State of Connecticut Nursing Facility Payment Modernization Project: Case Mix Implementation

April 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

AGENDA

- Project Overview
- Rate Methodology Overview
- Rate Phase-In
- Value Based Purchasing
- Other Implementation Items
- Q&A

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ACRONYMS

- **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.

- **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.

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

NF PAYMENT MODERNIZATION GOALS & OBJECTIVES

- To reflect the Department’s overall interest and work in modernizing rates.
- Establish a framework to align with value-based payment in the future.
- Align direct care 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.

RATE METHODOLOGY OVERVIEW

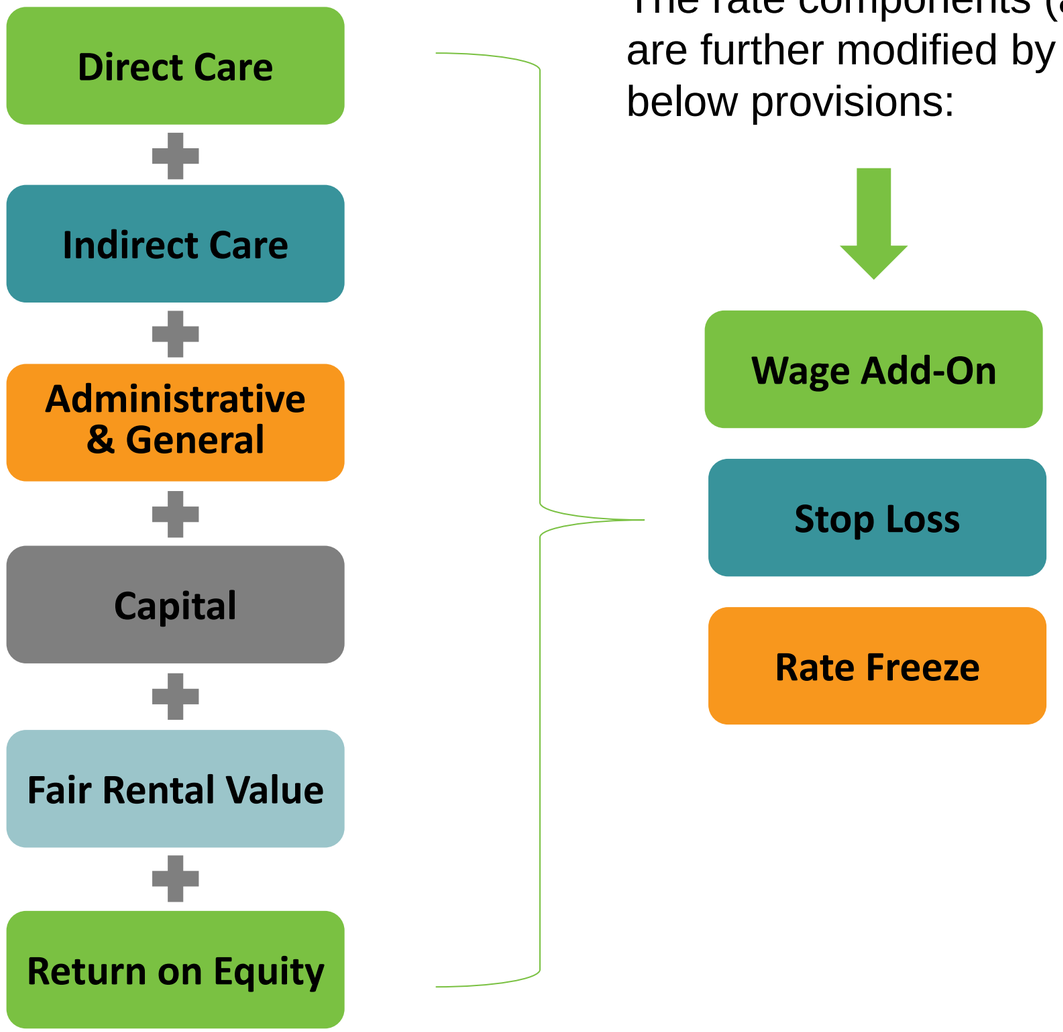
MAJOR MODERNIZATION AREAS

- **Implementation Date:** July 1, 2022
- **Direct Care:** An acuity (case mix) component will be incorporated into the adjustment
- **Cost Basis:** 2019 cost reports will be utilized as the basis for the rate system
- **Phase-In:** 3 year transition plan to allow facilities time to adjust to new payment system
  - “Hold-harmless” first year rate implementation
- **Value-Based Purchasing:** Incorporation of a value-based purchasing component.
  - Elements to be determined
  - SFY 2023 no dollars at risk

