

Medicaid Nursing Facility Reimbursement Nursing Facility Base Rates Stakeholder Meeting #2

Indiana Family and Social Services Administration
July 15, 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 \sim 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

FSSA Reimbursement Goals

To develop Nursing Facility (NF) payment 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.

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Agenda



- Consideration of Potential Changes
- Analysis of Case Mix Index (CMI) and Direct Care Cost
- State Research
- Next Steps



Consideration of Potential Changes

Revisit - Overview of Rate Components

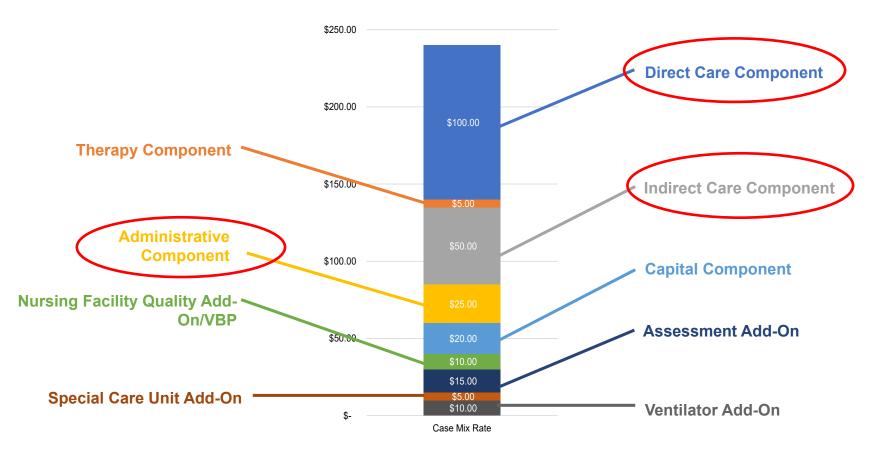
(Example for illustration purposes only – not an actual facility)



Today's discussion will focus only on the following "core" rate components:

- Direct Care
- Indirect Care
- Administrative

Other components shown will be addressed as part of the Stakeholder Meeting #3 discussion.



Revisit - Overview of Rate Component Adjustments and Limits



	Minimum Occupancy Adjustment for Fixed Portion		t for Fixed	Allowed Profit - Difference between Component Facility- Specific and Median Cost Per Day				O
Rate Component	Case Mix Adjusted ?	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?	Overall Rate Component Limit
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		100% Median		
Capital	No	Yes	100%	Yes	60%	None	Yes	100% Median

Core Rate Components – Key Observations



CONSIDERATION

CMI Adjustment

Complexity and Frequency

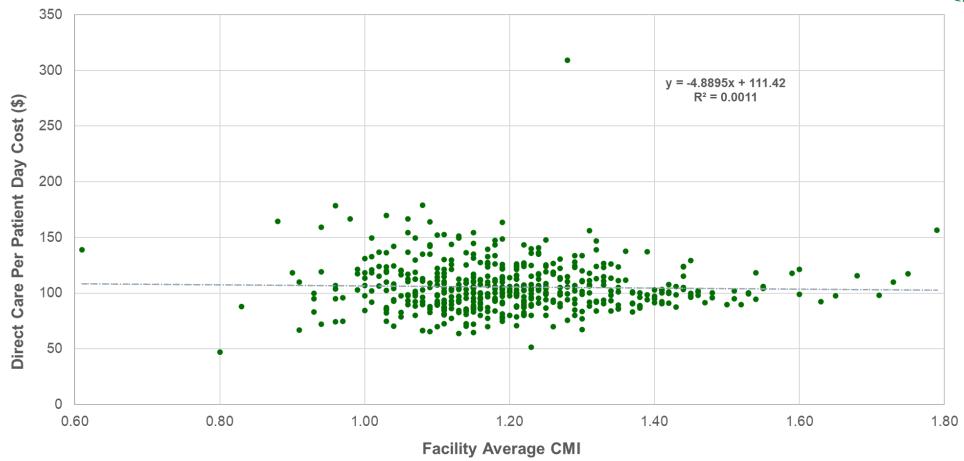
Limitations to a Cost-based Approach

DISCUSSION

- No correlation between facility CMI and cost per day values
- Correlations do not improve when considering multiple variables
- Some form of CMI adjustment may still be necessary to assure access to services for high acuity residents
- Also necessary to apportion cost between Medicaid and other payer
- Methodology could be simplified and streamlined
- Could stabilize rates by reducing frequency of acuity updates
- Types of costs included in various components may benefit from re-alignment
- "Locks in" historical cost structure rewards historical inefficiency and a erects a barrier to investing in staffing and other improvements
- Cost of annual cost reporting, desk reviews, and audits
- Administrative burden of frequent updates and multiple retroactive changes
- Slow to reflect changes in the environment (e.g. pandemic or wage inflation)

