Indiana Medicaid
Long Term Supports and Services (LTSS)
Finance Work Group

Reimbursement Topics

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
February 1, 2021

Why Reform Indiana's LTSS System?

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.

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

Indiana's Path to LTSS 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 HCBS within 72 hours
2. Move LTSS into an mLTSS 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

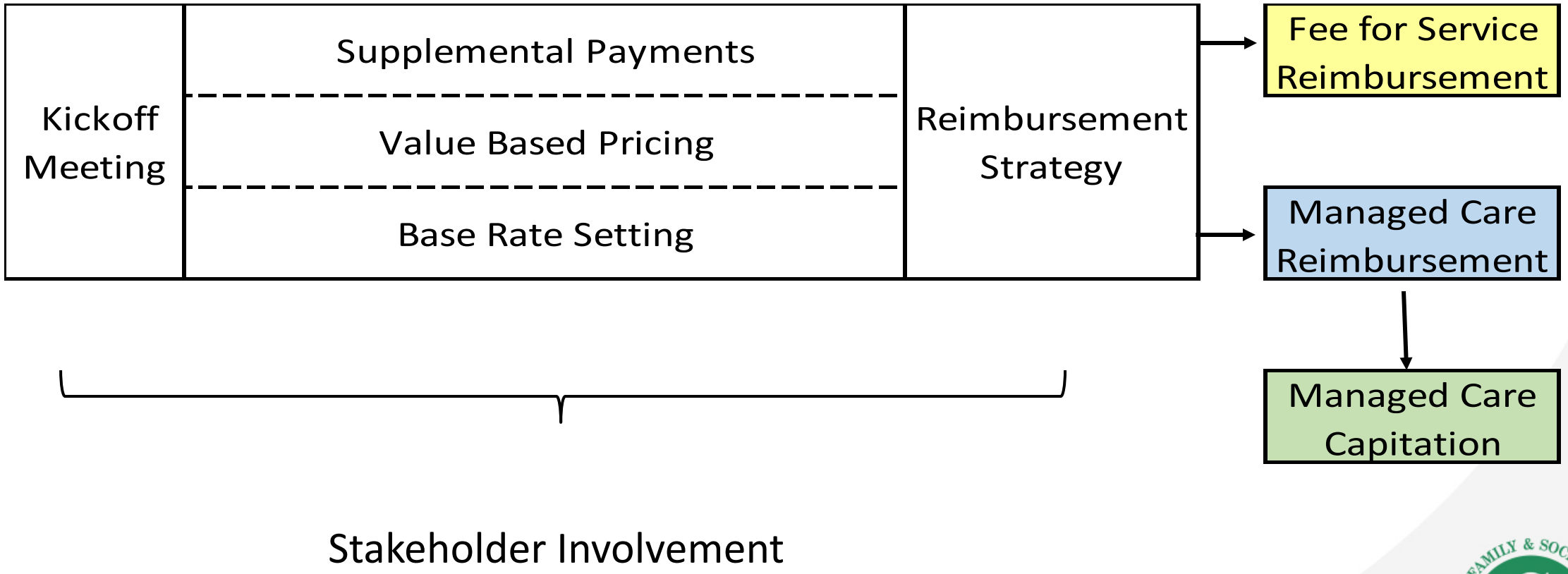
*All KR work will be coordinated with Medicaid supplemental payment reform and depends upon finalization of federal guidelines

Rate Methodology Goals and Objectives

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

1. **Alignment and Transparency** - bring continuity and alignment across the rate methodologies and rates for all programs, providing a consistent framework
2. **Sustainability** - facilitate adequate participant access to services and be sustainable under the FSSA budget and operations
3. **Promotion of Person-Centeredness and Value-Based Purchasing** - striving to align provider and participant incentives to achieve access to person-centered services, encourage appropriate utilization, and drive healthy outcomes for all Hoosiers that we serve