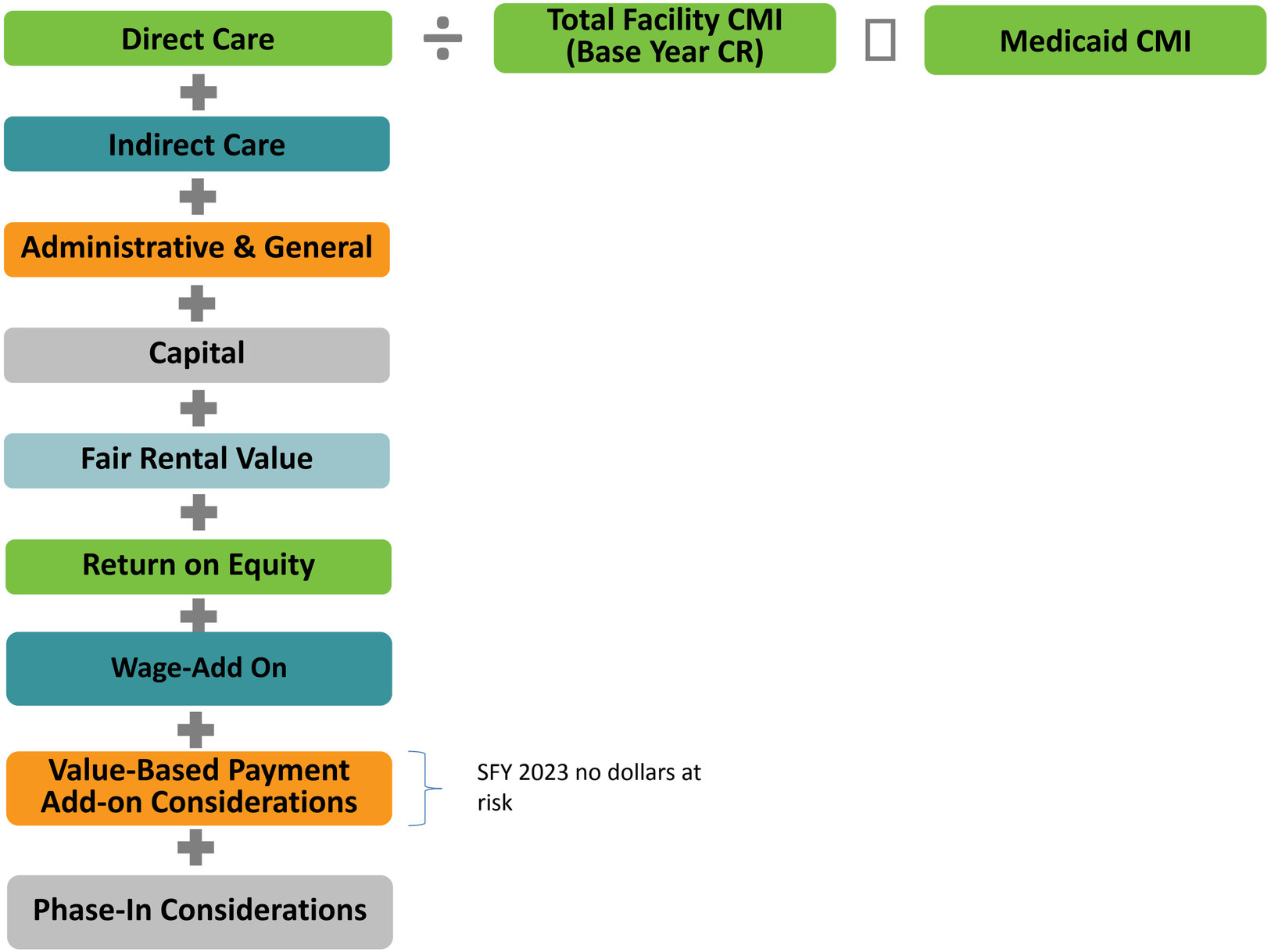
OTHER MODERNIZATION AREAS

- **Methodology:** Rates to be calculated in accordance with Connecticut Regulations 17-311-52 and 17b-340.
  - Include acuity (case mix) into the direct care component
  - No methodology change to non-direct care areas
  - No change in any component cost classifications proposed
- **Rate Streamlining:** A single facility rate for both CCNH and RHNS beds will be determined
- **Specialized Care:** Vent and AIDS units/facilities will continue to receive a separate reimbursement rate.
- **Wage Add-Ons:** All legislated wage add-ons are included in the new system

