Medicaid Nursing Facility Reimbursement
Nursing Facility Base Rates
Kick-off Meeting

Indiana Family and Social Services Administration

May 27, 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
  - FSSA Reimbursement Goals and Benefits to Stakeholders
  - Milliman Team - Introductions
- Overview of Current Methodology
  - Regulatory Environment
  - Complexity
  - Overview of Current Rate Components
  - Questions on Current Methodology
- Planned Research
- Next Steps

FSSA Reimbursement Goals

To develop Nursing Facility (NF) rate setting 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 rate methodologies will **reflect input** from all types of stakeholders including providers, advocates, participants and their families, and others.
  - Rate methodologies will be developed using a **transparent process**, so all stakeholders can understand how the rates are calculated.
- 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**.
  - Rates will be based on a sound methodology that **recognizes the resource requirements of higher acuity patients**.
  - New methodologies will seek opportunities to **reduce administrative burden** of the cost reporting process.

Introduction to the Milliman team

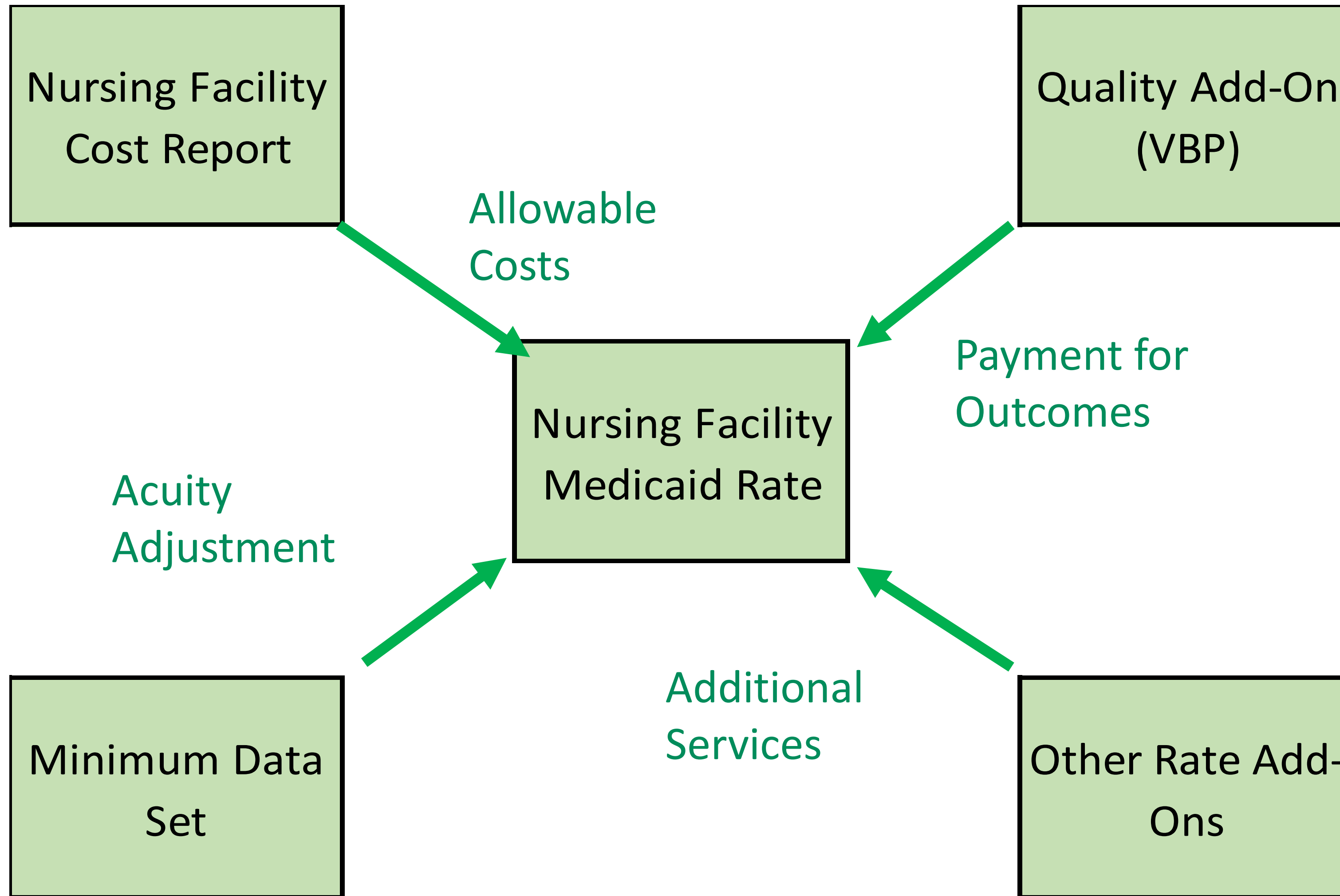
- Christine Mytelka, Milliman
- Jim Pettersson, Milliman
- Ben Mori, Milliman
- Anne Jacobs, Milliman
- Jessica Bertolo, Milliman
- Brad Armstrong, Milliman

