MINUTES

Payment Methodologies for Medicaid Providers Interim Study

Representative Jean Hunhoff, Chair
Senator Larry Tidemann, Vice Chair

First Meeting, 2016 Interim
Monday, June 27, 2016

Room 414 – State Capitol
Pierre, SD

The first meeting of the Payment Methodologies for Medicaid Providers Interim Study Committee was called to order by Representative Jean Hunhoff, Chair, at 10:00 a.m. (CDT) on June 27, 2016, in Room 414 of the State Capitol, Pierre, South Dakota.

A quorum was determined by the following members answering the roll call: Representative Jean Hunhoff, Chair; Senator Larry Tidemann, Vice Chair; Senators Scott Parsley and Deb Peters; Representatives Spencer Hawley, Leslie Heinemann, Thomas Holmes, and Fred Romkema. Senator Bruce Rampelberg was excused.

Staff members present included Jason Simmons, Senior Fiscal Analyst; Clare Charlson, Principal Research Analyst; Jessica LaMie, Research Analyst; and Paul Giovanetti, Senior Legislative Secretary.

NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council office. This meeting was web cast live. The archived web cast is available at the LRC web site at http://sdlegislature.gov.

Opening Remarks

Representative Jean Hunhoff commented that she appreciates the Committee members, staff members, and presenters for taking their time to look into the payment methodologies for Medicaid providers. She continued to review the guidelines of the Committee.

Discussion of the Scope and Goals of the Committee

Representative Hunhoff reviewed the scope of the interim study (Document #1) and the goals for the Committee. The goal for the Committee is to assess existing payment methodologies for Medicaid providers to determine adequacy of payments and to conclude with recommendations for any changes.

Medicaid 101

Ms. Lynne Valenti, Secretary, Department of Social Services, reviewed the basics of the Medicaid program in South Dakota (Document #2). Medicaid is a federal-state partnership and has a contract known as the Medicaid State Plan that outlines how the state administers its Medicaid program. There is a formal process for making changes to the Medicaid State Plan. This process requires favorable tribal consultation and approval by the Centers for Medicare and Medicaid Services (CMS). It also requires formal public notice and comment. Additionally, notice of changes are published through the LRC Register and all State Plan Amendments are published on-line.

Medicaid eligibility is based on age, financial and non-financial factors including citizenship, legal immigrant status, residency, or disability. Children, pregnant women, very low income parents, low income elderly, and disabled are eligible for Medicaid in South Dakota. The income levels are as follows: children up to 209% of the federal poverty level (FPL); pregnant women up to 138% FPL; parents of covered children up to 53% FPL; and elderly or disabled adults with low incomes which varied by age and disability.

South Dakota has four Home and Community Based Waivers. The Department of Human Services offers the Community Hope Opportunity Independence Careers Empowerment Success Waiver (CHOICES), Family Support 360 Waiver, and the Assistive Daily Living Services Waiver. The Department of Social Services offers the Home & Community Based Waiver (HCBS).

CHIP is the Children's State Health Insurance Program, authorized by Title XXI of the Social Security Act; it also is administered by CMS. CHIP covers children up to age 19 who have incomes too high to qualify for Medicaid, up to 209% FPL. In South Dakota, CHIP has the same benefits and services as Medicaid.

Medicaid is an entitlement program which means that all eligible individuals must be served. Medicaid covered 146,736 unduplicated individuals during state fiscal year (SFY) 15. One of every seven South Dakotans in any given month will have health coverage through Medicaid or CHIP. One of every three children under the age of 19 in South Dakota has health coverage through Medicaid or CHIP, and 50% of children born in South Dakota will be on Medicaid or CHIP during the first year of their life. 35.5% of South Dakota Medicaid enrollees are Native American.

The Federal Medical Assistance Percentage (FMAP) is how much CMS pays for a state's Medicaid services. South Dakota's SFY16 blended rate was 48.38% state general funds and 51.62% federal funds.

Covered healthcare services must be medically necessary and ordered by a physician. These services include Inpatient Hospital, Graduate Medical Education (GME), Disproportionate Share Hospital Payments (DSH), Outpatient Hospital, Prescription Drugs, and Physician Services. Total South Dakota Medicaid expenditures were $882.5 million in SFY15. The Medicaid budget is a large part of the state's spending.

Senator Scott Parsley asked if the department had the budgetary projections verses actual expenditures from the last seven years. Secretary Valenti said that she did not have the figures but could get them for the committee.

Representative Thomas Holmes asked if it is possible for an infant to qualify for both the Birth to Three Program and CHIP. Secretary Valenti replied that if the parents of a child meet the income levels the child can qualify for both programs.

