Medicaid Nursing Facility Reimbursement Nursing Facility Upper Payment Limit Program Stakeholder Meeting #2

Indiana Family and Social Services Administration

July 8, 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

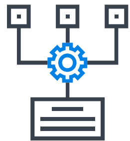
1. Ensure Hoosiers have access to home- and community-based services within 72 hours
2. Move LTSS into a managed model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the state

Agenda

- Directed Payments Funding Flow Considerations
- Directed Payment Uniform Increase Scenarios
- Other State Research
- Next Steps

Directed Payments Funding Flow Considerations

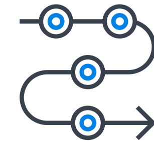
Options for Transitioning NF UPL Program to MLTSS



1. § 438.6(c) state directed payment arrangement

- State directed payment arrangements allow FSSA to require MCEs to make specified payments to providers
- FSSA can require a "directed fee schedule" (ex: Medicare minimum fee schedule, or a payment increase percentage)
- FSSA can also layer in value-based purchasing as a component of the total payment pool (ex: carve out a portion of directed payments, which providers could "earn back" based on quality metrics)

2. Temporary pass through payment program



- Pass-through payments are "add-ons" to the base capitation rate that MCEs are required to pass through to contracted providers
- New Managed Care Final Rule allows states transitioning FFS populations to managed care to create temporary pass through payments for up to 3 years
- New pass through payments would be limited to legacy FFS UPL payments in aggregate, allocated to the populations that transitioned to MLTSS
- FSSA can inform, but cannot direct the provider-level payment distributions by MCEs

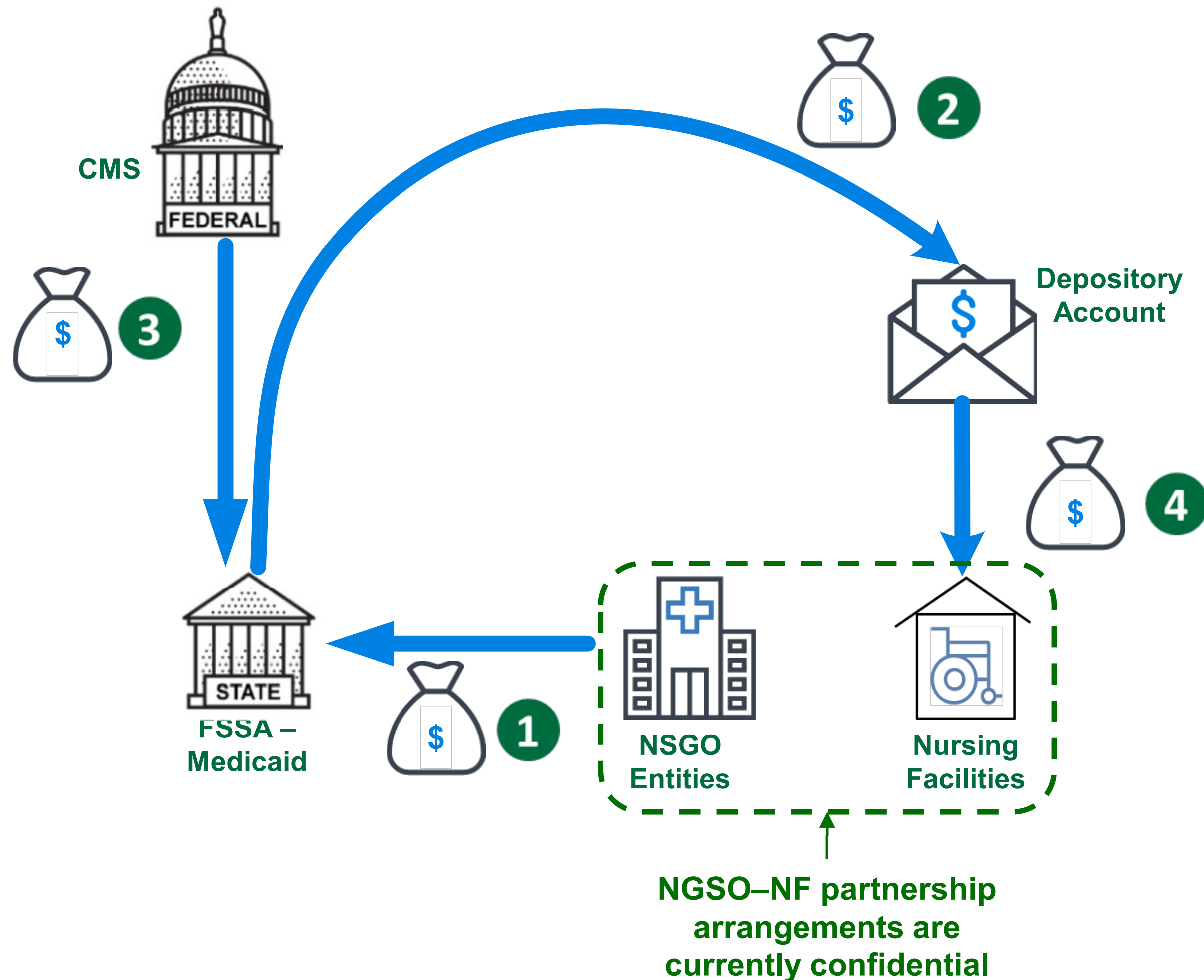
Presentation will focus on directed payment arrangements, elements of which can be incorporated into a pass through payment program (but cannot be required)

