# Medicaid Nursing Facility Reimbursement
# Nursing Facility Base Rates
# Stakeholder Meeting #2

Indiana Family and Social Services Administration

July 15, 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

# FSSA Reimbursement Goals

To develop Nursing Facility (NF) 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.**

# Agenda

- Consideration of Potential Changes
- Analysis of Case Mix Index (CMI) and Direct Care Cost
- State Research
- Next Steps

# Consideration of Potential Changes

# Revisit - Overview of Rate Components

**(Example for illustration purposes only – not an actual facility)**

Today's discussion will focus only on the following "core" rate components:

- Direct Care
- Indirect Care
- Administrative

Other components shown will be addressed as part of the Stakeholder Meeting #3 discussion.

# Revisit - Overview of Rate Component Adjustments and Limits

| Rate Component | Case Mix Adjusted ? | Minimum Occupancy Adjustment for Fixed Portion | | Allowed Profit - Difference between Component Facility-Specific and Median Cost Per Day | | | | Overall Rate Component Limit |
|---|---|---|---|---|---|---|---|---|
| | | Applied? | Assumed Fixed Portion of Component Costs | Allowed? | Maximum Allowed Percent of Difference | Maximum Allowed Percent of Median Component Cost | Subject to Quality Metric Score? | |
| Direct Care | Yes | Yes | 25% | Yes | 30% | 10% | Yes | 120% CMI Adjusted Median |
| Therapy | No | No | NA | No | NA | NA | NA | None |
| Indirect Care | No | Yes | 37% | Yes | 60% | 5% | Yes | 115% Median |
| Administrative | No | Yes | 84% | Component set at median component value, so no limit on profit if costs < median | | | No | 100% Median |
| Capital | No | Yes | 100% | Yes | 60% | None | Yes | 100% Median |

# Core Rate Components – Key Observations

| CONSIDERATION | DISCUSSION |
|---|---|
| **CMI Adjustment** | • No correlation between facility CMI and cost per day values<br>• Correlations do not improve when considering multiple variables<br>• Some form of CMI adjustment may still be necessary to assure access to services for high acuity residents<br>• Also necessary to apportion cost between Medicaid and other payer |
| **Complexity and Frequency** | • Methodology could be simplified and streamlined<br>• Could stabilize rates by reducing frequency of acuity updates<br>• Types of costs included in various components may benefit from re-alignment |
| **Limitations to a Cost-based Approach** | • "Locks in" historical cost structure – rewards historical inefficiency and a erects a barrier to investing in staffing and other improvements<br>• Cost of annual cost reporting, desk reviews, and audits<br>• Administrative burden of frequent updates and multiple retroactive changes<br>• Slow to reflect changes in the environment (e.g. pandemic or wage inflation) |

# Direct Care Cost as a Function of Facility Average CMI

Direct Care Per Patient Day Cost ($)

350
300
250
200
150
100
50
0

0.60 0.80 1.00 1.20 1.40 1.60 1.80

Facility Average CMI

$y = -4.8895x + 111.42$
$R^2 = 0.0011$

# Straw Man Options for Consideration: Core Rate Components

| Option 1: Current Cost Based, with Simplifications | Option 2: Price Based, Adjusted Using Facility CMI | Option 3a: Price Based, Tied to Resident CMI | Option 3b: Price Based, Tied to Resident CMI "Tiers" |
|---|---|---|---|
| ▪ Establish "core" component rates using predetermined percentile (e.g., median value or other)<br>➢ Direct Care and Indirect Care – **continue lesser of facility specific or percentile**<br>➢ Administrative – percentile<br>▪ Same as Option 2 otherwise | ▪ Establish **statewide standardized rates for all three "core" components** using predetermined percentile (e.g., median value or other)<br>▪ Remove adjustments for profit allowance, occupancy and total component caps<br>▪ Establish rates for **3-5 year** period, based on **desk reviewed** costs, with interim year updates tied to indexing value<br>▪ Continue to adjust for **facility average Medicaid CMI**, but less frequently -<br>➢ Establish reasonable corridor, and adjust for changes in Medicaid CMI only when actual CMI is outside of corridor | ▪ Same as Option 2, except for CMI adjustment, described below<br>▪ Instead, adjust the single statewide standardized Direct Care rate component to establish a single statewide rate for each of the **48 CMI groups** | ▪ Same as Option 3a, but collapse the 48 CMI groups into a smaller number of "tiers" (for example, **5-6 "tiers"**) |

Consideration should also be given to the potential transition to the Patient Driven Payment Model (PDPM) for future CMI measurement

