Medicaid Nursing Facility Reimbursement Quality and Value Based Reimbursement Stakeholder Meeting #2

Indiana Family and Social Services Administration

July 22, 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

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.

Agenda

- Value Based Purchasing Principles
- Consideration of Potential Changes
- Deep Dive into Current Nursing Facility Performance
- Examples from Other States
- Consideration of Measure Evaluation Criteria
- Next Steps

Value Based Purchasing Principles

VBP Guiding Principles

- Align VBP to larger quality strategy as just one of many levers to drive desired outcomes
- Use measures defined by 3rd party
- Standardize data collection methods or instruments
- Limit the number of goals and select the right measures to drive desired outcomes
- Rely on data analysis to confirm perceived performance gaps
- Approach quality measures as a work in progress and adjust/evolve over time as measures achieved
- Align the payment timing to the measurement period
- Adjust the size of payments to make participation worthwhile
- Where possible, align VBP programs across payers to boost purchasing power

Consideration of Potential Changes

Evolution of Quality Rate Add-On Performance Measures

The measures, components and weights used to calculate the quality score have evolved over time. What path should future evolution take?

Quality Score Component	Maximum Quality Points Awarded (effective 7/1/2019)	Maximum Quality Points Awarded (effective 7/1/2020)
1. Nursing Home Health Survey Score	55	25
2. Long-Stay Quality Measures	30	60
3. NF Staff Retention Rate	10	10
4. Advance Care Planning	5	5
Total Maximum	**100**	**100**

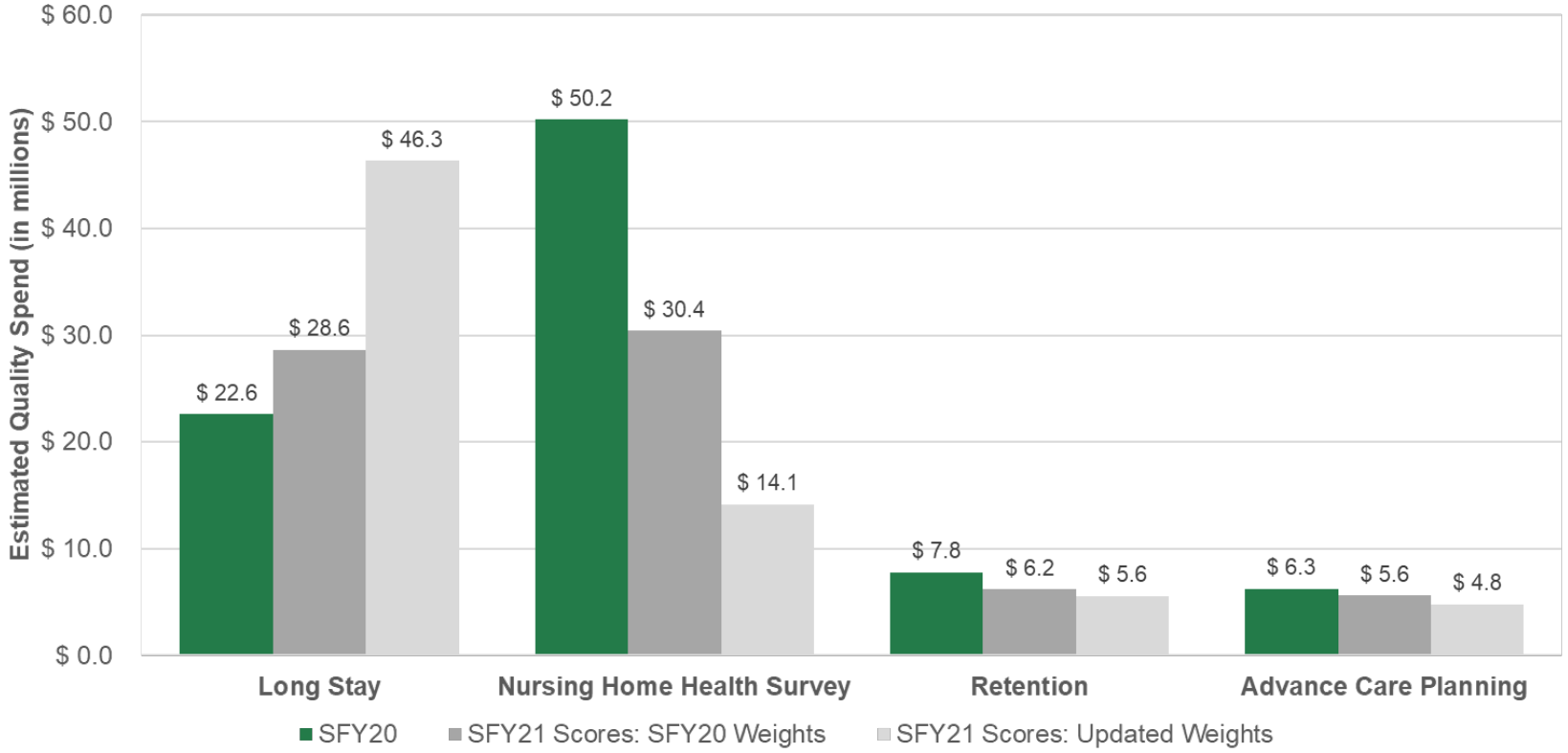
Previous measures tied to the Quality Add-On from 2013-2019 include:

- Report Card Scores (75 pts)
- Normalized weighted average nursing hours per resident day (10 pts)
- RN/LPN & CNA retention & turnover rates (9 pts)
- Administrator & Director of Nursing turnover rates (6 pts)

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Total Quality Add-On Payments: SFY 2020 and SFY 2021

Over time, an increasing percent of Quality Add-On dollars have been tied to the Long Stay Measures.



Percent of Maximum Quality Add-On Points Achieved: SFY 2020 and SFY 2021

In 2020:

- 42 facilities received 0 (zero) points for Advance Care Planning
- 498 facilities received 100% of available points for Advance Care Planning

Of the four (4) components, the Long-Stay Measure component showed the largest increase in quality score achievement from 2020 to 2021.

Timing of Quality Add-On: SFY 2023

Under the current VBP model, CY2021 performance determines Quality Add-on payments for SFY 2023.

Survey: Most recently published nursing home health survey score as of 6/30/2020
(possible survey publication date of 4/1/2021-6/30/2022)

Long-Stay: Most recently published 4 quarter average nursing home compare long-stay quality measures of the previous calendar year
(1/1/2021-12/31/2021)

Retention: Most recently completed calendar year Schedule X
(1/1/2021-12/31/2021)

Advanced Care Planning: for previous calendar year
(1/1/2021-12/31/2021)

SFY 2023
7/1/2022 – 6/30 /2023
Quality Add-On

Quality Score Components and Measures – Key Observations

CONSIDERATION	DISCUSSION
Correlation of Quality Score and Various Facility Characteristics	• No correlation between facility Total Quality Score and Case Mix Index (CMI) or Direct Care Spending • Some demographic facility characteristics (Urban/Rural, Percent of Residents Who Are BIPOC, Bed Size) show very weak positive or negative correlation with quality score
Complexity and Timing	• Reducing the number of components and/or measures could enable greater emphasis on performance on remaining components and/or measures • Lag between measurement periods and performance reporting needs to be considered for any changes to components or measures
Considerations Regarding Current Components and Measures	• There is little room for improvement on the Advance Care Planning component • There may be some overlap among current quality score components • Some Long-Stay Measures have been or will be discontinued by Medicare • Current quality measures reflect overall facility performance and are not specific to residents receiving Medicaid

Options for Consideration: Quality Score Components and Measures

Option 1: Maintain Status Quo	Option 2: Remove Component(s)	Option 3: Reduce the Number of Measures in Existing Component(s)	Option 4: Change Component Weighting	Option 5: Add New Components and/or Measures
▪ Maintain existing components and measures ➢ Long Stay Measures no longer calculated by CMS would be phased out	▪ Remove the Advance Care Planning Component And/or ▪ Remove the Health Survey Component	▪ Remove 1-2 Long Stay Measures ➢ In addition to phasing out of Long Stay Measures no longer calculated by Medicare	▪ In keeping with the evolution of weights from 2019 to 2020, modify the weighting such that: ➢ Long Stay Measures are more heavily weighted ➢ The weight assigned to the other components is reduced	▪ Add new Long Stay Measures And/or ▪ Add new measures other than Long Stay Measures And/or ▪ Add a new component using Medicaid-specific measures or other measures And/or ▪ Temporarily replace the current retention measure due to workforce issues

Long-term Program Enhancements

(Targeted for implementation ~1-2 years after mLTSS Go-Live)

- Reward for improvement over time, as well as actual performance levels
- Add component and/or measures:
  - Based on resident and family surveys
  - That more broadly reflect quality of care (e.g., potential preventable hospital events)
- Where possible, use measures that are Medicaid-specific (rather than measures based on all-payers) and that align with mLTSS program goals
- More closely align the payment timing to the measurement period
- Further evaluate impact of and approaches to account for:
  - Impacts of serving residents who have complex behavioral health needs or other complex needs
  - Various facility characteristics that might be associated with quality performance

