Medicaid Nursing Facility Reimbursement Nursing Facility Upper Payment Limit Program Stakeholder Meeting #1

Indiana Family and Social Services Administration

June 3, 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
- Overview of Current Methodology
- Overview of Managed Care Supplemental Payment Options
- Project Methodology
- Next Steps

FSSA Reimbursement Goals

To develop Nursing Facility (NF) supplemental payment 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** - Striving 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 supplemental payment methodologies will reflect input from all types of stakeholders including providers, advocates, participants and their families, and others.
  - Rate supplemental payment will be developed using a transparent process, so all stakeholders can understand how the payments are calculated, distributed, and financed
- 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
  - Supplemental payments will be based on a sound methodology that recognizes the resource requirements while tying payment to quality and outcomes
  - New methodologies will seek opportunities to maintain the objectives of the base claim payment methodology

Introduction to the Milliman team

- Christine Mytelka, FSA, MAAA
- Ben Mori
- Jim Pettersson, CPA
- Anne Jacobs, MHA
- Jessica Bertolo, MBA
- Brad Armstrong, FSA, MAAA

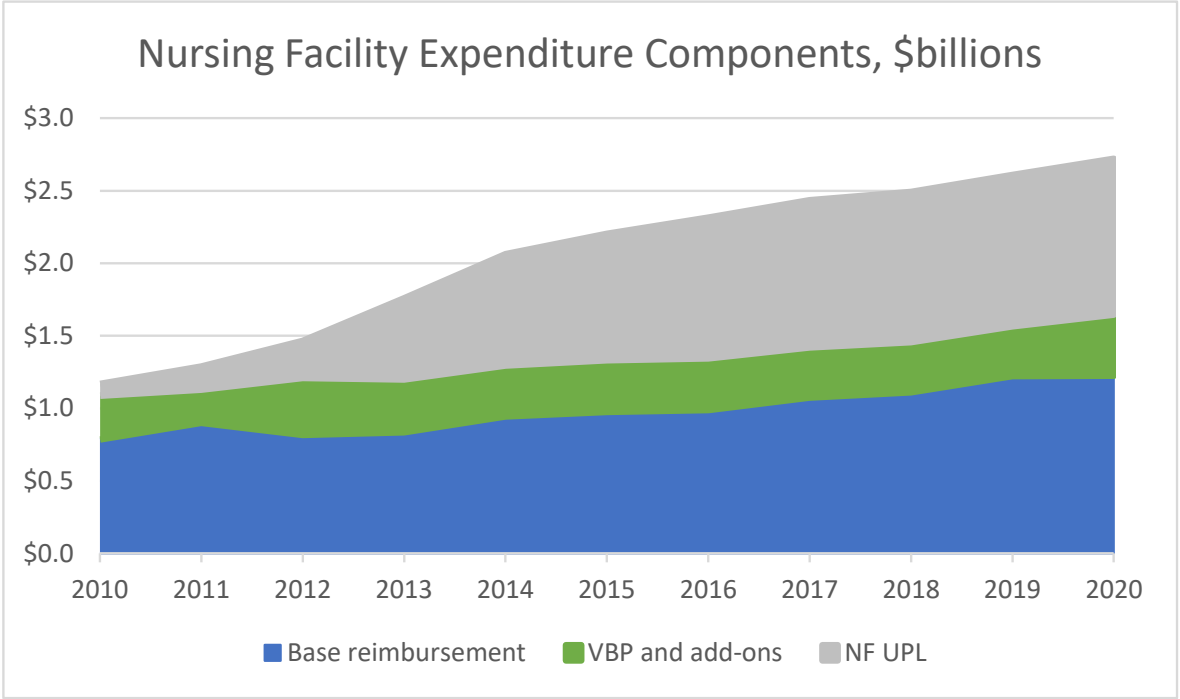
Overview of Current Methodology

Medicaid Nursing Facility Funding Streams

Current fee-for-service (FFS) reimbursement components, stratified by non-federal funding source:

- **General fund:** ($340 million in SFY 2020) funds the state share of most of the **base per diem reimbursement**
- **Quality Assessment Fee (QAF):** ($120 million in SFY 2020) funds the state share for the **VBP and other add-ons** to the base rate
- **Intergovernmental transfers (IGTs)**, ($300 million in SFY 2020) fund the state share of the **NF Upper Payment Limit (UPL) program**

- SFY 2020 NF UPL program gross total payments were **$1.0 billion** (out of $2.7 billion in Medicaid NF expenditures)



Gross expenditures are Medicaid payments only, excluding patient pay and Medicare payments, and are not offset by the provider assessment or IGTs

Nursing Facility UPL Program Overview

- The UPL payment program per Indiana State Plan 4.19D is applicable to participating nursing facilities owned or operated by a non-state governmental owned (NSGO) entity
- Quarterly supplemental payments are made based on the difference between estimated payments under Medicare and base Medicaid payments, with annual settlement adjustments
- The current UPL supplemental payments are strictly utilization based and do not include a quality component
- The non-federal share of UPL payments is financed by intergovernmental transfers (IGTs) contributed from NSGO entities, primarily by county-run hospitals (IGTs will be an estimated 33.52% of total computable payments by FFY 2023)

UPL Payment - Calculation Steps

Per Indiana State Plan 4.19D

Interim Quarterly Payments:

1. Extract annual Medicaid days from each facility's **most recent Medicaid cost report** (1-3 year lag) and **prorate** the annual cost reporting period days by the ratio of:

   (Number of days in the UPL payment quarter) / (Number of days in the UPL payment year)

2. Estimate Medicaid base payments by multiplying the Medicaid average per diem rate(1) effective for the UPL payment quarter to the prorated Medicaid days
3. Estimate payments under Medicare by multiplying the estimated average federal per diem rate(1) for the UPL payment quarter to the prorated Medicaid days
4. Calculate the quarterly UPL payments based on each facility's difference between the estimated Medicare payments and estimated Medicaid base payments

