Medicaid Nursing Facility Reimbursement Conceptual Design – all NF Workstreams Stakeholder Meeting #3

Indiana Family and Social Services Administration

September 9, 2021 - DRAFT

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
5. NEW: Recruitment, retention, and training of workforce objective (in development - updates to come)

What are the strategic objectives of the redesign?

To develop 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.

Agenda

- Background – Current challenges, other options
- Overall Conceptual Design
- Base Rates Framework
- Supplemental Payment and Quality Framework
- Next Steps
- Appendix: Alignment with Evaluation Criteria

Nursing Facility Rate Setting Method
Background

Conceptual Design
Process Framing and Tactical Objectives

- **Conceptual Design**: This is a high-level conceptual design for the new nursing facility rate setting methodology. The design was informed by program goals and stakeholder concerns.
- **Stakeholder feedback**: We are soliciting stakeholder feedback on the high-level design to help shape program details. As these details are developed over the next several weeks, we will continue to share feedback and refinements.
- **Funding**: FSSA intends to preserve the aggregate funding that would have been available under the current rate methodology.
- **Timing** : The state intends to transition to the new rate methodology prior to mLTSS. Due to the complexity, we are targeting January 2023.
- **State direction**: The state intends to direct MCE base rate reimbursement for at least five years. Supplemental payments will continue to require state involvement.

Why is a new NF rate setting method needed?

Base Rates

Improve quality. Stakeholders expressed concern that current methodologies create a long lag time for compensating NFs that make quality improvements, creating a **barrier to investment** in quality improvements such as infection control or enhanced staffing.

Improve access for higher need residents. Facilities that accept higher need residents must wait before rates increase (time lag).

Incentivize efficiency. Nursing facility (NF) rates are currently based on historical costs…efficient facilities receive little benefit by reducing unnecessary costs.

Facility-centric. Rates specific to the resident rather than to the facility would better support a person-centered focus by aligning reimbursement with value to each resident.

Increase transparency and predictability. Complex process requiring annual cost reports each year, individualized rates for 500+ facilities each quarter and retroactive adjustments has resulted in providers not understanding how much they will ultimately be paid.

Decrease administrative costs for the state and providers. State administrative costs for the current process are millions of dollars each year.

Why is a new NF rate setting method needed?

Upper Payment Limit (UPL) Supplemental Payments

Indiana's current nursing facility supplemental payments represent the facility-specific gap between Medicaid base payment the Medicare UPL. The non-federal share of payments is funded by intergovernmental transfers (IGTs) from NSGO partners. Concerns with this program include:

No differentiation for high quality or high staffing ratio facilities.

Undermines the quality add-on. Because the UPL target isn't related to quality, lower quality add-on payments result in higher supplemental payments.

Lack of accountability and transparency. The efficacy of the variation in the enhanced per diem rate differentials across facilities under the current UPL program is unclear. Additionally, it is unclear what portion of each payment goes to the nursing facility and what portion to their NSGO partner.

Why is a new NF rate setting method needed?

Value Based Payments

Indiana's current VBP program is funded through the Quality Assessment Fee (QAF) and paid through a Quality add-on rate component

