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

Authority: IC 2-5-26

MEETING MINUTES[1]

Meeting Date:	**September 30, 2009**
Meeting Time:	**9:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 431**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Ryan Mishler; Sen. Vi Simpson; Sen. Sue Errington; Sen. Connie Sipes; Rep. William Crawford; Rep. Charlie Brown; Rep. Peggy Welch; Rep. Timothy Brown; Rep. Suzanne Crouch.**

Members Absent: **Sen. Luke Kenley; Rep. Don Lehe.**

Chairperson Miller called the meeting to order at 9:35 a.m. and stated that because there was another meeting scheduled to use the room during the afternoon, testimony on the nursing home reimbursement issue would be limited and divided equally between the two sides.

Medicaid Managed Care Organizatin (MCO) update

Ms. Pat Casanova, Director of OMPP, FSSA, provided the Commission with a handout on health coverage program enrollment. Ms. Casanova stated that there was a one percent increase in enrollment from last month and that the program will exceed one

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

million recipients this fiscal year. See Exhibit 1.

Ms. Donna Maynard, Anthem, provided a handout indicating the number of providers by region, the number of members per provider, and statistics on Medicaid claim payments. See Exhibit 2. When asked by the Commission whether Anthem performs coordination of benefits, Ms. Maynard stated that Anthem does check to make sure that it is the payor of last resort. In response to whether Anthem has non-member providers, Ms. Maynard said that there are some providers who do not wish to participate in MCO Medicaid, but the provider does not want to turn the patient away- in those cases, Anthem will individually work with the provider for reimbursement. When asked whether there are accommodations for out-of-state providers, Ms. Maynard stated the provider needs to have an Indiana Medicaid number in order to receive reimbursement. Commission members requested that Ms. Maynard find out the number of claims considered in the second quarter and used in figuring its timeliness statistics.

Mr. John Barth, MHS, provided the Commission with statistics on MHS's Medicaid claim payments and reasons for claim denials. See Exhibit 3. Mr. Barth stated that MHS has been working on lowering the denial of claims percentage, and has been able to lower the percentage from 19.8% to 12.75% in August of 2009. When asked whether MHS performs coordination of benefits, Mr. Barth responded in the affirmative. When asked whether MHS was conducting outreach with providers who have been unhappy with MHS, Mr. Barth stated that MHS has been doing outreach, including in-person contacts and helping billing offices.

Ms. Jean Castor, MDwise, provided the Commission with statistics on MDwise's Medicaid claim payments and reasons for claim denials. See Exhibit 4. Ms. Castor informed the Commission that MDwise did fall below the 98% benchmark in timeliness for payment of claims, and said that MDwise is working to correct this. When asked whether MDwise performs coordination of benefits, Ms. Castor stated that MDwise has a contract with MHS to help conduct this review and the review is done retroactively. Ms. Castor stated that MDwise has moved behavioral health services from a contract basis to in house.

Ms. Patty Hebenstreit, counsel for MDwise, informed the Commission about MDwise's actions after CompCare (an entity MDwise had contracted with in 2007 and 2008 to pay claims for behavioral health services) breached the contract and did not pay claims. See Exhibit 4. Ms. Hebenstreit stated that MDwise has filed a lawsuit against CompCare and has established an alternative payment process for those providers affected by the breach of contract. Ms. Hebenstreit stated that providers have been given time to resubmit claims and MDwise has been paying interest on the claims. Ms. Hebenstreit stated that providers are provided an assignment form allowing for MDwise to recoup the claims costs in litigation against CompCare. Responding to a question about the assignment form and whether the provider will not be able to receive punitive damages, Ms. Hebenstreit stated that a provider can decline to complete the assignment form and pursue legal action against CompCare if the provider chooses. In response to a question about providers who have gone out of business, Ms. Hebenstreit stated that MDwise has performed outreach to contact as many affected providers as possible.

