

**Members**

Rep. Timothy Brown, Chairperson  
Rep. Don Lehe  
Rep. Suzanne Crouch  
Rep. William Crawford  
Rep. Charlie Brown  
Rep. Peggy Welch  
Sen. Patricia Miller  
Sen. Ryan Mishler  
Sen. Brandt Hershman  
Sen. Jean Breaux  
Sen. Timothy Skinner  
Sen. Earline Rogers



# 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  
Kathy Norris, Fiscal Analyst for the Commission  
Al Gossard, Fiscal Analyst for the Commission

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

## MEETING MINUTES<sup>1</sup>

Meeting Date: October 24, 2012  
Meeting Time: 10:00 A.M.  
Meeting Place: State House, 200 W. Washington  
St., the Senate Chamber  
Meeting City: Indianapolis, Indiana  
Meeting Number: 2

**Members Present:** Rep. Timothy Brown, Chairperson; Rep. William Crawford; Rep. Charlie Brown; Rep. Peggy Welch; Sen. Patricia Miller; Sen. Ryan Mishler; Sen. Jean Breaux; Sen. Timothy Skinner; Sen. Earline Rogers.

**Members Absent:** Rep. Don Lehe; Rep. Suzanne Crouch; Sen. Brandt Hershman.

Chairperson Tim Brown called the meeting to order at 10:05 a.m.

### **Universal and Single Electronic Verification of Medicaid Eligibility**

Ms. Pat Casanova, Director, Office of Medicaid Policy and Planning (OMPP), gave an overview of the Medicaid eligibility electronic process. See Exhibit 1. Ms. Casanova explained the Division of Family and Resources gathers the eligibility information, inputs the information into the Indiana Case Eligibility System (ICES), which is daily downloaded into the Medicaid Management Information System (IndianaAIM), and is accessible to check Medicaid eligibility by Medicaid providers through different electronic channels. See

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

## Exhibit 1.

Chairperson Tim Brown stated that the Medicaid verification is not really a single verification system because providers have to check both IndianaAIM and a managed care provider database in order to confirm eligibility and get reimbursed. Chairperson Brown commented that he is disappointed in this because this is a huge hassle factor that discourages providers from participating in the Medicaid program and is also contrary to state law. Ms. Casanova responded that she is aware of the problem and that her office is working on an operational solution.

Mr. Mike Rinebold, Indiana State Medical Association, concurred that a single verification is needed to eliminate the hassle factor for providers. Ms. Kim Williams, Indiana Academy of Ophthalmology, stated that members were still experiencing some problems, but have learned that if the provider prints off the IndianaAIM sheet showing that the provider checked and found the patient to be eligible for Medicaid, the provider will be reimbursed but has to go through the appeals process with the managed care organization. Ms. Williams testified that the biggest issue is third party liability and making sure the system accurately reflects all insurance coverage.

#### **Medicaid Claims Processing Contractor Changes**

Ms. Casanova informed the Commission of a new Medicaid Management Information System (MMIS) for which FSSA is currently negotiating with Hewlett Packard Enterprise Services to replace the outdated 20-year old computer system. Ms. Casanova stated that she hopes that the negotiations will be completed by November 15, 2012, with the development and installation of the system occurring from January, 2013 through June, 2015. Ms. Casanova said that the MMIS will include: (1) Medicaid claims processing and payment; (2) third party liability cost avoidance and recovery; (3) provider enrollment; (4) call center operations; and (5) management and financial reporting. See Exhibit 1.

In response to whether the new system would be able to handle all of the changes resulting from the federal Affordable Care Act, including the increase in numbers of Medicaid eligible individuals, Ms. Casanova stated that yes, the new system factors that influx in, but that the negotiations have not yet discussed a block grant Medicaid format. In response to a question about federal reimbursement for the new system, Ms. Casanova informed the Commission that costs of the system are eligible for an enhanced federal match and that the federal government will need to approve the final contract. Commission members requested an update on the cost and term of the contract once negotiations are completed.

#### **Dual Eligible Medicaid Recipient Update**

Ms. Casanova informed the Commission that Indiana Medicaid spends more than \$4 billion in state and federal dollars to care for the aged, blind, and disabled population. Ms. Casanova stated that many of these recipients are dually eligible for Medicare and Medicaid, but don't receive coordinated care. Ms. Casanova indicated that her office established a council to address this issue and is reviewing options, including looking at other states' programs, to create better care for this population at a reduced cost. When asked what options were being considered, Ms. Casanova mentioned the Program of All Inclusive Care for the Elderly (PACE) program, the Balanced Incentive program, and the implementation of health homes. See Exhibit 1.

