor has determined that the patient's anticipated life expectancy is six months or less if the disease runs its normal course. Nurses who work for a hospice receive special training in end of life treatment and pain management. In 2002, OMPP paid out approximately $12 million in room and board payments for dually eligible patients. This amount was passed through hospice providers to nursing facilities. OMPP reimbursed approximately $3.1 million for routine homecare: $1.9 million for care provided in private residences and $1.2 million for care in nursing facilities. Hospice care equals 0.4% of Indiana Medicaid expenditures in 2002. Because OMPP reimburses room and board for hospice care at 95% of the Medicaid room and board rate, the state saved $633,841 in 2002. (See Exhibit 7).

Jean MacDonald, representing IAHHC, stated that in order to receive home health care under Medicaid, prior approval of the number of hours of care needed by the patient is required. Health Care Excel contracts with OMPP to review and approve or change the number of hours requested by a patient's provider. Ms. MacDonald commented that CHOICE rates differ due to the distance that a provider may have to travel to provide

services. Medicaid waivers do not reimburse for mileage, however, CHOICE rates may include mileage reimbursement. (See Exhibit 8, handout from IAHHC).

Darlene Albertson, representing Hancock Memorial, reiterated that the difference in CHOICE rates and Medicaid waiver rates are due to mileage traveled and time. A Medicaid waiver provider has a difficult time recouping the actual cost of services provided. Despite not recovering actual costs, providers have made a commitment not to abandon patients. In response to a Commission question, Ms. Albertson stated that a cost shift does occur between waiver and CHOICE services in order to recoup costs.

Paul Holeman, representing Advantage Home Health Care, reiterated that prior authorization is required before Medicaid will reimburse for home health services. Mr. Holeman further stated that he appreciates OMPP's offer to sit down with providers to establish a new reimbursement system.

Melissa Durr, representing AAA, informed the Commission that the CHOICE claims process is completed and reviewed on a local basis. CHOICE payments are annually audited. Medicaid waiver rates do not include overhead costs or mileage. AAA encourages CHOICE recipients not to choose the most expensive provider for a service. Ms. Durr stated that it is important to allow for flexibility in order for these services to be received throughout the state.

John Cardwell, representing Indiana Home Care Task Force, stated that there are a record number of people on CHOICE's waiting list. The CHOICE program has an excellent reputation among consumers because the program addresses a person's individual needs. Additional funding is needed to serve more people. The CHOICE program allows more people to receive a smaller number of services. A Medicaid waiver recipient receives the waiver services as well as all other Medicaid services, including pharmacy.

Grant Monahan, representing the Indiana Retail Council, explained to the Commission that Medicaid pharmacy reimbursement consists of a flat cost (average wholesale price (AWP) less 13.5% for brand name drugs and AWP less 20% for generic drugs) plus a dispensing fee of $4.90. The state Medicaid program has a co-payment requirement of $3 for brand-name drugs and $0.50 for generic drugs, although OMPP has proposed increasing the generic drug co-payment to $3. Federal law prohibits a pharmacist from denying services to a Medicaid recipient for inability to pay the co-payment. Pharmacists are concerned about the effects of the proposal to increase the co-payment for generic drugs. In response to a question, the Commission was informed that 80% of Medicaid recipients who are required to pay a drug co-payments do pay the co-payment and that certain groups of Medicaid recipients are exempted from making a co-payment. The Commission encouraged pharmacists to aggressively pursue collecting the co-payment and asked Mr. Monahan to provide the Commission with the amount of hours spent on tracking Medicaid spenddowns.

Medicaid Spenddown

Staff briefly updated the Commission on the judge's ruling on the motion for a preliminary injunction in Ringo et al. v. John Hamilton, et al. which prevents FSSA from enforcing a provider bulletin issued in May, 2003, changing OMPP's policy on counting medical services reimbursed by a third party as part of person's Medicaid spenddown. (See Exhibit 9 for the judge's ruling). Susan Stoops Watson, representing the National Kidney Foundation, informed the Commission that problems exist in the current Medicaid spenddown program and shared an example with the Commission. Robert Fechtman,

representing the plaintiffs in the court case, reiterated that the judge found that the plaintiffs would be irreparably harmed by the policy change and that FSSA needs to make such a change through the public rule making process. The Commission requested that FSSA keep the Commission informed on FSSA's position on this case and whether the ruling would be appealed.

Sen. Miller repeated that the Commission's next meeting would be September 16, 2003, at 10:30 a.m. A Commission member requested that the effect of the continuing eligibility change on a child's eligibility for the Children's Health Insurance Program and Medicaid be discussed at the next meeting. Sen. Miller adjourned the meeting at 1:15 p.m.