Medicaid Home Health and HCBS Reimbursement Kick-off Meeting

Indiana Family and Social Services Administration

May 20, 2021

Why Reform Indiana's LTSS System?

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

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.

Indiana's Path to Long-term Services and Supports 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 home- and community-based services within 72 hours
2. Move LTSS into a managed 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

Agenda

- Project Background
  - FSSA Reimbursement Goals and Benefits to Stakeholders
  - Milliman Team - Introductions
- Project scope
  - Legislative activity
  - Key Areas of Focus/Questions
  - Current programs/anomalies
  - Planned research and analysis
- Project Methodology
  - General approach
  - Potential evaluation criteria
- Stakeholder engagement
- Timelines
- Next Steps

FSSA Reimbursement Goals

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

- **Alignment** - Bring continuity and alignment across the rate methodologies, providing a consistent framework and supporting payment rates that advance FSSA goals.
- **Sustainability** - Facilitate adequate participant access to quality services, as required by CMS. Cost effective, provide for long-term workforce growth and provider stability, and affordable by the State. Reduce administrative burden. Ensure predictability.
- **Promote Person-Centeredness and Value-Based Purchasing** - Strive to align provider and participant incentives to achieve access to person-centered services, encourage services that drive healthy outcomes and participant satisfaction.
- **Reduce Disparities** – Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.

These goals will be translated into evaluation criteria, to be used for evaluating the current system relative to potential options. Criteria will be established through the stakeholder process.

Benefits to Stakeholders

- All stakeholders
  - New rate methodologies will reflect input from all types of stakeholders including providers, advocates, participants and their families, and others.
  - Rate methodologies will be developed using a transparent process, so all stakeholders can understand how the rates are calculated.
- Individuals and their circle of support
  - May see higher quality and more choice.
  - New methodologies will be designed to support access to services and promote staff retention.
- Provider stakeholders
  - Payment methods will promote payment equity and predictability.
  - Rates will be based on a sound methodology that recognizes the resource requirements of higher acuity patients.
  - New methodologies will seek opportunities to reduce administrative burden of the cost reporting process.

Introduction to the Milliman team

- Christine Mytelka, Milliman
- Jim Pettersson, Milliman
- Ben Mori, Milliman
- Anne Jacobs, Milliman
- Jessica Bertolo, Milliman
- Brad Armstrong, Milliman

Project Scope

Medicaid Programs Included in Community Reimbursement Projects

Scope: Community LTSS services to be included in MLTSS

(Facility reimbursement will be considered in separate workstreams)

Home Health Services

- Home health aide
- Skilled nursing (LPN/RN)
- Therapies
- SFY 2020: $295 million paid

Division of Aging HCBS

- Assisted Living
- Attendant Care
- All other A&D waiver services
- SFY 2020: $442 million paid

Legislative Activity

- **American Rescue Plan Act (ARPA):**
  - Enhanced FMAP effective April 2021 through March 2022
  - 10% FMAP increase to “enhance, expand, or strengthen” home and community based services – “supplement not supplant” (includes reimbursement increases)
  - SMD guidance released May 14, 2021 and allows spend through March 31, 2024
  - Other funding for state and local governments
- **State Appropriation Activity:**
  - $10 million per year for home health
  - $2 million per year for Assisted Living
  - $40 million per year for DDRS, with 95% to flow through to DSP wages
- **Under consideration in Biden’s infrastructure bill:**
  - $400 billion over eight years – short on details
  - Goals: strengthening the workforce, expanding services, eliminating waiting lists

Community Reimbursement : Key Areas of Focus

- Growth of the workforce – beyond rate adequacy
- Sustainable rates that allow for workforce planning
- Create capacity to meet future demands
- Fiscal alignment between community service options and with facility services, through reimbursement, enhancing access and individual choice
- Incentive structure that supports quality, equity, and person-centeredness
- Frequency of cost reporting – balancing fiscal oversight with administrative burden
- Process for annual updates – aligned and predictable
- Transparency for providers, FSSA, and individuals receiving services
- CMS compliant methodology