Quality Rate Add-On Performance Measures: Nursing Facility Retention Rate

Based on data from current Schedule X reporting and calculated as follows:

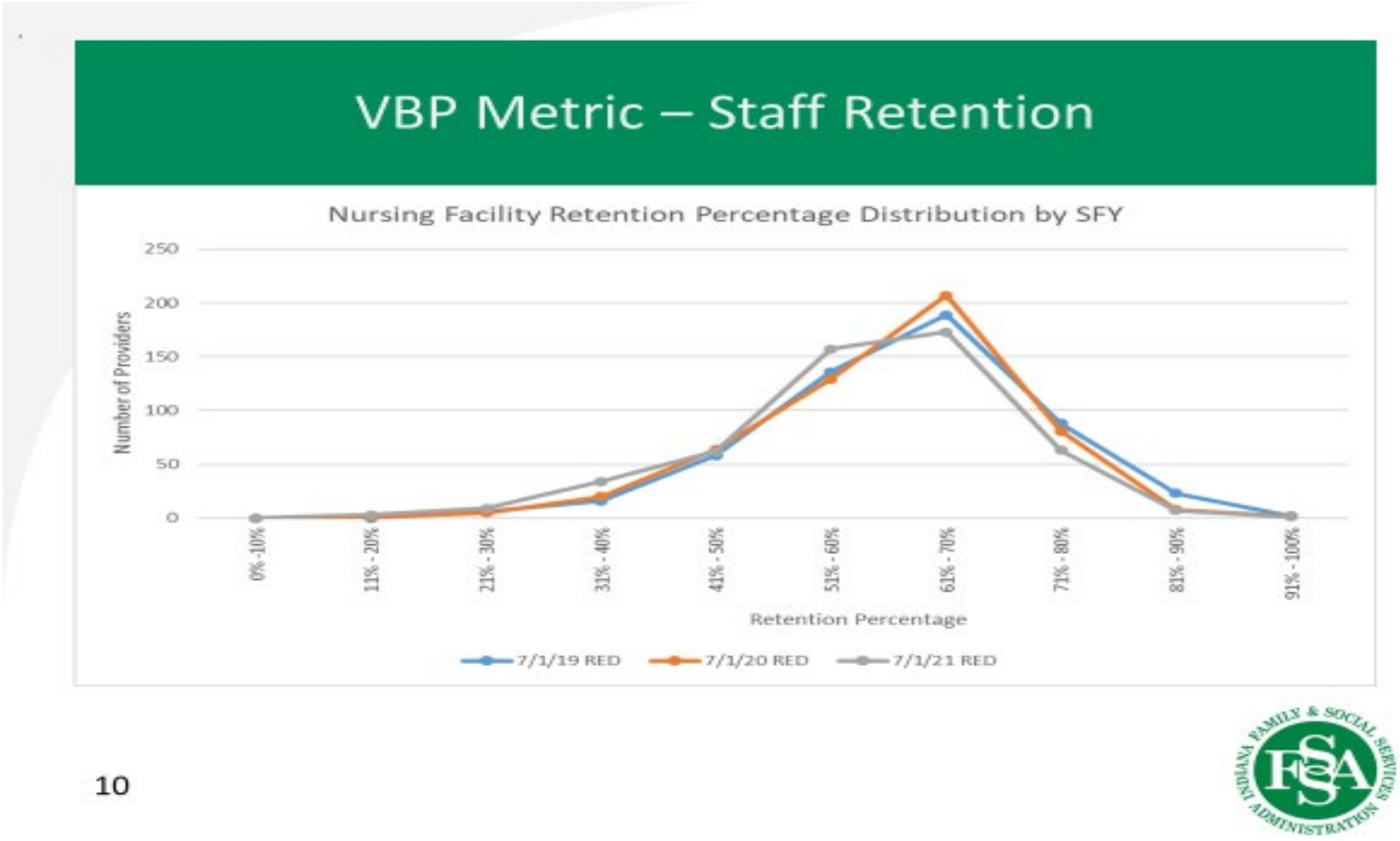
$$\text{NF Staff Retention Rate} = \frac{\text{Total Employees at the Beginning of the Calendar Year that are Still Employed at the End of the Calendar Year}}{\text{Total Employees at the Beginning of the Calendar Year}}$$

Nursing Facility Retention Rates	Quality Points Awarded
Less than or equal to 53%	0
Greater than 53% and less than 72%	Proportional quality points awarded as follows: 10 – [(72% – nursing facility's retention rate) x 52.6316)]
Equal to or greater than 72%	10

Should alternative approaches be used to calculate the Staff Retention subcomponent, perhaps on a temporary basis?

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Historic Nursing Facility Retention Rates



What underlies these historical trends?
How should historical trends inform future quality measures?

Source: FSSA Nursing Facility Rating Methodology Workgroup Meeting #12, July 15, 2021

Medicare 5-Star Staffing Levels: April 2021

Medicare 5-Star Staffing Metric	Registered Nursing Hours					Total Nursing Hours				
	Indiana Hours	Indiana Rank	Min Rank = 50	Max Rank = 1	National Average	Indiana Hours	Indiana Rank	Min Rank = 50	Max Rank = 1	National Average
Reported Hours Per Resident Per Day (Weighted Average)	0.65	35	0.25	1.85	0.67	3.81	35	3.31	6.64	3.90
Case-Mix Hours Per Resident Per Day (Weighted Average)	0.44	5	0.32	0.48	0.40	3.40	3	2.84	3.43	3.21
Adjusted Hours Per Resident Per Day (Weighted Average)	0.62	39	0.27	2.29	0.71	3.61	44	3.16	6.86	3.91

Source: April 2021 Medicare 5-Star Report, https://data.cms.gov/provider-data/dataset/4pq5-n9py, accessed May 4, 2021

Quality Rate Add-On Performance Measures: Nursing Home Health Survey

- Score is “total weighted health survey score developed and published by CMS”
- Facilities without a survey score as of June 30 are awarded statewide average score

Nursing Home Health Survey Scores	Quality Points Awarded
0 – 21	25
22 - 77	Proportional quality points awarded as follows: 25 – [(nursing home health survey score – 21) x 0.4385965)]
78 and above	0

Should the weight associated with the Health Survey component be reduced? Or maintained?

Source: http://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_4/4.19d_i-44.pdf

Current Nursing Facility Performance: Deep Dive

Characteristics of Nursing Facilities by Quality-Add-On Payment Status[1]

Facility Characteristic	Quality Add-On Paid	Quality Add-On Not Paid	All Nursing Facilities
Number of Facilities[1]	426	85	511
Percent of Total Facilities[1]	83.4%	16.6%	100.0%
Percent of Facilities Located within an SBA-Designated HubZone (all types)[2]	20.0%	29.4%	21.5%
Average Total Quality Score: Weighted by Estimated Medicaid Occupied Beds[3]	63.38	11.73	53.45
Percent of All Residents at or Below Poverty Level within Facility's Zip Code[4]	13.3%	15.0%	13.6%
Percent of Seniors 65+ on Medicaid within Facility's Zip Code[4]	9.4%	9.9%	9.6%
Average Medicaid Utilization Rate (Medicaid Occupied Beds/Occupied Beds)[1]	63.4%	70.6%	64.7%
Est. Percentage of Medicaid Recipients within Facility Who Are BIPOC[5]	10.7%	20.0%	12.5%
Average Reported Medicaid CMI: Weighed by Medicaid Occupied Beds[1]	1.21	1.18	1.20