Complexity of Rate Methodology

Examples of current rating methodologies

Less Complex		Moderate Complexity		More Complex
Hospice	**Home Health**	**Adult Day Care**	**Assisted Living**	**Nursing Facility**
Medicaid Rates aligned with Medicare Rates	Rates had been set using cost reports, are now frozen pending new methodology	Rates set using combination of provider surveys and data from US Bureau of Labor Statistics	Rates set as a composite of rates for similar HCBS services	Rates set individually for each of 500+ facilities based on cost report data

Nursing Facility – Most Complex



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Most Complex – Most Labor Intensive

Nursing Facility: 520 Rate Calculations

Nursing Facility Medicaid Rates

Distribution of Nursing Facilities by Daily Rate (Medicaid Rate w/ VBP)

FFS Rates

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

Can rate setting be streamlined without losing critical detail?

Regulatory environment

Forward compatibility under **managed care**

- State-directed payment option and requirements
- Administrative feasibility

Federal payment methodology requirements

- Safeguard against unnecessary utilization
- Efficiency, economy, and quality of care
- Access

State Plan and Indiana Code

- 405 IAC 1-14.6 Rate Setting Criteria for Nursing Facilities
- Indiana State Plan Attachment 4.19-D Methods and Standards for Establishing Payment Rates – Skilled Nursing and Intermediate Care Facility Services
- Level of detail compared to what is required by CMS

Overview of Current Methodology

Key Questions

- What is working well?
  - What rate components or parameters should not be changed, and why?
- What should be changed?
  - What rate components or parameters should be changed, and why?

Highlights of Current Methodology

- Sum of nine separately calculated rate component values
- Most significant components (in dollars) are cost based, audited, and subject to adjustments and limits
- Key adjustments and limits include:
  - Case-mix index (CMI), or acuity adjustments, made quarterly –
    - Based on Resource Utilization Group (RUG) classifications
    - Used to recognize differences in acuity between facilities, and changes in acuity over time
  - Minimum Occupancy Adjustment
    - Reduces the fixed portion of some of the rate component cost per day values for the facilities with lower occupancy
  - Allowed Profit Add-On
    - Allows lower cost facilities to receive a portion of the difference between their actual cost per day and the statewide median cost per day for certain rate components
  - Overall Rate Component Limit
    - Establishes a maximum value for each of the more significant rate components
- Rates are updated quarterly for changes in CMI, reconciled retroactively, and set on a fiscal year basis (new rates 7/1)

Overview of Rate Components

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

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

Direct Care Component

Rate Component Parameters

- Facility-specific CMI adjusted cost per day, plus allowed profit
  - CMI (Case-Mix Index) is a relative measure of resident acuity, based on differences in expected nursing resource requirements
- Allowed profit up to 30% of difference between facility-specific and median CMI adjusted cost
  - Subject to Quality Score Percentage adjustment, determined by relative scoring of quality metrics (except designated children's facilities)
  - Total allowed profit is capped at 10% of Statewide CMI adjusted cost
- Total component amount limited to 120% of CMI adjusted median value

Preliminary Observations

- RUGs may not be available in future for CMI adjustment
- Rates are updated quarterly to reflect changes in Medicaid CMI, and annually to reflect new facility cost data and changes in total CMI
- All facilities are limited to 120% of CMI adjusted median
- Quality incentive related to the allowed profit adjustment is mitigated when Direct Care Costs exceed the 120% component limit