#### **Medicaid Nursing Facility Phase 3 Quality Care Payment Update**

Ms. Faith Laird, Division of Aging, briefly reviewed the different phases that changed nursing facility reimbursement and that resulted from the passage of SB 493 in 2003. Ms. Laird stated that Phase 1 unified the eligibility for nursing facilities and Medicaid waivers at

300% of the Federal Poverty Level (FPL) (increasing from 100% FPL), increased the number of waiver slots, implemented a quality assurance and improvement program, and promoted assisted living, adult family care services, and adult day services. See Exhibit 2. Ms. Laird stated that Phase 2 was initiated when FSSA determined in late 2007 that there were weaknesses in the system, including the fact that individuals with low needs were living in nursing facilities and that there was little improvement in the quality of care received by patients at nursing facilities despite increased reimbursement to nursing facilities. Ms. Laird testified that Phase 2 redesigned funding based on needs of nursing facility residents, increasing add-on payments for ventilation and special care nursing facility units. Other changes in Phase 2 included: (1) updated nursing facility report card scores annually; (2) increased payments for nursing facilities in the top quartile on report card scores; and (3) removed payments for nursing facilities in the bottom quartile of the report card scores.

Ms. Laird discussed the growth in Medicaid waivers from 2003 to the present being around 180%. See Exhibit 2. Ms. Laird also discussed the improvement in nursing facility report card scores and nursing staff levels. Ms. Laird stated that Phase 3 is being implemented in response to nursing facility concerns with reimbursement being based on report card scores and not adequately measuring quality. For example, Ms. Laird commented that the previous reimbursement did not factor in staffing hours per patient day, staffing retention and turnover, clinical quality of care measures, or customer satisfaction. Ms. Laird informed the Commission that a Clinical Panel was formed with interested parties in January, 2010, to consider what should be factored in when determining nursing facility reimbursement. See Exhibit 2, page 13, for a list of considerations. Ms. Laird said that the Clinical Panel made 12 recommendations for inclusion which were agreed to by the nursing facility industry and the Division of Aging. See Exhibit 2, page 14. The recommendations were then assigned weighted points. Ms. Laird estimated that the Phase 3 reimbursement would be implemented in July, 2013.

Commission members asked questions concerning whether promotions within a company to another owned facility counted against a facility as turnover and Ms. Laird responded in the affirmative because the residents and staff consider this as turnover.

Ms. Laird reminded the Commission that the General Assembly passed a law in 2011 requiring FSSA to maximize the nursing home quality assessment fee (QAF). Ms. Laird testified that the previous QAF percentage was 3.7% of the nursing facility net patient revenue (collecting \$98 million) and that the current QAF percentage is 6.0% (\$157 million). Ms. Laird stated that the new funding is paid to nursing facilities solely for quality care.

Mr. Bob Decker, Hoosier Owners and Providers for the Elderly, testified that although he was proud of Indiana for rewarding quality and paying for performance, he disagreed with the distribution of weighted points that was assigned to each factor for reimbursement. Mr. Decker stated that he believes the inclusion of a staffing component in the distribution will result in nursing facilities paying staff more just to keep staff happy and keep reimbursement high. Mr. Decker said that the staffing component is already addressed in the direct care component of nursing home reimbursement and causes a redundancy and a misallocation of resources. Ms. Laird responded that most nursing homes requested that the staffing component be included in the reimbursement.

Mr. Jim Leich, Leading Age Indiana, stated that Indiana is an exemplar in the country on residential care and outcomes. Mr. Leich stated that the use of nursing homes has dropped when considering the increase in the aged population. Mr. Leich commented that he believes the staffing component is important and differs with Mr. Decker on this. Mr.

Leich stated that he would want to include some other quality measures as well.

Mr. Zach Cattell, Indiana Health Care Association, commented that the rule making process with the nursing facility reimbursement has resulted in some good changes and provides consistent measurements with the baseline. Mr. Cattell stated that internal promotions do not count as turnover if the promotion is in the same building but does have issues with the intra-company transfer counting against a facility. Mr. Cattell testified that he has some concerns with how the distribution is done with the curve and with the therapy component and how that is not counted in the measurements of nursing time. Mr. Cattell stated that he is appreciative of Indiana being on the cutting edge of the country in modeling reimbursement based on quality.

### **Final Report**

Chairperson Brown presented the final report to the Commission for review and approval. Commission members moved passage of the Final Report and the Report was recommended by a vote of 9-0. See Exhibit 3.