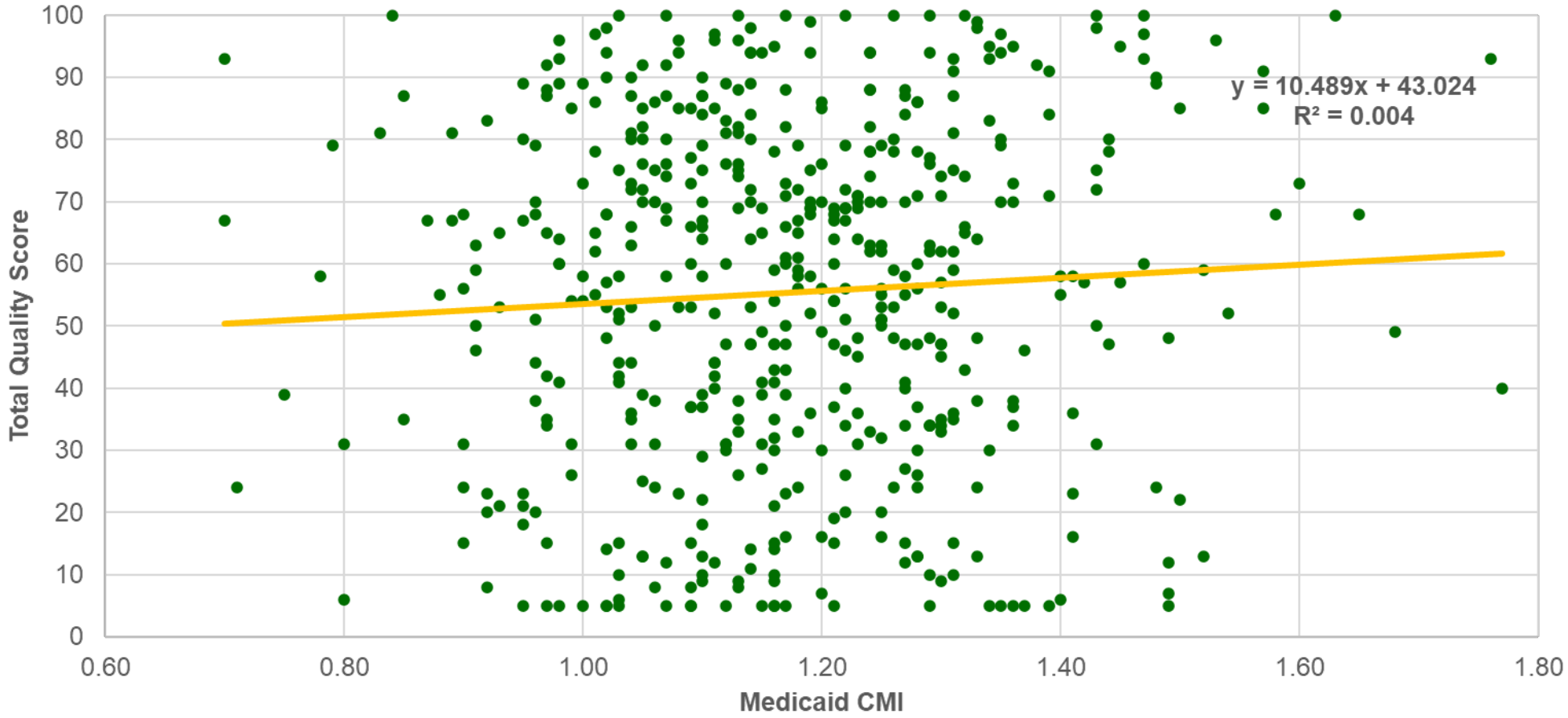
Future analyses will include:

- Alternative measures of CMI to reflect behavioral health and other resident needs
- More recent data

Notes:

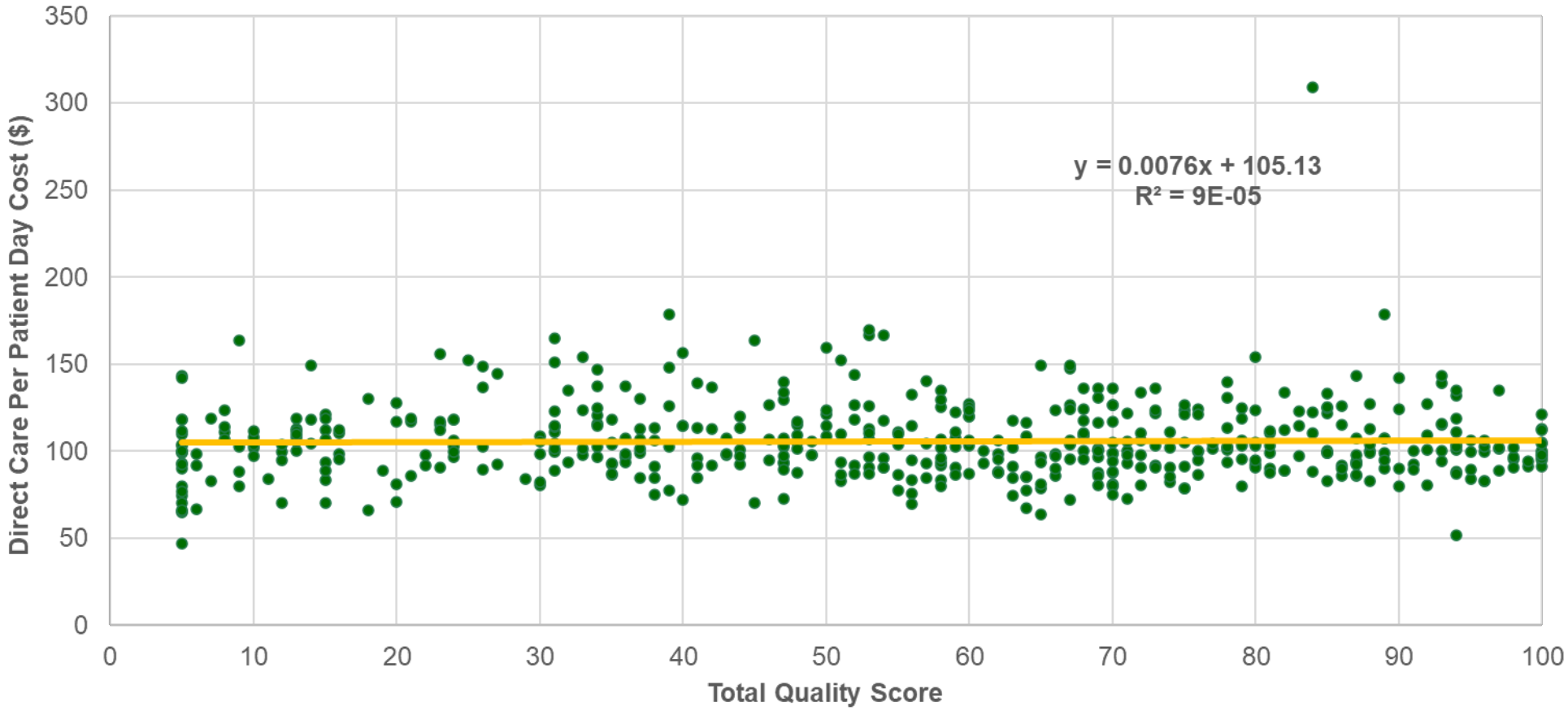
1. As reported in the LTCIS Database dated July 1, 2020, received May 24, 2021.
2. As indicated by the nursing facility's physical street address. Source: https://www.sba.gov/federal-contracting/contracting-assistance-programs/hubzone-program, accessed July 9, 2021.
3. Estimated Medicaid beds were determined using the bed count from the April 2021 Medicare 5-Star ratings, times the occupancy and Medicaid utilization rates reported in the July 2020 LTCIS database.
4. As reported in the US Census Bureau's *American Community Survey*'s 5-year data tables (2015-2019). Source: https://www.data.census.gov, accessed July 9, 2021.
5. Estimated using the number of unique recipients within the nursing facility, as reported in EDW, during the experience window corresponding to each facility's reported experience period in the LTCIS database.

