MAPOC Presentation

October 14, 2022

Two Main DSS Topics

1. Nursing home policy update:
    - How Medicaid pays for nursing home care
    - Major reform #1: Acuity
    - Major reform #2: Quality
2. Inventory of DSS/Medicaid Projects

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   - How Medicaid pays for nursing home care
   - Major reform #1: Acuity
   - Major reform #2: Quality
2. Rev

Goals for Nursing Home Section:

(1). Remind MAPOC members about these reforms
(2). Be clear about open policy questions
(3). Solicit input and answer questions

Overview of Medicaid Reimbursement for Nursing Homes

Nursing Homes 101

Overview

- **205** nursing homes in CT; total licensed capacity **24,295 beds**
- Range from 25 to 360 licensed beds

Two main state roles

1. Medicaid <u>financing</u> *(DSS primarily)*
   - 2020: **70%** of CT nursing home residents paid by Medicaid; average daily rate (including implied income) = **$280** *(~$100k per year)*
   - FY 2022: CT Medicaid spent a total of **$1.12 billion** (state + federal) on nursing home care *[state share = $490m]*
   - Medicaid also covers alternatives to nursing home care ("home and community-based services"). FY 2022: CT Medicaid spent **$950 million** on home and community-based services *[state share = $390m]*
2. <u>Regulating</u> *(DPH primarily)*
   - DPH protects the health and safety of nursing home residents by **inspecting and licensing**

CT Medicaid Nursing Home Financing – summary

Medicaid's payment method

- CT Medicaid sets per-home per diem rates using a **"cost-based" methodology**
  - Homes submit cost reports, categorizing their costs into 5 buckets[1]
  - When CT Medicaid rebases, a home's reimbursement is based on its allowable costs in those 5 buckets, with bucket-specific ceilings

Reform efforts

- In 2019, **CT was an outlier**: only Alabama, Alaska, Arkansas, and Idaho had a payment policy similar to CT's: cost-based reimbursement with no quality payments and no adjustment for acuity
- We initiated two major reform efforts:
  1. July 2022: Acuity / case mix adjust. Adjust payments based on the health needs / expected costs of Medicaid residents
  2. July 2023: Pay for quality. Adjust payments based on a home's measured quality scores

1. The 5 cost buckets are: direct, indirect, fair rent, capital, admin / general). 2. Cost-based reimbursement with no quality payments and no acuity

CT Medicaid Nursing Home Financing – process

High level overview

- CT Medicaid sets per-home per diem rates using a **"cost-based" methodology**
  - Homes submit cost reports, categorizing their costs into 5 buckets
  - When CT Medicaid rebases, a home's reimbursement is based on its *allowable* costs in those 5 buckets, with bucket-specific ceilings
- Other states: cost-based, price-based, or cost-informed

Regulatory language

- [Section 1903(a)(7) of the federal Social Security Act]: Requires Medicaid reimbursement to be "economic and efficient" and in accordance with patient care
- [C.G.S. 17b-340]: DSS Commissioner is authorized to use nursing facility cost reports to determine Medicaid rates

Highest level overview

1. Nursing homes incur costs
2. Nursing homes submit cost reports to DSS
3. When rebasing, DSS identifies "allowable" costs
4. DSS sets a per resident per day rate based on these reports using formula

To be a good fiscal steward and follow CMS guidance, DSS identifies "allowable" and "not allowable" costs

Categorizing spending

Allowable Costs:

1. **Direct** - Nursing & nurse aide salaries, related fringe benefits and nursing pool costs.
2. **Indirect** - Recreation, social worker, dietary, housekeeping, laundry, and supplies related to patient care.
3. **Administrative and General** - Maintenance and plant operation expenses, salaries and related fringe benefits for administrative and maintenance personnel.
4. **Property (Fair Rent)**
5. **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and depreciation.