Directed Payment Value-Based Purchasing Balancing

Range of Value-Based Purchasing Consideration

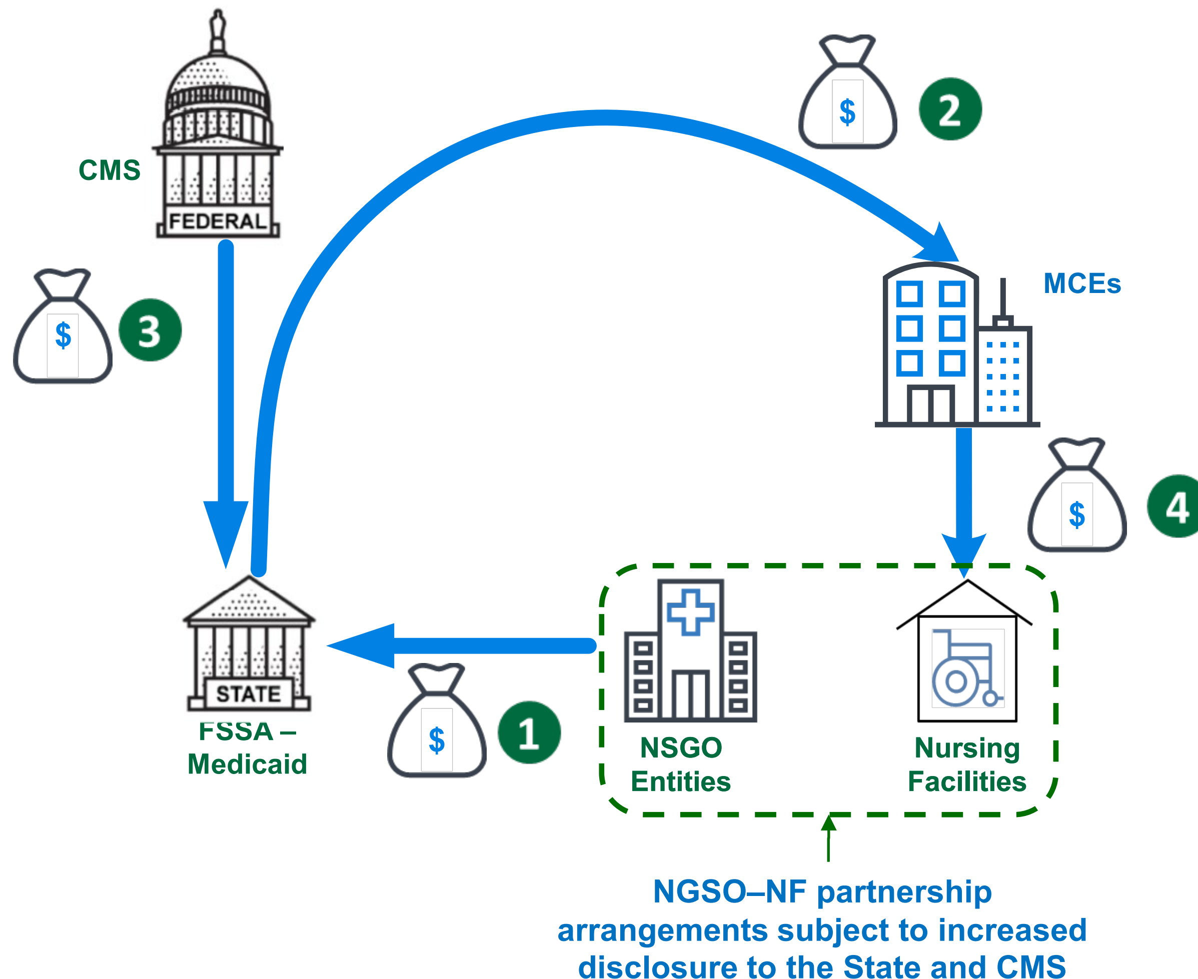
Full Directed Fee Schedule Increase	Mix of Directed Fee Schedule and Quality Payment Pool	Full Quality Payment Pool
• Full directed fee schedule increases without quality pool • Potential transitional period retaining select existing supplemental payments • May require quality portion beginning in years 2-3	• Portion of payment pool dedicated to directed fee schedule increases • Portion dedicated to a quality pool with pay-for-performance requirements with a payment withhold where providers can "earn back" their utilization-based payment	• Full quality payment pool without directed fee schedule • Quality metrics could include mix of baseline qualifications and higher thresholds