SFY 2020 Total Quality Score by Medicaid CMI



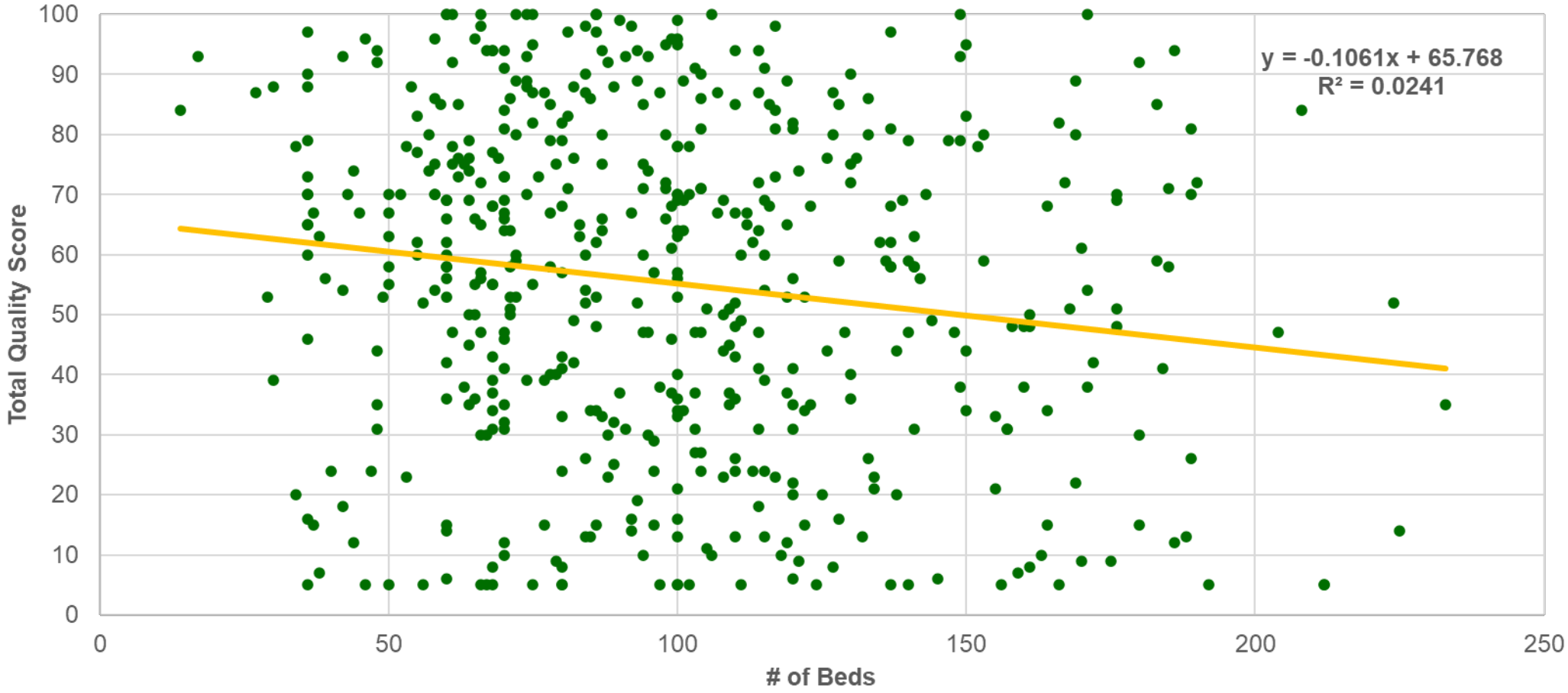
Source: July 2020 LTCIS Cost Report

Reported Direct Care Per Patient Day Cost vs. Total Quality Score: SFY 2020



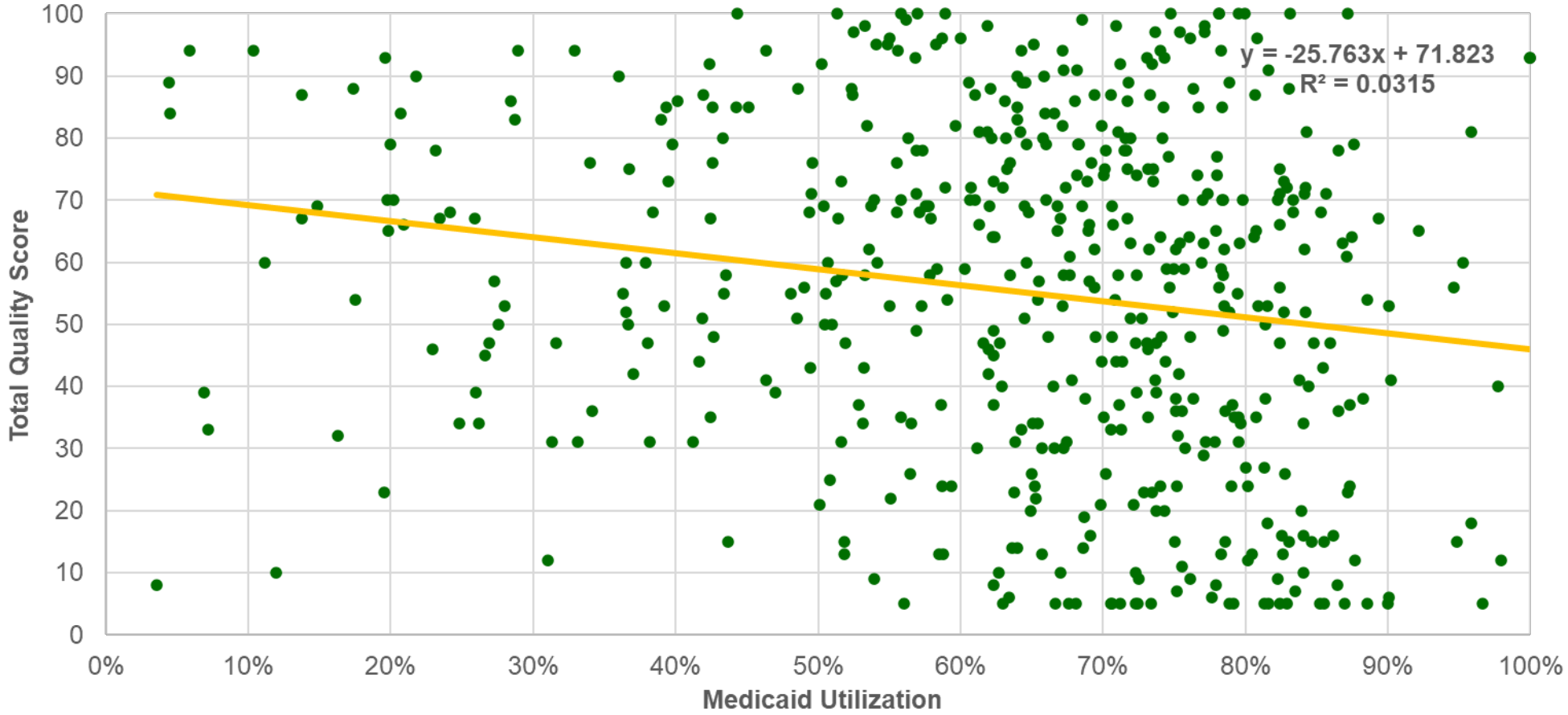
Source: July 2020 LTCIS Cost Report

SFY 2020 Total Quality Score by Total Beds



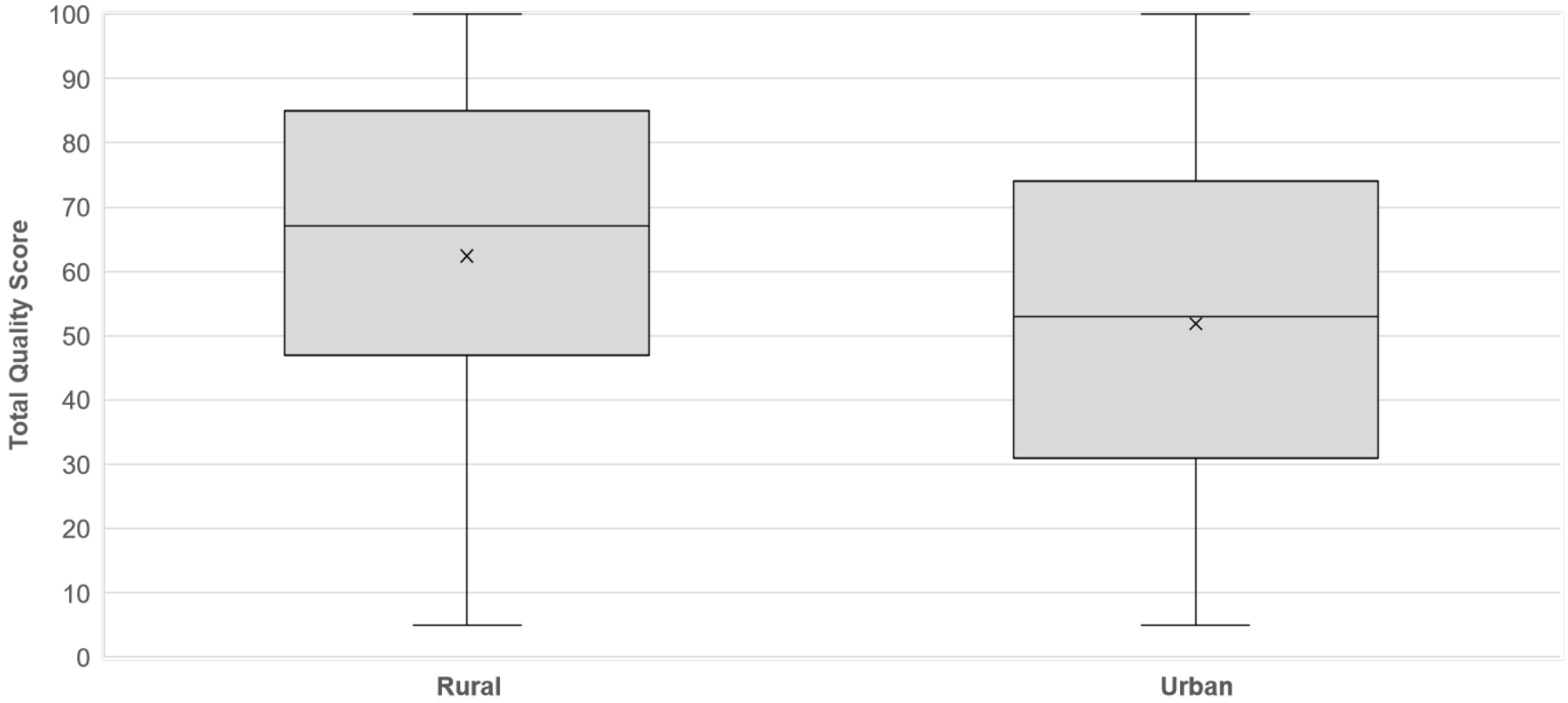
Source: July 2020 LTCIS Cost Report

SFY 2020 Total Quality Score by Facility Medicaid Utilization Rate (i.e., Percent of Medicaid Beds)