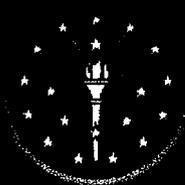
The meeting was adjourned at approximately 12:10 p.m.



# Family & Social Services Administration Office of Medicaid Policy and Planning

## Select Joint Commission on Medicaid Oversight

### October 24, 2012





## Medicaid Eligibility at a Glance

- Medicaid member eligibility decision and information (such as member demographic, financial status, aid category) begins with Indiana Case Eligibility System (ICES) under Division of Family Resources with Family & Social Services Administration (FSSA).
- From a Medicaid perspective, the ICES member eligibility information is sent to the Medicaid Management Information System (IndianaAIM) each night per the ICES schedule.
- Other Medicaid member eligibility updates, such as managed care entity (MCE) and primary medical provider (PMP) changes, are also sent to IndianaAIM nightly through a member services system (Enrollment Broker) and plans (Anthem, MHS, MdWise).



## IndianaAIM is the single source for member Eligibility verification

- For all Medicaid providers, IndianaAIM delivers the unified member Medicaid eligibility information across all eligibility verification channels:
  - Real time web portal (Web Interchange)
  - Real time automated voice response system (AVR)
  - Real time HIPAA electronic data interface (EDI) Health Care Eligibility/Benefit Inquiry (270/271 transactions)
  - Batch 270/271 transactions, mostly used by hospital and institutional settings
- No matter which channel originates the member eligibility request, the information provided is consistent as it comes from the same IndianaAIM eligibility verification system (EVS) engine.
- All providers have been instructed to check eligibility before rendering services.



## Limited Member/Provider Impact for Exception Processes

- Since eligibility information updates are processed nightly, certain information may not be updated in a real-time manner, including retro-actively granting eligibility scenarios.
- However, most eligibility changes are not effective until the next day, and therefore should not have impact on processing provider claims.
- Claims can be resubmitted for retro-active eligibility dates and will be processed as expected.



## IndianaAIM is the single source for member Eligibility verification

- IndianaAIM delivers the unified member Medicaid eligibility information across all eligibility verification channels through centralized eligibility verification system (EVS) engine.
- Indiana Medicaid adopts most current claim forms and process standards published by CMS for all claim processing including professional (CMS-1500), institutional (UB-04), dental, and pharmacy claims. The 2012 ADA form is currently under evaluation.
- Office of Medicaid Policy and Planning reviews CMS code set updates (HCPCS and CPT) annually and implements these changes in IndianaAIM.
- Indiana Medicaid leads other states Medicaid agencies in ICD-10 implementation. Per CMS, Indiana's implementation is the model to follow.



# **New Medicaid Management Information System (MMIS)**

## **Key Dates**

- September 24, 2012: Contract awarded through competitive procurement to Hewlett Packard Enterprise Services (HPES) to replace 20 year old system
- November 15, 2012: Contract Negotiation completion target date
- January 2013 – June 2015: Develop and install system
- July 1, 2015: New System cut-over target date



# **New Medicaid Management Information System (MMIS)**

- Medicaid Claims Processing & Payment
- Third Party Liability Cost Avoidance and Recovery
- Provider Enrollment
- Call Center Operations
- Management and Financial Reporting



## **New Medicaid Management Information System (MMIS) Benefits**

- Adaptable to accommodate health care program changes, new programs, cost containment initiatives
- Scalable to accommodate significant program growth
- Rapid Response to State and Federal Medicaid changes
- Aligned with Centers for Medicare and Medicaid Services (CMS) conditions for continued enhanced Federal funding



## Aged Blind and Disabled/Duals Population

- Indiana Medicaid spends more than \$4 billion (state and federal) to care for the ABD population.
- Many of these beneficiaries are dually eligible for Medicare and Medicaid, but are not receiving coordinated care, which leads to poor health outcomes.
- State is reviewing options for creating better care at reduced cost.
- Looking at other states for best practices in managing target population.



## Aged, Blind and Disabled/Duals Population

- FSSA established a Duals Advisory Council with membership representing aging, DD and mental health provider associations, State Department of Health, AARP and advocate organizations.
- Stakeholder meetings held on Dec. 13, 2011; April 20, 2012; July 13, 2012
- All meeting agendas, minutes, notes can be found on the FSSA website at:  
<http://www.in.gov/fssa/ompp/4347.htm>



## Aged Blind and Disabled Population

- The current timeline to find a solution that works for Indiana tax payers, consumers, and providers continues to be fluid as we seek input from all parties.