Community Reimbursement – Key Questions

- How much funding is needed to support sustainable investment in long-term growth?
- Given the targeted appropriation increase for assisted living, how do we maintain alignment with other HCBS services?
- Short home health service visits vs long visits: how do we compare to other states, and for which services is access more of a concern?
- Do other states have alternative service models for individuals who need full time skilled nursing?
- Does the prior authorization process contribute to constrained access? How do other states manage this?
- Taking into account the administrative burden, is cost reporting needed, and if so, at what frequency?
- What incentives should be prioritized and built into reimbursement?
- How can reimbursement be well-positioned for the transition to MLTSS?

Anomalies in Current Program

- Different wages between DSPs in facility and community care
- Different rate structures for home health services and HCBS respite (Overhead rate is used for home health service, but not for HCBS respite)
- Annual update process, cost reporting, and auditing for nursing facilities but not for HHA or HCBS services
- Prior authorization for home health services, but ISPs for HCBS
- Varied regulatory and oversight requirements, impacting compliance cost
- What aspects of the current rates are supportive of program goals?
- What aspects of the current rates are of concern to you and why?

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Planned research and analysis

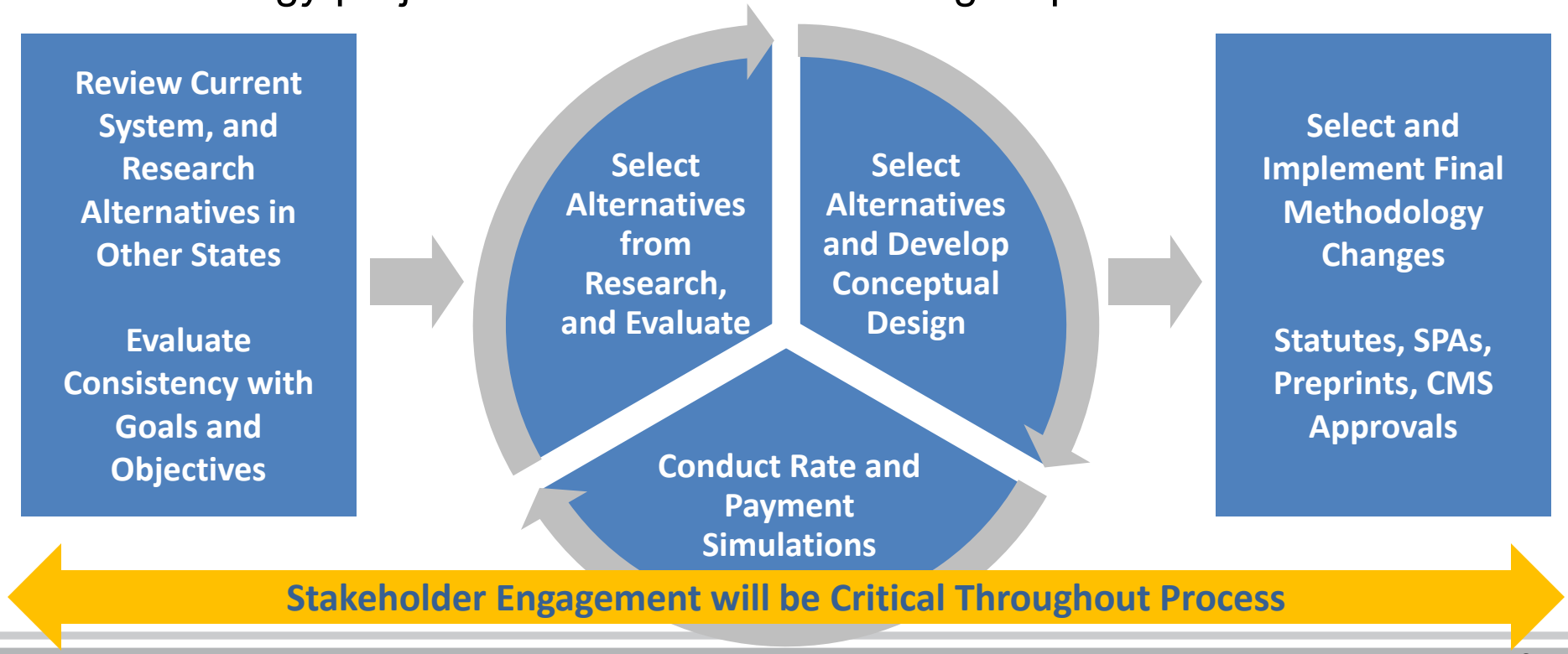
- Level of additional funding available through 2024
- Programs in other states – utilization, reimbursement, rate structure
- Rate methodology, cost reporting process, and update frequency in other states
- Scope of service and other requirements in other states
- DSP wages in other states
- Access difficulties by service type
- Correlation between member acuity/conditions and hours of service received
- Review of quality measures, evaluation of alignment with goals and/or gaps between Indiana performance and other states
- What other research or data analytics should we consider?