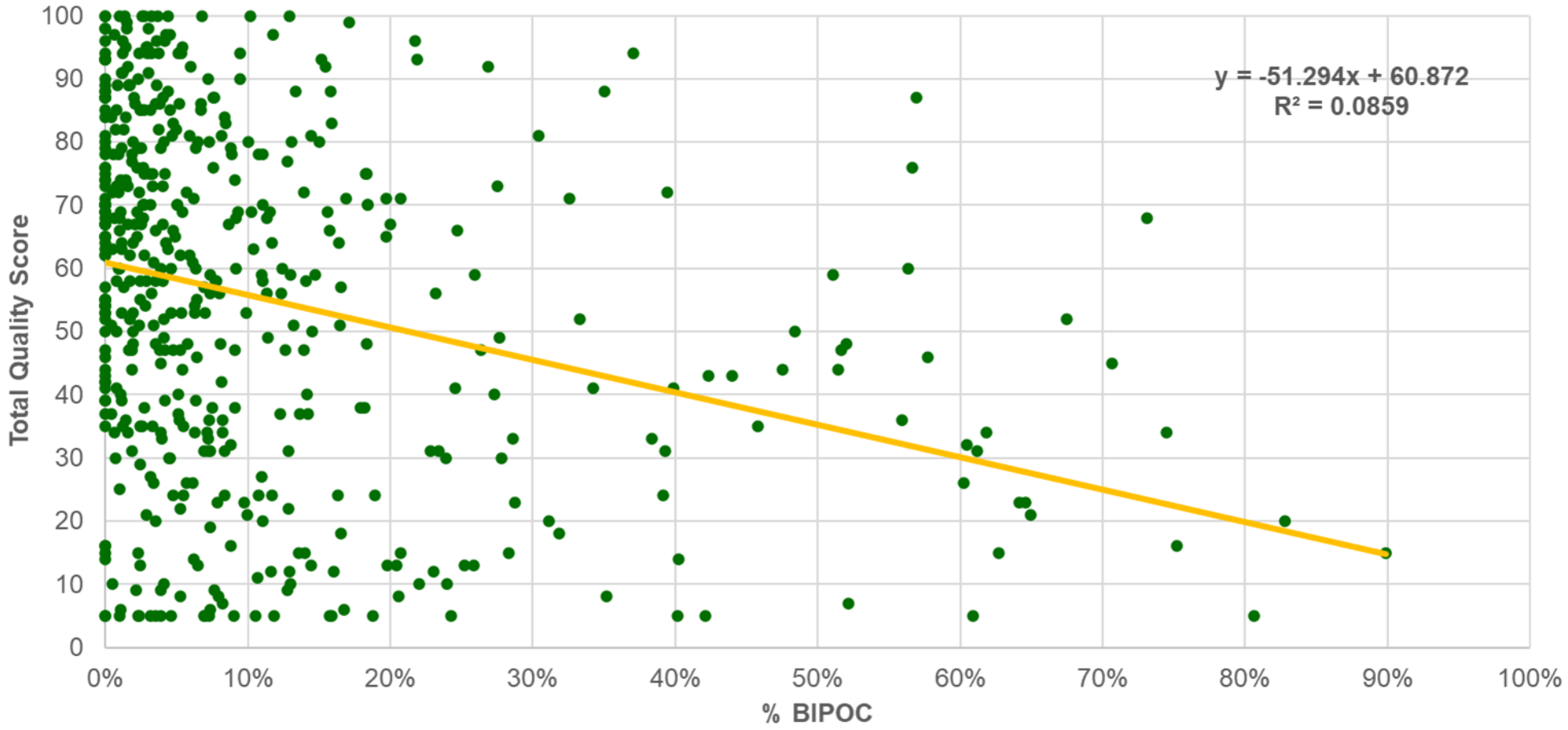
Source: July 2020 LTCIS Cost Report

Total Quality Score: Rural vs. Urban Facilities



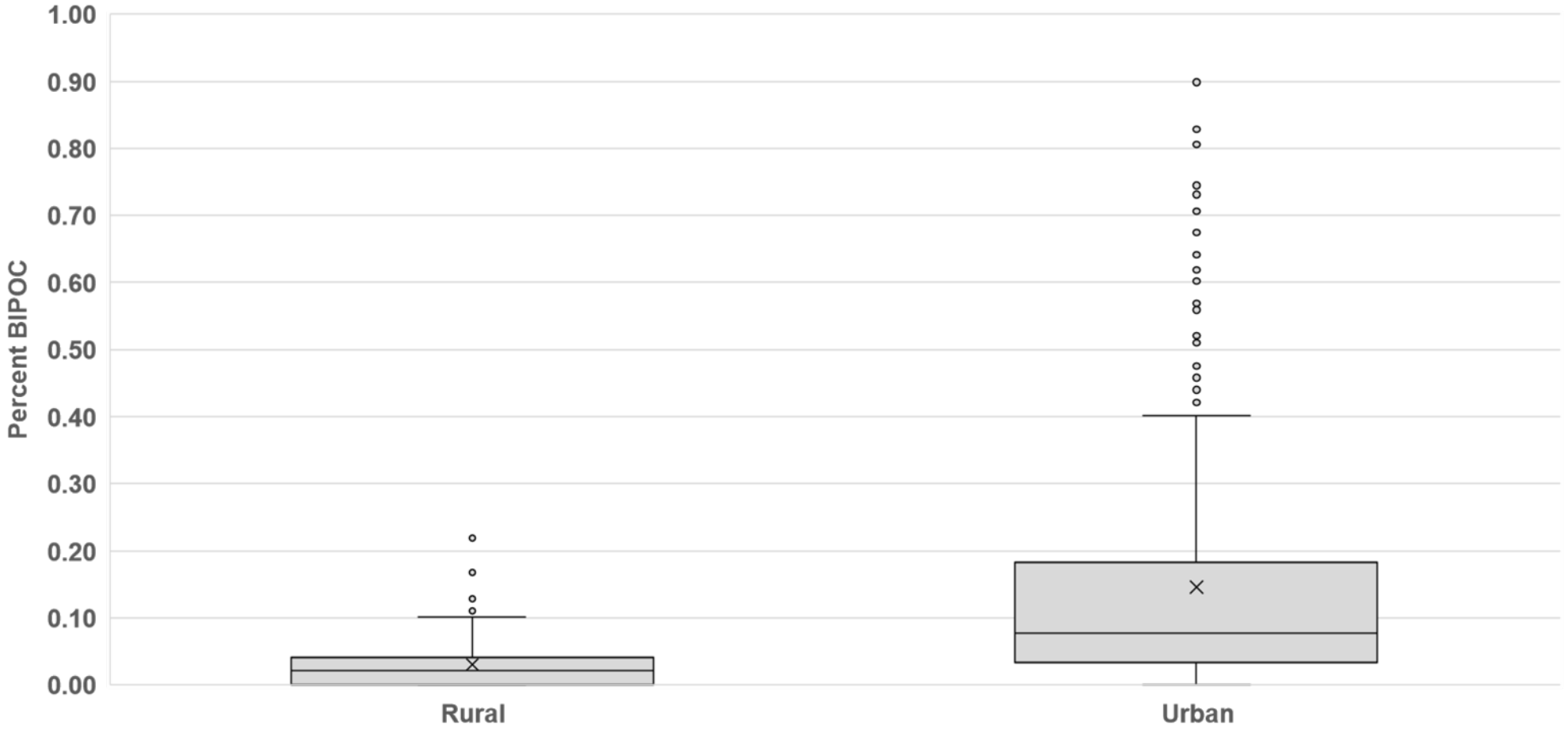
Source: July 2020 LTCIS Cost Report

SFY 2020 Total Quality Score by Percentage of Facility Residents Who Are BIPOC



Source: July 2020 LTCIS Cost Report

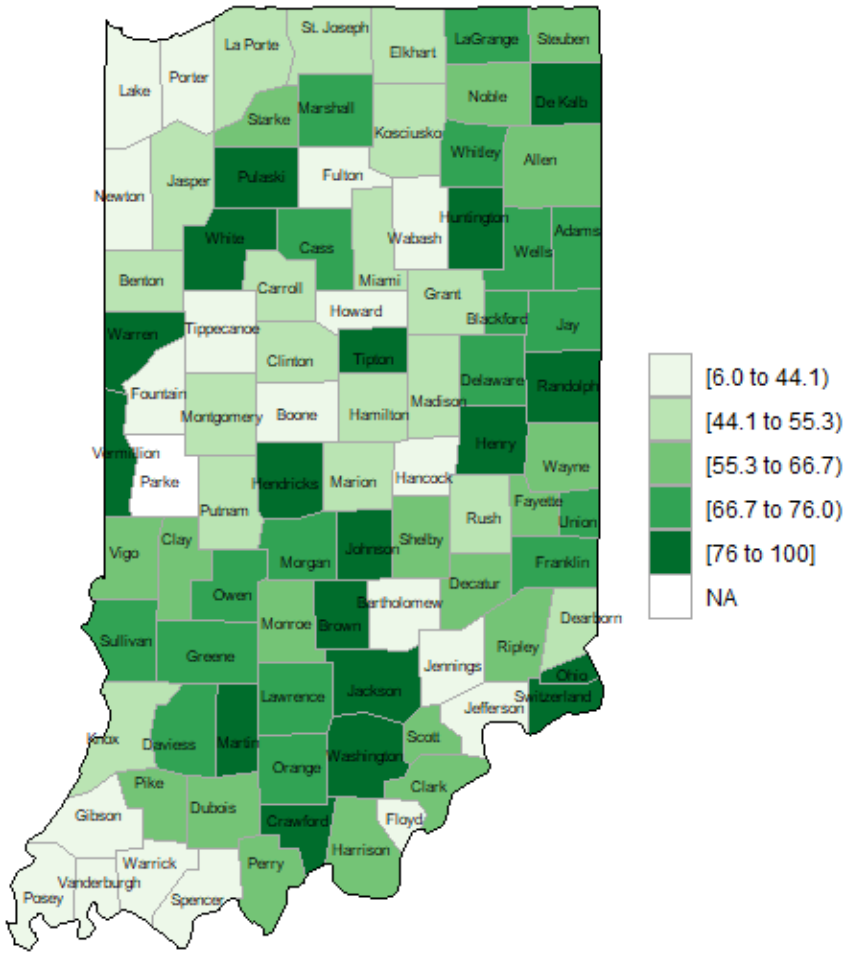
Percentage of Medicaid Nursing Facility Who Are BIPOC: Rural vs. Urban Facilities



Due to the correlation between Urban/Rural and Percentage of Residents Who Are BIPOC, it is not clear which of these two characteristics might be most closely associated with differences in quality scores.