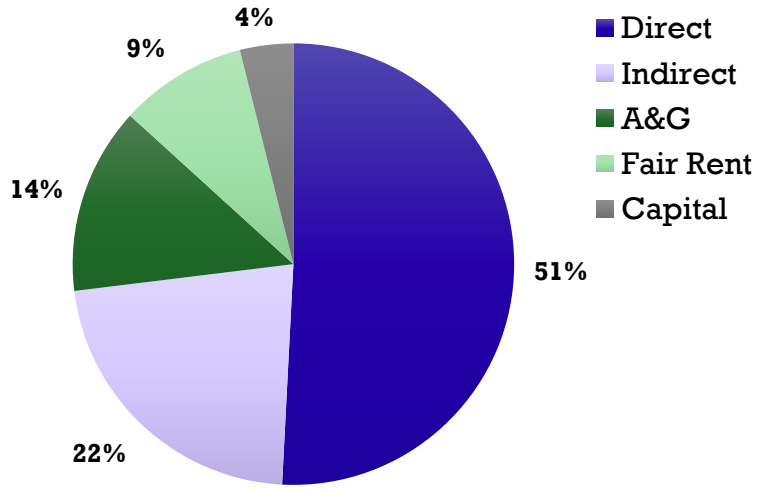
Unallowable Costs:

i. Disallowed salaries and fees and those over reasonable cost caps
ii. Disallowed managerial administrative compensation over reasonable cost caps
iii. Disallowed rent
iv. Building interest, depreciation, amortization
v. Physical therapy, speech therapy, and occupational therapy expenses (paid by Medicare)
vi. Miscellaneous desk review disallowances not related to patient care (advertising, bad debt etc.)

Breakdown of "allowable costs: in CT

In FY 2018, 23% of costs included on Connecticut nursing facility cost reports were unallowable.

That year, 51% of allowable costs went to "direct" care.



Acuity

Introduction to acuity-based payments

Summary: Acuity-based reimbursement uses data on nursing home residents' care needs to calculate and update rates

Status: Live as of July 1, 2022. Phased roll-out

Policy rationale: 2 main rationales – see below

(1). Gives homes financial incentives to serve our highest needs residents

a. Enables CT to pay homes based on the complexity of their residents' care needs

b. Ensures that homes that serve a disproportionately high share of high needs residents are compensated accordingly

c. Ensures that, as homes serve higher needs residents, their reimbursements rates quickly adjust to match their resident pool

(2). Be a good fiscal steward

a. Ensures that *Medicaid* dollars are flowing to homes based on the level of needs of *Medicaid* residents

b. Encourages nursing homes to further support *rebalancing* between institutional and home and community-based services, by lowering payments to homes for lower acuity individuals

Reminder: authorizing statute

(a) The Commissioner of Social Services [may] shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services [. In the course of developing such a system, the commissioner shall review the skilled nursing facility prospective payment system developed by the Centers for Medicare and Medicaid Services, as well as other methodologies used nationally, and shall consider recommendations from the nursing home industry.] effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities

based on cost years ending on September thirtieth in accordance with the following:

Acuity matches payments to residents' estimated need

High level overview of acuity system

(1). Collect data	(2). Develop resident-specific "needs" score	(3). Calculate payments	(4). Adjust over time
Use Minimum Data Set (MDS) data from nursing homes	Using MDS + others: develop a "needs" score for each, known as a case mix index	Translate these scores into reimbursement rates for each home	Over time, repeat steps (1) – (3) to ensure payments reflect residents' needs

A version of this system is used by most states

Use Minimum Data Set (MDS) data from nursing homes

[Step (1)]. Definition: Minimum Data Set

- **Comprehensive, standardized assessment** of each resident's functional capabilities and health needs, including physical, psychological and psychosocial functioning
- **Federally mandated** for all residents in Medicare or Medicaid-certified nursing homes
- **Conducted by trained nursing home clinicians**

(1). Collect data

Use Minimum Data Set (MDS) data from nursing homes

Example questions from the Minimum Data Set

B2. Hearing

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used) in last 5 days.

0. **Adequate**—no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty**—difficulty in some environments (e.g. when person speaks softly or setting is noisy)
2. **Moderate difficulty**—speaker has to increase volume and speak distinctly
3. **Highly impaired**—absence of useful hearing

B3. Hearing Aid

Enter Code

Hearing aid or other hearing appliance used in above 5-day assessment.