# Straw Man Options for Consideration: Option 3a Illustration – 48 CMI Groups

Note: Values shown below are not actual, and are for illustration purposes only

Sample of CMI Groups for Illustration Purposes: Total of 48 CMI Groups

| CMI Classification (A) | CMI Relative Weight (B) | Direct Care Base for 1.00 CMI (C) | CMI-Adjusted Direct Care Rate (D=B*C) | Other Rate Components (E) | Standard Rate for CMI Group (F=D+E) |
|---|---|---|---|---|---|
| Base (CMI 1.00) | 1.00 | $85.00 | $85.00 | $100.00 | $185.00 |
| | | | | | |
| ES3 | 3.00 | $85.00 | $255.00 | $100.00 | $355.00 |
| ES2 | 2.23 | $85.00 | $189.55 | $100.00 | $289.55 |
| ES1 | 2.22 | $85.00 | $188.70 | $100.00 | $288.70 |
| | | | | | |
| CE2 | 1.39 | $85.00 | $118.15 | $100.00 | $218.15 |
| CE1 | 1.25 | $85.00 | $106.25 | $100.00 | $206.25 |
| CD2 | 1.29 | $85.00 | $109.65 | $100.00 | $209.65 |
| CD1 | 1.15 | $85.00 | $97.75 | $100.00 | $197.75 |
| | | | | | |
| PB2 | 0.70 | $85.00 | $59.50 | $100.00 | $159.50 |
| PB1 | 0.65 | $85.00 | $55.25 | $100.00 | $155.25 |
| PA2 | 0.49 | $85.00 | $41.65 | $100.00 | $141.65 |
| PA1 | 0.45 | $85.00 | $38.25 | $100.00 | $138.25 |

# Straw Man Options for Consideration: Option 3b Illustration – 6 Case Mix Tiers

Note: Values shown below are not actual, and are for illustration purposes only

| Case Mix Tier (A) | Tier Relative Weight (B) | Direct Care Base (C) | CMI-Adjusted Direct Care Rate (D=B*C) | Other Rate Components (E) | Standard Rate for Tier Group (F=D+E) |
|---|---|---|---|---|---|
| 6 | 2.4 | $85.00 | $204.00 | $100.00 | $304.00 |
| 5 | 1.6 | $85.00 | $136.00 | $100.00 | $236.00 |
| 4 | 1.3 | $85.00 | $110.50 | $100.00 | $210.50 |
| 3 | 1.1 | $85.00 | $93.50 | $100.00 | $193.50 |
| 2 | 0.9 | $85.00 | $76.50 | $100.00 | $176.50 |
| 1 | 0.7 | $85.00 | $59.5 | $100.00 | $159.50 |

# Straw Man Options for Consideration: Key Decision Points

| Decision Point | Option | Option |
|---|---|---|
| **Pure Price Based - Or - Facility Specific with Cap** | **Option 2: Pure Price Based** | **Option 1: Facility Specific with Cap** |
| | • Simpler, transparent, and understandable<br>• Rewards efficiency<br>• Enhances payment equity<br>• Where CMI does not fully reflect resource needs, may need adjustment (specialty facilities)<br>• Financial incentive to reduce staffing, although this could be mitigated by robust quality payments | • Reduces financial incentive to reduce staffing<br>• Continued reliance on facility specific cost data |
| **Facility CMI - Or - Resident CMI** | **Option 2: Facility CMI** | **Option 3a: Resident CMI** |
| | • The current approach, familiar<br>• Each facility has a different average CMI, so 500+ rates | • Rates follow residents – immediately – no lag between admitting a high acuity resident and higher reimbursement<br>• Requires each resident to have an assessment |
| **48 CMI Groups Or Collapse** | **Option 3a: One Rate for Each CMI (48)** | **Option 3b: Group CMIs into 5 – 6 Tiers** |
| | • Each Rate has Direct Correspondence to CMI | • Grouping CMIs simplifies reimbursement<br>• Broader range of acuity in each tier |