## Other Related Initiatives

- Program of All Inclusive Care for the Elderly (PACE)
  - PACE provides on site comprehensive services including nursing supervision, ancillary services (lab, PT, OT) to dually eligible individuals.
- Balanced Incentive program to reduce institutionalization
  - Federal approval received September 4, 2012
- Health Homes for certain populations are under consideration and policy development



QUESTIONS ?





# The Indiana Family and Social Services Administration

## Nursing Facility Quality Payments Update on Phase 3

Division of Aging  
Faith Laird, Director  
October 24, 2012





## Background

- Effort to balance expenditures in long-term care
- Phase 1 (SEA 493 in 2003)
  - Uniform eligibility of 300% SSI for NF and Waiver
  - Added spousal impoverishment provision to waiver
  - Expanded waiver slots (services)
  - Created self-directed care option
  - Quality Assurance/Quality Improvement Program



## Background—Phase 1

- Promotion of
  - Assisted Living
  - Adult Family Care
  - Adult Day Services
- Money Follows Person Grant
  - Transition of > 775 persons by 12/31/12
- Developed 16 statewide Aged and Disabled Resource Centers (ADRCs) with \$1.1M grant



## Background—Phase 2

- Too many individuals in NFs with low needs
- Quality had not improved in NFs despite large increase in reimbursement from the Quality Assessment Fee—over \$100M annually
  - As measured by the Report Card Scores
- Staffing levels declined
- Wages increased minimally



## Phase 2 Response

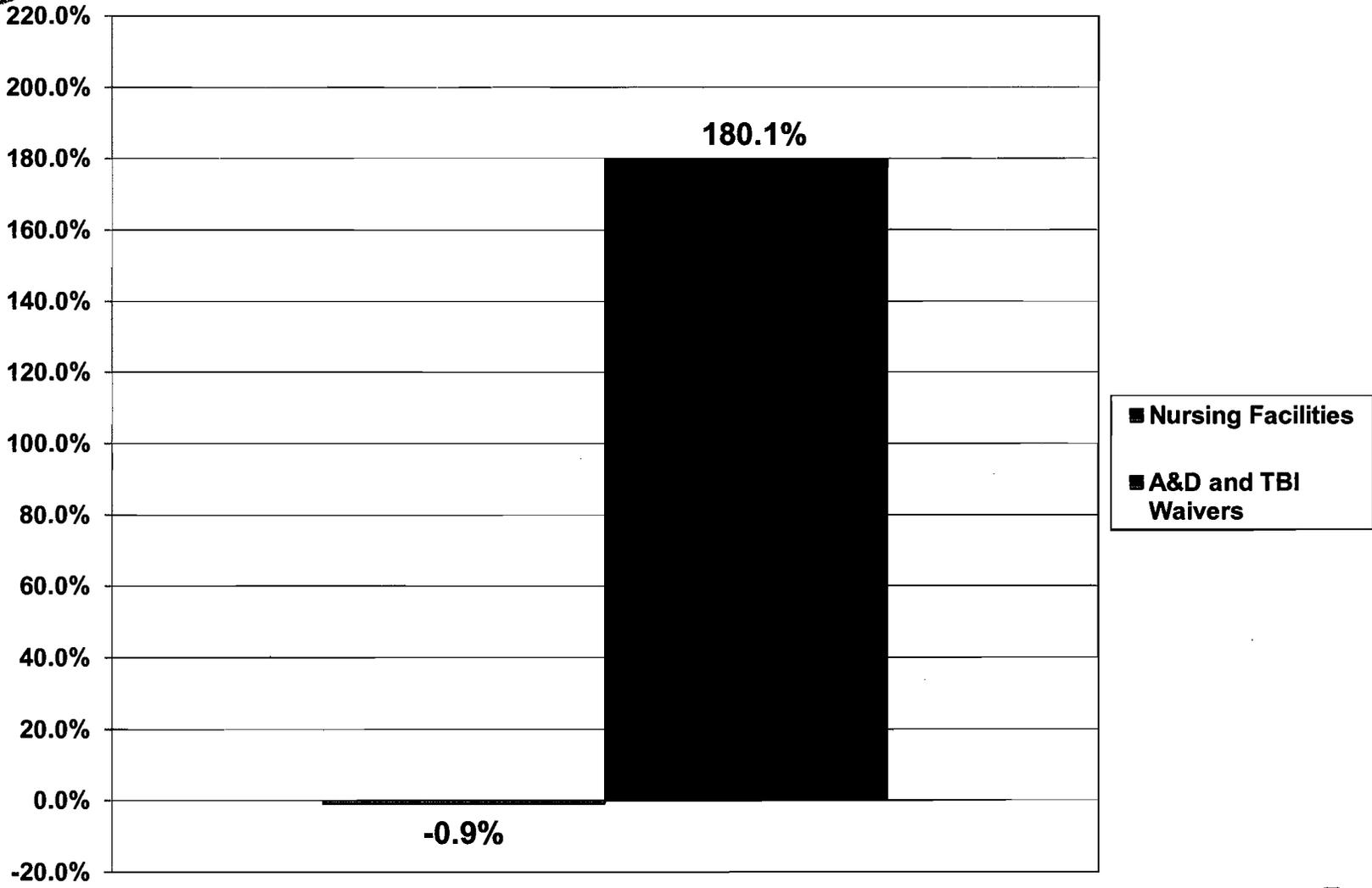
- Redesigned funding based on needs of NF clients
- Increased add-on payments for vent and special care units
- Updated report card scores (RCS) annually
- Increased RCS payment for top quartile from \$3 to \$5.75 per day
- Removed RCS quality payment for bottom quartile