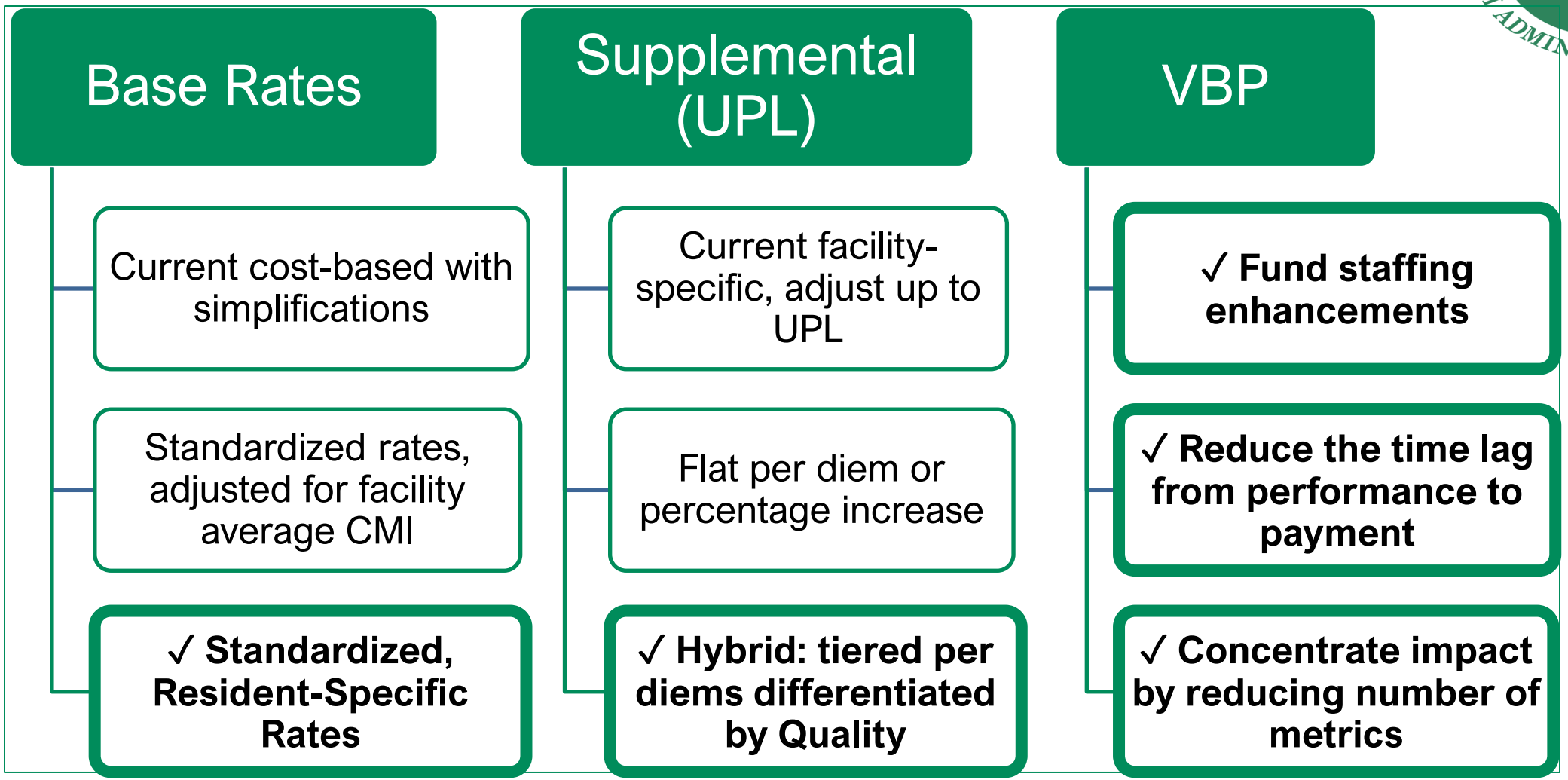
Fresher metrics. Stakeholders expressed interest in reducing the time lag between performance and payment, so that payments reward recent accomplishments.

Concentrating efforts on fewer high priority goals will improve success.

Support staffing. We received stakeholder feedback regarding the high cost of attracting and retaining staff, especially nursing staff, and propose to support these efforts through funding for enhanced staffing.

Quality focus. Gradually increase funding devoted to quality metrics that are strongly **aligned** with program goals, while shifting away from reporting metrics

What options were considered?



Overall Conceptual Design

Overall Conceptual Design
Twin programs for mLTSS and FFS

Quality-Based Supplemental Payments

Maintain aggregate per diem funding for the NF UPL program

Payment Pool 1 – **reporting** based, NSGO facilities only - 110% to 115% of non-federal share

Payment Pool 2 - **Quality** based – Tiered per diem rates based on CMS long stay measures, staffing

Quality-based tiered rate differentials to grow over time, with performance measures evolving with priorities

Resident-Specific Standardized Base Rates

Standardized Resident-specific rates, developed based on cost percentiles

Acuity adjusted, one rate for each CMI acuity level (currently 48)

Budget neutral preserving QAF funding (value of all add-ons) and reflecting sunset of 3% rate reduction

Rebase rates at least every 5 years, with **annual updates** based on an index (e.g. SNF Medicare market basket)