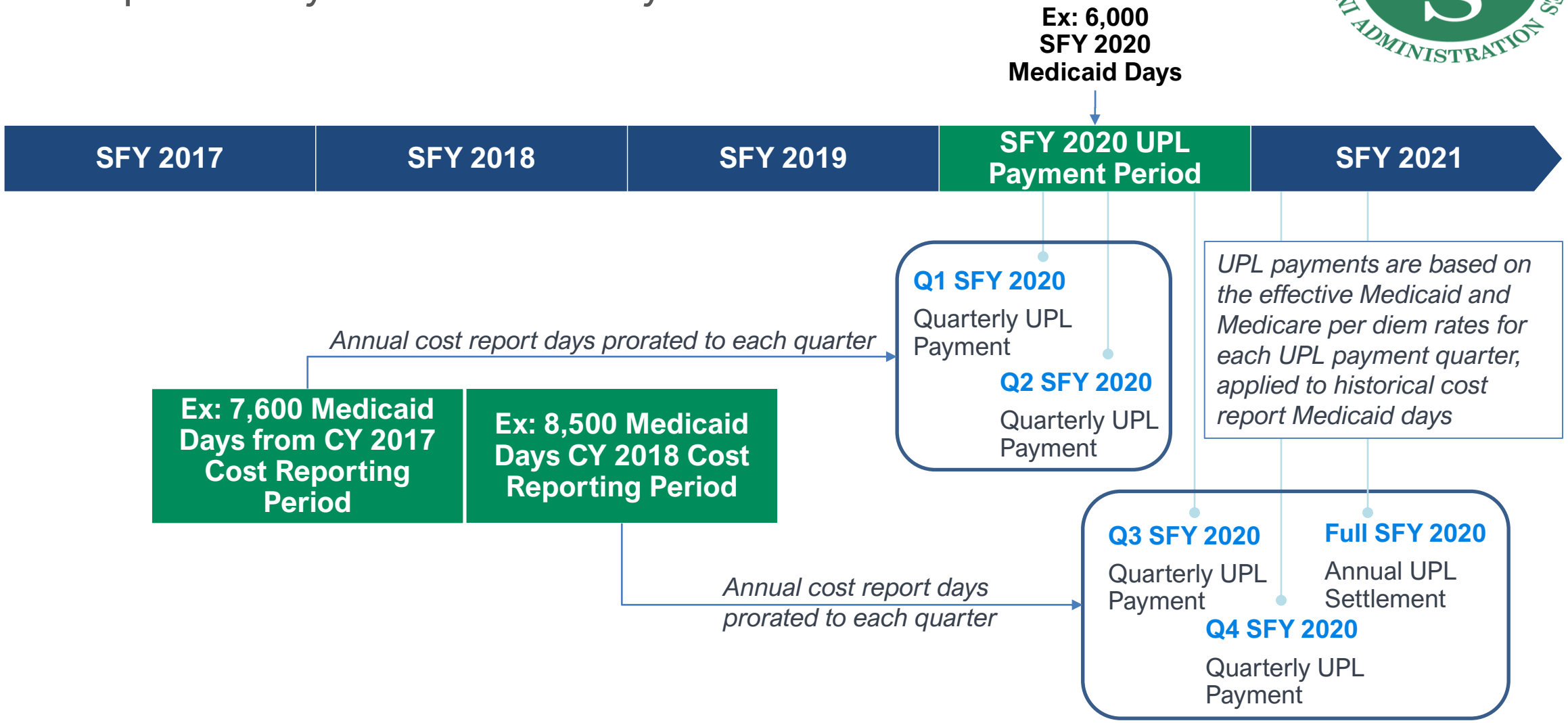
Annual Settlements:

5. Extract most recent available annual cost report data and determine each facility's difference between the annual updated UPL payments and interim quarterly payments

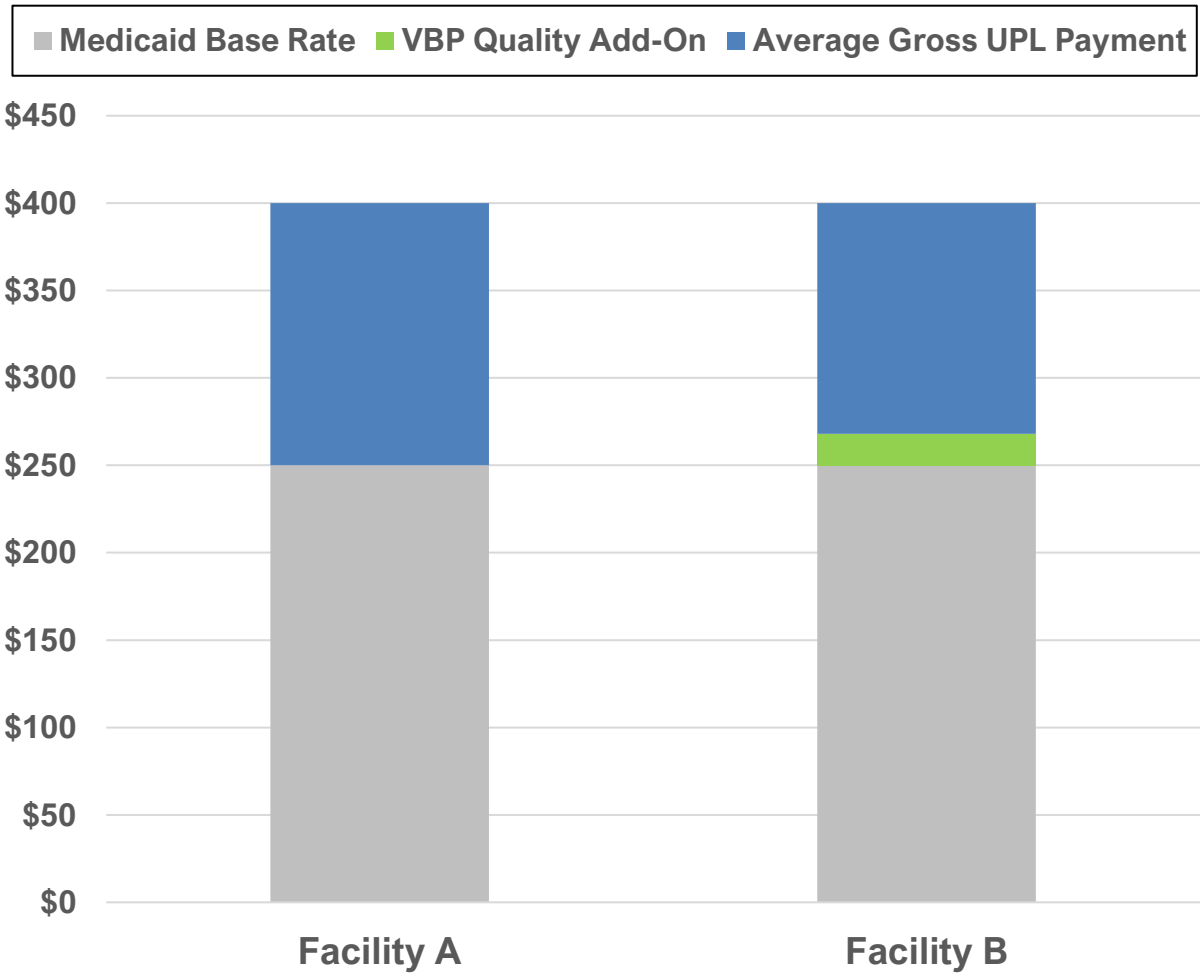
Note: (1) The state plan specifies use of Medicare RUGs as basis for facility case mix adjustments to average per diem rates.