# Straw Man Options for Consideration: Key Advantages and Disadvantages

| Option | Key Advantages | Key Disadvantages |
|---|---|---|
| **Option 1: Current Cost Based, with Simplifications** | • Fewer changes, so potentially less fiscal impact to providers in the long term<br>• May create additional incentive to increase nursing and other care-related resources, but also dependent on other quality incentive components | • Separate rate for each facility<br>• Facility-specific rates not consistent with objective to simplify rate-setting process |
| **Option 2: Price Based, Adjusted Using Facility CMI** | • Significant movement toward simplicity<br>• Enhances payment equity across facilities<br>• Creates significant incentives for cost effectiveness | • Separate rate for each facility<br>• Facility-specific rates not consistent with objective to simplify rate-setting process<br>• More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins |
| **Option 3a: Price Based, Tied to Resident CMI** | • One statewide rate for each CMI group (48 rates)<br>• Significant simplification<br>• Enhances payment equity across facilities<br>• Creates significant incentives for cost effectiveness | • More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins |
| **Option 3b: Price Based, Tied to Resident CMI "Tiers"** | • One statewide rate for each CMI group "Tier" (e.g., 5-6 rates)<br>• Significant simplification<br>• Enhances payment equity across facilities<br>• Creates significant incentives for cost effectiveness | • More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins |

# Straw Man Options for Consideration: Preliminary Evaluation of Options using Evaluation Criteria

| Option | Resulting Number of Rates | Evaluation Criteria (Scoring: 5 = High, 3 = Neutral, 1 = Low) | | | |
|---|---|---|---|---|---|
| | | Quality, Access, and Reducing Disparities | Efficiency and Payment Equity | Transparency, Simplicity and Predictability | Alignment and Forward Compatibility |
| **Option 1: Current Cost Based, with Simplifications** | One rate for each facility | **3**<br><br>(Dependent on separate quality incentive component) | **3** | **1** | **3** |
| **Option 2: Price Based, Adjusted Using Facility CMI** | One rate for each facility | | **4** | **3** | **4** |
| **Option 3a: Price Based, Tied to Resident CMI** | One statewide rate for each CMI group (48) | | **5** | **5** | **5** |
| **Option 3b: Price Based, Tied to Resident CMI “Tiers”** | One statewide rate for each CMI group “Tier” (e.g., 5-6) | | **5** | **5** | **5** |

# Straw Man Options for Consideration: Mitigating the Impacts of Rate-Setting Changes

- Transition to a simplified cost-based model, such as Option 1, would likely have little impact on payments, and may not require a transition strategy
- Transition to a price based model (e.g., Options 2, 3a, or 3b) may result in significant fiscal impacts to individual providers
- If selected, may need to establish a payment transition approach to help mitigate the fiscal impacts
- Mitigation options include:
  - Temporarily maintain current methodology in parallel with new methodology implementation, and blending rates for providers on a time limited basis (e.g., first 2 years). This approach would increase the complexity of the change for the transition period.
  - Prospectively establish rates under the new methodology on a time limited basis that are proportionally adjusted to limit the "gains" or "losses" to a predetermined percentage (e.g., no more or less than 5% change in year 1, and 10% in year 2). Rates could be determined in advance, and would not increase the complexity beyond the initial implementation of the change.

# Analysis of CMI and Direct Care Cost

# Direct Care Cost as a Function of Facility Average CMI

**Sub-Splits We Examined for Significance:**

- Urban/Rural
- Private/Public
- Profit/Non-Profit
- UPL/Non-UPL Facilities
- Large/Small Facilities (Defined as a Minimum of 100 Beds)
- Medicaid Utilization (High vs. Low, High is 70% Minimum)
- Percent of Non-White Residents (High vs. Low, High is 25% Minimum)
- Medicaid CMI (High vs. Low, High is 1.2 Minimum)

**Of the sub-splits examined, none produced a significant correlation between facility average CMI and direct care per patient day cost.**

# Direct Care Cost as a Function of Facility Average CMI: Rural Facilities

# Direct Care Cost as a Function of Facility Average CMI: Urban Facilities

$y = -6.8004x + 116.99$
$R^2 = 0.0024$

Direct Care Per Patient Day Cost ($)

200
180
160
140
120
100
80
60
40
20
0

0.60 0.80 1.00 1.20 1.40 1.60 1.80

Facility Average CMI

# Direct Care Cost as a Function of Facility Average CMI: High % Non-White Facilities (At Least 25%)

$y = 38.111x + 63.634$
$R^2 = 0.1101$

Direct Care Per Patient Day Cost ($)

180
160
140
120
100
80
60
40
20
0

0.60 0.80 1.00 1.20 1.40 1.60 1.80

Facility Average CMI

# Direct Care Cost as a Function of Facility Average CMI: Low % Non-White Facilities (Less Than 25%)

$y = -16.547x + 124.47$
$R^2 = 0.0111$

Direct Care Per Patient Day Cost ($)

350
300
250
200
150
100
50
0

0.60 0.80 1.00 1.20 1.40 1.60 1.80

Facility Average CMI

# Direct Care Cost as a Function of Facility Average CMI: Large Facilities (100 Beds or More)

y = -0.9187x + 106.77
$R^2$ = 6E-05

Direct Care Cost Per Patient Day Cost ($)