NF Funding Flow Process – Current FFS UPL Program



1. NSGO entities (primarily county hospitals) make IGTs to FSSA based on the actual non-federal share of the pending UPL payment
2. FSSA makes UPL payments to the NGSOs which place funds in a Depository Account (total computable)
3. CMS provides federal matching funds to FSSA for the UPL payment
4. Nursing facilities have exclusive access to the depository account for operating expenses for the fiscal year

NF Funding Flow Process – Illustrative Directed Payment Under Managed Care



1. NSGO entities (primarily county hospitals) make IGTs to FSSA based on the **projected** non-federal share of pending **directed** payment

2. FSSA makes funding increases to **MCEs**

3. CMS provides federal matching funds to FSSA for **funding increases to MCEs**

4. **MCEs make directed payments to nursing facilities based on contract year utilization**

Key Directed Payment Funding Flow Considerations

Options for UPL Directed Payment Program in MLTSS

1. Funding Increases Made Through Monthly Capitation Rates

- Directed payments funding increases made by FSSA to MCEs via **increases to base monthly capitation rates**, based on FSSA projections
- MCEs would pay under **enhanced fee schedule** at **claim adjudication**
- Payment pool size and provider payment distribution would be **variable** depending on **actual contract year utilization** (as reflected in the encounter data)
- **MCEs** would be at risk for the aggregate payment pool exceeding capitation rates
- **Providers** would be at risk for the aggregate payment pool and individual provider distributions being less than the IGT basis due to **actual utilization below projections** and **quality metric performance**

2. Funding Increases Made Through Quarterly Separate Payment Term

- Directed payment funding increases made by FSSA to MCEs via **quarterly separate payment terms** (outside of capitation rates)
- MCEs would pay providers on a **quarterly lump sum basis** as determined by FSSA
- Payment pool size would be **fixed** (determined prospectively based on FSSA projections), but provider payment distributions would be **variable** depending on **actual contract year utilization** (as reflected in the encounter data)
- **MCEs** would be at limited risk
- **Providers** would be at risk for the individual provider distributions being less than the IGT basis due to **actual utilization below projections** and **quality metric performance**