UPL Payment - Calculation Timeline

Example Facility – Illustrative Only



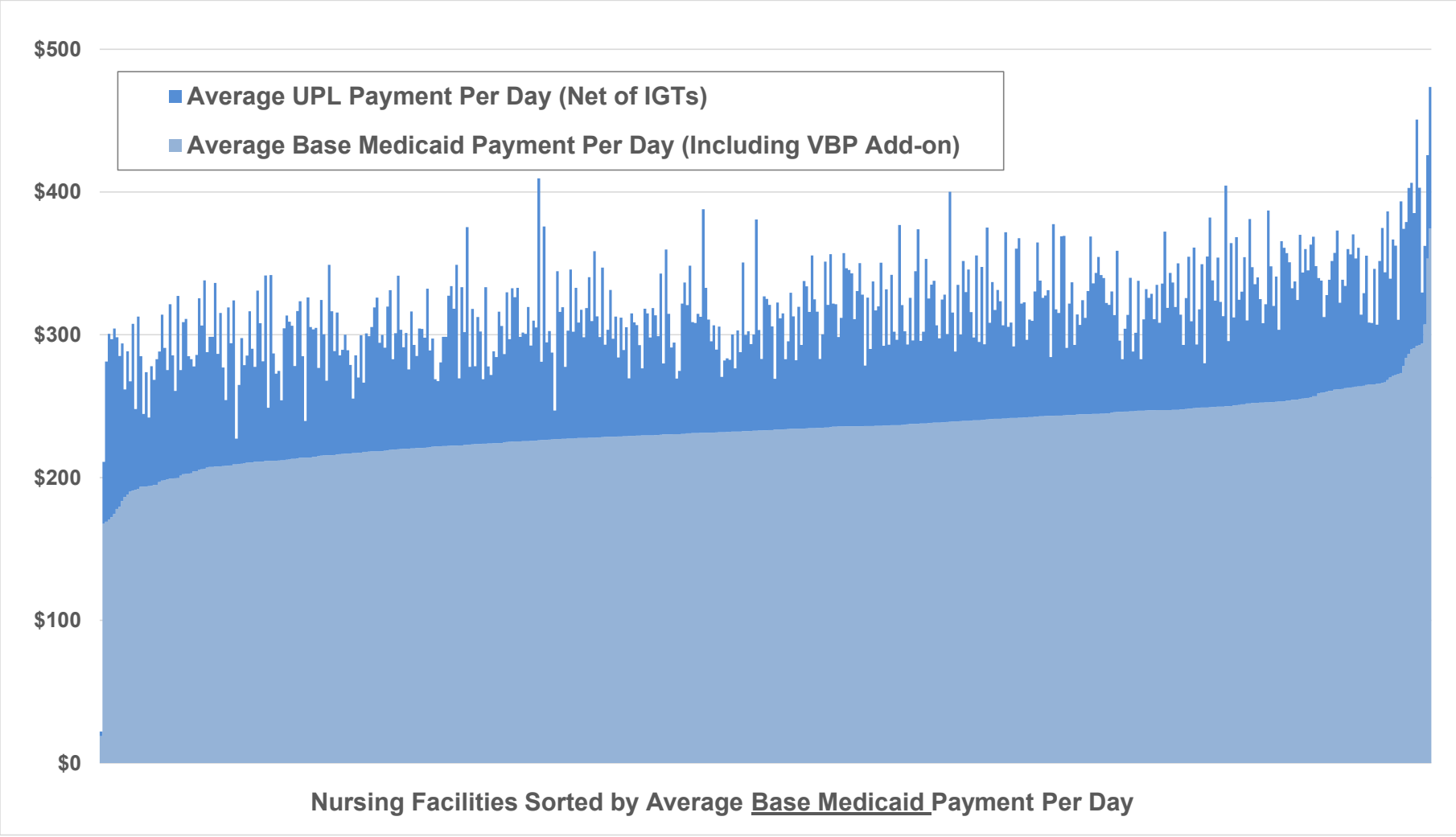
UPL Payment – Per Diem Example



- The Medicare target under the UPL payment methodology potentially neutralizes differences in Medicaid base payments (such as quality add-ons/VBP)
- For example:
  - Facility A and Facility B have identical case mix, but FSSA pays Facility A $0 quality add-on/VBP and Facility B the maximum quality add-on
  - FSSA makes a smaller UPL payment for Facility B in order to pay up to Medicare