Facility Average CMI

# Direct Care Cost as a Function of Facility Average CMI: Small Facilities (Less Than 100 Beds)

Direct Care Per Patient Day Cost ($)

350
300
250
200
150
100
50
0

$y = -9.3044x + 116.44$
$R^2 = 0.0027$

0.60 0.80 1.00 1.20 1.40 1.60 1.80

Facility Average CMI

# State Research

# Rebasing Frequency

States update the maximum allowable payment rates periodically

- 23 states rebase annually (**Indiana**)
- 15 states update every two to four years
- 11 states have other processes
- 2 states have no method found in MACPAC review

| State | Rebasing Frequency/Process |
|---|---|
| **Arkansas** | Direct care component of rate is rebased annually; indirect, administrative, and operating cost components rebased at least once every three years with the existing per diem inflated forward into the next rate period using the inflation index. |
| **Florida** | Every 4th year, nursing home prospective payment rates are rebased to reflect changes in cost based on the most recently audited cost report for each participating provider |
| **Louisiana** | Every 2nd year, base resident-day-weighted median costs and prices based using most recent four month or greater unqualified audited or desk reviewed cost reports available, or the Department may apply historic audit adjustment factor to most recently filed cost reports. In between rebasing, index factor is applied to base resident-day weighted medians and prices. |
| **Maryland** | Each cost center rebased between every two and four rate years. Prices rebased more frequently if State determines an error in data or in calculation that results in substantial difference in payment, or if significant change in provider behavior or costs resulted in inequitable payment across providers. In years in which prices are not rebased, prices subject to annual indexing. |
| **New Hampshire** | Rates rebased at least every 5 years with limitations: (1) Only when rates are rebased are costs inflated; (2) Costs are inflated to rate year midpoint using CMS prospective payment system (PPS) skilled nursing facility input price index by expenses category index; (3) Resulting rate reduced by budget adjustment factor equal to 26.82% in accordance with Medicaid State Plan. |

*Source: MACPAC States Medicaid Fee For Service Nursing Facility Payment Policies, 2019*

# Underlying Basis for Rates

States generally utilize facility costs or set a specific allowable price to determine maximum payment to facilities

- 32 states use facility costs (**Indiana**)
- 15 states set allowable price
- 3 states use mix of facility costs and allowable prices
- 1 state uses lesser or private pay charge or facility cost

| State | Price Based Rates |
|---|---|
| **Kentucky** | Fair-market pricing and historical cost analysis for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost. Standard price comprised of following components and percentages of total rate:<br>1. Personnel 65%<br>2. Non-personnel operating 6%<br>3. Administration 13%<br>4. Food 4%<br>5. Professional supports & consultation 2%<br>6. Non-capital facility related cost 3%<br>7. Capital rate 7% |
| **Louisiana** | Rates based on case-mix price-based system calculated from cost report and other statistical data. |
| **New York** | Direct and indirect prices are a blend of statewide price and peer group price. Direct price subject to case mix adjustment and wage index adjustment. Indirect price subject to wage index adjustment. |
| **Texas** | Direct and indirect care prices are 107% of median peer group per diem costs |

*Source: MACPAC States Medicaid Fee For Service Nursing Facility Payment Policies, 2019*

# Acuity System

Adjustments to the basic payment methodology based on resident acuity levels

- 35 states use RUGs (**Indiana**)
- 7 states use another state-specific method
- 9 states have no acuity adjustment/none found in MACPAC review

| State | State-Specific Adjustment Method |
|---|---|
| **Arizona** | Prospective per diem reimbursement system recognizes members in 4 levels (1-3, ventilator dependent/other specialty care) as identified through medical and functional assessment data from Pre-admission Screening (PAS) instruments (initial and reassessments) from most recent 6 months proceeding rate effective date |
| **Delaware** | Primary patient care cost center based on patient index system in which all nursing home patients are classified into patient classes: 0 – Independent, 1 – Supervision, 2 – Moderate assistance, 3 – Maximum assistance through evaluation by Medicaid review nurses according to amount of staff assistance needed for activities of daily living |
| **Maine** | 44 case mix resident classification groups based on Resident Assessment Instrument (RAI) tool comprised of the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs) |
| **Massachusetts** | 6 patient groups based on nursing management minutes measuring resident care intensity by discrete caregiving activities or the characteristics of residents requiring a given amount of care |

*Source: MACPAC States Medicaid Fee For Service Nursing Facility Payment Policies, 2019*