Representative Leslie Heinemann inquired about the history of the 209% FPL that is used for the CHIP Program and why other states have levels up to 300-400% FPL. **Ms. Brenda Tidball-Zeltinger, Deputy Secretary, Department of Social Services** replied that CHIP has flexibility in the upper level that the state can set. The 209% has been the upper level since the start of the program in South Dakota. Medicaid will cover children if their parent income is from 0% to 182% FPL. CHIP will cover from 183% to 209% FPL. There are other states that have raised their upper level to 300 or 400% FLP.

Representative Hunhoff asked if Graduate Medical Education and Disproportionate Share Hospital Payments are separate payments to the hospitals or combined payments. Secretary Valenti replied that the payments are separate.

Representative Heinemann asked if the department had figures on the GME and DSH payments. Secretary Valenti replied that for SFY15 DSH Payments totaled $1.5 Million paid to 23 hospitals and GME payments totaled $2.8 Million to three healthcare systems.

Representative Hunhoff requested an explanation of the prescription drug rebate program. Ms. Tidball-Zeltinger explained that prescription drug companies are required to enter into the drug rebate agreement in which the drug company sends rebates back to the state. The state received $23 Million in drug rebates for SFY15.

Representative Fred Romkema asked how the state rates nationally on generic drug utilization. Ms. Tidball-Zeltinger replied that South Dakota is on the high end of Medicaid generic drug utilization at 83.3%. The national average ranges from 65% to 85%.

Medicaid crosses budgets for several State agencies including the Department of Social Services, Department of Human Services, Department of Health, Department of Corrections, Department of Military and Veterans Affairs, and Department of Education. State administration of Medicaid includes claims processing, care management, quality control or program integrity, and program management.

The Health Homes Program provides enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to increase health outcomes and reduce costs related to uncoordinated care. Health Homes was recommended by the Medicaid Solutions Workgroup and provide six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referrals to community and support services. Improvement in a number of health outcomes has been noted in the program's first year.

Representative Hunhoff asked if the Health Homes Program is voluntary or mandated. Secretary Valenti replied that Medicaid does not allow the state to mandate that recipients participate in the program. Of the patients eligible to participate in the Health Homes Program, the department said 75-80% choose to participate.

Representative Romkema asked for the number of Health Homes in South Dakota and a description of the typical patient that would participate in the program. Secretary Valenti replied that there are two types of Health Homes, Primary Care Health Homes and Behavioral Health Health Homes. There are 100 Primary Care Health Homes throughout the state and eleven Behavioral Health Health Homes. Patients that have one or more chronic illness and are at risk for additional chronic conditions, or that have a serious mental illness are those that can participate in the program.

The Money Follows the Person (MFP) Program provides services to institutionalized individuals to transition to home and community based settings. This was recommended by the Medicaid Solutions Workgroup. MFP targets Medicaid eligible recipients who are institutionalized for 90 days or more. MFP

provides services during transition and for 365 days following transition. Services include: transition services, non-medical transportation, assistive technology, consumer preparation, and behavior crisis intervention.

Provider Reimbursement

Ms. Brenda Tidball-Zeltinger, Deputy Secretary, Department of Social Services reviewed over provider reimbursement and payment methodology for Medicaid (Document #3). The goal of any effective rate setting methodology is to include all allowable and reasonable costs and allow the provider to cover the cost incurred for the provision of the service while incentivizing quality care. Medicaid funded services cannot be reimbursed at rates greater than private pay. Federal requirements can be very specific or provide a general framework that allows states to have more flexibility in establishing reimbursement methods. Reimbursement rates are set using two primary sources; other payer fee schedules (private pay, Medicare, etc.) or costs reported through annual cost reports. Federal requirements state that the Medicaid rate cannot exceed the Medicare upper payment limits (UPL) for hospital care, clinic care, and nursing homes.

Representative Hunhoff requested clarification on the Medicare UPL rates that are submitted to CMS. Ms. Tidball-Zeltinger clarified that before 2013 states only had to submit the UPL calculation when a change was made to the Medicaid rate. Under the 2013 mandate, all states are required to submit the UPL calculation annually. In 2014, inpatient hospital based services were at 63% UPL, clinic service at 86% UPL, nursing homes 44% UPL, and outpatient hospital based services 63% UPL.

Representative Holmes requested an example of the UPL calculation. Ms. Tidball-Zeltinger provided the example of an individual going into a clinic on Medicaid. Medicare would pay $100 to the provider for that visit while Medicaid will pay $86 for that visit. The Medicaid cost cannot exceed the Medicare UPL or private pay rate. For an ultrasound, if private pay will pay the provider $200, then the Medicaid payment cannot exceed the $200.

Fee-for-service rates based on other payers is used for provider groups less reliant on state funding for example physician visits, transportation cost, dental, chiropractic, durable medical equiptment, crossovers, etc. There are over 4,000 providers under this methodology with SFY15 expenditures of $135.2 million.