0. **No**
1. **Yes**

B4. Speech Clarity

Enter Code

Select best description of speech pattern in last 5 days.

0. **Clear speech**—distinct intelligible words
1. **Unclear speech**—slurred or mumbled words
2. **No speech**—absence of spoken words

Active Diseases in the last 30 days

Cancer

☐ 1. **Cancer** (with or without metastasis)

Heart/Circulation

☐ 2. **Anemia** (includes aplastic, iron deficiency pernicious, and sickle cell)
☐ 3. **Atrial Fibrillation and Other Dysrhythmias** (includes bradycardias, tachycardias)
☐ 4. **Coronary Artery Disease (CAD)** (includes angina, myocardial infarction, ASHD)
☐ 5. **Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE or PTE)**
☐ 6. **Heart Failure** (includes CHF, pulmonary edema)
☐ 7. **Hypertension**
☐ 8. **Peripheral Vascular Disease/Peripheral** **rial Disease**

tinal

J1. Pain Management (answer for all residents, regardless of current pain level)

At any time in the last 5 days, has the resident:

Enter Code

a. Been on a scheduled pain medication regimen?

0. **No**
1. **Yes**

Enter Code

b. Received PRN pain medications?

0. **No**
1. **Yes**

Enter Code

c. Received non-medication intervention for pain?

0. **No**
1. **Yes**

Using MDS + others: develop a "needs" score for each, know as a case mix index

[Step (2)]. Definition: Case Mix Index

Definition

- Reflects the fact that not all residents are alike
- Case refers to residents
- Mix refers to differences in care needs among those residents
- Case Mix Index (CMI): amount of direct care staff resources each resident is expected to need

Example

Low CMI:
fewer care needs

High CMI:
greater care needs

A resident with a CMI of 2.00 is predicted to require twice the direct care resources as a resident with a CMI of 1.00.

Translate these scores into reimbursement rates for each home

[Step (3)]. High-level overview: How acuity influences payment calculations

Step	What it means
(1). Determine "days divisor"	Ensures that state dollars are not going to pay for excess empty beds
(2). Determine a home's "normalizing Case Mix Index" (CMI)	Calculate a home's total *all payer* case mix index (CMI)
(3). Calculate normalized-by-CMI direct care cost per day	Calculates the direct care costs, after adjusting for CMI score
(4) / (5). Calculate Direct Care Cost Medians and Limits	Establish "peer group" median cost. Direct care costs capped at 135% of peer group median
(6). Calculate facility allowable direct care cost per day	Take the minimum of {a home's normalized direct care cost, direct care cost limit}
(7). Determine statewide case mix neutrality factor	Adjustment factor to ensure that program does not exceed mandated costs to the state
(8). Calculate a home's Medicaid Case Mix Index	Calculate a home's *Medicaid* CMI
(9). Calculate Medicaid allowable direct care cost per day	Conceptually, scale up / down payment based on comparing "Medicaid" to "all payer" CMI

Translate these scores into reimbursement rates for each home

Conceptual example #1: Acuity matches Medicaid reimbursements to Medicaid member's needs

Example

Imagine two homes that have the same *average* acuity

- Home A: Medicaid members have **higher**-than-average acuity
- Home B: Medicaid members have **lower**-than-average acuity

Assume: Homes are otherwise 100% identical

Before acuity

Homes A and B would get paid the same reimbursement rate from Medicaid…

…even though Medicaid members were more needy, on average, in Home A

With acuity

Home A would receive higher Medicaid payments than Home B, reflecting its higher needs residents

Acuity ensures that homes serving higher needs Medicaid members…
…get appropriate Medicaid compensation

Translate these scores into reimbursement rates for each home

Conceptual example #2: Acuity helps be a good fiscal steward

Example

Consider a nursing home that has 50% Medicaid and 50% non-Medicaid members

- Medicaid members: acuity score of 0.5 on average
- Non-Medicaid members: acuity scores of 1.5 on average

Before acuity

Medicaid payment rate depends on average per resident costs, unadjusted for acuity

With acuity

Medicaid payment rate depends on average per resident costs, adjusted for acuity.