# Rate Adjustments: Ventilator Care

Adjustments to the basic payment methodology for specific types for nursing facilities with ventilatory dependent patients

- 37 states provide an adjustment: either add-on to base rate or separate all-inclusive fixed rate

| State | Example Ventilator Adjustments |
|---|---|
| Indiana | Additional $11.50 per Medicaid resident day provided to nursing facilities that provide inpatient services to more than eight ventilator-dependent residents, as determined by MDS data |
| **Alabama** | $120.00 supplemental daily payment for ventilator-dependent/tracheostomy resident indexed annually |
| **Arizona** | Ventilator dependent residents are one of 4 base rate reimbursement levels |
| **Florida** | $200 add-on per Medicaid day of 40,000 ventilator Medicaid days per fiscal year |
| **Georgia** | All-inclusive per diem rate of $540.55 that covers all skilled nursing care services for a ventilator dependent resident |
| **Idaho** | Calculation of a staffing wages and equipment costs add-on to cover the additional direct care staff and equipment/supply requirements to meet needs of ventilator-dependent residents |
| **Illinois** | $208 add-on per day for each individual resident receiving ventilator services |
| **Iowa** | Ventilator reimbursement rate equal to Medicare-certified hospital-based nursing facility direct care patient-day-weighted median times 120% times the provider's Medicaid average case mix index, plus Medicare-certified hospital-based nursing facility non-direct care rate patient-day-weighted median times 110% |
| **Mississippi** | Additional $178.34 per diem rate for beneficiaries receiving ventilator dependent care |
| **Rhode Island** | $200.00 differential rate to providers of ventilator bed services; limited to a maximum of 30 beds on a statewide basis |

*Sources: MACPAC States Medicaid Fee For Service Nursing Facility Payment Policies, 2019*
*https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/GA/GA-19-0013.pdf*

# Rate Adjustments: Specialty Care

## Mental Health or Cognitive Impairment Add-On

- 22 states provide rate adjustment for nursing facilities caring for patients suffering from mental, behavioral, or cognitive impairments, such as traumatic brain injuries, dementia, and Alzheimer's

## Other High-Need Condition Add-On

- 21 states provide rate adjustments for nursing facilities caring for patients suffering from conditions requiring specialized assistance, such as AIDS

| State | Examples |
|---|---|
| **Colorado** | For residents with severe cognitive dementia or acquired brain injury, supplemental payment based on resident's Cognitive Performance Scale (CPS) score. $1 - $3 add-on based on CPS percentage greater than mean plus 1-3 standard deviations. |
| **District of Columbia** | Add-on payment for each resident who qualifies as behaviorally complex or bariatric |
| **Georgia** | Rates adjusted from 1-4.5% based on percentage of Medicaid patients whose Brief Interview for Mental Status (BIMS) score are less than or equal to five. |
| **Illinois** | Per diem rates $264.14 - $767.46 for residents with traumatic brain injuries; $0.63 per diem add-on for residents who score I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia |
| **Mississippi** | Annually, new bed value adjustment for licensed Alzheimer's units' beds will be determined by multiplying the nursing facility new bed value by 37.20%, to account for the additional construction costs required to be licensed as an Alzheimer's unit. |
| **Nevada** | Three-tiered add-on rate for behaviorally complex individuals ranging from $111.23 - $326.26 |

*Source: MACPAC States Medicaid Fee For Service Nursing Facility Payment Policies, 2019*

# Next Steps

# Nursing Facility Reimbursement – Project Timelines

| CY 2021 | | | | | | | | | | | | | CY 2022 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |

**Review of current program and research alternatives** (Apr – Jul 2021)

**Finalize Rates, Methods, and Simulation Results** (Sep – Nov 2021)

- Select and Evaluate Alternatives
- Conceptual Design, with Refinements
- Simulate Rates and Payments

(Jun – Oct 2021)

**State and CMS approval process** (Dec 2021 – Jun 2022)

**Stakeholder engagement will occur throughout the process**

# Next Steps

- Focus on other rate components:
  - Therapy Component
  - Capital Component
  - Assessment Add-On
  - Ventilator Add On
  - Special Care Unit Add-on
- VBP Add-on component will continue to be addressed as part of the separate VBP workstream

# Next Steps

- Please continue to send input
- Next meeting August 19, 2021
- 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

# 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 July 8, 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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*In performing the analysis supporting this presentation, we relied on data and other information provided by FSSA and its vendors, and specifically from data provided by FSSA's rate setting contractor, Myers & Stauffer. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.*

*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.***