MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of Connecticut Nursing Facility Payment Modernization Project

September 3, 2019

AGENDA

- Welcome and Introduction
- Nursing Facility Payment Modernization Overview
- Project Phases
- Methodology Overview
- Other Payment Considerations
- Case Mix Resident Roster Process
- Provider Learning
- Project Timeline and Q&A

ACRONYMS USED IN THIS PRESENTATION

CMI
Case-Mix Index; a weight assigned to a specific Resource Utilization Group or an average for a given population that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.

MDS
Minimum Data Set; a core set of screening, clinical and functional elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid.

RUG-IV
Resource Utilization Group, Versions IV; A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.

FRV
Fair Rental Value; the fair market value of property while rented out in a lease arrangement.

RN
Registered Nurse

ADL
Activities of daily living; a component of the RUG classification system that indicates the level of functional assistance or support that is required by the resident.

PDPM
Patient Driven Payment Model; the new reimbursement methodology effective 10/1/19 for Medicare Part A – SNF patient stays in a nursing home.

VBP
Value Based Purchasing; payment methodology that links provider payments to improved performance by health care providers. Performance measures are defined in the methodology, and utilized in the reimbursement calculations.

IP Address
Internet Protocol Address; unique address of personal computers that is utilized to communicate with other devices.

LPN
Licensed Practical Nurse

Nursing Facility Payment Modernization Overview

NF PAYMENT MODERNIZATION

Initiative Objectives

To reflect the Department's overall interest and work in modernizing rates

To further the Department’s long-standing long-term service and supports rebalancing agenda, which utilizes diverse strategies to ensure that Medicaid members have meaningful choice in the means and setting in which they receive LTSS

Establish a framework to align with value-based payment in the future

NF PAYMENT MODERNIZATION

Guiding Principles

- Align reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care
- Implement periodic adjustments to reimbursement rates to account for changes in the acuity mix of each provider’s residents
- Encourage sufficient provider spending on direct care resources

Project Phases

PROJECT PHASES

Three Phase Implementation

Phase 1:

- RUG-IV Based Case Mix Transition
- Value-Based Purchasing-VBP (Long Stay Quality Measures-QMs)

Phase 2:

- MDS Verification Review Program
- Evaluation of the Capital and FRV Components
- VBP Evaluation and Enhancements

Phase 3:

- Transition to Patient Driven Payment Model (PDPM)
- Capital and FRV Component Modernization
- VBP Evaluation and Enhancements

Methodology Overview

METHODOLOGY

What is Case Mix?

Nursing facility “case mix” determines the overall differences within a group of residents and compares individual cases relative to one another within the mix. It is a means to identify acuity differences among residents within a population.

Why Case Mix?

Case mix systems align reimbursement with the anticipated resource needs based on the acuity of specific residents. Rates are updated periodically to allow for changes in resident needs over time.

RUG-IV 48 Grouper

The Medicare Resource Utilization Grouper (RUG) version IV 48 group model will be utilized to categorize CT residents into case mix groups. National CMS RUG weights will be utilized.

Time Weighted Calculation Methodology

All MDS assessments that were active within a quarter will be utilized to calculate a case mix index (CMI) average weighted by the number of days in the quarter that the MDS was active.