NF Distribution of Average Medicaid Payment Per Day

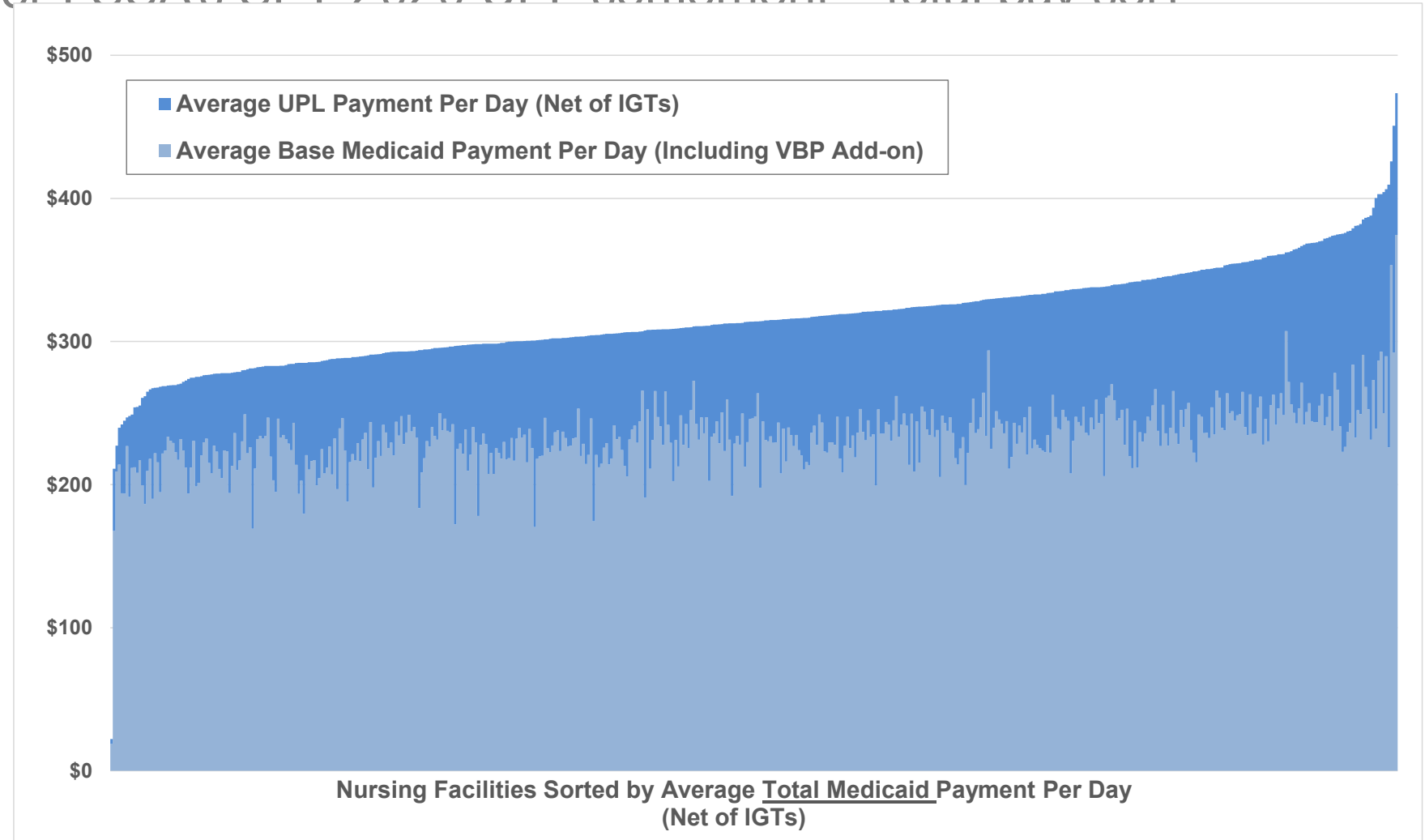
Per FSSA's SFY 2020 UPL settlement – base pay sort



- Average Medicaid payment per day across 502 participating nursing facilities (each bar represents one facility)
- Average UPL payments net of IGTs (federal share) do not necessarily represent the amounts retained by the nursing facilities

NF Distribution of Average Medicaid Payment Per Day

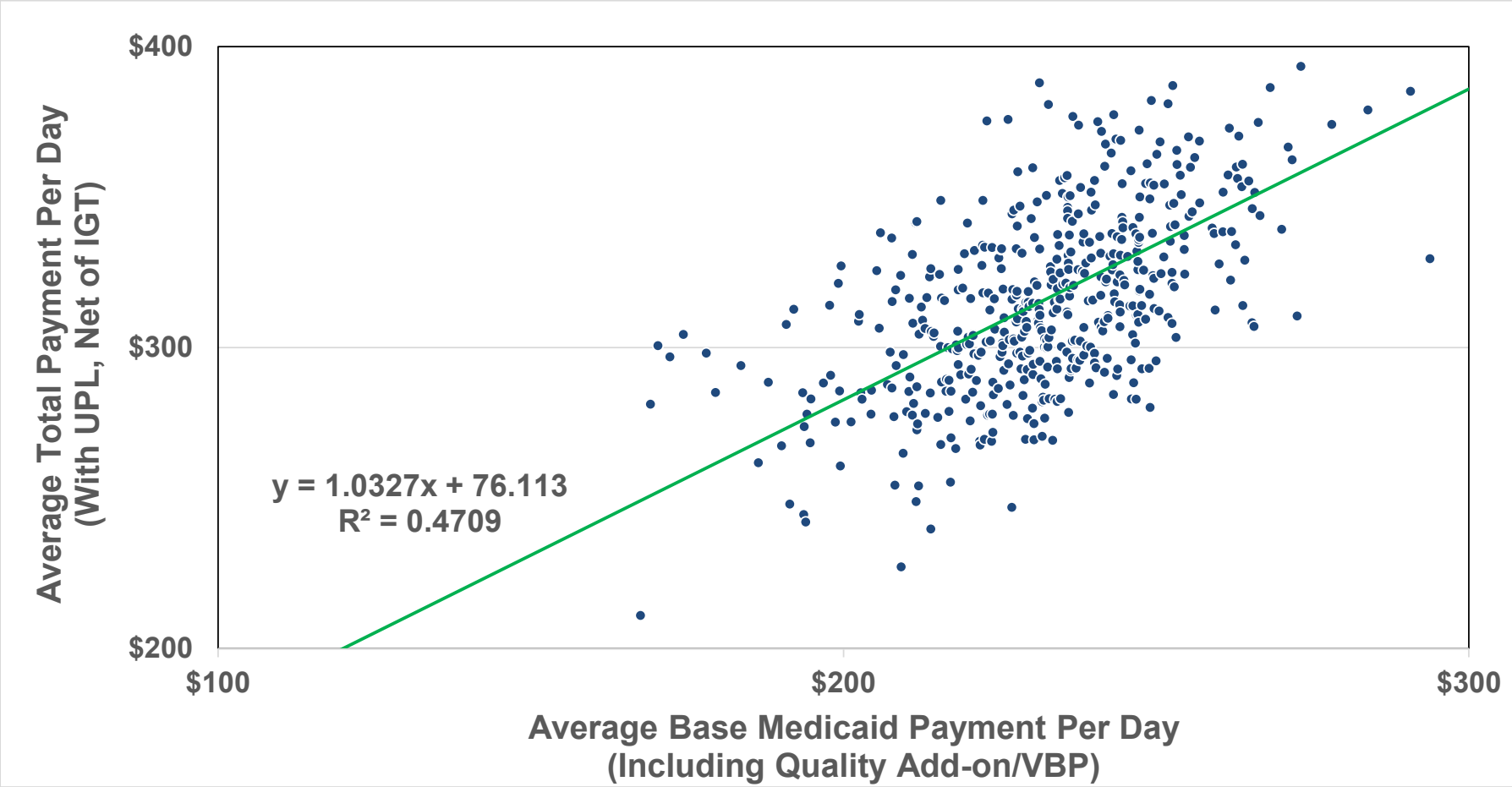
Per FSSA's SFY 2020 UPL settlement – total pay sort