➔ In this example, under acuity **the home would be paid less, reflecting that, for this home, Medicaid residents are lower acuity than average residents**

Acuity ensures that state resources are spent wisely

[Step (4)]. Adjusting payments over time ensures that Medicaid rates reflect resident's needs. Example

(4). Adjust over time

Over time, repeat steps (1) – (3) to ensure payments reflect residents' needs

- Imagine a home that has 100 beds, 50% Medicaid residents, and an average acuity of 1.0 for both Medicaid and non-Medicaid residents
- Imagine the home is going to create a high-needs unit that will serve 50 additional residents, all Medicaid, with an average acuity of 2.0

Before acuity

Medicaid reimbursement would **remain fixed until next comprehensive rebasing period**

At that point, Medicaid reimbursement would increase…but not enough to reflect higher level of Medicaid needs:

- All-payer average acuity: 1.0 -> 1.33: +33%
- Medicaid average acuity: 1.0 → 1.5 +50%

After acuity

Medicaid reimbursement **adjusts quarterly to reflect higher acuity**

Medicaid rates would increase by 50%, reflecting higher needs of *Medicaid* residents

Reminder

Introduction to acuity-based payments

Summary: Acuity-based reimbursement uses data on nursing home residents' care needs to calculate and update rates

Status: Live as of July 1, 2022

Policy rationale: 2 main rationales – see below

(1). Gives homes incentives to serve our highest needs residents

a. Enables CT to pay homes based on the complexity of their residents' care needs

b. Ensures that homes that serve a disproportionately high share of high needs residents are compensated accordingly

c. Ensures that, as homes serve higher needs residents, their reimbursements rates quickly adjust to match their resident pool

(2). Be a good fiscal steward

a. Ensures that Medicaid dollars are flowing to homes based on the level of needs of *Medicaid* residents…not residents from other payer sources

Acuity: phase-in and next steps

Selected Parameters	SFY 2023	SFY 2024	SFY 2025
Cost report year	2019	2019	2019
Case mix neutrality limit	0.75%	1.51%	2.27%
Stop gain	$6.50	$20	None
Stop loss	$0	$5	None

Quality

Introduction to quality payments

Summary: Adjust payments based on a home's measured quality scores. Joining majority of states + Medicare who do this

Status: Will begin July 1, 2023 *we are finalizing details of this policy*

Policy rationale: 2 main rationales – see below

(1). Gives homes financial incentives to improve patient care

a. Help "make the business case" for homes to invest in their residents and quality
b. Under previous systems, homes had no *direct* financial incentives to boost patient quality

(2). Lower medical spending

Achieving high quality care can decrease medical spending…

…which is paid for by HUSKY outside of the per-diem rate

Example: Pressure ulcers

Clinical context

Pressure ulcers (bed sores) impact an estimated 2+ million people per year… and can cause severe pain…

…and, if hospitalized, can cost tens of thousands of extra dollars (source) and death

How homes can help

Strong evidence, via randomized control trials, that homes can take steps to reduce pressure ulcer incidence rate

JAMA Internal Medicine

Table 1. Intervention Effect and Quality of Supporting Randomized Controlled Trials (RCTs)

Strategy	Description of Preventive Interventions	Participant Population	No. of RCTs/ No. of Participants	Pressure Ulcers, RR (95% CI)[b]	Randomization[a]	Allocation Concealment[a]	Blinding of Outcome Assessment[a]	Source
1	Pressure redistribution foam (ie, cubed foams,[24,25] visco-elastic foam,[26] and high-density foams)[25-27] vs standard hospital mattresses	Medical, surgical, and rehabilitation patients	5/2016	0.40 (0.21-0.74)	4 RCTs	2 RCTs	None	McInnes et al[16]
2	Oral nutritional supplements (eg, daily drinks of 237 mL, 2 kcal/mL)[28] and standard hospital diet vs standard hospital diet	Elderly hospital patients	4/1224	0.85 (0.73-0.99)	4 RCTs	None	1 RCT	Stratton et al[17]
3	A hyperoxygenated fatty acid regimen for skin dryness, applied twice per day to the sacrum, trochanter, and heels (Mepentol; Laboratorios Bama-Geve SA, Barcelona, Spain) vs matched greasy placebo[22]	Patients from home care and/or geriatric centers	1/380	0.42 (0.22-0.80)	1 RCT	None	1 RCT	Reddy et al[12]
4	A foam cleanser combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Clinisan; Shiloh Health Care, Oldham, England) vs soap and water for incontinence care[23]	Residents of long-term care sites	1/93	0.32 (0.13-0.82)	1 RCT	None	1 RCT	Hodgkinson et al[18]