## Phase 2 Response

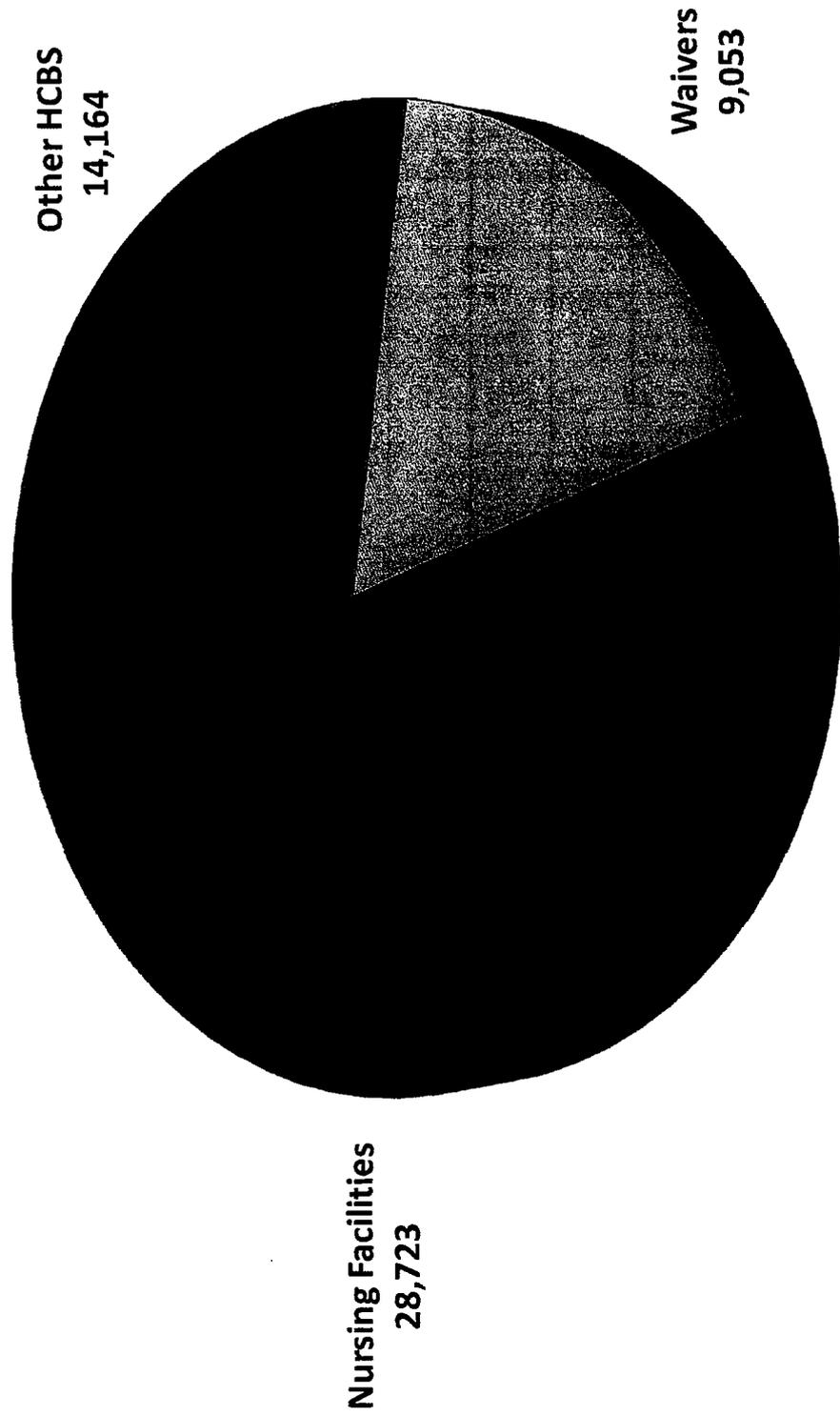
- Revised other reimbursement components
  - Profit add-on
  - Changed administrative component to price based
  - Increased occupancy threshold