Types of Costs Included in Component

- Nursing and nursing aid salaries and wages
- Nurse consulting services
- Pharmacy consultants
- Medical director services
- Nurse aide training
- Medical supplies (various types) and oxygen
- Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators (limit $1.50 per day)
- Replacement dentures costs exceeding Medicaid dental benefit limit
- Parenteral and Enteral Nutrition costs other than meals, nutritional supplements, sterile water and legend and non-legend drugs
- Medical records personnel and software
- Support and license fees for resident support services (e.g., MDS and medical records)
- Costs for the coding and input of MDS data

Therapy Component

Rate Component Parameters

- Facility-specific Medicaid therapy cost per day
- Medicaid cost per day determined using a "Medicare-like" cost apportionment methodology
- Allocates costs to Medicaid based on therapy cost center cost-to-charge ratios

Preliminary Observations

- Therapy services are reimbursed as a separate component
- There is no overall rate component limit for therapy services, potentially eliminating a barrier to more services to be provided

Types of Costs Included in Component

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy

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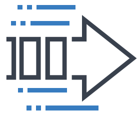
Indirect Care Component



Rate Component Parameters

- Facility-specific cost per day, plus allowed profit, subject to limits
- Minimum occupancy applied to fixed portion of costs (37%)
- Allowed profit up to 60% of difference between facility-specific and median cost
  - Subject to Quality Score Percentage adjustment, determined by relative scoring of quality metrics
  - Total allowed profit is capped at 5% of Statewide median cost
- Total component amount limited to 115% of Statewide median value

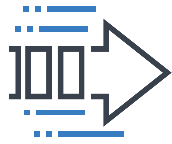
Preliminary Observations

- All facilities are limited to 115% of Statewide median
- Social services, activities and recreation could be grouped with Direct Care component costs
- Quality incentive related to the allowed profit adjustment is mitigated when Indirect Care Costs exceed the 115% component limit

Types of Costs Included in Component

- Dietary services and supplies, raw food
- Patient laundry services and supplies
- Patient housekeeping services and supplies
- Social services
- Behavioral and Psychological consulting services
- Activities and recreational supplies and services
- Repairs and maintenance
- Utilities and cable/satellite television
- Pets, pet supplies and maintenance, and veterinary expenses
- Educational seminars for indirect staff
- Non-Ambulance transportation costs related to activities and other non-covered services
- Admissions
- Nursing consulting services not directly related on hands-on resident care
- Non-nursing patient care services

Administrative Component



Rate Component Parameters

- 100% of the average allowable administrative component cost of the median resident day
- Minimum occupancy applied to fixed portion of costs (84%)

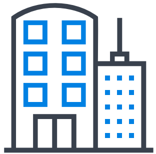
Preliminary Observations

- Payments for this component may exceed actual cost per day amounts incurred by facility
- Incentives for managing administrative-related costs

Types of Costs Included in Component

- Administrator, co-administrators and owners' compensation
- Patient-related and nursing facility-related home office costs
- All appropriate business operations salaries, supplies, fees, etc.
- Advertising
- License dues and subscriptions
- Insurance
- Working capital interest
- Management consulting fees

Capital Component



Rate Component Parameters

- Facility-specific cost per day, plus allowed profit, subject to limits
- Occupancy adjustment applied to 100% of costs
- Allowed profit up to 60% of difference between facility-specific and median cost
  - Subject to Quality Score Percentage adjustment, determined by relative scoring of quality metrics
  - Total allowed profit is capped at Statewide median cost
- Total component amount limited to Statewide median value

Preliminary Observations

- Occupancy adjustments have not been reviewed or modified for several years (observation applies to all rate components subject the adjustment)

Types of Costs Included in Component

- Fair rental value allowance, in lieu of the costs of all depreciation, interest, letter of credit fees, lease, rent amortization expense, deferred loan fees, or other consideration paid for use of property
- Facility specific allowable cost is determined as follows:
  1. Determine per bed historical cost (excluding operating leases) of land, building, improvements, vehicles and other costs
  2. Adjust for inflation based on the change in the R. S. Means Construction Index
  3. Multiply statewide median per bed value times number of beds
  4. Multiply extended rental rate, based on U.S. Treasury bond 10-year amortization, constant maturity rate, plus 3%
- Add property taxes, property insurance, and non-capitalized costs associated with minor equipment purchases not directly attributable to a specific department