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106015

Reminder: authorizing statute and overall approach

Authorizing legislation

Sec. 17b-340d. Acuity-based methodology for Medicaid reimbursement of nursing home services.
(a) The Commissioner of Social Services shall implement an acuity-based methodology for Medicaid reimbursement of nursing home services effective July 1, 2022. Notwithstanding section 17b-340, for the fiscal year ending June 30, 2023, and annually thereafter, the Commissioner of Social Services shall establish Medicaid rates paid to nursing home facilities based on cost years ending on September thirtieth in accordance with the following:

(2) Beginning July 1, 2022, facilities will be required to comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics will be phased in, beginning July 1, 2022, with a period of reporting only.

Overall approach

- DSS, DPH, and the industry are meetings regularly to discuss quality program design using lessons learned from other states and CMS quality measures
- DSS will host public meetings to solicit feedback on quality program design after January 1, 2023
- DSS will also report at a future MAPOC on progress

Remaining steps to implement policy in July 1, 2023…and beyond

1. Finalize metrics
2. Finalize financial calculations
3. Begin payment adjustments 7/1/23
4. Revise / test and learn

Finalize **initial list of quality measures + adjustments** (e.g. risk adjustment / numerator / denominators)

Determine **exact calculations** linking higher / lower quality to change in nursing home reimbursements

Example of policy decisions:

- Stop gain?
- Only allow homes that are not under CMS / state investigation to quality?
- Size and scope of program

- DSS and the industry are **working collaboratively**
- Reimbursement adjusted for quality will begin 7/1/23

Note: CMS state plan amendment (SPA) approval required

Implement consumer satisfaction survey. Reporting only starting 7/1/23. Consumer satisfaction survey results will be incorporated into reimbursement impacts once a baseline is established.

Quality measures will be monitored and adjusted over time, reflecting desired outcomes for resident care.

Two Main DSS Topics

1. Nursing home policy update:
    - How Medicaid pays for nursing home care
    - Major reform #1: Acuity
    - Major reform #2: Quality

2. Inventory of DSS/Medicaid Projects

Completed Projects

Major DSS / Medicaid initiatives from last session

Project	Effective Date	Status
(1). Medicaid and CHIP postpartum care (extends coverage from 60 days to 12 months)	April 1, 2022	Complete and Active
(2). Prenatal care for noncitizen women (CHIP unborn child)	April 1, 2022	Complete and Active
(3). Covered CT	July 1, 2022	Complete and Active
(4). Adult Dental Rate Increase	July 1, 2022	Complete
(5). Family Planning Clinic Rate Increase	July 1, 2022	Complete
(6). Minimum wage increase for home health and waiver service providers	July 1, 2022	Complete
(7). Raise Community Spouse Protected Amount	July 1, 2022	Complete
(8). Continue Vent Bed Rate Add-on	July 1, 2022	Complete
(9). Radiologist Mammogram rate increase	July 1, 2022	Complete
(10). Associate Licensed Behavioral Health Practitioner Coverage	October 1, 2022	Complete
(11). Naturopath Coverage-removed age limit	October 1, 2022	Complete

Pending or In-Process Projects

Project	Effective Date	Status
(A). Additional 150 Autism Slots	July 1, 2022	In process. DSS has hired 1 staff, 2 more to be hired. Waitlist is being reviewed
(B). PRTF Funding	July 1, 2022	In process. DSS reviewing PRTF rate methodologies from other states.
(C). Behavioral Health Integration	October 1, 2022	Review Collaborative Care Model (CoCM) and the associated fiscal note
(D). State-funded coverage for noncitizen children	January 1, 2023	On track
(E). State-funded postpartum coverage for noncitizens (coverage for 12 months)	April 1, 2023	On track