METHODOLOGY

RUG-IV 48-Group

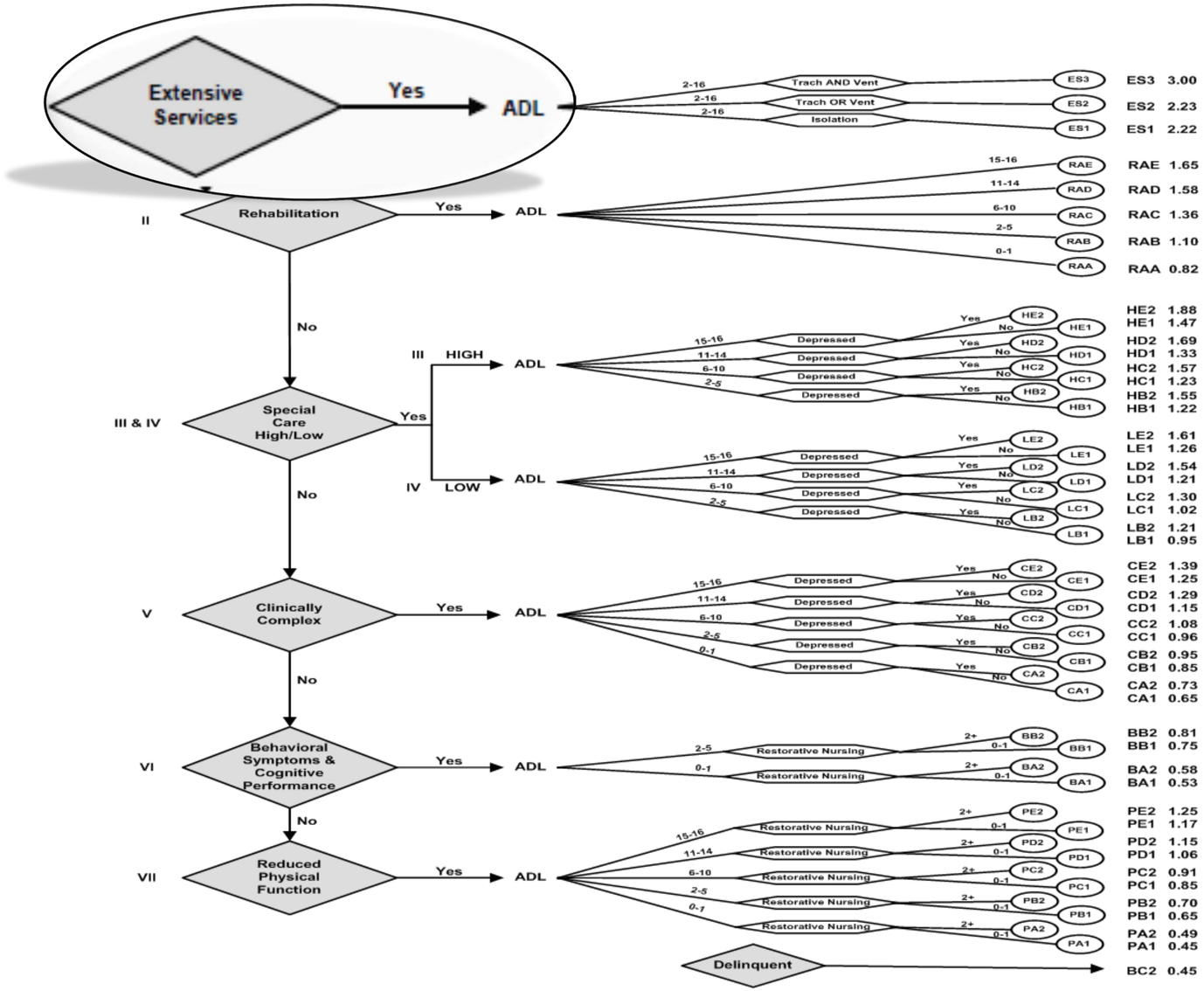
- There are 7 major resident classification groups
- Information from the Minimum Data Set (MDS) assessment will be utilized to classify residents into one of these categories
- Residents will then be further classified into sub groups based on resource utilization

MAJOR RUG CATEGORIES

MAJOR CATEGORIES

METHODOLOGY

RUG-IV – 48-Group Hierarchical Classification



METHODOLOGY

Time Weighted Example

Preliminary Time Weighted Resident Listing for the Quarter 01/01/2011 - 03/31/2011
Records Received as of 04/20/2011

Provider Number: 12000
Provider Name: SAMPLE FACILITY

Resident Name	Resident ID	Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
Resident 1	10001	NQ/02/99/99	12/15/2010	CA2	01/01/2011		03/14/2011	73	1.06	Medicaid
		NC/03/99/99	03/15/2011	PC1	03/15/2011	A2300	03/31/2011	17	0.81	Medicaid
							Total days:	90		
Resident 2	10002	NQ/02/99/99	12/20/2010	PD1	01/01/2011		03/19/2011	78	0.89	Medicaid
		NC/03/99/99	03/20/2011	PD1	03/20/2011	A2300	03/31/2011	12	0.89	Medicaid
							Total days:	90		
Resident 3	10003	NT/99/99/01	01/22/2011		01/22/2011	A1600	01/22/2011			
		NP/99/01/99	01/26/2011	SSA	01/22/2011	A1600	02/04/2011	14	1.28	Medicare
		NC/01/02/99	02/05/2011	RAB	02/05/2011	A2300	02/16/2011	12	1.24	Medicare
		NP/99/03/99	02/17/2011	RAB	02/17/2011	A2300	03/31/2011	43	1.24	Medicare
							Total days:	69		
Resident 4	10004	NT/99/99/01	03/26/2011		03/26/2011	A1600	03/26/2011			
		NC/01/01/99	03/26/2011	RAB	03/26/2011	A2300	03/31/2011	6	1.24	Medicare
							Total days:	6		

METHODOLOGY

Time Weighted Example Cont.