Directed payment transition example: Indiana Physician Faculty Access to Care (PFAC) program

Key Considerations	PFAC Supplemental Payment – FFS	PFAC Directed Payment – Managed Care
Eligible providers/ services	• **FFS** physician services at eligible medical school faculty physician group **enrolled in the Medicaid program**	• **Managed care** physician services at eligible medical school faculty physician groups **contracted with MCEs**
Payment basis	• **FSSA** determines payment increases under an enhanced fee schedule on a **quarterly lump sum basis based on quarterly FFS paid claims data**	• **FSSA enhances monthly capitation rates to MCEs based on projected directed payment increases** • **MCEs** pay enhanced fee schedule increases **during claim adjudication throughout the contract year (without reconciliation)**
Non-Federal Funding Source	• IGTs based on non-federal share of actual **provider payment** increases	• IGTs for the non-federal share of actual **MCE capitation rate** increases
Payment risk	• **None**	• **MCEs are at risk for utilization above projections** • **Providers are at risk for utilization below projections**

PFAC payment timeline - FFS

Illustrative example payment scenario:

Physician Faculty Access to Care	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Total
FFS claim base payments	$16.0M	$14.0M	$18.0M	$12.0M			$60.0M
Supplemental Payment up to ACR			$16.0M	$14.0M	$18.0M	$12.0M	$60.0M
IGT (Hospital System to State)			$5.0M	$3.0M	$7.0M	$5.0M	$20.0M
Net Payment to Hospital Systems			$10.0M	$6.0M	$14.0M	$10.0M	$40.0M

Note: In this example, the supplemental payment is equal to the FFS base payment (effectively doubling total reimbursement payment).

PFAC payment timeline - managed care

Illustrative example "Average" payment scenario:

Physician Faculty Access to Care	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Total
MCE claim base payments	$16.0M	$14.0M	$18.0M	$12.0M			$60.0M
Supplemental Payment up to ACR	$16.0M	$14.0M	$18.0M	$12.0M			$60.0M
IGT (Hospital System to State)						$20.00M	$20.0M
MCE Capitation Payment Increases	$15.0M	$15.0M	$15.0M	$15.0M			$60.0M
Net Payment to Hospitals							$40.0M
Net Impact to MCEs							$0.0M
Monthly Base Capitation Rate	$500	$500	$500	$500			
PFAC Capitation Add-On **(1% increase)**	$5	$5	$5	$5			
Revised Monthly Capitation Rate	$505	$505	$505	$505			

Notes: In this example, the supplemental payment is equal to the base payment, effectively doubling the payment. MCEs make the directed payment at the time the claim payment is made. IGTs are paid after the contract year end once final enrollment is known. Risk to both MCEs and hospitals if rating period utilization is higher or lower than capitation rate estimates

Illustrative NF UPL directed payment timeline

Illustrative "Average" NF UPL payment scenario under PFAC approach
(not actual payment estimates or proposed approach)

NF UPL Payment	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Total
MCE claim base payments	$300.0M	$325.0M	$350.0M	$325.0M			$1,300.0M
Supplemental Payment up to ACR	$150.0M	$175.0M	$162.5M	$175.0M			$700.0M
IGT (NSGOs to State)						$231.0M	$231.0M
MCE Capitation Payment Increases	$175.0M	$175.0M	$175.0M	$175.0M			$700.0M
Net Payment to NFs							$469.0M
Net Impact to MCEs	$25.0M	$0.0M	-$25.0M	$0.0M			$0.0M
Monthly Base Capitation Rate	$4,500	$4,500	$4,500	$4,500			
UPL Capitation Add-On **(33% increase)**	$1,500	$1,500	$1,500	$1,500			
Revised Monthly Capitation Rate	$6,000	$6,000	$6,000	$6,000			

Notes: In this example, the supplemental payment is approximately one third of base payments. MCEs make the directed payment at the time the claim payment is made. IGTs are paid after the contract year end once final enrollment is known. Risk to both MCEs and hospitals if rating period utilization is higher or lower than capitation rate estimates.