Base Rates Framework

Overview – How Rates Would Be Determined

Conceptual Design – Base Rates Standardized and Resident-Specific

Parameter	New Methodology	Current Methodology
Number of Rates Annually	▪ 48 total rates – one per CMI group	▪ 2,000+ total rates –500+ facilities each quarter
Case Mix Adjustment	▪ One statewide rate for each CMI group –**resident-specific**	▪ Rates based on **average facility** Medicaid CMI each quarter
Determination of CMI classifications	▪ No change - performed by Nursing facility, subject to validation by State agent	
Rate Effective Period	▪ 12 month period	▪ Revised each quarter
Frequency of State Rate Rebasing	▪ At least every 5 Years	▪ Annually
Interim Year Rate Adjustments	▪ Annually based on CMS SNF Market Basket Index	▪ NA – Rates rebased each year
Rate Components	**4**	**9**

Conceptual Design – Base Rates
Statewide Standardized Rate

Each component of the 48 standardized rates to be developed based on a **percentile of historical per diem costs**.

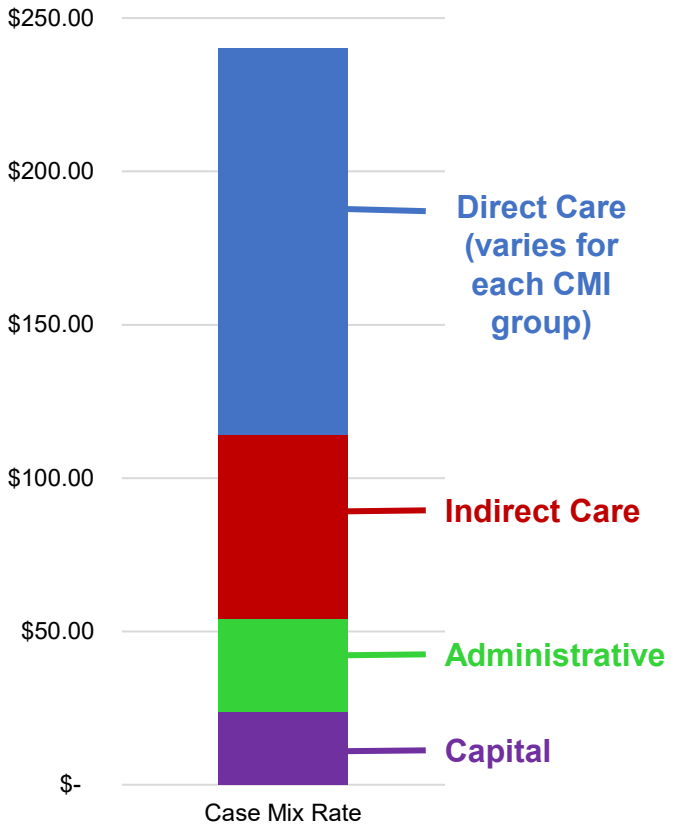
- For example, the standardized Direct Care component (before acuity adjustment) could be developed based on the 60th percentile.
- All components to be trended forward from the cost report time period to the rating period.

Preserve Funding: Percentiles will be selected to achieve the same level of aggregate funding under the current rates, including:

- Funding made available by the sunset of the 3% rate reduction, effective 7/1/2021.
- All QAF funding supporting the current rates: the ventilator add-on, special care unit add-on and quality add-on .

Quality add-on: Although the current quality add-on and VBP program will be discontinued, quality will be supported through quality tiers in the supplemental payments, and funding will supported by UPL funds.

Proposed Rate Components
(Example for illustration purposes only)