CURRENT RATE METHODOLOGY



CASE MIX METHODOLOGY



SHADOW RATES

DRAFT April 1, 2022 REIMBURSEMENT RATE
(FOR DEMONSTRATION PURPOSES ONLY)
ABC Facility

DISCLAIMER: ***Please Note this rate sheet is for demonstration purposes only, and will not be utilized for Medicaid payment/claim adjudication purposes. It is designed to show the potential provider impact from the transition to a case mix (acuity-based) reimbursement system. Facility cost and rate information is subject to change from subsequent audit/review findings, CMI updates, additional legislative changes, and/or further system modification.***

Number:		Actual Resident Days:	20,200
County:		Bed Days Available:	21,900
Geographic Location:	2 - CCNH Non-Fairfield	Occupancy %:	92.24%
Cost Year Begin:	10/1/2018	# Beds:	60
Cost Year End:	9/30/2019		

CMI INFORMATION

Quarter Ending	Normalizing (Base Year) CMI	Medicaid CMI	Case Mix Neutrality Factor	Medicaid CMI for Rate Setting
12/31/2021	1.0960	0.9776	100%	0.9776

NET OPERATING

Description	Direct Care	Indirect Care	Admin. & General	Capital/Other	Provider Tax
Facility Costs	$2,487,442	$1,296,050	$1,017,626	$142,153	$333,356
Inflation Multiplier	1.0554	1.0554	1.0554	1.0554	1.0554
Inflated Costs	$2,625,246	$1,367,851	$1,074,002	$150,028	$351,824
Days Used in Division	20,200	20,200	20,200	20,200	20,200
Divided by Days	$129.96	$67.72	$53.17	$7.43	$17.42
Total Facility CMI	1.0960	NA	NA	NA	NA
Cost Per Diem at Total Facility CMI	$118.58	NA	NA	NA	NA
Limit	$171.56	$67.62	$36.82	NA	NA
Allowed Per Diem	$118.58	$67.62	$36.82	$7.43	$17.42
Facility's Medicaid CMI	0.9776	NA	NA	NA	NA
Rate	$115.92	$67.62	$36.82	$7.43	$17.42
Incentive Allowance	NA	$0.00	$0.00	NA	NA
Final Rate	**$115.92**	**$67.62**	**$36.82**	**$7.43**	**$17.42**

Grand Total Net Operating Components **$245.21**

SHADOW RATES

- Shadow Rates have been issued to all Medicaid providers for the 10/1/21, 1/1/22 time periods. 4/1/22 will be released shortly
- Shadow Rates were designed to communicate the impact of the case mix reimbursement system to each individual provider
- The Year 1 Phase-In Methodology is incorporated
- Shadow rates are for information purposes only and are not utilized for payment