EDS update

Mr. Rick Shaffer, EDS, provided the Commission with EDS' Medicaid claims data. See Exhibit 5. Mr. Shaffer discussed EDS' outreach efforts, which included 300 provider contacts per month. Mr. Shaffer also discussed EDS' coordination of benefits, stating that EDS subcontracts with MHS for cost avoidance and recovery.

Expiration of FSSA

Senator Miller discussed the issue of having FSSA expire, and the past occurrences where FSSA was not renewed in a timely fashion. Senator Miller moved that staff draft legislation for the Commission's consideration that would remove the expiration dates of FSSA and the Commission consented.

Medicaid Managed Care Quality Strategy Committee update

Ms. Jill Claypool, FSSA, stated that FSSA is still waiting to receive the appointment letters for the Medicaid Managed Care Quality Strategy Committee. However, Ms. Claypool stated that FSSA has begun looking at the issues assigned to the Committee to study. Concerning emergency room utilization, FSSA has reviewed thirty cases from each MCO. Ms. Claypool also informed the Commission that FSSA has had an outside source look at prior authorization by MCOs and the source will analyze the denials and appropriateness of requiring prior authorization. Ms. Claypool further reported that FSSA has assembled a standardization subcommittee that includes members from OMPP, MCOs, EDS, and providers. The subcommittee is meeting monthly to standardize some of the forms used by MCOs, starting with the prior authorization form. Ms. Claypool further stated that the Healthcare Effectiveness Data and Information Set (HEDIS) report and the Consumer Assessment of Healthcare Providers and System (CAHPS) report for calendar year 2008 have been completed. See Exhibit 6.

Medical Review Team update

Ms. Claypool stated that FSSA has made efforts to reduce the backlog of medical reviews needed in the Medicaid disability application process. FSSA has hired new staff as well as third-party vendors to assist in reviews that are over 90 days old. Ms. Claypool stated that the backlog has been reduced from 7,167 (that are over 90 days) in December, 2008, to 2,662 in August, 2009. See Exhibit 6. Commission members requested that FSSA provide the number of days that the claims are over 90 days old.

Phase II nursing home reimbursement

Ms. Faith Laird, FSSA, provided a presentation on balancing long term care (See Exhibit 7), the proposed rule changing nursing home reimbursement, a summary of the Phase II reimbursement changes, and the fiscal impact of the changes. See Exhibit 8. Ms. Laird reviewed the progress that the state has made in long term care through the implementation of Phase I: creating uniform eligibility at 300% of SSI, creation of a self-directed care option for people on CHOICE and the Aged and Disabled (A&D) Medicaid waiver, establishment of a comprehensive home and community based services program, and increasing services under, and the number of slots allocated for, the A&D waiver.

Ms. Laird stated that nursing homes received a huge retroactive payment in 2005 from the quality assessment fee, and have received increases in reimbursement annually thereafter with the intent that improvement in quality of care would occur. Ms. Laird testified that quality care in nursing homes has not improved. Ms. Laird informed the Commission that Indiana continues to lag behind other states in shifting funding from nursing facility care to home and community based care (Indiana is 45th) and that there are too many individuals in nursing homes who could be receiving care in the community. Ms. Laird reported that nursing facility report card scores were better in 2003 than in 2007 and staffing numbers have declined, despite nursing homes receiving the additional funds from the quality assessment fee.

Ms. Laird reported the following nursing home reimbursement changes included in Phase II:

- reduction in low needs case mix indices (the bottom four resident classifications), grandfathering current residents in these categories
- provision of additional payments for high need care residents (special needs, Alzheimer's patients, and ventilator units)
- additional payment based on the facility's report card score (requiring the scores to be updated annually)
- elimination of the additional payment on profits for facilities with the lowest report card scores (score of 358 or higher), maintaining the payment for those with the highest scores (score of 82 or less), and creating a graduated additional payment for those with scores in between.
- changing the administrative component of the facility's reimbursement rate from a cost based reimbursement to a price based reimbursement.
- changing the minimum occupancy rate for facilities with more than 50 beds from 85% to 90% (affects administrative, direct care, and indirect care components of reimbursement)

Ms. Laird stated that FSSA has negotiated with nursing home associations on these changes, giving the example that FSSA originally proposed to change the occupancy rate to 95% but agreed in negotiations to change the rate to 90%. Ms. Laird reported that the average rate reduction under Phase II is sixty-five cents, and that 46% of the nursing facilities will see a rate increase. Ms. Laird said there will be a Phase III in the future that will move towards value based purchasing.