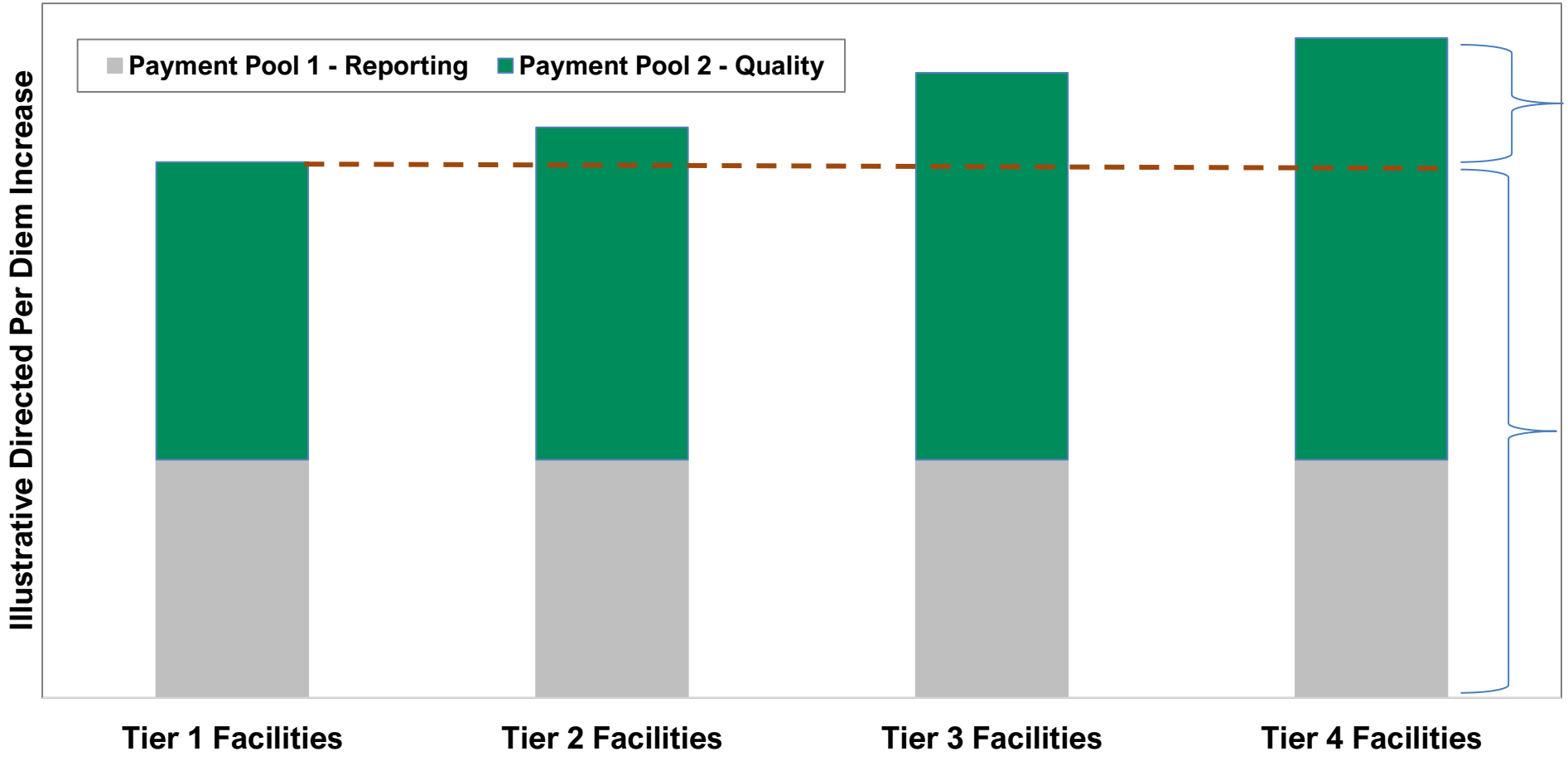
Conceptual Design: UPL/VBP Framework

Conceptual Design – Supplemental Payments Support Quality and Accountability

- ✓ Directed payments through a **per diem payment increase**:
  - *Payment Pool 1 (Reporting):* **Fund IGTs** plus a premium for NSGO providers, with reporting requirements
  - *Payment Pool 2 (Quality):* Fund additional per diem increases tied to **quality tiers and staffing**
- ✓ **Maintains funding** per diems, using the aggregate UPL
- ✓ **Forward compatible** with managed care: § 438.6(c) state directed payment arrangement
- ✓ **Alignment**: Identical programs for fee-for-service and managed care
- ✓ **Quality (VBP)**
  - Reward higher **quality** facilities
  - Support facilities with higher **staffing** levels
  - Expand and improve quality incentives over time, aligning with mLTSS goals

Directed Payment Per Diem Increase Examples

Quality tier per diem rates are being modeled such that the initial value of the rate differentials are consistent with the value of the current quality add-ons



Quality Pool Phase-In

Illustrative quality payment pool 1 phase-in approach over time – FSSA plans to expand value of the quality tiered rate differentials and adjust quality tier measures in future years.