# Growth in Waivers Compared to Medicaid Nursing Facility Clients Since January 2003



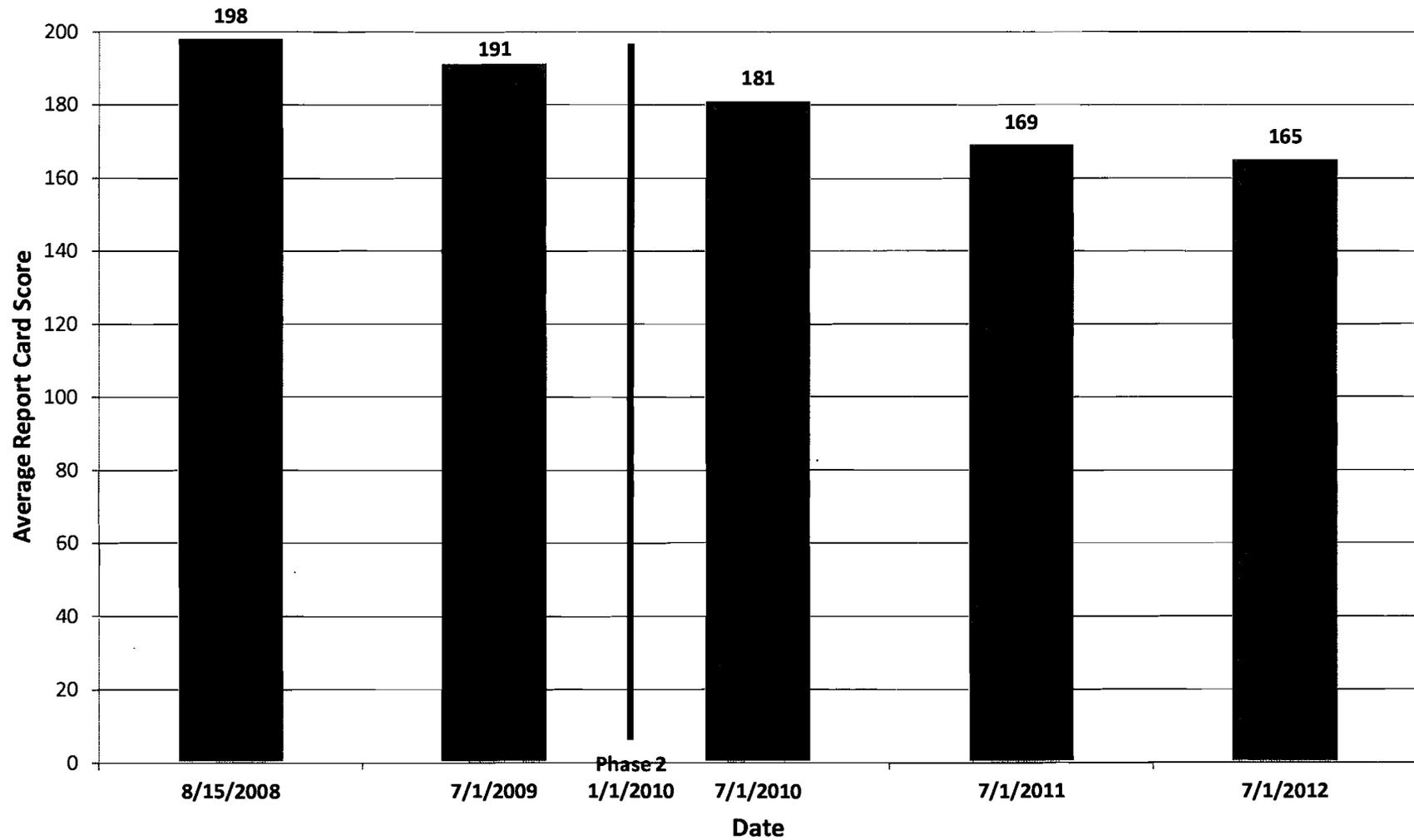


**Division of Aging  
Total Clients Served  
June 2012**





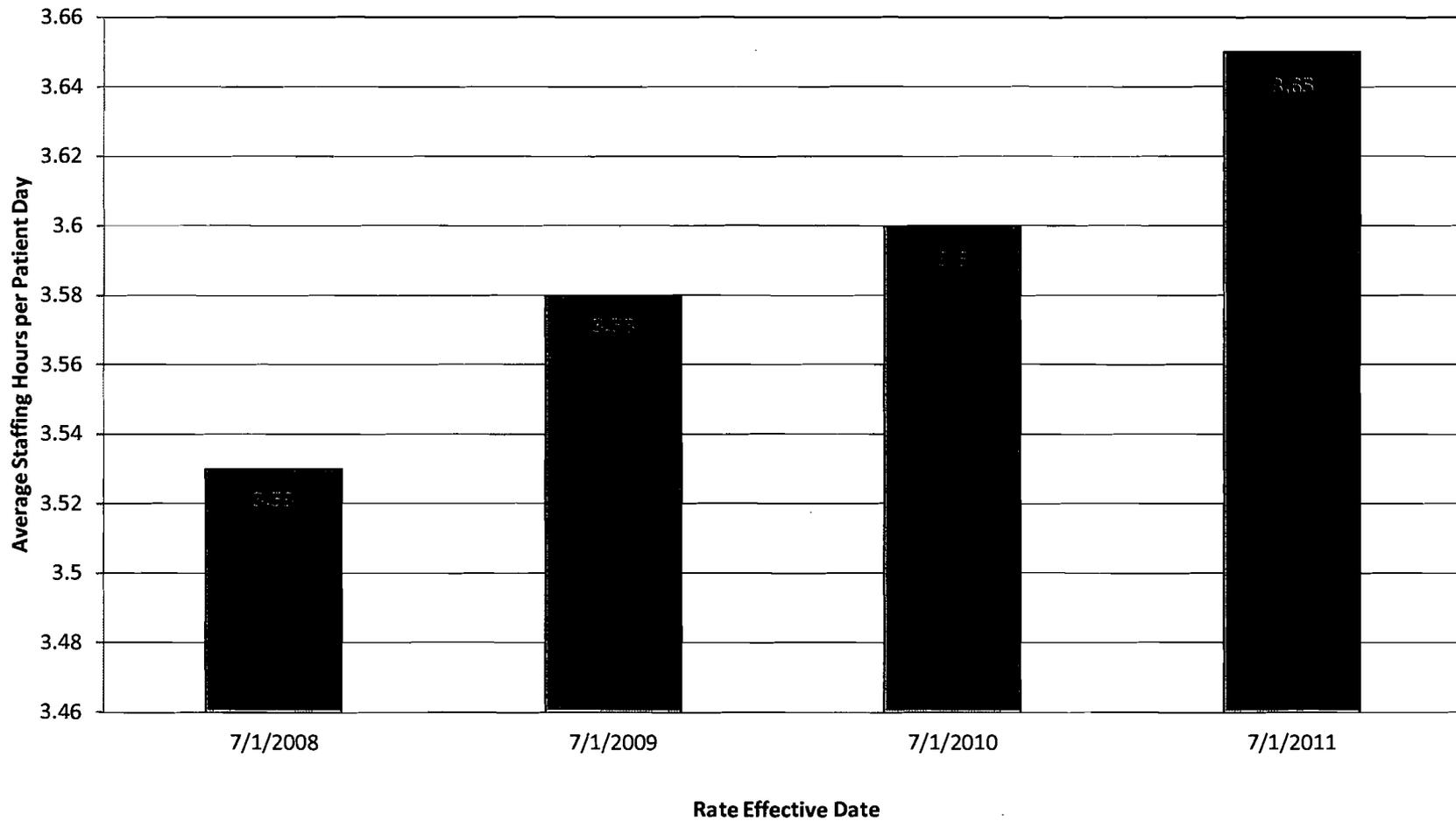
## Nursing Facilities Report Card Score Trend Analysis





## Nursing Facilities

### Direct Care Staffing Hours per Patient Day





## Why Phase 3?

- Concern that RCS not adequate to measure quality
- Not measured:
  - Staffing hours per patient day
  - Staffing retention and turnover
  - Clinical quality of care measures (CMS)
  - Customer satisfaction



## Phase 3 Clinical Expert Panel formed January 2010

- Nursing facility resident advocate groups
- State Ombudsman
- Nursing Facility Administrators and Directors of Nursing
- State's Rate Setting Contractors
- Indiana State Department of Health
- Educators
- Nurses
- Physicians and Nurse Practitioner
- Researchers
- Division of Aging staff