Mr. Jim Leich, IAHS, stated that Indiana has one of the best nursing facility reimbursement systems in the country with respect to how money is distributed and the built in incentives for quality care. Mr. Leich testified that these willl be enhanced by the Phase II reimbursement changes. Mr. Leich acknowledged that he had some concerns with the initial proposed changes but participated in policy discussions with FSSA that led to improvements in the proposal. Mr. Leich informed the Committee that there will be some winners and some losers from his association.

Mr. Bob Decker, HOPE, testified that he supports the process that FSSA followed in determining the reimbursement changes, which allowed for compromises and changes in the proposal. Mr. Decker stated that he is excited that the reimbursement changes result in demanding performance from nursing homes.

Mr. Vince McGowen, Magnolia Health Systems, testified that the reimbursement changes will get the attention of providers by affecting profits. Mr. McGowen stated that the reimbursement changes do three things: (1) allow providers to spend money on nursing without being subject to maximum allotments; (2) reward patient care over provider profits; and (3) promote home and community based services by offering incentives to keep out lower need individuals. Mr. McGowen commented that out of Magnolia's 33 facilities, 16 will see a decrease in reimbursement but that he accepts this responsibility and accountability, and is committed to doing a better job with patient care.

Ms. Michelle Niemier, United Senior Action, stated that she supports the reimbursement rule changes, commenting that Indiana is ranked worst in the country for quality care in nursing homes. Ms. Niemier testified that she believes that more than 11% of nursing facility residents could be served in the community and that this needs to change. Ms. Neimier supports providing additional reimbursement to facilities who provide quality care. See Exhibit 9.

Mr. John Cardwell, Indiana Home Care Task Force, stated that he supports the Phase II reimbursement changes and indicated that there is still a need to improve home and community based services. Mr. Cardwell commented that he was impressed with FSSA's willingness to talk with all of the interested groups through the proposal process.

Mr. Paul Chase, AARP, stated that Indiana has taken steps to balance Indiana's long term care system, but still has more to do. Mr. Chase testified that he supports the reimbursement changes, including increasing the minimum occupancy rate. See Exhibit 10.

Ms. Becky Carter, Indiana Assisted Living Association, stated that she supports the proposed reimbursement changes as well. Mr. Diedrick VanderVelde, Indiana Assisted Living Association and Medicaid waiver provider, informed the Commission that he opened a new 70 apartment assisted living building in Charleston, Indiana, in April, 2009. The building was fully occupied by Labor Day, with 59 of the apartments being used by waiver recipients. Mr. VanderVelde estimated that his building will save the state $1.1 million by providing care outside of a nursing home setting. Mr. VanderVelde testified that there is an opportunity for the state fo save a lot of money if more programs like his were available across Indiana. See Exhibit 11.

Mr. Ken Adkins, President of the Indiana Association of Area Agencies on Aging, stated that his association supports FSSA's long term care initiatives and the proposed Phase II nursing home reimbursement changes. See Exhibit 12.

Mr. Brent Waymire, Vice President of Hickory Creek Healthcare Foundation, stated that his company includes 15 nursing homes with 78-80% of the patients on Medicaid. Mr. Waymire testified that he supports the proposed reimbursement changes. See Exhibit 13.

Mr. Steve Smith, IHCA, testified that he supports improvement of quality and said that he supports the proposed reimbursement changes, although he had hoped for more changes to the rule.