Other Rate Components

Component	Rate Component Parameters
Nursing Facility Quality Add-On/VBP	Based on nursing facility's total quality score using latest published CMS data as of the end of each state fiscal year and other quality measures; maximum amount is $18.45 per patient day.
Assessment Add-On	Equal to (Quality Assessment Fee x non-Medicare patient days) / total patient days from the most recently completed desk-reviewed annual financial report.
Special Care Unit Add-On	Additional reimbursement for nursing facilities that provide specialized care to residents with Alzheimer's disease or dementia, as defined by 405 IAC 1-14.6-2(hh). Add-on is calculated using MDS information and is equal to (Annual Medicaid Alzheimer Days from Resident Roster x Alzheimer per diem) / total Medicaid days.
Ventilator Add-On	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.

Source: https://www.in.gov/medicaid/files/long-term%20care.pdf

Questions on Current Methodology

- Acuity adjustment:
  - Are incremental costs for higher acuity residents material enough to justify the need for an acuity adjustment?
  - Does the variation in Medicaid acuity necessitate quarterly rate adjustments? Could a corridor, or acceptable range of variation, be applied?
  - Would less frequent acuity adjustments create a barrier to accepting more complex or higher acuity residents?

Questions on Current Methodology

- Occupancy adjustments are applied to provide incentives for efficient use of fixed cost assets, and to enhance equity of payment for facilities that have higher occupancy:
  - Do these adjustment create additional incentives for efficiency?
  - How have these adjustments affected statewide occupancy over time?
- Rate component limits v. individual cost-based rates:
  - Should rate component adjustments and limits be adjusted, and if so, how?
  - Do rate component limits need to be adjusted to maintain or enhance the balance between access to quality care and provider efficiency, and if so, how?

Questions on Current Methodology

- Cost components: Should cost elements and rate components be restructured or grouped to better reflect current service delivery? If so, how?
- Nursing Facility Quality Add-on/VBP:
  - Does the quality/VBP add-on provide sufficient incentive for quality improvement, and does it measure key program priorities?
  - Does the quality/VBP interaction with the “profit add-on” enhance or take away from the effectiveness of the quality add on
- Complexity: If quarterly updates and retroactive reconciliations are difficult under managed care, how critical are they to providers?
- Audits: How burdensome is the current audit process? What are the pros and cons of maintaining the current periodicity?

Questions on Current Methodology

- Disparities: Does the current methodology inadvertently maintain disparities between race and quality, staffing ratios, cost, and likelihood of being served in the community?
- Nursing wage variations: How should FSSA eliminate the nursing wage variation between facilities, and for HCBS compared with nursing facility settings
- Add-on components: Are current special care add-ons necessary given additional funding provided by the acuity adjustment?

Rate Adequacy

Industry view

- Rates should cover **all** costs incurred for Medicaid residents
- Values shared by industry previously have been revised – new estimate of costs excluded from the rates is approximately **$125 million** per year
- Rates as a percent of average allocated costs: **92.4%** (Industry estimate)
- After sunset of 3% rate reduction as of June 30, 2021: **95.4%**

Current rate methodology

- Rates cover reasonable and necessary costs
- Reductions applied under current methodology
  - Minimum Occupancy
  - Replace capital with Fair Rental Value (FRV)
  - Limitations to admin/profit/etc.

Planned analysis

- Review margin/(shortfall) by facility and relation to occupancy, acuity, disparities, etc.
- Analyze whether methodology rewards efficient and high quality providers

Planned Research

Planned Research

- National review of nursing facility payment policies and rate development methodologies to identify 6-8 "Exemplar States" providing similar services
- Summarize Indiana and Exemplar States' information and performance outcomes in matrix format for review and evaluation
- Evaluate key rate-setting component parameters against Nursing Facility Reimbursement Evaluation Criteria to determine optimal methodologies to meet FSSA goals

Potential Considerations

- How the option meets each of FSSA's goals for the program
- Consideration of the level of effort to develop and administer
- Analysis of risks and benefits
- Potential for incorporation into VBP methodologies and strategies
- Consideration of consistency of rate methodology across programs for similar services

Planned Research

RESEARCH AREA	CONSIDERATIONS	
Rate-setting Components	• Direct Care • Indirect Care • Administration	• Capital • Fair Rental Value (FRV)
Process Methodologies	• Acuity adjustments • Standardization of rate-setting components	• Reliance on audited costs • Frequency of rate updates and audits
Performance Outcomes	• Quality measures • Occupancy rates	• Disparities/Social determinants of health

Next Steps

Next Steps

- Please send input on suggested research and analysis
- Next meetings
  - *Preliminary results of research and analysis: June*
  - *Follow-up analysis, evaluation of options, and first conceptual design: July*
- 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.