NF UPL Directed Payment Component Comparison

Payment Component	Current FFS NF UPL Payment	Directed Payment Option #1: Capitation Rate Increases	Directed Payment Option #2: Separate Payment Term
MCE payment term	• N/A	• Increase to MCE monthly base capitation payments based on projected increases	• Separate quarterly payment term to MCEs for directed payments based a actual directed increases
Supplemental payment pool	• **Not fixed** in aggregate • Expands or contracts in aggregate based on Medicaid days from cost reports (2-3 year lag)	• **Not fixed** in aggregate • Expands or contracts in aggregate based on contract year utilization	• **Fixed** in aggregate • Determined prospectively based on projection using the most recently available Medicare per diem rates and Medicaid encounter data

Payment distribution to providers	• Payments made by **FSSA to NGSOs which place funds in depository account available to NFs**
	• Quarterly payments determined by FSSA based on facility-specific Medicare-Medicaid shortfall
		• Payments made by **MCEs to NF billing NPI** at claim adjudication	• Payments made quarterly by **MCEs to NF billing NPI** on lump sum basis determined by FSSA using:
			  • Quarterly encounter data submissions, or
			  • Projected annual payments divided by four

NF UPL Directed Payment Component Comparison

Payment Component	Current FFS NF UPL Payment	Directed Payment Option #1: Capitation Rate Increases	Directed Payment Option #2: Separate Payment Term
Payment Reconciliation	• Annually	• Not required	• Required annually
IGT basis	• Non-federal share of **actual supplemental payments** (adjusted during reconciliation)	• Non-federal share **base capitation rate increases** to MCEs (reconciliation not required)	• Non-federal share of **separate payment term increases** to MCEs (reconciliation to be determined)
Risk	• Limited risk to providers • No quality component	• MCEs would be at risk for the aggregate payment pool exceeding capitation rates • Providers would be at risk for the aggregate payment pool and individual provider distributions being less than the IGT basis due to actual utilization below projections and quality metric performance	• MCEs would be at limited risk • Providers would be at risk for the individual provider distributions being less than the IGT basis due to actual utilization below projections and quality metric performance

Directed Payment Pool Option Comparison #1 Capitation Increase vs. #2 Separate Payment Term

	Pros	Cons
Option #1: Capitation Increase	▪ Aggregate payment pool size most closely reflects contract year utilization ▪ Does not necessarily require a reconciliation process ▪ Monthly capitation rate increases are CMS' preferred approach	▪ Increases risk to MCEs and providers ▪ Less FSSA control over the payment pool size and quality pool adjustments ▪ May result in more variance in provider level projections compared to actual payments
Option #2: Separate Payment Term	▪ Provides more FSSA control over the aggregate payment pool size and IGTs ▪ Reduces risk to MCEs and providers ▪ Provider payment variance from projections based on relativity to other providers, not from a change in pool size ▪ Administratively simpler for quality pool "hold back" adjustments	▪ Separate payment term requires justification to CMS ▪ Increased administration associated with the reconciliation process ▪ May result in larger payment adjustments during the reconciliation process

Funding Flow Considerations

Key decision points that would impact the NF UPL directed payment funding flow:

- Should directed payment funding increases be made via monthly capitation rate increases or via quarterly separate payment term?
- If separate payment term:
    - Should quarterly interim payments be based on each quarter's encounter data, or projected annualized amounts divided by four?
    - Should FSSA conduct reconciliation for payments and IGTs?
- Should IGT funding requirements be 100% prospective (determined in advance based on capitation rate increases), or should there be retrospective IGT adjusted based on reconciliation?
- Should directed payments include a quality pool withhold of a certain percentage of the payment pool for providers to earn back based on quality metrics? If not, how else should quality performance be incorporated into the directed payment methodology?