Preliminary Time Weighted Resident Listing for the Quarter 01/01/2011 - 03/31/2011
Records Received as of 04/20/2011

Provider Number: 12000
Provider Name: SAMPLE FACILITY

RUG-III Group	Medicaid Residents Days (a)	Medicaid Residents CMI (b)	Medicaid Residents CMI Points (c = a x b)	All Residents Days (d)	All Residents CMI (e)	All Residents CMI Points (f = d x e)
SE3	0	2.10	0.00	0	2.10	0.00
SE2	0	1.79	0.00	75	1.79	134.25
SE1	0	1.54	0.00	7	1.54	10.78
RAD	0	1.66	0.00	0	1.66	0.00
RAC	0	1.31	0.00	0	1.31	0.00
RAB	0	1.24	0.00	61	1.24	75.64
RAA	0	1.07	0.00	0	1.07	0.00
SSC	0	1.44	0.00	0	1.44	0.00
SSB	27	1.33	35.91	27	1.33	35.91
SSA	20	1.28	25.60	34	1.28	43.52

METHODOLOGY

Time Weighted Example Cont.

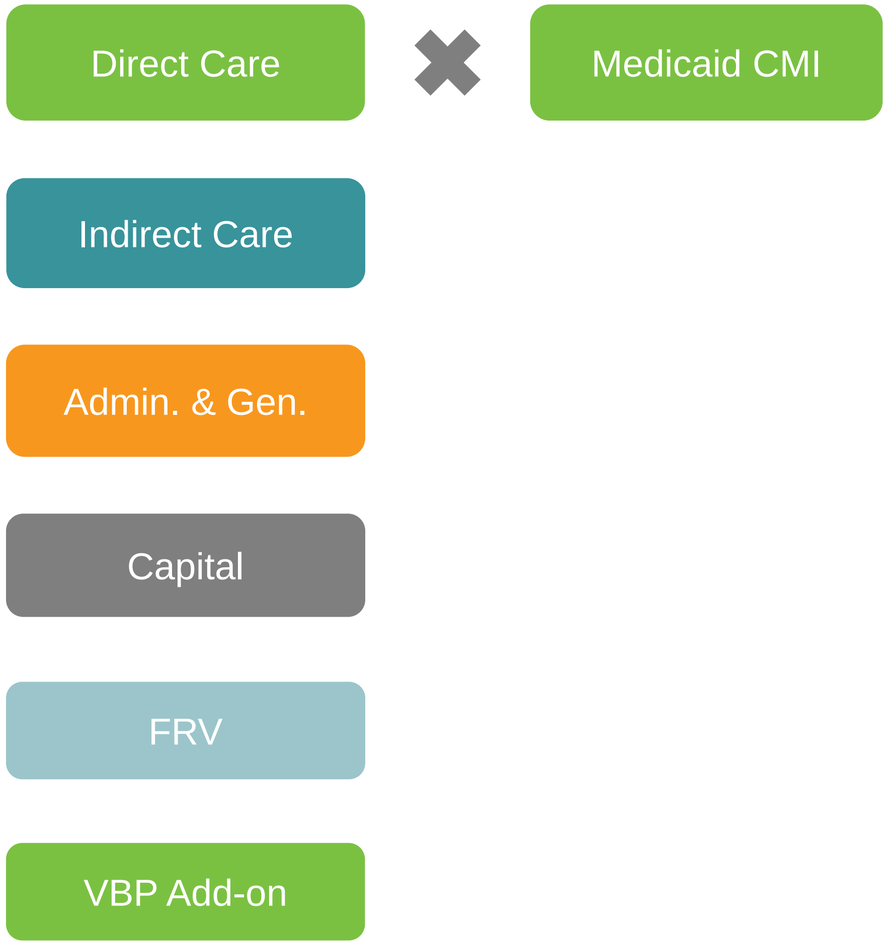
BA1	0	0.60	0.00	0	0.60	0.00
PE2	63	1.00	63.00	63	1.00	63.00
PE1	0	0.97	0.00	0	0.97	0.00
PD2	0	0.91	0.00	38	0.91	34.58
PD1	181	0.89	161.09	231	0.89	205.59
PC2	0	0.83	0.00	0	0.83	0.00
PC1	17	0.81	13.77	17	0.81	13.77
PB2	0	0.65	0.00	0	0.65	0.00
PB1	0	0.63	0.00	0	0.63	0.00
PA2	0	0.62	0.00	0	0.62	0.00
PA1	0	0.59	0.00	0	0.59	0.00
BC1	0	0.59	0.00	0	0.59	0.00
Totals	541		538.35	834		895.74