LTSS Reimbursement Review – Project Approach



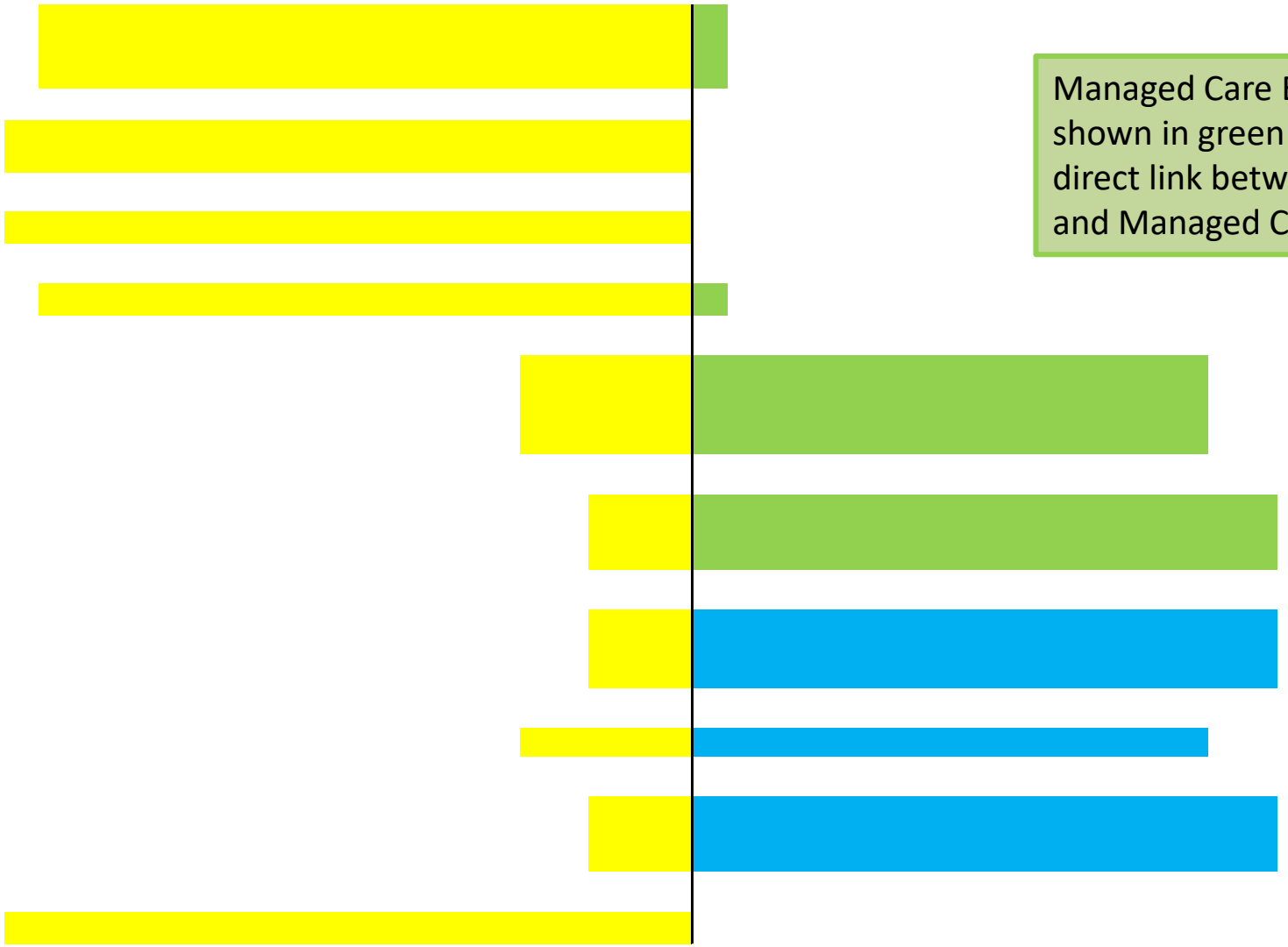
Current View: FFS / Managed Care Reimbursement Connection

Dollar amounts below are CY19 Managed Care Encounter Claims (in millions)

Current Managed Care Programs				
Service Category	**HCC**	**HHW**	**HIP**	**Directed Payments**
IP Hospital	$282	$291	$793	FFS
OP Hospital	$269	$197	$732	FFS
Pharmacy	$304	$150	$616	
Ancillary	$71	$129	$176	
Physician	$119	$176	$402	Medicare
Total	**$1,045**	**$943**	**$2,719**	
% Directed Payments	**53%**	**52%**	**71%**	