Note: Final directed payment funding flow and methodology approach subject to CMS approval

Directed Payment Uniform Increase Scenarios

Directed fee schedule payment distribution options under consideration for NF UPL

1. **"Uniform Dollar or Percentage Increase"** above current negotiated rates (typically a retrospective lump sum payment)
   - Set percentage increase applied to MCE paid amount
   - Set dollar increase per resident day
2. **"Minimum Fee Schedule"** which MCEs can pay no less than for contracted providers (typically a prospective increase applied to negotiated rates, as opposes to separate lump sum payments)
   - Medicare or Medicare-equivalent rate
   - Alternative fee schedule established by the State

Uniform Dollar or Percentage Increase would result in a greater formula change and greater payment impacts compared to current FFS UPL methodology

Illustrative NF UPL Directed Payment Distribution

Based on FSSA's SFY 2020 UPL settlement

Estimated gross payment per day across nursing facilities:

Note: Nursing facilities are sorted by average base Medicaid per diem, inclusive of the VBP add-on.

- Illustrative modeled **gross** directed payment scenarios show approximately a 52% increase vs. a $121 per diem increase, to result in the same **gross** aggregate $1B UPL payment pool as in SFY 2020
- Does not include adjustments for changes in volume, Medicaid base per diem rates, Medicare per diem rates, or reductions for IGTs
- ***Illustrative only – not actual or proposed payment impacts***

Illustrative NF UPL Directed Payment Distribution

Based on FSSA's SFY 2020 UPL settlement

Estimated <u>gross</u> supplemental payment per day change histogram under an illustrative directed <u>52% uniform increase</u>:

Number of Nursing Facilities

160
140
120
100
80
60
40
20
0

≤ -$75	(-$75, -$50]	(-$50, -$25]	(-$25, $0]	($0, $25]	($25, $50]	($50, $75]	> $75
11	28	68	106	139	99	38	12

Estimated Per Diem Change: Relative to SFY 2020 Gross UPL Payment Per Day

- Uniform percent increase approach amplifies differences in base payments, resulting in more outliers than a uniform % increase approach
- **Gross** payment change estimates does not include adjustments for changes in volume, Medicaid base per diem rates, Medicare per diem rates, or reductions for IGTs
- ***Illustrative only – not actual or proposed payment impacts***

Illustrative NF UPL Directed Payment Distribution

Based on FSSA's SFY 2020 UPL settlement

Estimated <u>gross</u> supplemental payment per day change histogram under an illustrative directed <u>$121 per diem uniform increase</u>:

Estimated Per Diem Change: Relative to SFY 2020 Gross UPL Payment Per Day	Number of Nursing Facilities
≤ -$75	9
(-$75, -$50]	24
(-$50, -$25]	74
(-$25, $0]	106
($0, $25]	137
($25, $50]	101
($50, $75]	46
> $75	4

- Uniform add-on approach does not reflect differences in base payments, resulting in fewer outliers than a uniform % increase approach
- **Gross** payment change estimates do not include adjustments for changes in volume, Medicaid base per diem rates, Medicare per diem rates, or reductions for IGTs
- ***Illustrative only – not actual or proposed payment impacts***

Questions on New Supplemental Payment Program

- How closely should the supplemental payments align with the differences in base Medicaid payments (in coordination with the base rate work stream)?
- Should directed UPL payment increases be uniform, or should there be provider-specific increases like under the current UPL methodology?
- How could a uniform increase align with the current VBP per diem add-on methodology in the base payments?