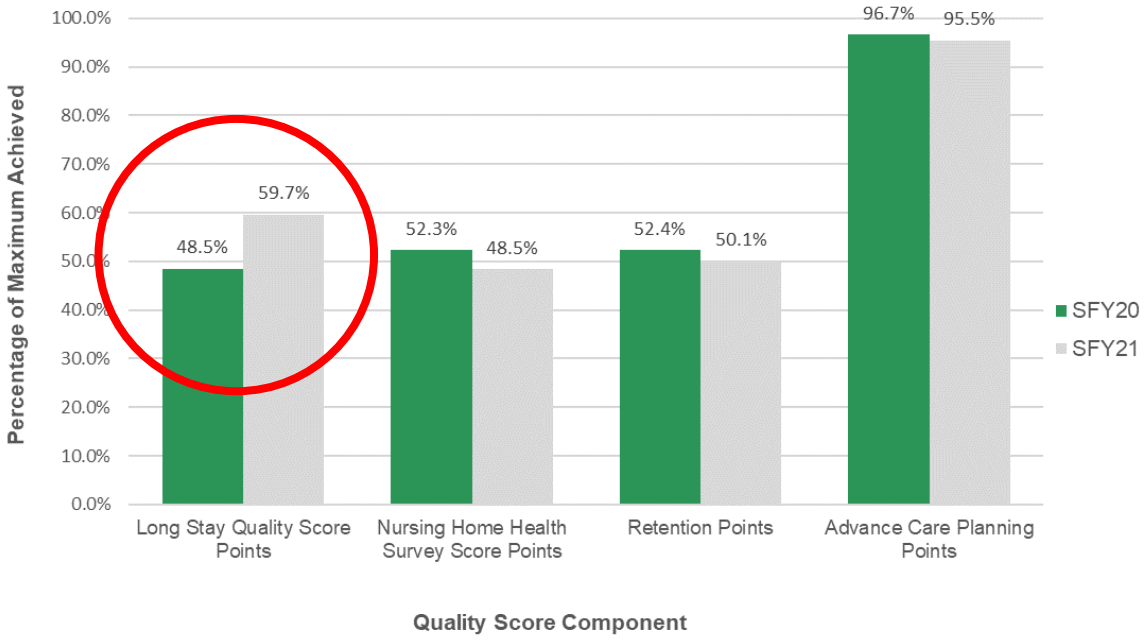
Source: July 2020 LTCIS Cost Report

Average Medicaid Nursing Facility Total Quality Score by County: Weighted by Estimated Medicaid Beds



Source: July 2020 LTCIS Cost Report

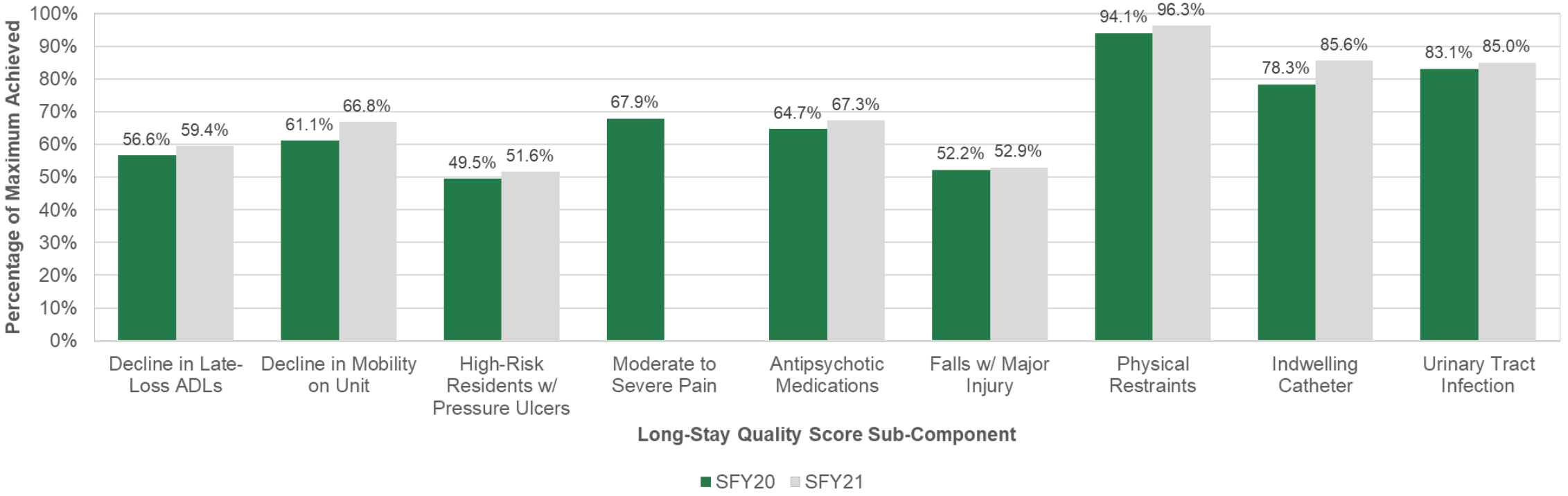
Quality Score Achievement – Long Stay Measure Component



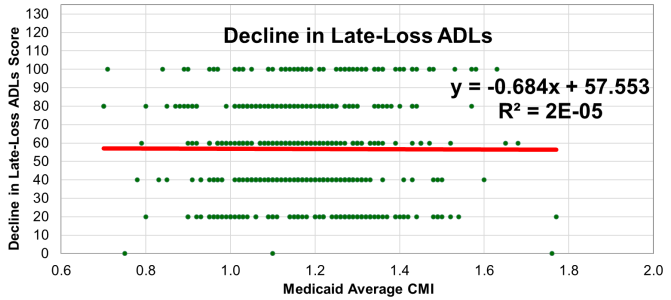
- Percentage of long-stay residents whose need for help with daily activities has increased
- Percentage of high risk long-stay residents with pressure ulcers
- Percentage of long-stay-residents with catheter inserted and left in their bladder
- Percentage of long-stay residents with urinary tract infection
- Percentage of long-stay residents who were physically restrained*
- Percentage of long-stay residents experiencing one or more falls with major injury
- Percentage of long-stay residents who received an antipsychotic medication
- Percentage of long-stay residents whose ability to move independently worsened
- *Percentage of long-stay residents who self-report moderate to severe pain***

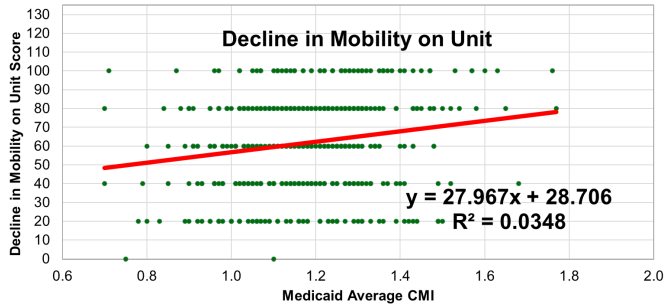
*Notes: * indicates measure was removed from CMS 5-Star Rating System; ** indicates measure is no longer being calculated and reported by CMS so is no longer used for IN NF VBP*

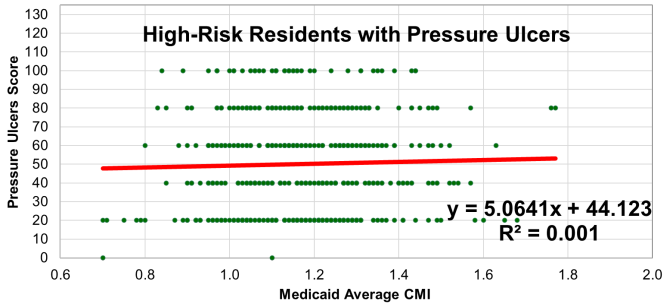
Long Stay Quality Score Sub-Components: All Facility Averages