## Phase 3 Clinical Expert Panel considered

- ISDH report card score
- Direct care staffing hours per resident day
- Nurse retention and turnover
- Administrator and director of nursing retention
- Medical director certification and hours spent in facility per month
- Nursing facility clinical quality indicators
- Re-balancing of facility residents-promoting transitions from facility to community
- Resident self-reported quality of life and satisfaction with care
- Family satisfaction with care
- Nursing facility staff satisfaction



## Phase 3 Clinical Expert Panel recommendations agreed to by industry and Division

- Nursing home report card scores
- Resident, family and staff satisfaction survey
- Nursing hours per resident day
- RN/LPN and CNA retention rate
- RN/LPN, CAN, Administrator and Director of Nursing turnover rate
- Medical Director Certification



## Phase 3 Report Changes to be Implemented

- Each of the 12 quality domains assigned points
  - Based on weighting by the CEP
- Total quality score is sum of quality points awarded to each facility for all twelve quality measures
- Add-on to rate based proportionately to score
- Current Report Card Score add-on after maximization of the quality assessment fee up to \$14.30 per day
- Total quality score will be substituted for current Report Card Score



## Phase 3 Timeline

- Issued RFP for satisfaction surveys: Sept.7, 2012
- Contract award for surveys: December 2012
- Conduct satisfaction surveys: Jan-March 2013
- Rule promulgation currently in process
- Expected implementation date: July 1, 2013



## Maximization of the Quality Assessment Fee

- QAF was maximized effective 07/01/2011
- Previous QAF%: 3.7% (% of NF Net Patient Revenue)
- Current QAF %: 6.0% (% of NF Net Patient Revenue)
- Assessment Fee Amount Prior to Maximization: \$98M
- Estimated Additional Assessment Fee Amount: \$58M
- Estimated Total New Assessment Fee Amount: \$157M
- New funding going to NFs due to maximizing QAF is utilized exclusively for quality

# Questions?



## **Select Joint Commission on Medicaid Oversight**

### FINAL REPORT

#### I. STATUTORY DIRECTIVE

The Indiana General Assembly enacted legislation (IC 2-5-26) directing the Commission to do the following:

- (1) Determine whether the contractor for the Office of Medicaid Policy and Planning (OMPP) under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.
- (2) Determine whether a managed care organization that has contracted with the OMPP to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state.
- (3) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process

Medicaid claims and eliminate reimbursement backlogs, delays, and errors.

(4) Oversee the implementation of a case-mix reimbursement system developed by the OMPP and designed for Indiana Medicaid-certified nursing facilities.

(5) Study and investigate any other matter related to Medicaid.

(6) Study and investigate all matters related to the implementation of the Children's Health Insurance Program established by IC 12-17.6.

## **II. SUMMARY OF WORK PROGRAM**

The Commission met two times during the 2012 interim: September 18, 2012, and October 24, 2012.

At the September 18th meeting, the Commission heard testimony from Indiana's three Medicaid managed care organizations concerning claim payments and access to providers. The Commission received updates on the following: (1) the implementation of the hospital assessment fee; (2) Medicaid electronic claims processing; (3) Indiana Medicaid waivers; and (4) the

Indiana Check-up Plan (Healthy Indiana Plan). The Commission also received information on the Medicaid Prepayment Review process.

At the October 24th meeting, the Commission heard testimony on the following: (1) universal and single electronic verification of Medicaid eligibility; (2) Medicaid claims processing contractor changes; (3) Dual eligible recipient update; and (4) Medicaid nursing home reimbursement and Phase 3 quality care payments. The Commission also considered the Commission's final report.

To read a more complete account of this testimony and other matters considered by the Commission, the minutes of the Commission's meetings can be found on the Commission's website at:  
<http://www.in.gov/legislative/>

#### **IV. COMMITTEE FINDINGS AND RECOMMENDATIONS**

The Commission made the following findings of fact:  
[INSERT]

The Commission made the following recommendations:  
[INSERT]

## WITNESS LIST

Mr. Roger Arguello, HP  
John Barth, MHS  
Patty Hebenstreit, MedWise  
Tim Kennedy, Indiana Hospital Association  
Benjamin Moore, MedWise  
Ms. Kristina Moorhead, FSSA  
Adrienne Shields, FSSA  
Shane Spotts, FSSA  
Pamela Staub, Anthem  
Susan Waschevski, FSSA  
Minga Williams, Anthem