Direct Care Cost as a Function of Facility Average CMI





Straw Man Options for Consideration: Core Rate Components



Option 1: Current Cost
Based, with
Simplifications

- Establish "core" component rates using predetermined percentile (e.g., median value or other)
 - ➤ Direct Care and Indirect
 Care continue lesser of
 facility specific or
 percentile
 - ➤ Administrative percentile
- Same as Option 2 otherwise

Option 2: Price Based, Adjusted Using Facility CMI

- Establish statewide standardized rates for all three "core" components using predetermined percentile (e.g., median value or other)
- Remove adjustments for profit allowance, occupancy and total component caps
- Establish rates for 3-5 year period, based on desk reviewed costs, with interim year updates tied to indexing value
- Continue to adjust for facility average
 Medicaid CMI, but less frequently -
 - ➤ Establish reasonable corridor, and adjust for changes in Medicaid CMI only when actual CMI is outside of corridor

Option 3a: Price Based, Tied to Resident CMI

- Same as Option 2, except for CMI adjustment, described below
- Instead, adjust the single statewide standardized Direct Care rate component to establish a single statewide rate for each of the 48 CMI groups

Option 3b: Price Based, Tied to Resident CMI "Tiers"

 Same as Option 3a, but collapse the 48 CMI groups into a smaller number of "tiers" (for example, 5-6 "tiers")

Consideration should also be given to the potential transition to the Patient Driven Payment Model (PDPM) for future CMI measurement

Straw Man Options for Consideration: Option 3a Illustration – 48 CMI Groups

Note: Values shown below are not actual, and are for illustration purposes only



Sample of
CMI Groups
for Illustration
Purposes:
Total of 48
CMI Groups

Classi	iMI fication (A)	CMI Relative Weight (B)	Direct Care Base for 1.00 CMI (C)	CMI-Adjusted Direct Care Rate (D=B*C)	Other Rate Components (E)	Standard Rate for CMI Group (F=D+E)
Base (0	CMI 1.00)	1.00	\$85.00	\$85.00	\$100.00	\$185.00
E	ES3	3.00	\$85.00	\$255.00	\$100.00	\$355.00
E	S2	2.23	\$85.00	\$189.55	\$100.00	\$289.55
E	S1	2.22	\$85.00	\$188.70	\$100.00	\$288.70
(CE2	1.39	\$85.00	\$118.15	\$100.00	\$218.15
(Œ1	1.25	\$85.00	\$106.25	\$100.00	\$206.25
C	CD2	1.29	\$85.00	\$109.65	\$100.00	\$209.65
C	CD1	1.15	\$85.00	\$97.75	\$100.00	\$197.75
F	PB2	0.70	\$85.00	\$59.50	\$100.00	\$159.50
F	PB1	0.65	\$85.00	\$55.25	\$100.00	\$155.25
F	PA2	0.49	\$85.00	\$41.65	\$100.00	\$141.65
F	PA1	0.45	\$85.00	\$38.25	\$100.00	\$138.25

Straw Man Options for Consideration: Option 3b Illustration – 6 Case Mix Tiers



Note: Values shown below are not actual, and are for illustration purposes only

Case Mix Tier (A)	Tier Relative Weight (B)	Direct Care Base (C)	CMI-Adjusted Direct Care Rate (D=B*C)	Other Rate Components (E)	Standard Rate for Tier Group (F=D+E)
6	2.4	\$85.00	\$204.00	\$100.00	\$304.00
5	1.6	\$85.00	\$136.00	\$100.00	\$236.00
4	1.3	\$85.00	\$110.50	\$100.00	\$210.50
3	1.1	\$85.00	\$93.50	\$100.00	\$193.50
2	0.9	\$85.00	\$76.50	\$100.00	\$176.50
1	0.7	\$85.00	\$59.5	\$100.00	\$159.50