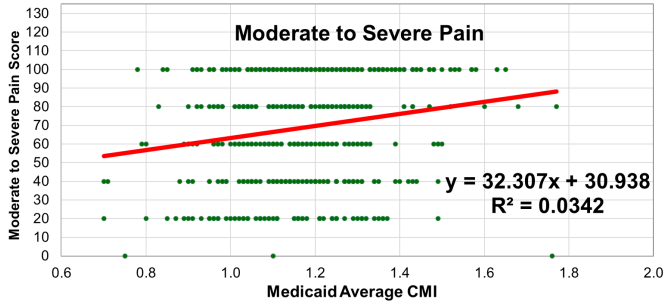


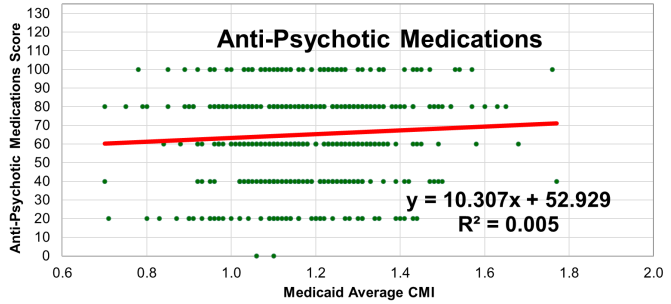
Long-Stay Subcomponent Scores as a Function of Medicaid CMI: SFY 2020

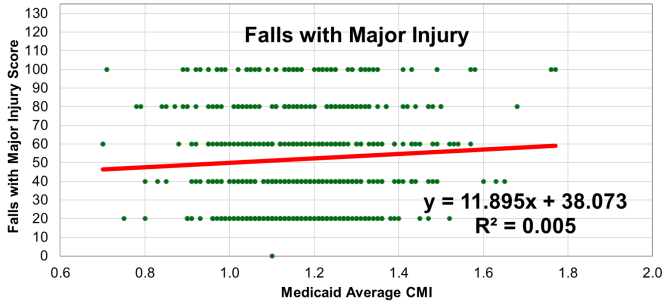


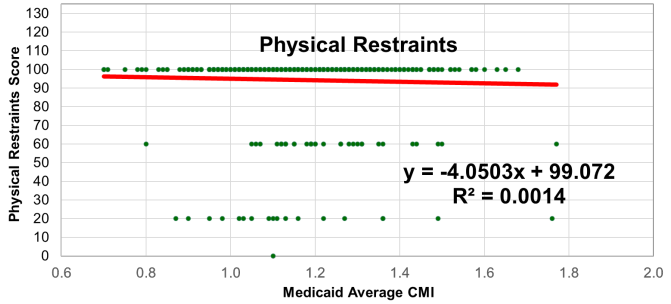


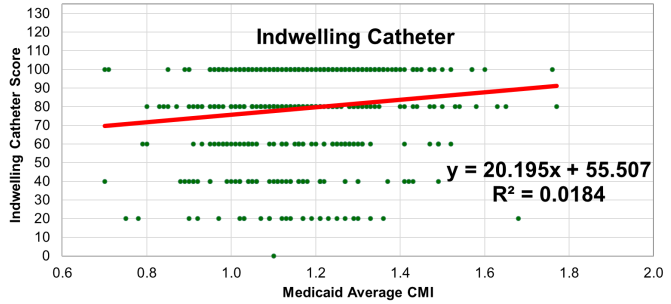


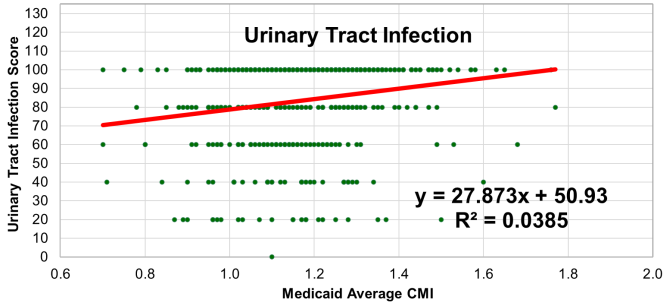












Summary: Long-Stay Subcomponents as a Function of Medicaid CMI

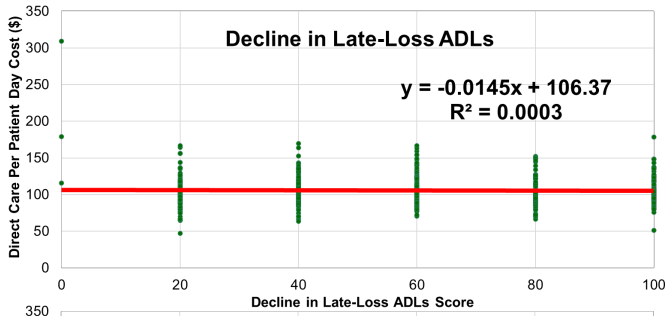
Long-Stay Measure	Slope	R-Squared
Decline in Late-Loss ADLs	-0.684	0.0000
Decline in Mobility on Unit	27.967	0.0348 *
High-Risk Residents with Pressure Ulcers	5.064	0.0010
Moderate to Severe Pain	32.307	0.0342 *
Anti-Psychotic Medications	10.307	0.0050
Falls with Major Injury	11.895	0.0050
Physical Restraints	-4.050	0.0014
Indwelling Catheter	20.195	0.0184
Urinary Tract Infection	27.873	0.0385 *

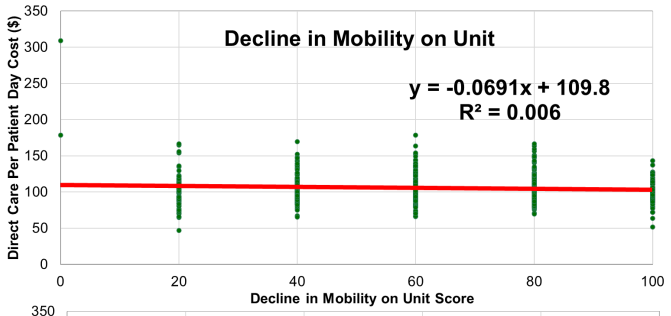
Major Findings:

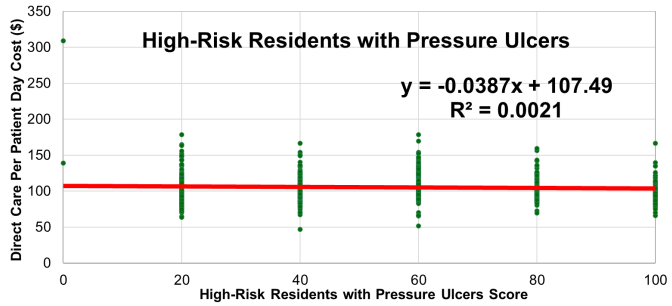
- There is no strong relationship between Medicaid CMI and the long-stay quality subcomponent scores
- There is a modest, positive correlation between Medicaid CMI and quality subcomponent scores for the mobility, pain, and urinary tract measures, but the low R-squared values suggest the relationship is very weak

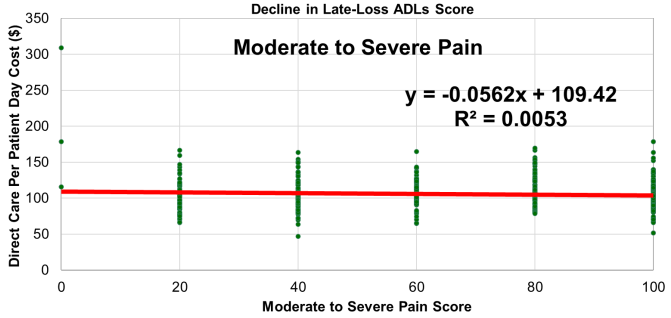
Reported Direct Care Per Patient Day Cost as a Function of Long-Stay Subcomponent Scores: SFY 2020

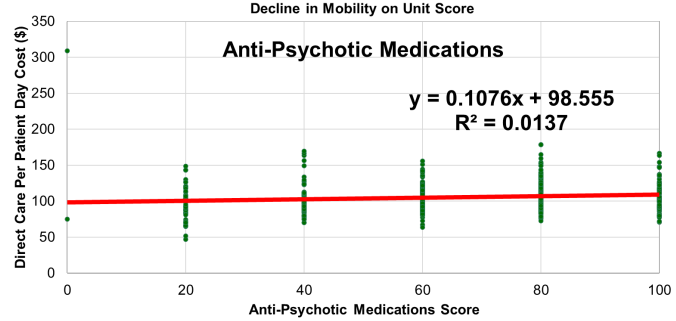
We do not see a strong relationship between Medicaid CMI and cost per day