Other State Research

Nursing Facility Supplemental Payment Programs – Example States

State/Program	Total Annual Payment Pool	Non-Federal Funding Source	Eligible Providers	Payment Distribution Method	Payout tied to Quality	Preprint Type
Arizona NF Supplemental Payment Program	$100 million	Provider assessment	All except ICFs and Veteran's Homes	Total Medicaid bed days	No	Uniform Payment Increase
New York VAP	$132 million	State appropriations	Financially distressed NFs	Medicaid rate adjustment	No	FFS-only (no Preprint)
New York NF Quality Pool	$50 million	Provider assessment	Non-Medicaid and specialty facilities excluded	Based on Medicaid revenue as percent of state total multiplied by award factor for top 3 quintiles	Yes	FFS-only (no Preprint)
Tennessee NF Minimum Fee Schedule	n/a	State appropriations and provider assessment	All Medicaid NF contracting with MCOs	State directed minimum fee schedule	No	Minimum fee schedule, alternative fee schedule
Texas QIPP	$1.1 billion	IGTs	NSGOs and private NFs with at least 65% Medicaid days	Proportional based on Medicaid days after meeting quality & programmatic goals	Yes	Uniform Payment Increase
Virginia	$7.3 million	IGTs	State-government owned NFs	Utilization as measured by encounters to fill UPL gap	No	Uniform Payment Increase

NF Supplemental Payment Example: Texas

State Directed Payment for Directed Uniform Payment Increase

Key Considerations	Texas: Quality Incentive Payment Program
Total Annual Payment Pool	• Approximately $1.1 billion payment pool
Non-Federal Funding Source	• IGTs
Eligible providers	• NSGO NFs and private NFs with at least 65% Medicaid days
Payment Distribution Method	• Based on improvements in four quality/program goal components • Proportional based upon historical Medicaid days

SY2022 Quality Metrics

Component	Eligible NF	Total Value	Distribution Timing	Measure
1	NSGO providers only	110% of non-federal share of QIPP program	Monthly	Proper submission of Quality Assurance and Performance Improvement Validation Report
2	All providers	30% of remaining QIPP funds after funding Components One and Four	Monthly	3 workforce measures on additional RN staffing coverage levels and workforce development program PIP
3	All providers	70% of remaining QIPP funds after funding Components One and Four	Quarterly	4 Long-Stay MDS Quality Metrics measured against program-wide and facility-specific targets
4	NSGO providers only	16% of QIPP funds	Quarterly	Alternating quarterly performance targets in evidence-based infection control policies, training documentation, and DS vaccination rate measures

Source: https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2022.pdf

NF Supplemental Payment Example: Arizona

Directed Uniform Payment Increase through FFS & State Directed Payment

Key Considerations	Arizona: Nursing Facility Supplemental Payment Program
Total Annual Payment Pool	• $100 million+ payment pool • Approximately 21% total reimbursement increase over base projected spending in CYE 2021
Non-Federal Funding Source	• NF assessment
Eligible providers	• All contracted Medicaid nursing facilities except ICFs and Veteran's Homes
Payment Distribution Method	• Allocated based each facility's share of total Medicaid bed days

Provider Type	Average Base Rate	Expected Increased Reimbursement under Directed Payment
Urban	118.3% of Medicare urban base rate	141.9% of Medicare urban base rate
Rural	102.2% of Medicare rural base rate	122.6% of Medicare rural base rate

Sources:
https://apps.azsos.gov/public_services/Title_09/9-28.pdf
AZ_438.6(c) Proposal A Preprint_2020-2021

NF Supplemental Payment Example: New York

Vital Access Provider (VAP) Program – FFS only

- Created in 2011, VAP funds operational costs for financially distressed healthcare entities' turnaround initiatives. Program is funded through state budget appropriations and federal matching funds.
- Eligible entities include hospitals, **nursing facilities**, assisted living facilities, diagnostic and treatment centers, and certified home health agencies, licensed home care service agencies, and consumer directed personal assistance program fiscal intermediaries.
- Successful applicants receive a temporary Medicaid rate adjustment of up to three years. Adjustment amount is based on project operating costs. Capital costs are not eligible.

Qualifications

Must demonstrate provider has financial need and is:

- Undergoing closure;
- Impacted by closure of other provider(s) in its service delivery area;
- Undergoing or impacted by a merger, acquisition, consolidation or restructuring

Application Demonstration

Must demonstrate that the temporary rate adjustment will achieve one of the following:

- Protect or enhance access to care and quality of care
- Improve health care services delivery cost effectiveness;
- Protect or enhance health care delivery system

Scoring Criteria

- Facility Financial Viability
- Community Service Needs
- Quality Care Improvements
- Health Equity

Viable Project Examples

- Expand access to ambulatory services
- Open urgent care centers
- Improve quality through reduced adverse events and overall costs;
- Expand services in rural areas through additional primary and specialty care services;
- Establish care coordination between providers and health care service delivery levels.