Straw Man Options for Consideration: Key Decision Points



	Option 2: Pure Price Based	Option 1: Facility Specific with Cap
Pure Price Based - Or - Facility Specific with Cap	 Simpler, transparent, and understandable Rewards efficiency Enhances payment equity Where CMI does not fully reflect resource needs, may need adjustment (specialty facilities) Financial incentive to reduce staffing, although this could be mitigated by robust quality payments 	 Reduces financial incentive to reduce staffing Continued reliance on facility specific cost data
	Option 2: Facility CMI	Option 3a: Resident CMI
Facility CMI - Or - Resident CMI	 The current approach, familiar Each facility has a different average CMI, so 500+ rates 	 Rates follow residents – immediately – no lag between admitting a high acuity resident and higher reimbursement Requires each resident to have an assessment
48 CMI Groups	Option 3a: One Rate for Each CMI (48)	Option 3b: Group CMIs into 5 – 6 Tiers
Or Collapse	Each Rate has Direct Correspondence to CMI	Grouping CMIs simplifies reimbursementBroader range of acuity in each tier

Straw Man Options for Consideration: Key Advantages and Disadvantages



Option	Key Advantages	Key Disadvantages
Option 1: Current Cost Based, with Simplifications	 Fewer changes, so potentially less fiscal impact to providers in the long term May create additional incentive to increase nursing and other care-related resources, but also dependent on other quality incentive components 	 Separate rate for each facility Facility-specific rates not consistent with objective to simplify rate-setting process
Option 2: Price Based, Adjusted Using Facility CMI	 Significant movement toward simplicity Enhances payment equity across facilities Creates significant incentives for cost effectiveness 	 Separate rate for each facility Facility-specific rates not consistent with objective to simplify rate-setting process More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins
Option 3a: Price Based, Tied to Resident CMI	 One statewide rate for each CMI group (48 rates) Significant simplification Enhances payment equity across facilities Creates significant incentives for cost effectiveness 	 More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins
Option 3b: Price Based, Tied to Resident CMI "Tiers"	 One statewide rate for each CMI group "Tier" (e.g., 5-6 rates) Significant simplification Enhances payment equity across facilities Creates significant incentives for cost effectiveness 	 More dependent on robust quality incentive component to offset incentive to reduce staffing and other resources and increase margins

Straw Man Options for Consideration: Preliminary Evaluation of Options using Evaluation Criteria



Evaluation Criteria (Scoring: 5 = High, 3 = Neutral, 1 = Low)

Option	Resulting Number of Rates	Quality, Access, and Reducing Disparities	Efficiency and Payment Equity	Transparency, Simplicity and Predictability	Alignment and Forward Compatibility
Option 1: Current Cost Based, with Simplifications	One rate for each facility		3	1	3
Option 2: Price Based, Adjusted Using Facility CMI	One rate for each facility	3	4	3	4
Option 3a: Price Based, Tied to Resident CMI	One statewide rate for each CMI group (48)	(Dependent on separate quality	5	5	5
Option 3b: Price Based, Tied to Resident CMI "Tiers"	One statewide rate for each CMI group "Tier" (e.g., 5-6)	incentive component)	5	5	5

Straw Man Options for Consideration: Mitigating the Impacts of Rate-Setting Changes

- FAMILY & SOCIAL SERVICES
- Transition to a simplified cost-based model, such as Option 1, would likely have little impact on payments, and may not require a transition strategy
- Transition to a price based model (e.g., Options 2, 3a, or 3b) may result in significant fiscal impacts to individual providers
- If selected, may need to establish a payment transition approach to help mitigate the fiscal impacts
- Mitigation options include:
 - Temporarily maintain current methodology in parallel with new methodology implementation, and blending rates for providers on a time limited basis (e.g., first 2 years). This approach would increase the complexity of the change for the transition period.
 - Prospectively establish rates under the new methodology on a time limited basis that are proportionally adjusted to limit the "gains" or "losses" to a predetermined percentage (e.g., no more or less than 5% change in year 1, and 10% in year 2). Rates could be determined in advance, and would not increase the complexity beyond the initial implementation of the change.