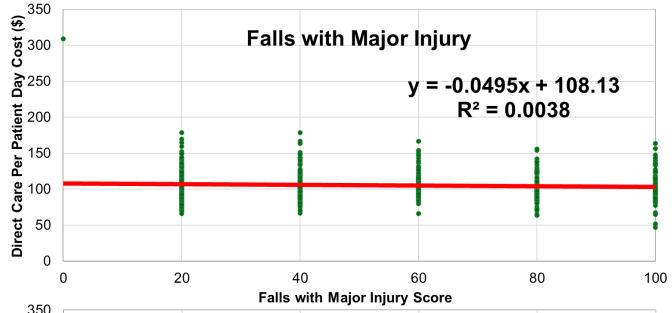


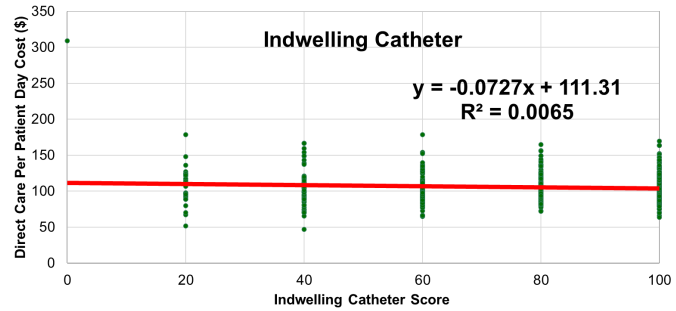


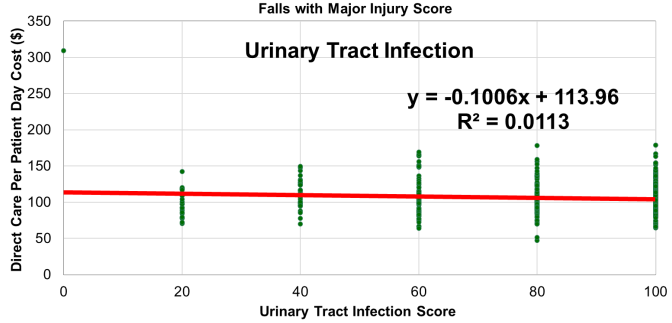












Examples from Other States

Examples of FFS VBP

Key Considerations	Ohio: Quality Incentive Payment	Minnesota: Performance-Based Incentive Payments (PIPP)
Qualifications for Participation	Nursing facilities with licensed occupancy percentage > 80% with score of at least 15 points for meeting quality metrics	Medicaid-certified nursing facilities that submit a proposal
Payment	Based on sum of points assigned to facility; 2.4% of base rate	Facilities can request an incentive payment up to 5% of their operating rate per diem for 1–3 years. $5.25 average in 2010
Metrics	• % of long-stay residents with pressures ulcers (at high risk) • % of residents with UTI • % of residents whose ability to move independently worsened • % of residents who had a catheter inserted and left in	Depends on NF proposal. Examples include prevalence/ number of falls, pressure sores, UTIs, food/activity domains
Metrics Source	CMS MDS 3.0	Minnesota Department of Human Services - each facility submits a separate quality proposal for PIPP

Sources:
http://www.registerofohio.state.oh.us/notices/viewDoc/21981;jsessionid=01df33158db74124c2d546241b64
https://doi.org/10.1093/geront/gnp140
https://mn.gov/dhs/assets/NH-PIPP-Project-summary-R14_tcm1053-474133.pdf

Examples of mLTSS VBP

Key Considerations	Tennessee: Quality Improvement in Long-Term Services and Supports (QuILTSS)	Minnesota: Integrated Care System Partnerships	Arizona: Withhold and Quality Measure Performance Incentive
Qualifications for Participation	Facilities that have identified the Medicaid and long-stay residents (at least 100 days) that have a BIMS score of 8 or above and comply with resident/staff survey requirements. Current on Assessment Fee and have not submitted false information	Special needs program contracts require health plans to implement value-based payment models with providers. One must be LTSS provider	ACS plans that meet targets for % of payments governed by VBP strategies
Metrics	Satisfaction, culture change/quality of life, staffing/staff competency, clinical performance as reported by persons or family of persons receiving services	Common measures proposed for seniors at outset of program: all-cause readmissions, inpatient utilization, advanced care planning, use of high-risk medications, medication reconciliation	ED utilization, readmissions within 30 days of discharge, HbA1c testing, LDL-C screening, flu shots for adults
Payment	Based on sum of points assigned to facility; bonus and person-centered innovations points available	Requirement in managed care contract; payment terms between MCO and ICSP not specified	Must meet VBP % target to access 1% capitation withhold

mLTSS VBP Quality Measures

Key Considerations	Tennessee: Quality Improvement in Long-Term Services and Supports (QuILTSS)	Minnesota: Integrated Care System Partnerships	Arizona: Withhold and Quality Measure Performance Incentive
Metrics	• Resident, Family, Staff Satisfaction • Culture change/quality of life • Staffing/staff competency • Clinical performance as reported by persons or family of persons receiving services	• Inpatient Utilization • Plan All-Cause Readmissions • Ambulatory Care • Ambulatory Care Sensitive Conditions • Evidence of Physician ordered life-sustaining treatment • Advance Care Planning • Falls w/ Fracture • Use of High-Risk Medications in the Elderly • Care of Older Adults	• ED utilization: ≤ 80 Visits Per 1000 Member Months • Readmissions within 30 days of discharge: ≤ 17% • HbA1c testing: 77% • Comprehensive Diabetes Admissions, Short-Term Complications: 300 per 100,000 Member Months • Flu shots for adults: 75%
Source	Division of TennCare	Combination from multiple sources: Minnesota DHS, HEDIS, MDS 3.0, AHRQ Standards	Arizona Health Care Cost Containment System

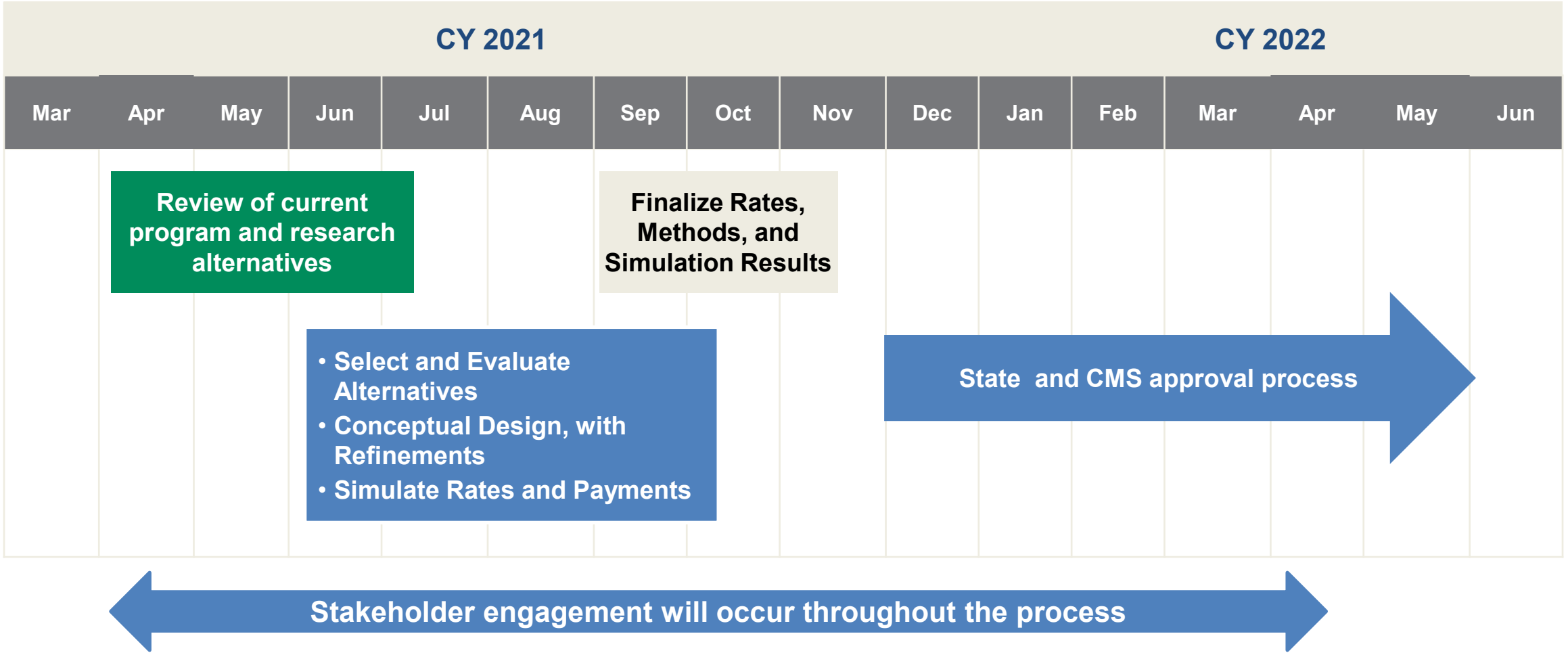
Potential Measure Selection Criteria

Potential Measure Selection Criteria

- Meaningful and Relevant
  - Consistent with mLTSS goals OR relating to a performance gap where performance today is less-than-optimal and where poor performance impacts resident experience and/or outcomes
  - Where feasible, measures Medicaid performance (versus all-payer performance)
- Reliable
  - Well-defined and precisely specified measures that can be implemented consistently and allow for comparability across all facilities (e.g., endorsed by NQF)
- Feasible
  - State has resources to collect and analyze data without undue burden and has 3 data points to observe trends
  - NFs are collecting or can collect data without undue burden
- Promotes Provider Accountability
  - Payment timing aligns to measurement period
  - NF can be held accountable for measure performance
  - Measure has sufficient denominator size
- Equitable
  - Measure is fair among NFs with varying characteristics, such as: resident acuity/case mix, bed size, percent of residents receiving Medicaid, location (urban/rural, underserved/well-served), etc..

Next Steps

Nursing Facility Reimbursement – Project Timelines



Next Steps

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

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.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this presentation prepared for FSSA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing the analysis supporting this presentation, we relied on data and other information provided by FSSA and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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.