- Average Medicaid payment per day across 502 participating nursing facilities (each bar represents one facility)
- Average UPL payments net of IGTs (federal share) do not necessarily represent the amounts retained by the nursing facilities

Medicaid Base vs. Total Payment Per Day Comparison

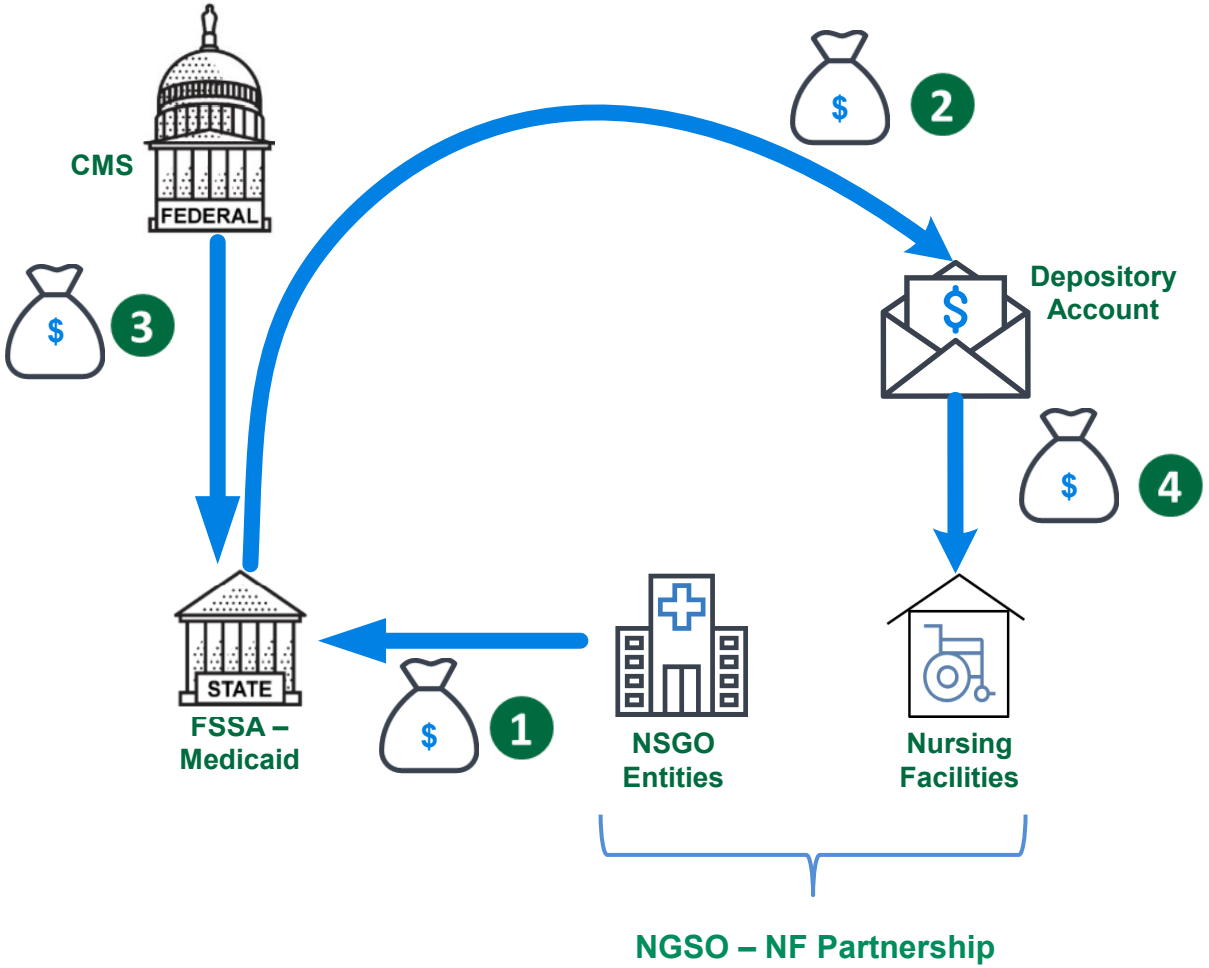
Per FSSA's SFY 2020 UPL settlement



- Each point represents one facility
- R-squared indicates **medium correlation** between base Medicaid rates and the total payments per day (with UPL, net of IGT)

Note: additional outlier nursing facilities not shown in graph axis range

NF UPL Program Funding Flow Process



1. NSGO entities (primarily county hospitals) make IGTs to FSSA based on the non-federal share of pending UPL payment
2. FSSA makes UPL payment to the Depository Account (total computable)
3. CMS provides federal matching funds for the UPL payment
4. Nursing facilities have exclusive access to the depository account for operating expenses for the fiscal year