Federally Qualified Health Centers/ Rural Health Centers rate methodology is federally prescribed. Rates are set on an encounter based rate which means all services are paid at the same rate per encounter.

The rate methodology for pharmacies and prescription drugs are mandated by the federal government. Currently there are over 300 providers, with SFY15 expenditures of $35.1 million (net expenditures after drug rebates). The current reimbursement is the lesser of:

- Provider's Usual and Customary Charge
- Average Wholesale Price (AWP) less 13% +$4.40
- The payment amount established by the US Department of Health and Human Services for multi-source drugs + $4.40; or

- The payment established by the department for drugs listed on the state's Maximum Allowable Cost (MAC) list + $4.40.

In February 2016 CMS announced requirement for states to transition to Actual Acquisition Cost (AAC) plus dispensing fee or similar methodology. AAC is the actual cost of drug from the manufacturer. CMS is contracting with an accounting firm to survey invoices from independent and chain pharmacies to develop the AAC. The dispensing fee accounts for the local pharmacy's cost to dispense prescriptions. The department is working with the South Dakota Pharmacy Association and pharmacists to validate dispensing fee findings.

Representative Heinemann stated that smaller pharmacies are not able to compete with larger pharmacies and asked how will this change effect the smaller pharmacies. Ms. Tidball-Zeltinger replied that there is going to be an aggregate cost established for the AAC that will address the different cost between small pharmacies and large chain pharmacies.

Senator Larry Tidemann asked if there is a difference in the dispensing fee for a 30-day prescription compared to a 90-day prescription. Ms. Tidball-Zeltinger replied that the fee is a one-time fee based on the dispensing of the drug regardless of the length of the prescription.

Senator Deb Peters asked what is preventing doctors from prescribing 90 or 180-day supply of a maintenance drug. Ms. Tidball-Zeltinger replied that there is a prescription review board establish controls to set refill rates and the frequency of a refill. If issues arise the department contacts the physician directly and works with them.

The rate methodology for hospital care is based on Medicare. There are 49 South Dakota hospitals. SFY15 expenditures were $191.3 million. Inpatient service rates are reimbursed similar to Medicare and other private payers on a Diagnosis-Related Group (DRG) basis. There are 37 states using this or similar methodology. Reimbursement is for episodes of care based on diagnosis, procedures, age, sex, discharge status, and presence of complications. Each DRG has a South Dakota specific weight to account for acuity and each hospital has a specific target amount used to calculate the reimbursement of the hospital stay. Starting in 2017, the 17 hospitals that currently bill Medicare using an Ambulatory Payment Classification (APC) for outpatient services will also bill Medicaid the same way. 12 states use this methodology which was developed in collaboration with hospitals, and through the recommendation of a financial workgroup formed in 2011. This method streamlines billing processes for DRG hospitals so they bill Medicare and Medicaid the same way. There are ten Specialized Units (or DRG-exempt) in South Dakota. Specialized units are reimbursed using the cost settlement method. These include three neonatal units, four rehab units, and three psychiatric facilities. Providers are paid a per diem based on historical costs or based on Medicare fee schedules.

For nursing homes and community based providers, rates are based on reported costs. Community based providers include: assisted living centers, in home services for the elderly and disabled, senior meals, psychiatric residential treatment and group care, behavioral health services, DHS community support services, and DHS assistive daily living services. These groups are heavily reliant on Medicaid funding.

Most providers submit cost reports to the state annually. Cost reports are due four months after the provider's operational year ends. Cost reports are used to identify the actual cost to provide services on a per unit basis. DSS and DHS use a standardized cost report format. Not all costs are allowable for Medicaid reimbursement because of federal requirements.

Cost reports include expenses and revenues. Expenses include salary and benefit costs, operating costs, utilities, supplies, and depreciation. The total allowable costs for each service are calculated. Providers report the total units of service provided and a per unit cost is calculated. Provider reimbursement staff validate cost report data through independent audits, desk review, on-site reviews, audit findings, and ongoing training and communication. Once cost report data is validated, it can be used to develop prospective reimbursement rates.

The committee discussed cost reports addressing the differences between federal requirements and state requirements, the process in which new rates are set, and specifically, the lag between when cost reports are submitted to the department and when new rates are set.