Appendices from prior presentations

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 April 29, 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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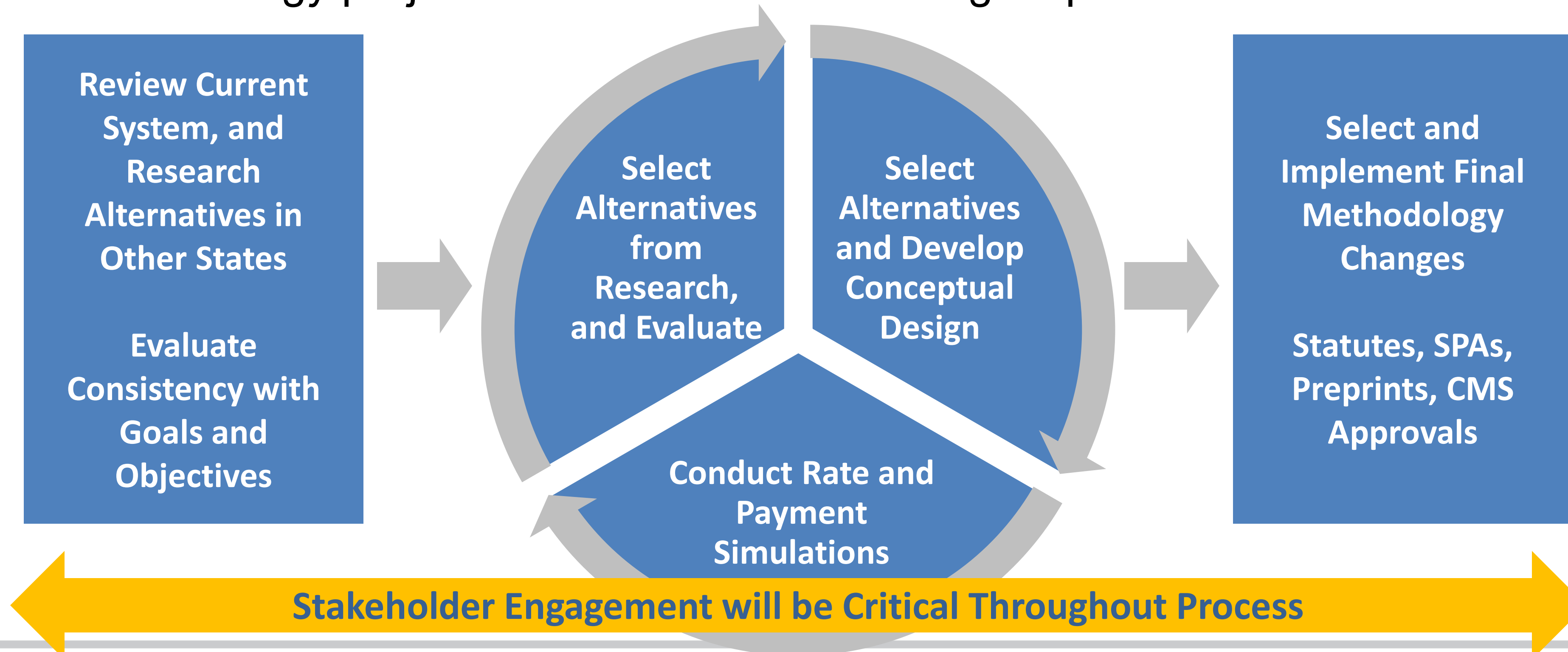
Guidelines issued by the Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Christine Mytelka is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this report.

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.

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
- Rate methodology projects will involve the following steps:



NF Reimbursement Evaluation Criteria

Potential Evaluation Criteria

Rate setting 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 Reimbursement 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** – Rate setting Method must be compatible with transition to managed care environment.

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

Finalize Rates, Methods, and Simulation Results

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

State and CMS approval process

Stakeholder engagement will occur throughout the process

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).