Medicaid Average CMI	**0.9951**

All Average CMI	**1.0740**

METHODOLOGY

Rate Calculation



- Base Year cost report and MDS data used:
  - ✓ 10/1/17-9/30/18 will be the base period cost and MDS data utilized for implementation
- Direct costs will be multiplied by the calculated Medicaid CMI
- Nursing Home Market Basket without Capital inflation factor will be applied to non-capital costs
- Cost component classifications will be closely aligned to the current reimbursement system

METHODOLOGY

Direct Care Component

Will utilize provider specific cost limited to an established cost ceiling

Will include at a minimum the following expenses which will be case mix adjusted:

- RN Salaries, Fringe Benefits and Fees
- LPN Salaries, Fringe Benefits and Fees
- Aides and Attendants salaries, Fringe Benefits and Fees

Base year cost report information will be normalized utilizing the base year CMI from MDS data to remove the effects of acuity from base year costs

Quarterly Medicaid case mix adjustments will be applied to the Direct care component

DIRECT CARE EXAMPLE

A. Direct Care Costs		$2,500,000
Resident Days		
Medicare	4,600	
Private Pay	4,200	
Medicaid	11,400	
B. Total Resident Days		20,200
C. Average Direct Care Costs		$123.76
Facility CMIs		
Medicare	1.15	
Private Pay	1.05	
Medicaid	0.95	
D. Average Total Facility CMI		1.02
E. Cost Per Case Mix Point or Normalized Costs (C/D)		$121.77
F. Medicaid CMI		0.95
G. Medicaid Case Mix Adjusted Costs (E x F)		$115.68

METHODOLOGY

Indirect Care Component

Will utilize provider specific cost limited to an established cost ceiling

To include at a minimum the following expenses:

- Dietary, Housekeeping and Laundry
- Social Services and Recreation Expenses
- Professional Fees and Therapy Expenses

METHODOLOGY

Administrative & General Component

A single state-wide per diem will be developed and reimbursed to all providers

To include at a minimum the following expenses:

- Plant Maintenance and Maintenance Salaries
- Administrative Salaries and Fringe Benefits
- Other Administrative Expenses

METHODOLOGY

Capital Component

No change from the current methodology

Phase 2 of the methodology development will be utilized to evaluate the current capital component

METHODOLOGY

Fair Rental Value

No change from the current methodology

Phase 2 of the methodology development will be utilized to evaluate the current FRV component

METHODOLOGY

Value Based Purchasing

- CMS long stay quality measures will be selected for benchmarking and monitoring improvements over time
- Reimbursement will be determined based on aggregate scores for each provider
- Additional quality metrics will be evaluated for implementation throughout all phases of the modernization project

Other Payment Considerations

OTHER PAYMENT CONSIDERATIONS

Phase-in Considerations

- Consideration will be given to an approach that would phase-in the new payment rates

- The phase-in options to be considered will be assessed during the modeling process

Case Mix Index Resident Roster Process

CMI RESIDENT ROSTER PROCESS

Reporting

Preliminary Reports

A preliminary resident roster will be created and distributed to each facility to allow for review of the MDS information collected for the roster. This report includes the resident days information for the quarter, RUG category, CMI, and payer source.

Final Reports

A final resident roster will be created and distributed to each facility after the review period to incorporate changes submitted on the MDS based on the preliminary review.

Web Portal

Preliminary and final resident rosters will be posted to a web portal hosted by Myers and Stauffer. IP addresses will be collected from users identified for each facility so providers can access their rosters once posted. This process helps to securely transmit protected health information.

CMI RESIDENT ROSTER PROCESS

Reporting Cont.

Clean-up Period

Preliminary resident rosters will be issued in the fall of 2019 for the base year rate-setting period (10/1/17-9/30/18). Four sets of quarterly rosters will be issued for each facility to review for accuracy. If discrepancies are noted MDS information should be re-submitted. After allowing for a period of review, revised MDS information will be gathered and Final rosters for the base year period will be issued and utilized for the cost normalization process.

Help Desk

Myers and Stauffer maintains a help desk that can be accessed during business hours to assist with any questions related to the preliminary and final resident rosters.

Provider Learning

PROVIDER LEARNING

Available Resources

Stakeholder Meetings

Updates prior to implementation will be provided at the Department's request

Live Training and Webinars

A combination of in-person training and live/recorded webinars will be utilized to educate providers on the transition to a case mix reimbursement system

Case Mix Index Report User Guide

A CMI report user guide will be developed to provide guidance on regulatory requirements, report elements, report details, and resources available for assistance

PROVIDER LEARNING

Available Resources Cont.