HOW JULY 1 RATES MAY VARY FROM SHADOW RATES

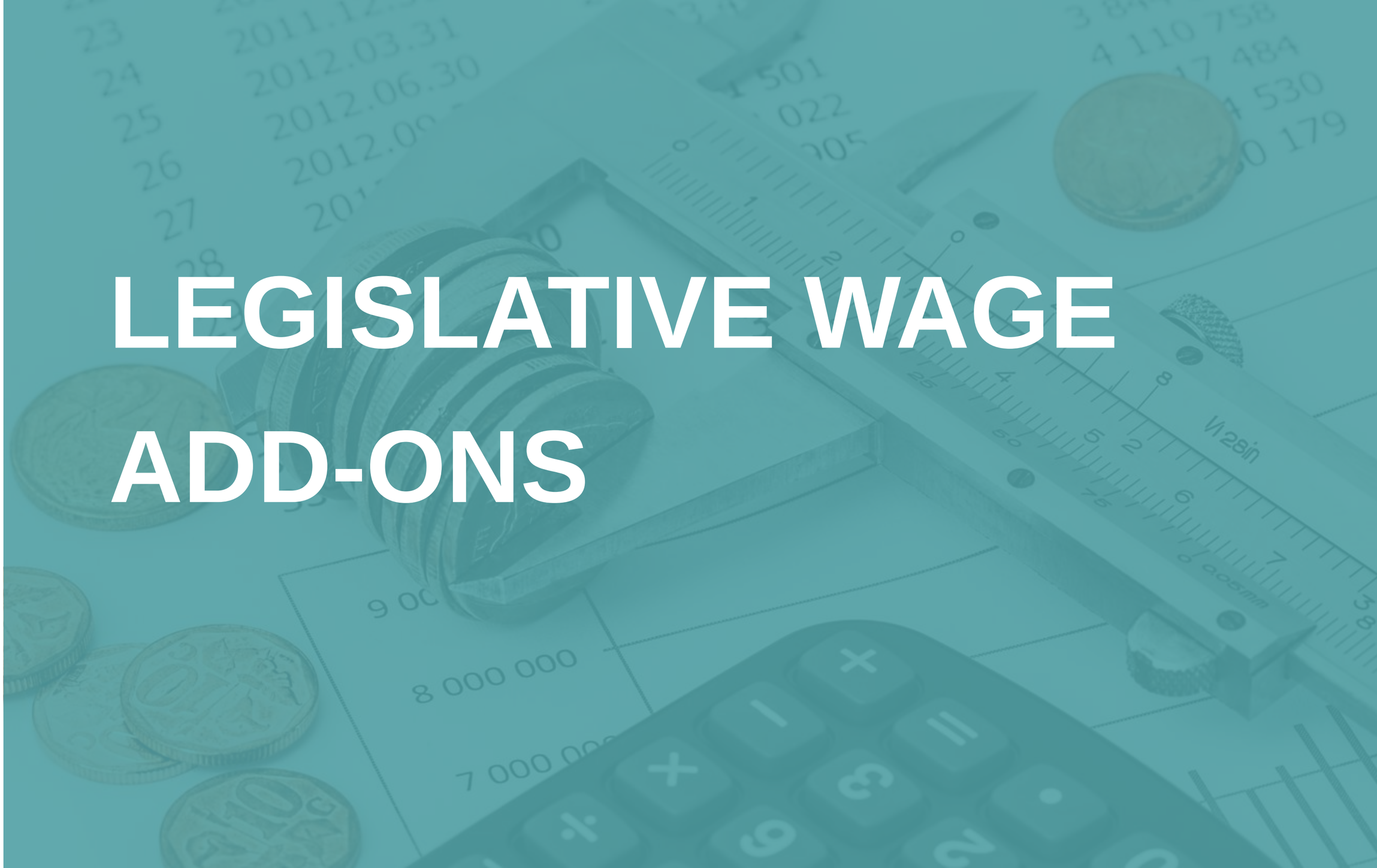
- Quarterly Case Mix Index Adjustments
- Legislative Add-Ons
  - 7/1/2022 4.5% wage add-on will be calculated based on the July 1 rate after phase-in
  - Benefits Enhancement Add-on
  - Social Worker Add-on (in 4/1 shadow rate only)
- Audit adjustments to the 2019 base year cost reports
- Fair Rental Value Updates

QUARTERLY CMI CYCLE

- The CMI calculation for each rate effective date period would correspond to active MDS assessment records as noted in the below table:

MDS Assessment Period	Corresponding Rate Period
1/1 - 3/31	7/1 - 9/30
4/1 - 6/30	10/1 - 12/31
7/1 - 9/30	1/1 - 3/31
10/1 - 12/31	4/1 - 6/30

LEGISLATIVE WAGE ADD-ONS



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Wage Add-On

Wage Add-On	**$18.51**
Social Worker Minimum Staffing Rate Increase	**$0.00**

Initial System Phase-In Parameters

Max System Allowed Gain from Issued Rate (Stop Gain)	**$6.50**
Max System Allowed Loss From Issued Rate (Stop Loss)	**$0.00**

Rate Setting Parameters

Case Mix Reimbursement Rate (Prior to Phase-In Adjustment)	$276.20
Current Issued Rate	$244.54
Variance to Issued Rate	$31.66
Adjustment to Case Mix Reimbursement Rate for Phase-In Parameters	($25.16)
Case Mix Reimbursement Rate (After Phase-In Adjustment)	$251.04
7/1/2022 4.5% Rate Increase	$11.30
Benefits Enhancement Add-On	$0.00
Case Mix Reimbursement Rate (After Increases)	**$262.34**
Total Gain/(Loss) from Issued Rate Prior to to 7/1/2022 Increases	$6.50