Project Methodology

Project Approach

Overall Project Approach

- FSSA has engaged Milliman to perform research and analysis to evaluate current methodologies relative to alternatives, offer options for consideration, then assist with redesign
- Rate methodology projects will involve the following steps:



Community Reimbursement Evaluation Criteria

Potential Evaluation Criteria

Rate setting methods may be evaluated against the following potential objectives, or *evaluation criteria*, which will be modified and updated as part of the stakeholder process:

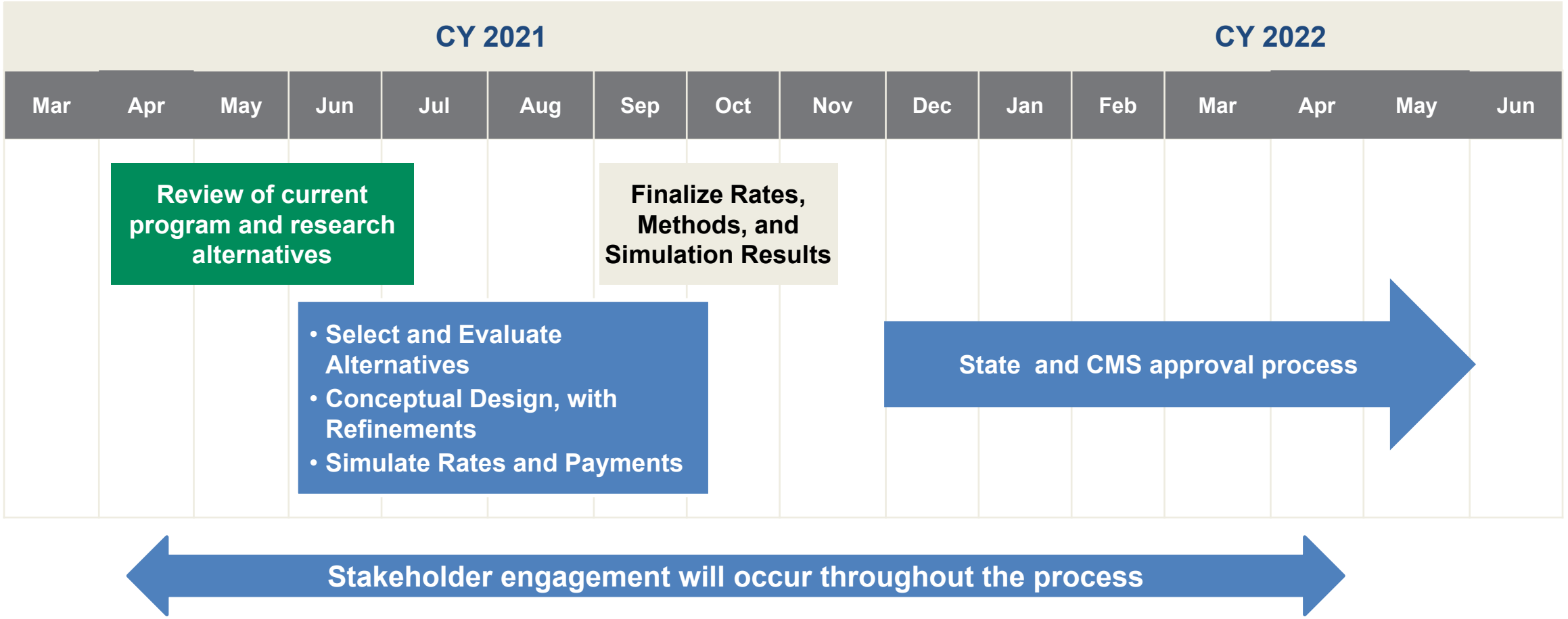
1. **Access** - Promote beneficiary access to care, from a range of providers, in consideration of socioeconomic or geographic barriers to care.
2. **Quality** – Promote the delivery of high quality care for all individuals. Build infrastructure and payment supports that enhance and sustain quality and person-centered planning.
3. **Efficiency** - Promote provider economy, efficiency, and good stewardship of federal and local funds that support the program.
4. **Payment equity** – Provide for payments that are equitable and rational. Recognize reasonable and measurable differences in intensity or cost of services. Provide for wages commensurate with skills and experience across all settings.
5. **Alignment** – Provide for alignment and consistency across services and with other programs.