SFY 20 Expenditures – Current View: FFS / Managed Care

SERVICE	SFY 2020
Nursing Facility Base Rates	$1,644
Nursing Facility UPL	$1,045
HCBS Waiver Svcs	$443
Home Health	$311
Hospital Inpatient	$1,826
Hospital Outpatient	$1,433
Pharmacy	$1,339
Ancillary	$493
Physician	$970
Other	$227



Managed Care Expenditures are shown in green for services with direct link between FFS rates and Managed Care rates

SFY 20 Expenditures – Future View: FFS / Managed Care

SERVICE	SFY 2020
Nursing Facility Base Rates	$1,644
Nursing Facility UPL	$1,045
HCBS Waiver Svcs	$443
Home Health	$311
Hospital Inpatient	$1,826
Hospital Outpatient	$1,433
Pharmacy	$1,339
Ancillary	$493
Physician	$970
Other	$227

Expenditures shown in gray are illustrative and will vary depending on program population and design. Reimbursement for these expenditures will need to be determined.

Nursing Facility Medicaid Rates

VIEW	SERVICE	SFY 2020	FEE FOR SERVICE	MANAGED CARE
Current	Nursing Facility Base Rates	$1,644		
Future	Nursing Facility Base Rates	$1,644		

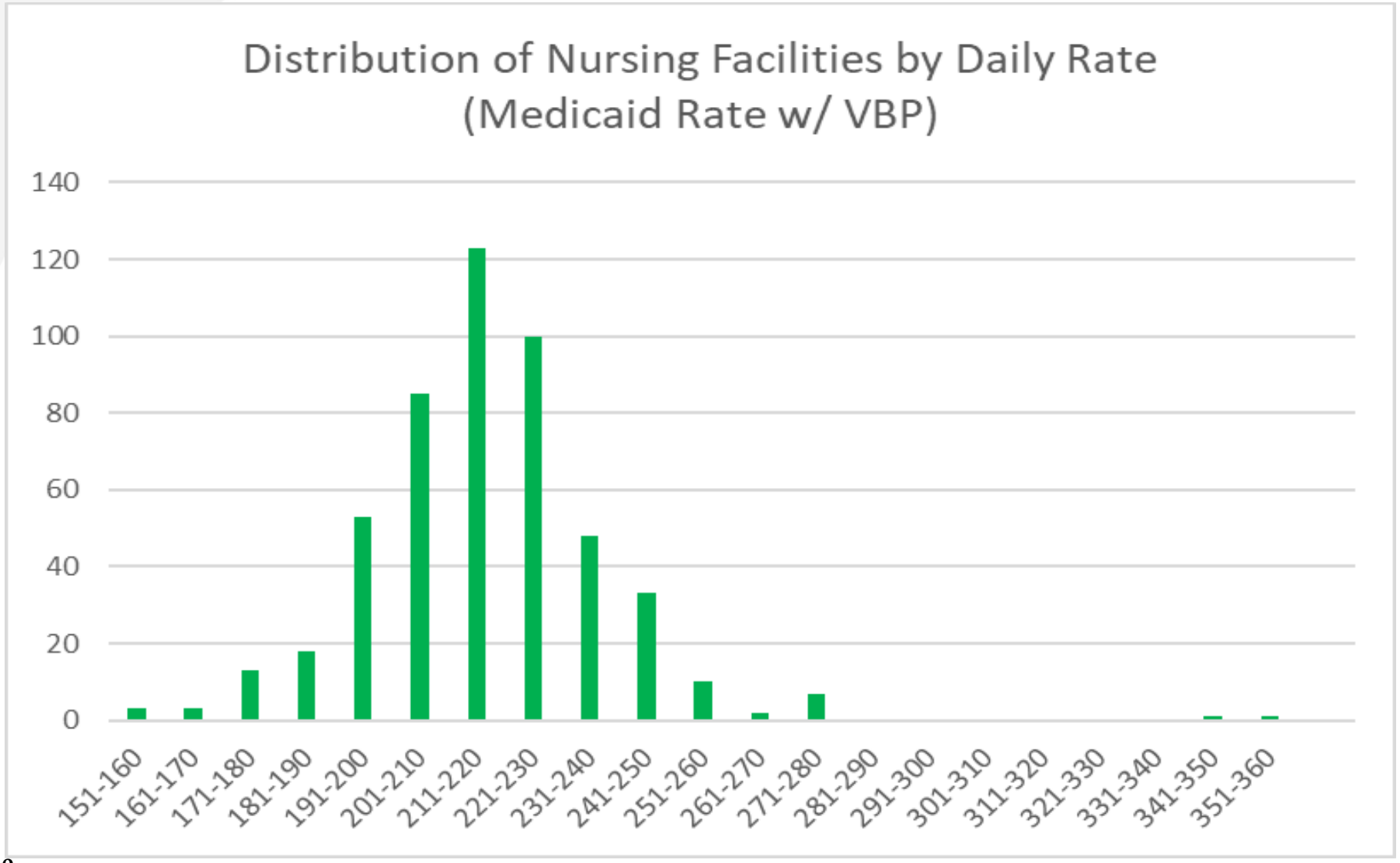
Current View

- FFS expenditures are 99% of total expenditures
- FFS base rates are set individually (based on cost reports) for each of 500+ nursing facilities
- Rating methodology is defined in statute
- FFS Medicaid rates include a VBP add-on and other add-ons funded via the Quality Assessment Fee (QAF) based supplemental program
- FFS Rates are generally set each July 1st and are adjusted quarterly
- Managed Care rates mirror FFS rates

Considerations

- Will FFS rating methodology be retained for remaining FFS population?
- Will Managed Care rates be linked to FFS rates?
- Can the QAF subsidy program be transitioned to a Managed Care environment?
- Will the QAF program be retained for remaining FFS population?
- Will the FFS VBP program be mirrored under Managed Care or will each MCE use their own VBP approach?