LEGISLATIVE ADD-ONS

- There are multiple legislative add-ons included in the Medicaid reimbursement rate
- For shadow rate purposes many of these add-ons are rolled up into the “Wage Add-On” section of the rate sheet
- Two legislative add-ons are reported in a separate section of the rate sheet:
  - 7/1/2022 4.5% wage add-on
  - Benefits Enhancement add-on

LEGISLATIVE ADD-ONS

Wage Add-On Rate Sheet Field

7/1/2019 2% Rate Increase (Prorated for 9 months)

+

10/1/2020 1% Rate Increase

+

1/1/2021 1% Rate Increase

+

7/1/2021 4.5% Rate Increase

=

Wage Add-on per Rate Sheet

Independent Rate Sheet Fields

Social Worker Add-on (1/1/2021)

7/1/2022 4.5% Rate Increase

Health Care and Pension Benefit Enhancement

7/1/2022 4.5% WAGE ADD-ON

- Wage add-on will be calculated based on the July 1 rate after phase-in
  - This allows for full value of the add-on to be recognized
- Wage add-on will be frozen at the initial calculated value
  - Value will not be impacted by subsequent audit, case mix, or other rate modifications

RATE PHASE-IN

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PHASE-IN OVERVIEW

- DSS is implementing a phase-in of rebase impact over a 3 year period (SFY 2023 – SFY 2025)
- Phase-In is a process that grants additional provider financial certainty for a limited period of time
- This limited time period allows for providers to evaluate the impact of the new reimbursement system on their operations and modify as necessary.

PHASE-IN PARAMETERS

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

* Statewide average CMI from MDS records dated 1/1/2022 – 3/31/2022 will serve as the base from which the case mix neutrality limit will be applied

PHASE-IN EXAMPLE # 1

Facility W/ Case Mix Rate GREATER Than Issued Rate

	SFY 2023	SFY 2024	SFY 2025
Case Mix Rate	$ 280.00	$ 280.00	$ 280.00
Issued Rate	$ 245.00	$ 245.00	$ 245.00
Initial Gain/(Loss)	$ 35.00	$ 35.00	$ 35.00
Phase-In Adjustment	$ (28.50)	$ (15.00)	None
Total Case Mix Rate After Phase-In	$ 251.50	$ 265.00	$ 280.00
Gain/(Loss) After Phase-In	$ 6.50	$ 20.00	$ 35.00