NF UPL Financing Considerations

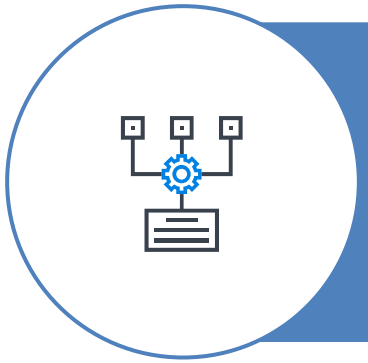
- Supplemental payments and their financing have received significant scrutiny in recent years from CMS / Federal government due to the acceleration of federal supplemental expenditures
- Although CMS' proposed Medicaid Fiscal Accountability Regulation (MFAR) was rescinded, it highlighted CMS' concerns with IGT-funded supplemental payments that will need to be addressed during the federal approval process under MLTSS
- FSSA anticipates that federal approval of managed care supplemental payments:
  - Will require detailed reporting of **IGT contributions**
  - Will require more **insight and transparency** on the distribution of funding to nursing facilities and county hospitals
  - May require IGT contributions based on the projected non-federal share of supplemental payments (as opposed to the final non-federal share)

Questions on Current Methodology

- What is working well?
  - What payment components or targets should the state try to maintain, and why?
  - Should the current FFS UPL methodology be retained for remaining FFS populations after MLTSS transition?
- What should change?
  - What payment components or parameters should be changed, and why?
  - How could the program be adjusted to better align with FSSA goals?

Overview of Managed Care Supplemental Payment Options

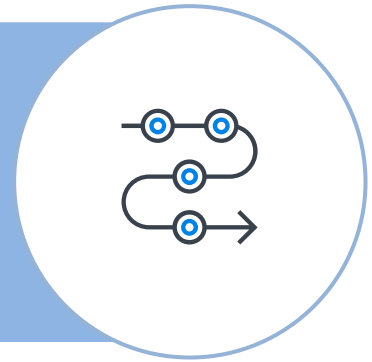
Options for Transitioning NF UPL Program to MLTSS



1. § 438.6(c) state directed payment arrangement

- State directed payment arrangements allow FSSA to require MCEs to make specified payments to providers
- FSSA can require a “directed fee schedule” (ex: Medicare minimum fee schedule, or a payment increase percentage)
- FSSA can also layer in value-based purchasing as a component of the total payment pool (ex: carve out 10% of directed payments, which providers could “earn back” based on quality metrics)

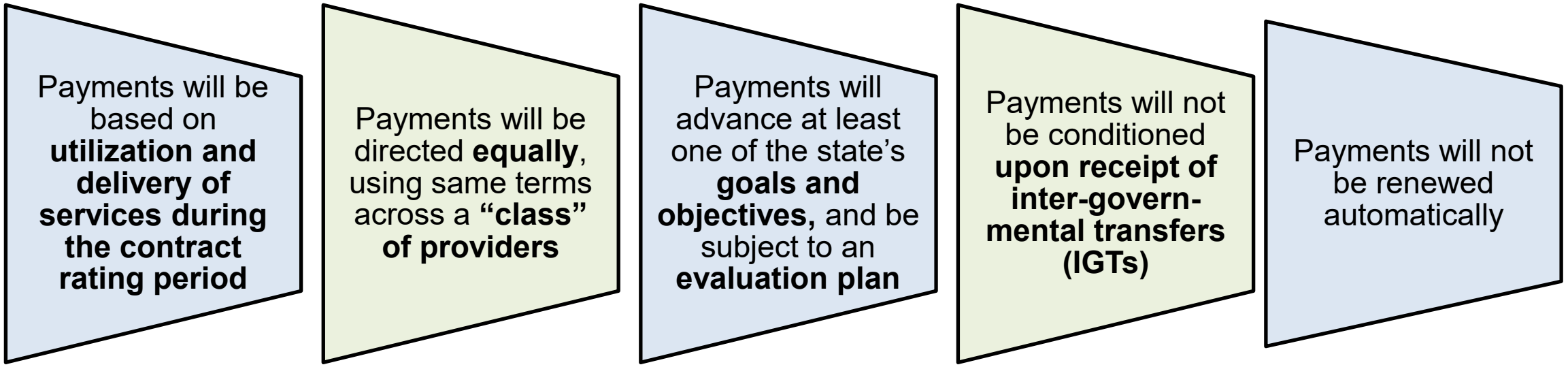
2. Temporary pass through payment program



- Pass-through payments are “add-ons” to the base capitation rate that MCEs are required to pass through to contracted providers
- New Managed Care Final Rule allows states transitioning FFS populations to managed care to create temporary pass through payments for up to 3 years
- New pass through payments would be limited to legacy FFS UPL payments in aggregate, allocated to the populations that transitioned to MLTSS
- FSSA can inform, but cannot direct the provider-level payment distributions by MCEs

CMS Managed Care Directed Payment Criteria

FSSA is considering directed Medicaid managed care supplemental payments under 42 CFR § 438.6(c), and would need to demonstrate in CMS' "Preprint" application the following:



- Standardized measure benchmark: FSSA must demonstrate in the CMS Preprint form that directed payments are below 100% of a standardized measure (for example, benchmarking to Medicare payments) for each provider class
- CMS' Preprint approval process, along with the Federal Consolidated Appropriations Act of 2021, are emphasizing the need for states to demonstrate how their Medicaid supplemental payments are consistent with efficiency, economy, and quality of care

UPL Transition Options Considerations

	Pros	Cons
Directed Payment	▪ Payments can be explicitly tied to quality, outcomes, and current utilization ▪ Payment pool can expand over time in the event of increases in managed care enrollment and utilization ▪ Highly transparent for all involved parties ▪ Can have long-term duration	▪ May result in greater facility-specific impacts, depending on the design ▪ Administrative burden is typically higher than pass through payments (requires annual Preprint, program evaluation, reconciliation, etc.) ▪ May require additional data and information collected from IGT contributing entities
Pass Through Payment	▪ Can provide stability by maintaining the same aggregate payment pool and facility fiscal impacts as the FFS UPL program during MLTSS transition ▪ Administrative burden is typically less than directed payments	▪ State cannot explicitly specify the payment distribution methodology ▪ Has little-to-no transparency (FSSA will not know the final MCE allocations to providers) ▪ Payment pool is capped and cannot expand in the event of increases in managed care enrollment and utilization ▪ Can only last up to 3 years