Analysis of CMI and Direct Care Cost

Direct Care Cost as a Function of Facility Average CMI



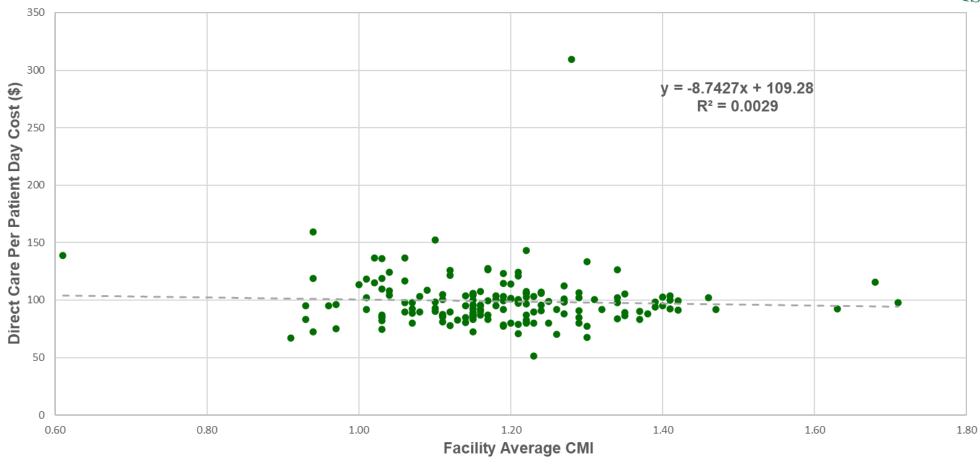
Sub-Splits We Examined for Significance:

- Urban/Rural
- Private/Public
- Profit/Non-Profit
- UPL/Non-UPL Facilities
- Large/Small Facilities (Defined as a Minimum of 100 Beds)
- Medicaid Utilization (High vs. Low, High is 70% Minimum)
- Percent of Non-White Residents (High vs. Low, High is 25% Minimum)
- Medicaid CMI (High vs. Low, High is 1.2 Minimum)

Of the sub-splits examined, none produced a significant correlation between facility average CMI and direct care per patient day cost.

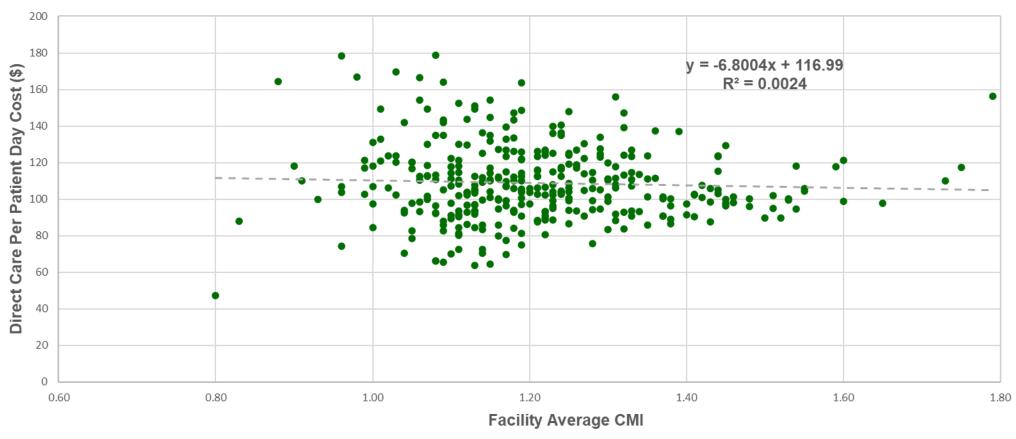
Direct Care Cost as a Function of Facility Average CMI: Rural Facilities