Sources: New York State Plan, Attachment 4.19-A https://www.hcrapools.org/medicaid_state_plan/DOH_PDF_PROD/nys_medicaid_state_plan.pdf
Public Health Law, Section 2826. https://www.nysenate.gov/legislation/laws/PBH/2826

NF Supplemental Payment Example: New York

Nursing Home Quality Pool (NHQP) – FFS only

Key Considerations	New York: Nursing Home Quality Pool (NHQP)
Total Annual Payment Pool	• $50 million payment pool
Non-Federal Funding Source	• NF assessment fee based on NF's Medicaid revenue as percent of state total
Eligible providers	• Excludes specialty facilities consisting of non-Medicaid facilities, Special Focus Facilities as designated by CMS, Continuing Care Retirement Communities, Transitional Care Units, specialty facilities, and specialty units within facilities
Payment Distribution Method	• Based on NF performance in quality, compliance, and efficiency measures • NFs are ranked and grouped by quintiles with three quintiles receiving payment based on Medicaid revenue as percent of state total multiplied by quintile award factor

Performance Category	Description	Maximum Points
Quality	14 measures: 10 CMS Long-Stay measures, 3 NY Dept of Health measures, 1 Pharmacy Quality Alliance measure	70 points
Compliance	CMS Five-Star Quality Rating Timely Submission and Certification of Complete NY State Nursing Home Cost Report Timely Submission of Employee Influenza Data	20 points
Efficiency	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1 of the MDS year	10 points

Sources:
New York State Plan, Attachment 4.19-D https://www.hcrapools.org/medicaid_state_plan/DOH_PDF_PROD/nys_medicaid_state_plan.pdf
https://www.health.ny.gov/facilities/long_term_care/reimbursement/letters/2020-12-29_dal.htm

Supplemental Payment Examples: Tennessee

Nursing Facility State Directed Fee Schedule

Key Considerations	Tennessee: State Directed Minimum Fee Schedule
Total Annual Payment Pool	• Not available
Non-Federal Funding Source	• State appropriations and provider assessment
Eligible providers	• All nursing facilities contracting with Tennessee's Medicaid managed care organizations
Payment Distribution Method	• State established minimum fee schedule for MCO-NF contracting • Alternative fee schedule established by the State not tied to the approved State plan fee schedule • Current methodology is prospective, cost-based system. Each facility's cost capped at 65th percentile and is retrospectively adjusted based on case mix and quality metric performance.

Sources:
TN 438.6c Proposal H 2020 Preprint_REVISED retrieved from CMS via FOIA request
TN_438.6(c) Proposal H_Attachment 1_2020 retrieved from CMS via FOIA request

Supplemental Payment Examples: Virginia

Nursing Facility Directed Uniform Payment Increases

Key Considerations	Virginia: State Government Nursing Facilities Payment Initiative
Total Annual Payment Pool	• $7.3 million (estimate)
Non-Federal Funding Source	• IGTs
Eligible providers	• State government owned nursing facilities (Virginia Commonwealth University Health System nursing facilities – 2 NFs)
Payment Distribution Method	• Based on the UPL gaps for each provider (base rate average is 57% of Medicare) • Quarterly payments made using MCO encounter data

Sources:
Virginia Proposal C_2020-2021_CRMC & VCU NFs Preprint retrieved from CMS via FOIA request
VA FY2021 CCC Plus Rate Report_2020 06 03 Final retrieved from CMS via FOIA request
VCU Nursing Facilities UPL Supplemental Payments https://www.dmas.virginia.gov/media/1862/vcu-nfs-upl-supplemental-payment-report.pdf

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

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

Next Steps

- Please continue to send input
- Next meeting August 12, 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.

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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.