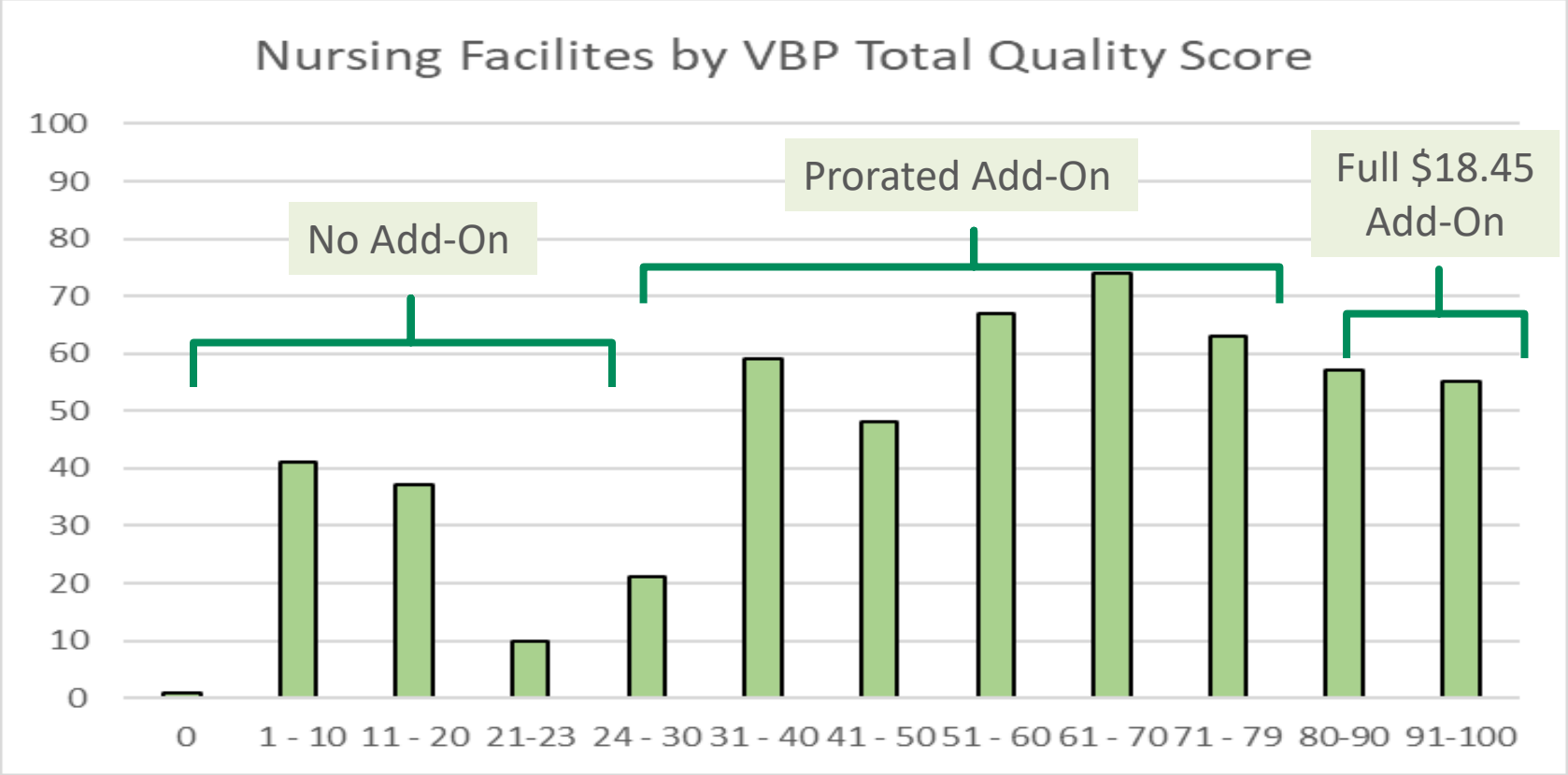
Nursing Facility Medicaid Rates



FFS Rates

- Average rate = **$217**/ Day
- Range of Rates = **$144** / Day to **$356** / Day

Nursing Facility VBP Program
Quality Add-On to Daily Rate (4/1/20 Rates)



Average Daily Rate Before Quality Add-on is **$209.52**
Full Add-On of $18.45 is paid to 21% of facilities; represents **8.3% increase**
Prorated Add-On is paid to 62% of facilities; represents **4.7% increase**
Remaining 17% of facilities receive no Add-On

Nursing Facility Supplemental (UPL) Rates

VIEW	SERVICE	SFY 2020
Current	Nursing Facility UPL	$1,045
Future	Nursing Facility UPL	$1,045