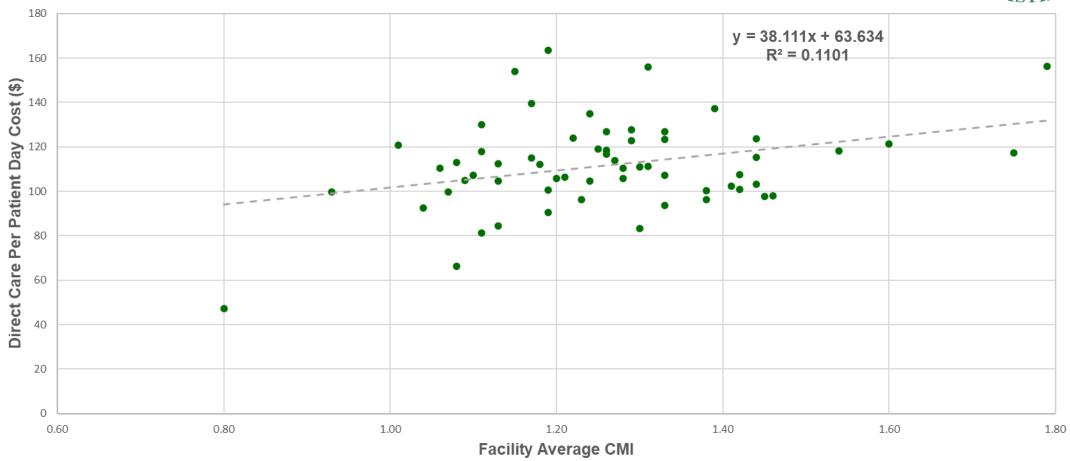
Direct Care Cost as a Function of Facility Average CMI: Urban Facilities





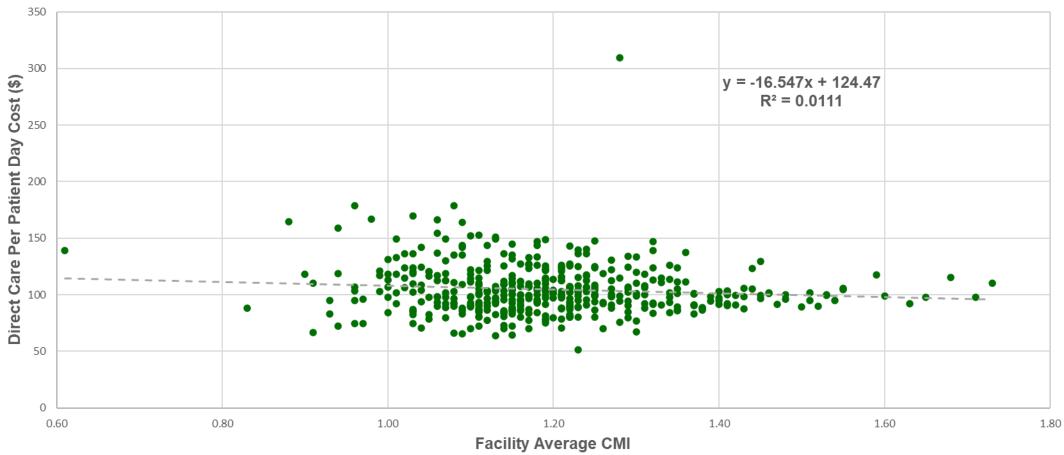
Direct Care Cost as a Function of Facility Average CMI: High % Non-White Facilities (At Least 25%)





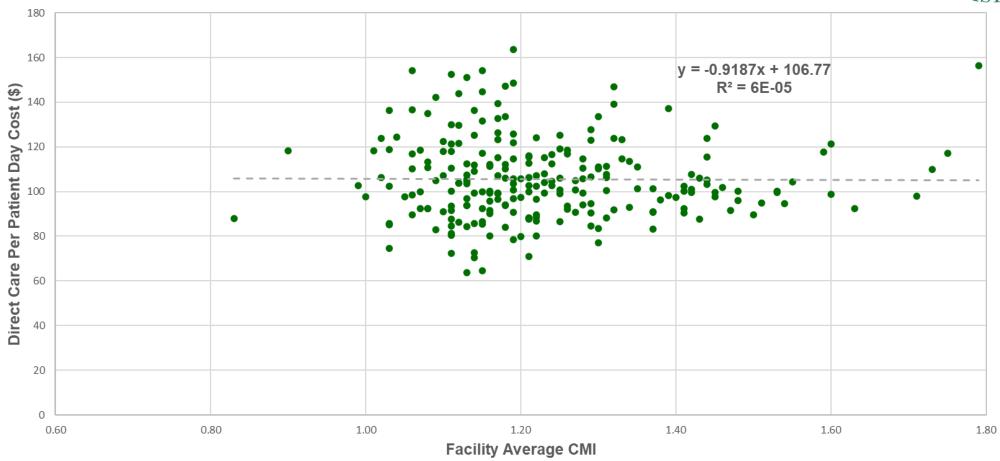
Direct Care Cost as a Function of Facility Average CMI: Low % Non-White Facilities (Less Than 25%)