Community Reimbursement Evaluation Criteria

Potential Evaluation Criteria (continued)

6. **Transparency** – Promote understanding of exactly what service or value is being purchased, and how related payments are determined. Facilitate oversight of fund flow.
7. **Reduce disparities**– Analyze and quantify disparities in access, quality, site of care, and person-centeredness, then build payment structures to level the playing field.
8. **Simplicity**– Reduce cost and administrative burden of current system, while maintaining only the complexity necessary to advance payment equity, quality, and other goals.
9. **Predictability**– Promote a clear understanding of the payment structure and how future updates will occur is a fundamental support for long-term planning and workforce development.
10. **Forward Compatibility** – Rate setting Method must be compatible with transition to managed care environment and projected growth in future workforce needs.

Community Reimbursement – Project Timelines



Stakeholder Engagement

Stakeholder Process

- Balanced input from the full range of stakeholders is critical to this process.
- FSSA wants to hear from a variety of stakeholders, including providers and associations, direct service providers, participants and their informal supports, families, advocacy streams, and other key state and federal government stakeholders.
- Stakeholder engagement will include multiple modes of communication, such as:
  - In-person meetings (when it becomes practical)
  - Webinars and virtual meetings
  - Project website, FAQs, and email address
- In addition, per federal requirements, prior to any rate method or rate changes there will be an official 30-day public comment period, followed by 30 days for FSSA to review and respond to public comment. CMS then has a 90 day approval process (which may be extended).

Next Steps

Next Steps

- Meetings to be held on Thursdays (3rd Thursday of the month).
- Meeting topics and agendas to be developed and sent five business days in advance of the Workstream meetings.
- If you'd like to participate, or have additional suggestions, please email backhome.Indiana@fssa.in.gov.

Questions, suggestions?

Submit them via email to:
backhome.Indiana@fssa.in.gov

…Because we are dedicated to helping Hoosiers live self-sufficient, productive lives of their choosing.

Caveats and Limitations

The services provided for this project were performed under the contract between Milliman and FSSA approved May 14, 2010, and last amended December 4, 2020.

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Guidelines issued by the Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Christine Mytelka is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

The work for this project is still on-going. FSSA has not made any final decisions. FSSA policy decisions, which have yet to be determined, will be subject to state legislative and federal approval.