Myers and Stauffer Help Desk and Staff Assistance

Myers and Stauffer maintains a help desk to assist with case mix rosters, and also has staff available during business hours to answer rate-setting questions as needed

DSS Website Dedicated to Nursing Home Reimbursement

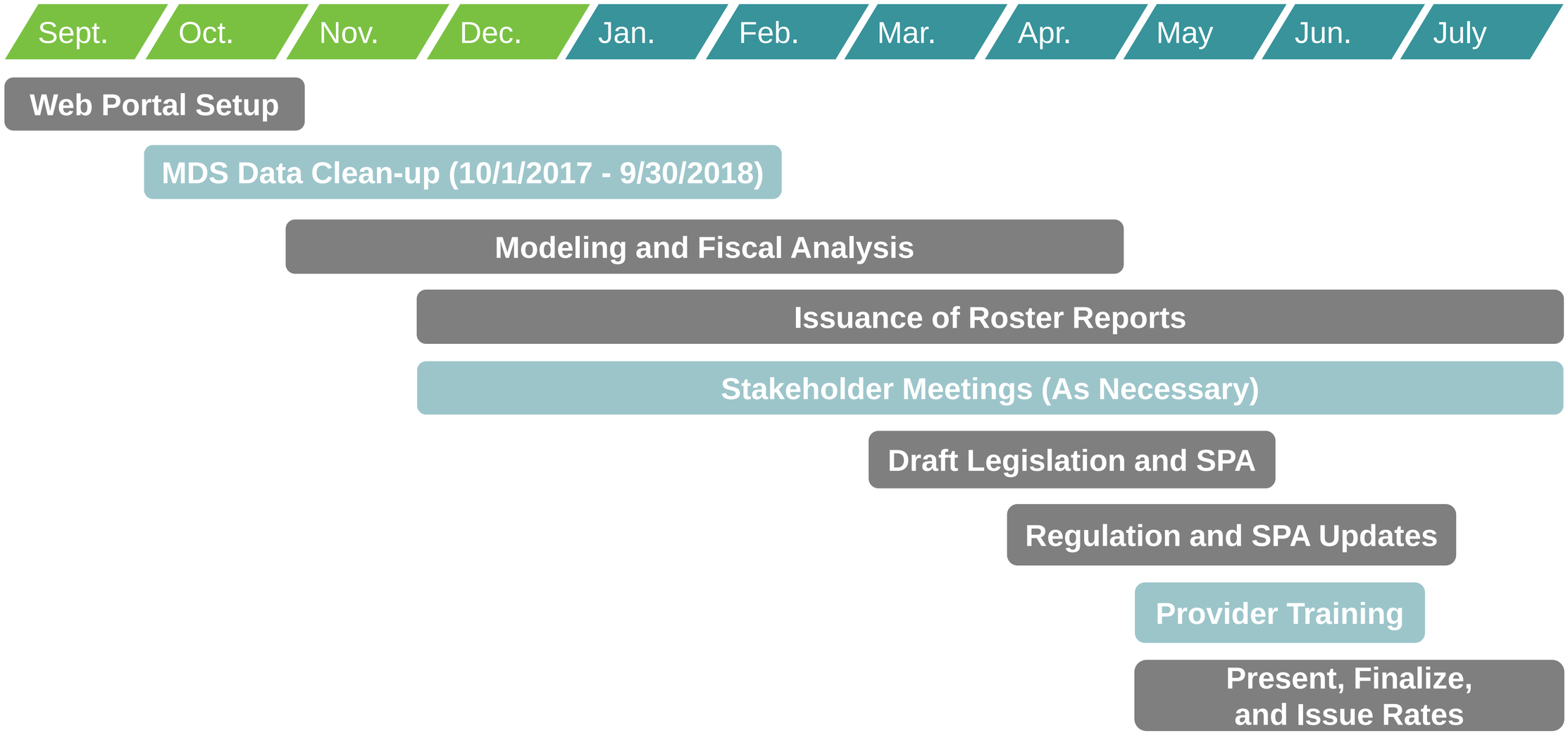
The DSS website will be utilized to post updated information, resource documents, training documents, presentations, and other pertinent provider communications. The website can be found using the following link:

https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Modernization-to-Acuity-Based-Methodology

Project Timeline

PHASE 1 PROJECT TIMELINE

Goal of 7/1/2020 Implementation



Questions?