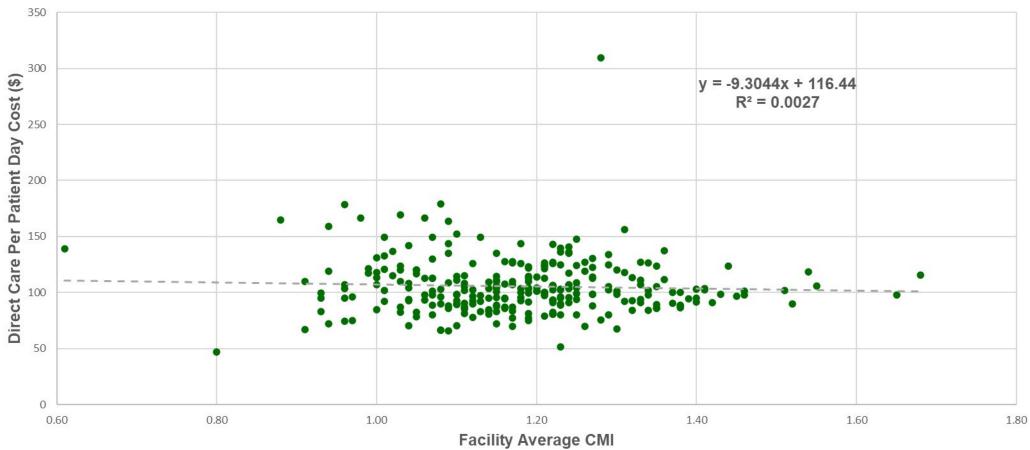
Direct Care Cost as a Function of Facility Average CMI: Large Facilities (100 Beds or More)





Direct Care Cost as a Function of Facility Average CMI: Small Facilities (Less Than 100 Beds)







State Research

Rebasing Frequency

States update the maximum allowable payment rates periodically

- 23 states rebase annually (Indiana)
- 15 states update every two to four years
- 11 states have other processes
- 2 states have no method found in MACPAC review



State	Rebasing Frequency/Process
Arkansas	Direct care component of rate is rebased annually; indirect, administrative, and operating cost components rebased at least once every three years with the existing per diem inflated forward into the next rate period using the inflation index.
Florida	Every 4th year, nursing home prospective payment rates are rebased to reflect changes in cost based on the most recently audited cost report for each participating provider
Louisiana	Every 2nd year, base resident-day-weighted median costs and prices based using most recent four month or greater unqualified audited or desk reviewed cost reports available, or the Department may apply historic audit adjustment factor to most recently filed cost reports. In between rebasing, index factor is applied to base resident-day weighted medians and prices.
Maryland	Each cost center rebased between every two and four rate years. Prices rebased more frequently if State determines an error in data or in calculation that results in substantial difference in payment, or if significant change in provider behavior or costs resulted in inequitable payment across providers. In years in which prices are not rebased, prices subject to annual indexing.
New Hampshire	Rates rebased at least every 5 years with limitations: (1) Only when rates are rebased are costs inflated; (2) Costs are inflated to rate year midpoint using CMS prospective payment system (PPS) skilled nursing facility input price index by expenses category index; (3) Resulting rate reduced by budget adjustment factor equal to 26.82% in accordance with Medicaid State Plan.

Underlying Basis for Rates

States generally utilize facility costs or set a specific allowable price to determine maximum payment to facilities

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- 32 states use facility costs (Indiana)
- 15 states set allowable price
- 3 states use mix of facility costs and allowable prices
- 1 state uses lesser or private pay charge or facility cost

State	Price Based Rates	
	Fair-market pricing and historical cost analysis for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost. Standard price comprised of following components and percentages of total rate:	
Kentucky	 Personnel 65% Non-personnel operating 6% Non-capital facility related cost 3% Administration 13% Capital rate 7% Food 4% 	
Louisiana	Rates based on case-mix price-based system calculated from cost report and other statistical data.	
New York	Direct and indirect prices are a blend of statewide price and peer group price. Direct price subject to case mix adjustment and wage index adjustment. Indirect price subject to wage index adjustment.	
Texas	Direct and indirect care prices are 107% of median peer group per diem costs	

Acuity System

Adjustments to the basic payment methodology based on resident acuity levels

- 35 states use RUGs (Indiana)
- 7 states use another state-specific method
- 9 states have no acuity adjustment/none found in MACPAC review