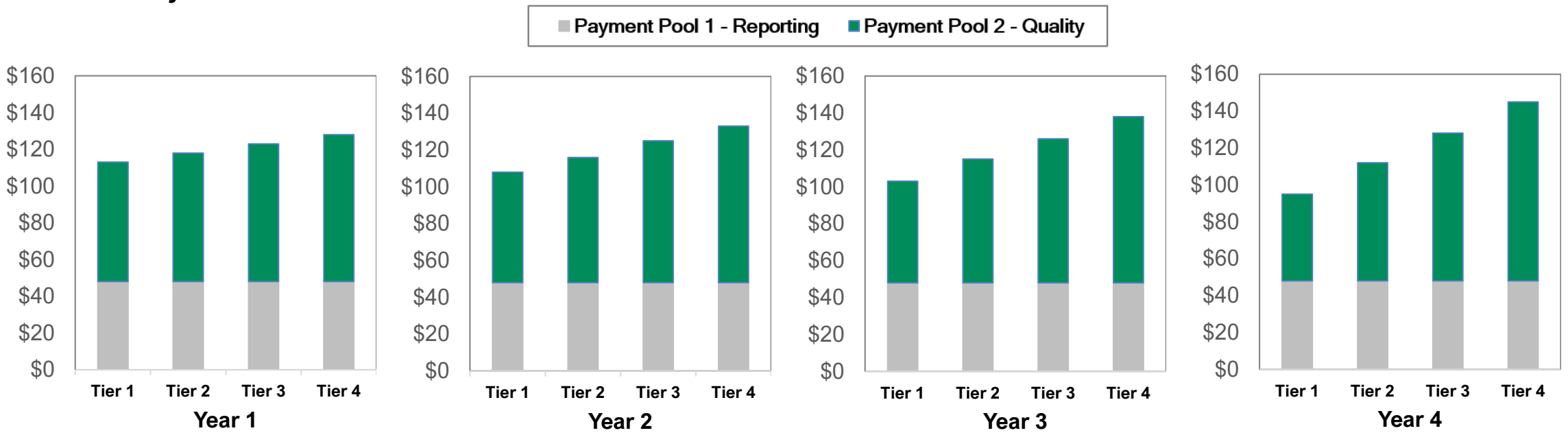


Illustration of potential expansion of Quality differentials over time *(not actual proposed per diems)*

NGSO – NF Partnership Payment Allocation

- ✓ FSSA is considering to direct the MCEs to make directed payments to the entity that holds the contract with the MCE, consistent with the approach used by Texas in its Medicaid nursing facility Quality Incentive Payment Program (QIPP).

- ✓ FSSA does not propose to explicitly require a payment distribution between NFs and NSGOs, but assumes funding from Payment Pool 1 would be retained by the NSGOs.

- ✓ Under Texas QIPP, nursing facilities attest at the time of enrollment that "no part of any payment made under the QIPP will be used to pay a contingent fee, consulting fee, or legal fee associated with the NF's receipt of QIPP funds."[1]

[1] Based on "TX_438 6(c) Proposal C- QIPP 2021_R1 Questions with responses - Copy (2).docx" received from CMS via FOIA.

Intergovernmental Transfers (IGTs)

- FSSA will continue to rely upon IGTs as the funding source for the non-federal share of directed payments
  - IGTs will be based on the non-federal share of total directed payments, allocated to each facility based on projected Medicaid days (regardless of quality tier)
  - FSSA is considering whether to include IGTs in the reconciliation process
- FSSA must be mindful of CMS' § 438.6(c) "Preprint" application requirements:
  - Directed payments for a contract year cannot be conditioned upon entering into or adhering to IGT agreements
  - Preprint requires disclosure of any written agreements that exist amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement
  - Under Texas QIPP, nursing facilities must certify that "the NF listed in the application is a non-state government-owned NF where a non-state governmental entity holds the license and is party to the facility's Medicaid contract; and all funds transferred to HHSC via an intergovernmental transfer (IGT) for use as the state share of payments are public funds."(1)

Source: 1. Based on "TX_438 6(c) Proposal C- QIPP 2021_R1 Questions with responses - Copy (2).docx" received from CMS via FOIA.