For nursing facilities, South Dakota's reimbursement method pays a daily rate unique to each resident. This methodology is referred to as a "case mix methodology". Rates for residents with special or extensive care needs are higher, while those with less need are at a lower rate. The majority of states utilize this type of methodology. The resident's care needs are identified through an assessment called the Minimum Data Set (MDS). The MDS is used to collect data regarding the individual's functional capacity including basic self-care activities such as bathing, dressing, toileting, eating, and mobility. The assessments are completed by the nursing home staff and monitored by state staff. Each level of care from the MDS is assigned a Case Mix Weight. Case mix scores range anywhere from .59 for an individual with lower care needs to 2.67 for a resident that requires extensive care. Currently the statewide case mix average is 1.17. When facilities are reimbursed for services, the direct care component of the rate is multiplied by the resident's case mix score resulting in an individualized rate for each resident based on their specific care needs. The total reimbursed rate is calculated by the following formula:

Facility Direct Care Rate x Resident Case Mix + Facility Non-Direct Care Rate = Total Rate per day

Representative Hunhoff requested clarification on the difference between direct care and non-direct care. Ms. Tidball-Zeltinger clarified that direct care includes medical care and supplies, non-direct care includes maintenance and facility costs.

Community Based Services payment methodology use input from providers to develop the model. Review and analysis of the raw cost report data can identify outliers and establish ranges and mean values for various components of the model.

Senator Parsley asked if the information is only based on the cost reports or does the department look at markets for salary levels. Ms. Tidball-Zeltinger replied that the rates are based on the cost reports provided by the providers.

Ms. Gloria Pearson, Secretary, Department of Human Services, introduced the three Medicaid waiver programs that are managed by the department.

Mr. Darryl Millner, Director of Budget and Finance, Department of Human Service, reviewed the three different payment methodologies. DHS Direct Support Community Based Providers are reimbursed through the Service Based Rates (SBR) System. The SBR System is a statistical model used to fairly and equitably distribute existing resources within the system based upon the care level and mix of services of the person supported. The system establishes a daily rate for every person supported in which those with higher needs receive a higher rate. The rate then falls into one of 40 payment tiers.

Representative Hunhoff asked if the current methodology compensates for non-direct care. Mr. Millner replied that the rate covers both direct and non-direct care. The non-direct care cost comes from the cost report.

Representative Romkema asked if there are caps on supplies for the individual. Mr. Millner replied that there is an established daily rate that includes all needs for caring for the patient.

DHS Family Support Community Based Providers have a payment methodology utilizing a mix of fee-for-service, actual cost, and negotiated rates. The fee-for-service is a 15-minute unit rate for the payment of case management services and is based on provider cost reports. Supplies and vendor services are reimbursed at market rates. Rates for personal care, respite, companion care and supported employment are negotiated by the participant with their provider. Participants must follow the Fair Labor Standards Act including state and federal minimum wage requirements.

Representative Hawley stated that this has impacted providers because they are no-longer able to provide case management and are reducing the number of patients they can serve. Mr. Millner replied that recipients have been hiring new case managers due to the conflict-free case management mandate that requires case management to be completed by a separate provider.

DHS Community Based Providers that provide Assistive Daily Living Services (ADLS) have a payment methodology that is a mix of fee-for-service and actual cost. The fee-for-service payment rates for ADLS are based on the same fee schedule that is utilized by the Community Based Services program within DSS and derived from provider costs reports. Supplies and vendor services are reimbursed at market rates.

Mr. Jason Dilges, Commissioner, Bureau of Finance and Management, and Mark Quasney, Budget Analyst, Bureau of Finance and Management, presented Governor Daugaard's rate study information (Document #4). Governor Daugaard formed an internal agency workgroup to collect data regarding provider rates and cost report information. The data collected was used to develop data driven decisions regarding provider rates. The study reviewed the most recent cost report information for 20 provider types and established a goal to get all providers to at least 90% of methodology costs over the next three years. After the rate changes from the 2016 Legislative Session, the workgroup's next step is to compile updated 2014-2015 cost reports for all provider groups and update the aggregate data by provider group.

Committee Discussion and Directives

The committee discussed the need for updated cost reports. Looking at data that is six years old is not an effective way to ensure that providers are being reimbursed adequately. The committee agreed that a

workgroup should be developed to look at cost reports and determine what improvement can be made. The workgroup should include provider input and address ways to simplify the cost report process.

Determination of Future Meeting Dates

The committee discussed future meetings. The next meeting will be a two-day meeting, August 17-18, 2016, in Pierre. The third and last meeting will be on October 25, 2016, in Pierre.

Mr. Jason Simmons, Senior Fiscal Analyst, Legislative Research Council presented that for the next meeting, to better understand providers and their organization, the Committee requests that providers complete a survey located on the LRC Website at http://sdlegislature.gov/docs/interim/2016/documents/PPM06-27-16ProviderSurvey.pdf prior to providing public testimony (Provider Survey).

Adjournment

SENATOR TIDEMANN MOVED, SECONDED BY REPRESENTATIVE ROMKEMA, TO ADJOURN. The motion prevailed unanimously on a voice vote.

The committee adjourned at 4:32 p.m. (CDT)