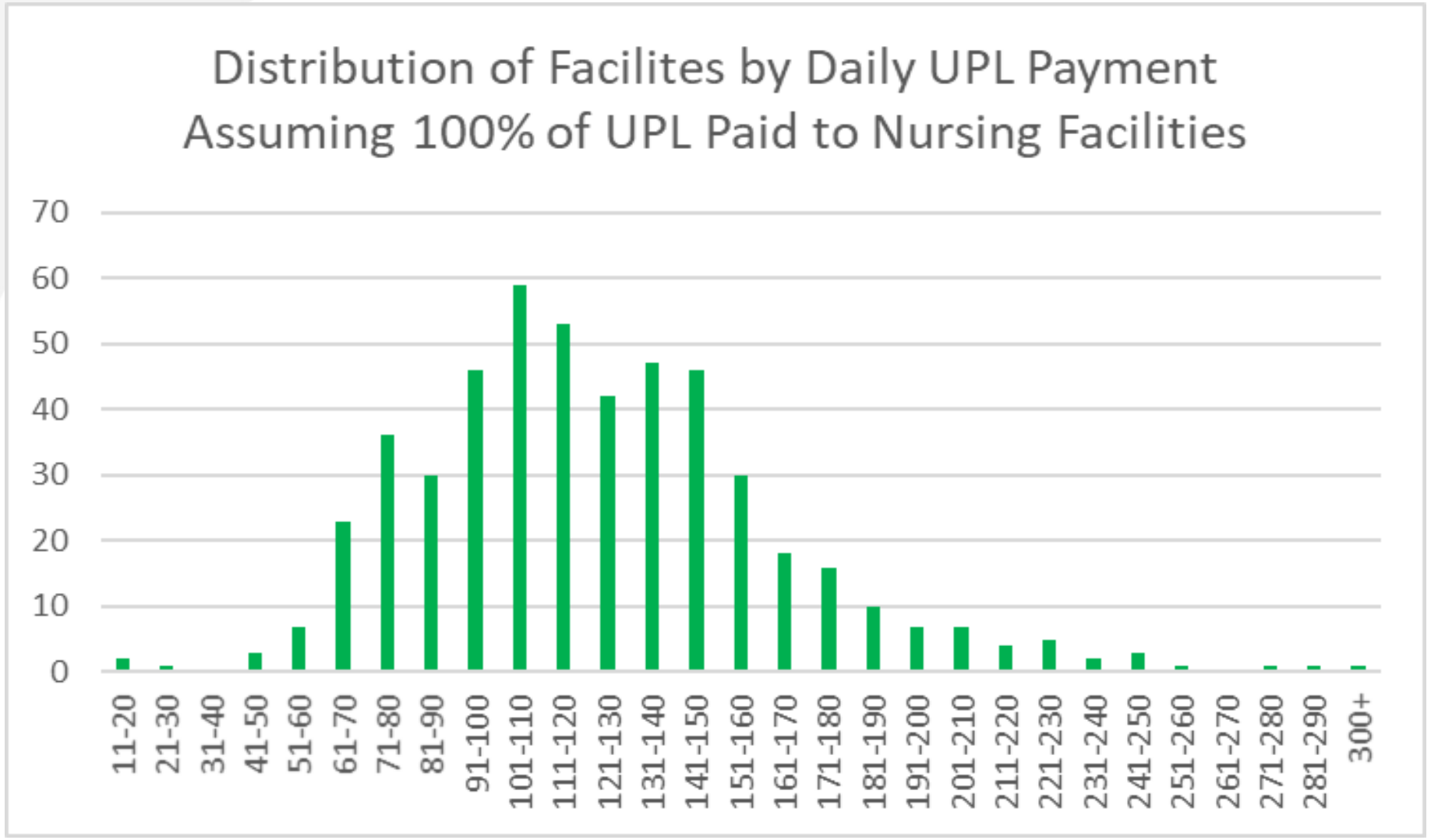
Current View

- The Supplemental Upper Payment Limit (UPL) program provides payments that represent the difference between Medicaid rates and Medicare rates
- Almost all Nursing Facilities in the State have an operating agreement with a county hospital which allows them to participate in the program
- County hospital pay the State share of the supplemental benefit

Considerations

- Can the UPL supplemental program be transitioned to a Managed Care environment?
- Will payments from the Managed Care Supplemental program be tied to quality metrics / VBP program?
- Would a UPL supplemental program be maintained for the FFS population?

Nursing Facility Supplemental (UPL) Rates



FFS UPL Rates

- Average rate = **$128**/ Day
- Range of Rates = **$11** / Day to **$398** / Day

Home Health Rates

VIEW	SERVICE	SFY 2020
Current	Home Health	$311
Future	Home Health	$311

Current View

- FFS expenditures represent 95% of total Home Health expenditures
- Current rating formula is specified in statute
- CMS has expressed concerns over current approach which uses a per day overhead payments
- Industry pain points include low LPN rates, lack of capacity for complex care

Considerations

- Will rates vary between FFS and Managed Care?
- Need to look at opportunity to refresh rates in a budget constrained environment
- Alignment of Home Health and Waiver Respite rates is a LTSS objective

Division of Aging Waiver
Home and Community Based Services Rates

VIEW	SERVICE	SFY 2020
Current	HCBS Waiver Svcs	$443
Future	HCBS Waiver Svcs	$443

Current View
- 100% of waiver services are currently paid through FFS
- Rates were reset 2/1/2020 for Division of Aging Waiver HCBS services

Considerations
- Will waiver services be modified as part of transition to managed care
- Current rates do not reflect impact of COVID
- Rates for respite care should be aligned with rates for similar Home Health Services

Next Steps

- Stakeholders to submit feedback on reimbursement approaches / potential concerns
- Specific topics will be identified for future Finance Stakeholder Meetings
- Meetings to be held every three weeks on Thursday afternoons at 2:30 pm: 2/25/21, 3/18/21, 4/8/21, 4/29/21 and 5/20/21