Permissible directed fee schedule options

- "Uniform Dollar or Percentage Increase" above current negotiated rates (typically a retrospective lump sum payment)
  - Set percentage increase applied to MCE paid amount
  - Set dollar increase per resident day
- "Minimum Fee Schedule" which MCEs can pay no less than for contracted providers (typically a prospective increase applied to negotiated rates, as opposes to separate lump sum payments)
  - Medicare or Medicare-equivalent rate
  - Alternative fee schedule established by the State
  - State plan approved per unit rate (not under consideration)
- "Maximum Fee Schedule" (not under current consideration)

Directed Fee Schedule Considerations

Directed Fee Schedule Option	Pros	Cons
Uniform percent or dollar increase (must be the same % or $$ per unit increase for each facility within a class)	• Can establish a predictable fixed payment pool • Provides consistent increases for each facility within a class • Carries forward differences in Medicaid base payments from quality add-on/VBP and redesigned base rates	• Does not provide flexibility to differentiate payment increases within a provider class • May result in greater facility-specific impacts, depending on the design
Medicare or Medicare-equivalent rate	• Results in consistent total reimbursement levels as the current program	• Not typically paid separately as a lump sum outside of enhanced fee schedule • Difficult to quantify resulting payment increases (if not paid separately as lump sum) • Partially neutralizes differences in Medicaid base payments from quality add-on/VBP and redesigned base rates • Payment pool size less predictable due to variance in utilization • Administrative burden of establishing facility-specific rate enhancements
Alternative fee schedule established by the State	• Provides opportunity to develop a simpler enhanced fee schedule target • Can pay providers at Medicare levels without requiring exact fee schedule	

Value-Based Purchasing Balancing

Range of Value-Based Purchasing Consideration

Full Directed Fee Schedule Increase

- Full directed fee schedule increases without quality pool
- Potential transitional period retaining select existing supplemental payments
- May require quality portion beginning in years 2-3

Mix of Directed Fee Schedule and Quality Payment Pool

- Majority of payment pool dedicated to directed fee schedule increases
- Smaller quality pool with pay-for-performance requirements where providers can “earn back” full increases (or other payment targets)

Full Quality Payment Pool

- Full quality payment pool without directed fee schedule
- Quality metrics could include mix of baseline qualifications and higher thresholds

Directed Uniform Payment Increases

Other State Nursing Facility Examples

Key Considerations	Texas: Quality Incentive Payment Program	Arizona: Nursing Facility Supplemental Payment Program
Total Annual Payment Pool	• Approximately $1.1 billion payment pool	• Approximately $100 million+ payment pool
Non-Federal Funding Source	• IGTs	• NF assessment
Eligible providers	• NSGO NFs and private NFs with at least 65% Medicaid days	• All contracted Medicaid nursing facilities
Payment Distribution Method	• Payments include the following components: – *All participating facilities:* Workforce development and national quality benchmark components (allocated based on share of Medicaid days) – *NSGOs only:* Quality assurance performance improvement validation and quality components (covering IGT contributions and allocated based on share of Medicaid days)	• Allocated based each facility's share of total Medicaid bed days

Directed Minimum Fee Schedules

Physician Services Medicare Fee Schedule Examples

Indiana: Directed Medicare Fee Schedule	Hawai`i: Directed Alternative Fee Schedule
• Under HIP, FSSA contractually requires MCEs to reimburse physician and ancillary providers no less than the Medicare fee schedule effective as of the incurred date of the service • No separate lump sum payment or retroactive settlement • Typically approach used nationally for Medicare minimum fee schedules	• Med-QUEST requires plans to pay an enhanced fee based on historical Medicare payment levels for eligible PCP and OB providers for select HCPCS • Plans can negotiate at fee schedules lower than Medicare • In our research to date (still on-going), this is the only example we have identified where rate enhancements are calculated retrospectively and paid as lump sum payments (based on the difference between Medicare and encounter paid amounts)

Questions on New Supplemental Payment Program

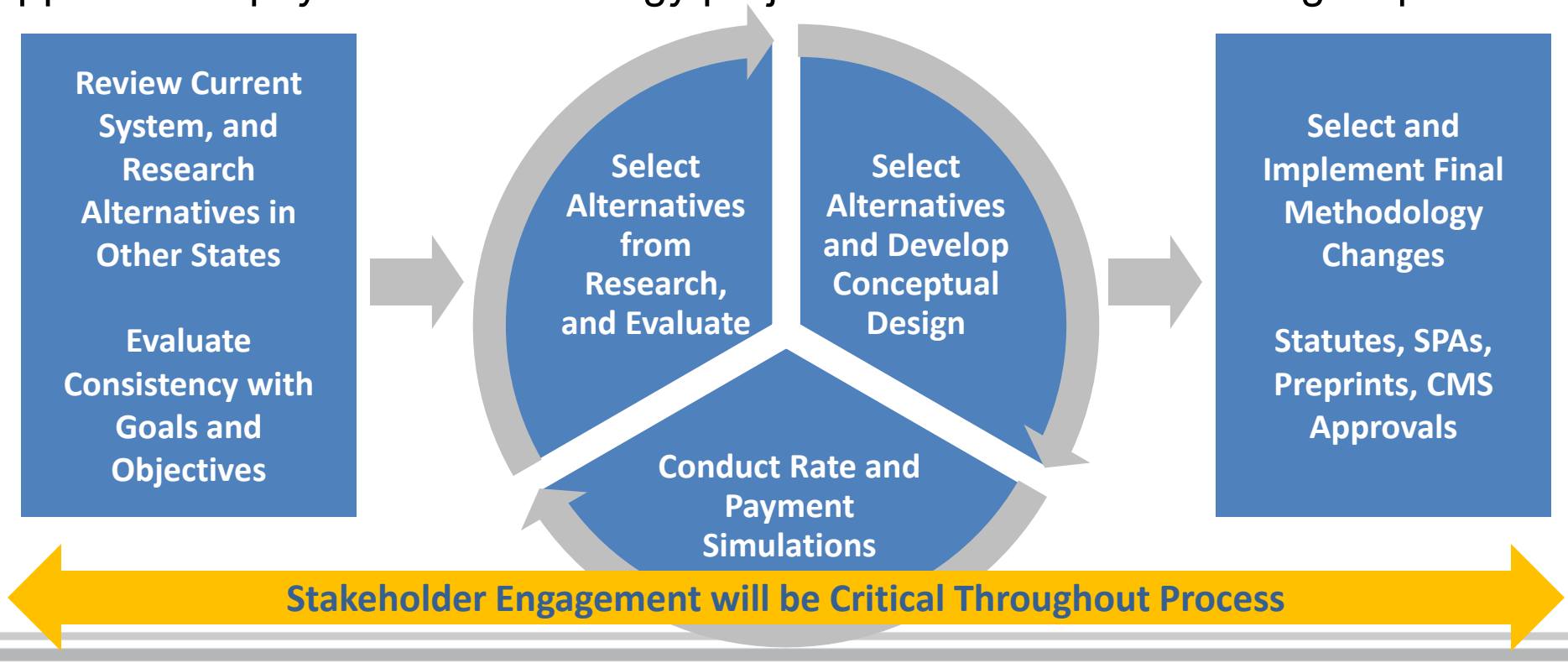
- What is the appropriate target aggregate expenditure level?
- How closely should the supplemental payments align with the differences in base Medicaid payments (in coordination with the base rate work stream)?
- What is the optimal supplemental payment allocation methodology?
- How can the distribution of payments to NFs and NSGO entities be better defined?
- What is the appropriate balance of utilization vs. quality-based payments?
- What are the appropriate quality metrics and performance targets (in coordination with the base rate work stream)?