Potential challenges

Transition to the proposed conceptual design

- Standardized rates may not be adequate for all facilities
  - Current workforce retention challenges
  - Specialized facilities (e.g. pediatric, rehabilitative)
  - May not recognize full workforce costs for well-staffed facilities (need to recognize in supplemental)
  - Inefficient facilities may require time to adjust
  - Very low occupancy facilities
  - Other
- Nursing facility claims will need to include the RUG classification for each resident
- The supplemental program should be sustainable
- Quality metric selection to align with broader mLTSS program goals

Next Steps

Next Steps

- Solicit stakeholder feedback on high level conceptual design
- Consider stakeholder feedback and adjust modeling as appropriate
- Continue modeling, share additional details on proposed model
- Refine modeling further in response to stakeholder feedback
- Payment simulation, with facility level detail
- Discuss transition planning with stakeholders
- Finalize model
- Approval process: public notice, state budget, CMS

Timeline: targeting implementation before mLTSS, if feasible

  - Conceptual design to be implemented as one integrated whole
  - Requires necessary approvals in place

Alignment with Evaluation Criteria

Access

- **Resident-specific** rates promote a person-centered focus and provide **immediate** payment changes for residents with higher or lower acuity needs.
- Increase payments to providers in historically underserved communities, providing financial capacity **to fund enhanced staffing and other improvements**. (Current system lacks in a low historical cost structure).
- Significant payment reductions to less efficient facilities may affect the long-term financial viability of providers, if facilities are unable to adjust.

Predictability

- Provides significant year over year stability of payment rate changes
- Provider rates are **known prospectively**, facilitating budgeting and planning.

Quality

- **Fewer measures** allows coordinated focus on priorities
- Base rate assumes minimum quality standards are met – dependent on effective **VBP staffing** measure to create incentives for improving quality of care.
- See other comments related to Access and Reduce Disparities.

Reduce Disparities

- Helps to level the playing field by **equalizing rates statewide,** both base rates and supplemental for patients at each CMI level.
- Does not explicitly consider disparities in access, quality, site of care and person-centeredness, but policy adjustments could easily be incorporated to help reduce observed disparities.

Alignment with Evaluation Criteria (Cont.)

Efficiency

- Creates additional incentives for efficiency and cost effectiveness, although reductions in long-term cost growth would not be realized until future periods following rebasing.

Alignment

- **Resident-specific** rates align with payment norms for HCBS
- Reduced payment for residents with lower CMI or acuity needs may help to **align with alternative service delivery** that can be provided in a home and community-based setting.
- **Timing** for rebasing and interim updates align with HCBS methodology and CMS requirements.
- Increased attention to paying for **quality** rather than volume aligns with current state and CMS direction.

Statewide Standardized Resident-Specific Rates

Payment Equity

- Base rates pay for value rather than historical individual facility cost
- Creates more equitable payment by establishing rates that pay the same amount to all facilities for each CMI classification.
- May need to consider adjustments for facilities with reasonable and measurable differences, for example:
  - Ventilator providers
  - Children's providers
  - Rural providers
- Supplemental payments tied to value (quality)

Forward Compatibility

- Integrated approach would be compatible with the transition to a managed care environment.

Alignment with Evaluation Criteria

Statewide Standardized Resident-Specific Rates

Simplicity

- Base rates significantly simplified when compared to current system.
  - Fewer rate components with no internal limits
  - Fewer rates
  - Rates are not updated (multiple times)
  - Reliance on cost reporting and audits is reduced
- Standardized supplemental payments grouped into a handful of tiers
- Quality efforts focused on priorities: staffing and CMS long stay measures

Transparency

- Payment on a **resident-specific basis** enhances transparency of payment for related services.
- Simplification of payment calculations, including **fewer and simpler components**, makes the rate-setting process easier to understand.
- **Annual updates based on indices** would also be much more transparent.
- Supplemental payments will have a clearer link to value that is being paid for.
- **VBP program** simplification enhances transparency and effectiveness.

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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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.