Ms. Mary Ann Maroon, Indiana Association for Home & Hospice Care, stated that she supports the proposed reimbursement changes and provided the Commission with descriptions of home and community services, including information on the Aged and Disabled Waiver and the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program. See Exhibit 14.

Due to running out of time for the proponent's testimony, the following individuals indicated their support for the proposed rule changes: Mr. Oren Bell, Mr. Jeff Haymaker, and Mr. Gary Olwood.

Ms. Donna Nackers, Kindred Healthcare representing 24 nursing homes, stated that she has concerns with some of the provisions in the Phase II proposal. Ms. Nackers testified that she supports the funding of home and community based services but not at the risk of nursing homes that are in serious financial hardship. Ms. Nackers stated that she has concerns with the proposal's lower reimbursement for lower level patients and with using the nursing home surveys as the sole benchmark for quality care. Ms. Nackers suggested including turnover, nurse to patient ratios, satisfaction surveys from patient, families, and employees as part of determining a nursing home's quality of care.

Mr. Scott Piotroski, Valley View Health Care Center, stated that the proposed Phase II reimbursement changes will negatively affect his facility by $122,000. Mr. Piotroski testified that the survey results should not be the only factor in determining

quality care. Mr. Piotroski also recommended that the changes proposed for Phase III be completed at the same time as Phase II.

Mr. James Wahls, Administrator at Regency Place of Castleton, stated that he has concerns with the proposal, that there is subjectivity on what a person looks at in determining whether there is quality of care, and more consideration should be given to other factors in this determination. Mr. Wahls stated that his facility will not have a negative impact in the first year that the changes are implemented, but this is variable.

Ms. Jill Pearson, Regency Place of Greenfield, stated that her facility will be adversely affected by the proposed reimbursement changes. Ms. Pearson stated that her facility had some problems a few years ago, and the facility employees have been working hard to correct the problems. Ms. Pearson testified that there should not be a disincentive to fix things built into the reimbursement system. Ms. Pearson further commented that low risk patients still have cognitive impairments and may need nursing facility care.

Mr. Mark Green, Extendicare, stated that he is concerned that the reimbursement changes will negatively impact quality of services. Mr. Green commented on the occupancy rate penalty that will result in a huge reduction in reimbursement, affecting patient care. Mr. Green stated that running a nursing facility is not profitable right now. Mr. Green suggested that payment for performance would be acceptable and referred to Oregon as a flat rate reimbursement state. Mr. Green further suggested that the use of the nursing home report card be phased in over a three year period to minimize the penalty. Mr. Green estimated that the 16 facilities in his company would lose around $800,000 to $1 million in the first year. Mr. Green stated that reimbursement should fund quality from the front end instead of penalizing facilities.

Mr. Steve Albrecht, Golden Living, stated that his company has 22 facilities in Indiana. Mr. Albrecht stated that he appreciates the increase in payments for special care and ventilator patients and commented that updating the survey used in determining reimbursement is long overdue. Mr. Albrecht expressed concern about the overall impact of the changes on operations. Mr. Albrecht stated that his company will be negatively impacted by $834,000 in the first year and that this will make operating in Indiana difficult. Mr. Albrecht referred to other states that use multiple factors in determining quality and stated that including wider criteria in measuring quality would greatly improve the proposal. See Exhibit 15.

Representative Crawford stated that he supports home and community based services but is concerned about de-institutionalization and the accessibility and availability of community services. Representative Crawford requested information on home and community based service waivers and the manner in which the waivers are geographically distributed, including race and ethnicity. Senator Sipes expressed concerns about the availability of services and mentioned that services were not available when Silvercrest closed as they were supposed to be.

When asked why the report card survey is the only measure used, Ms. Laird responded that this tool has been used to measure quality since 2003 and is not new. Ms. Laird further stated that staffing, quality measures, and management criteria are all components that will be used in later phases.

The meeting was adjourned at 12:50 p.m.