Project Methodology

Project Approach

Overall Project Approach

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



NF Supplemental Payment Evaluation Criteria

Potential Evaluation Criteria

Supplemental payment 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 with other programs.

NF Supplemental Payment 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** – Supplemental payment methodology must be compatible with transition to managed care environment.

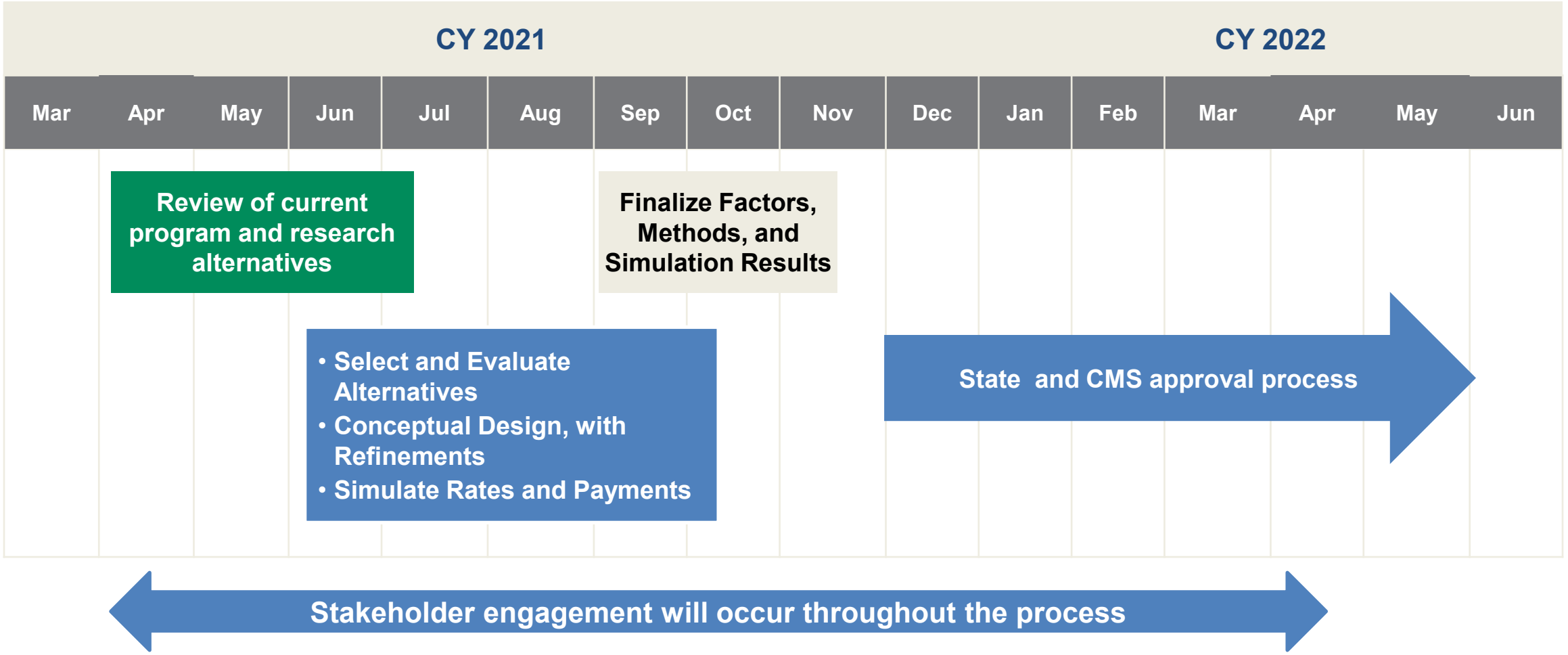
Planned Research

- National review of NF supplemental payment methodologies to identify 6-8 “Exemplar States” with an emphasis on directed payment programs
- Summarize Indiana and Exemplar States’ information and performance outcomes in matrix format for review and evaluation
- Components to be considered include:
  - Payment pool target
  - Payment distribution method
  - Quality metrics relied upon
  - Financing method
- Evaluate program parameters against NF Supplemental Payment Evaluation Criteria to determine optimal methodologies to meet FSSA goals

Potential Considerations

- How the option meets each of FSSA’s goals for the program
- CMS compliance
- Consideration of the level of effort to develop and administer
- Analysis of risks and benefits
- Potential for incorporation into VBP methodologies and strategies

Nursing Facility 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 groups, 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

- Please send input on suggested research and analysis
- Next meetings
  - *Preliminary results of research and analysis: July*
  - *Follow-up analysis, evaluation of options, and first conceptual design: August*
- Meeting topics and agendas to be developed and sent five business days in advance of the Workgroup meetings
- New workgroup members may email backhome.Indiana@fssa.in.gov to be added to the mailing list for this workstream

Questions?

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.

The information contained in this presentation has been prepared solely for the business use of FSSA, related Divisions, and their advisors for a provider stakeholder workgroup meeting presentation on June 3, 2021. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in health care modeling that will allow appropriate use of the data presented.

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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.