State	State-Specific Adjustment Method
Arizona	Prospective per diem reimbursement system recognizes members in 4 levels (1-3, ventilator dependent/other specialty care) as identified through medical and functional assessment data from Pre-admission Screening (PAS) instruments (initial and reassessments) from most recent 6 months proceeding rate effective date
Delaware	Primary patient care cost center based on patient index system in which all nursing home patients are classified into patient classes: 0 – Independent, 1 – Supervision, 2 – Moderate assistance, 3 – Maximum assistance through evaluation by Medicaid review nurses according to amount of staff assistance needed for activities of daily living
Maine	44 case mix resident classification groups based on Resident Assessment Instrument (RAI) tool comprised of the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs)
Massachusetts	6 patient groups based on nursing management minutes measuring resident care intensity by discrete caregiving activities or the characteristics of residents requiring a given amount of care

Rate Adjustments: Ventilator Care

Adjustments to the basic payment methodology for specific types for nursing facilities with ventilatory dependent patients



- 37 states provide an adjustment: either add-on to base rate or separate all-inclusive fixed rate

State	Example Ventilator Adjustments
Indiana	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
Alabama	\$120.00 supplemental daily payment for ventilator-dependent/tracheostomy resident indexed annually
Arizona	Ventilator dependent residents are one of 4 base rate reimbursement levels
Florida	\$200 add-on per Medicaid day of 40,000 ventilator Medicaid days per fiscal year
Georgia	All-inclusive per diem rate of \$540.55 that covers all skilled nursing care services for a ventilator dependent resident
Idaho	Calculation of a staffing wages and equipment costs add-on to cover the additional direct care staff and equipment/supply requirements to meet needs of ventilator-dependent residents
Illinois	\$208 add-on per day for each individual resident receiving ventilator services
lowa	Ventilator reimbursement rate equal to Medicare-certified hospital-based nursing facility direct care patient-day-weighted median times 120% times the provider's Medicaid average case mix index, plus Medicare-certified hospital-based nursing facility non-direct care rate patient-day-weighted median times 110%
Mississippi	Additional \$178.34 per diem rate for beneficiaries receiving ventilator dependent care
Rhode Island	\$200.00 differential rate to providers of ventilator bed services; limited to a maximum of 30 beds on a statewide basis

Rate Adjustments: Specialty Care

Mental Health or Cognitive Impairment Add-On

22 states provide rate adjustment for nursing facilities caring for patients suffering from mental,
 behavioral, or cognitive impairments, such as traumatic brain injuries, dementia, and Alzheimer's

Other High-Need Condition Add-On

 21 states provide rate adjustments for nursing facilities caring for patients suffering from conditions requiring specialized assistance, such as AIDS

State	Examples
Colorado	For residents with severe cognitive dementia or acquired brain injury, supplemental payment based on resident's Cognitive Performance Scale (CPS) score. \$1 - \$3 add-on based on CPS percentage greater than mean plus 1-3 standard deviations.
District of Columbia	Add-on payment for each resident who qualifies as behaviorally complex or bariatric
Georgia	Rates adjusted from 1-4.5% based on percentage of Medicaid patients whose Brief Interview for Mental Status (BIMS) score are less than or equal to five.
Illinois	Per diem rates \$264.14 - \$767.46 for residents with traumatic brain injuries; \$0.63 per diem add-on for residents who score I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia
Mississippi	Annually, new bed value adjustment for licensed Alzheimer's units' beds will be determined by multiplying the nursing facility new bed value by 37.20%, to account for the additional construction costs required to be licensed as an Alzheimer's unit.
Nevada	Three-tiered add-on rate for behaviorally complex individuals ranging from \$111.23 - \$326.26



Next Steps

Nursing Facility Reimbursement – Project Timelines





Next Steps



- Focus on other rate components:
 - Therapy Component
 - Capital Component
 - Assessment Add-On
 - Ventilator Add On
 - Special Care Unit Add-on
- VBP Add-on component will continue to be addressed as part of the separate VBP workstream

Next Steps



- Please continue to send input
- Next meeting August 19, 2021
- Meeting topics and agendas to be developed and sent five business days in advance of the Workgroup meetings
- New workgroup members may email <u>backhome.Indiana@fssa.in.gov</u> to be added to the mailing list for this workstream

Caveats and Limitations

WYJONI & SOCIAL SERVICES

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 July 8, 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.