PHASE-IN EXAMPLE # 2

Facility W/ Case Mix Rate LESS Than Issued Rate

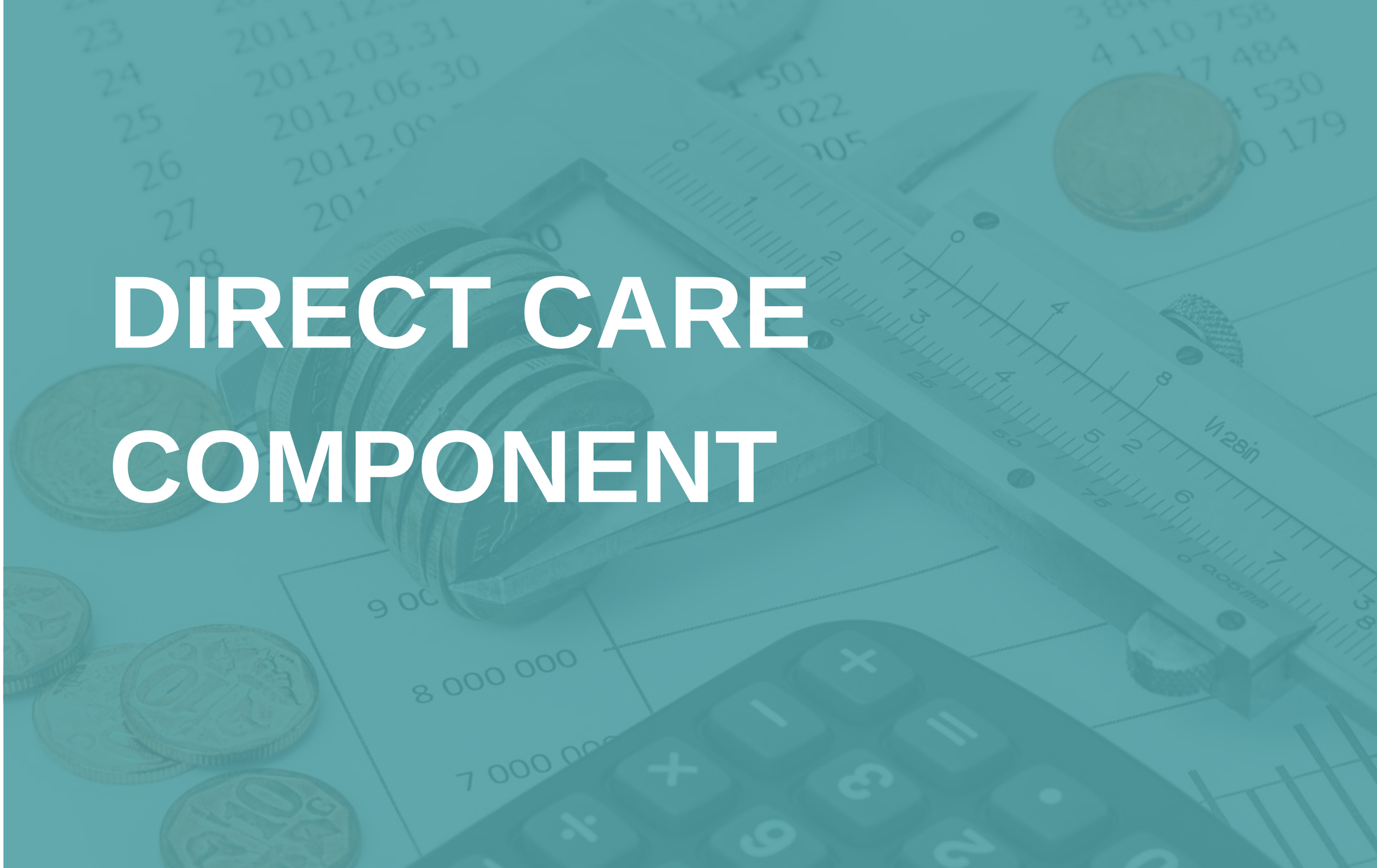
	SFY 2023	SFY 2024	SFY 2025
Case Mix Rate	$ 235.00	$ 235.00	$ 235.00
Issued Rate	$ 245.00	$ 245.00	$ 245.00
Initial Gain/(Loss)	$ (10.00)	$ (10.00)	$ (10.00)
Phase-In Adjustment	$ 10.00	$ 5.00	None
Total Case Mix Rate After Phase-In	**$ 245.00**	**$ 240.00**	**$ 235.00**
Gain/(Loss) After Phase-In	$ -	$ (5.00)	$ (10.00)

VALUE BASED PURCHASING

VBP INCORPORATION

- VBP program will have no dollars at risk for SFY 2023
- For the period after initial phase, DSS will propose further modifications to the payment strategy involving performance on quality metrics
- Stakeholder workgroups have been established to work toward selecting initial metrics and implementation strategy
- Additional quality metrics will be evaluated for implementation throughout all phases of the modernization project

DIRECT CARE COMPONENT



DIRECT CARE PARAMETERS

- **Peer Groups:**
  - Fairfield County
  - Non-Fairfield Counties
- **Cost Component Limit:** 135% of Median
- **Minimum Occupancy Percentage:** 90%
- **Efficiency Percentage:** None

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Grand Total Net Operating Components **$245.21**

STEP 1: DETERMINE DAYS DIVISOR

- Days are the greater of actual resident days or 90% of Bed Days Available

Beds	60
Bed Days Available (Beds X Days in CR Period)	21,900
Minimum Occupancy %	90%
Days @ Min. Occupancy	19,710
Total Days from CR	17,500
Greater of Total CR Days or Days @ Min. Occupancy	19,710

STEP 2: DETERMINE NORMALIZING CMI

- Normalizing CMI is total all-payer CMI
- MDS assessments periods are matched to the corresponding cost reporting period, and a total days-weighted Normalizing CMI is calculated:

MDS Assessment Period	CMI Points (RUG Weights X Days)	Days
10/1/18 – 12/31/18	4,400	4,250
1/1/19 – 3/31/19	4,700	4,500
4/1/19 – 6/30/19	4,900	4,750
7/1/19 – 9/30/19	4,100	4,000
Totals for CR Period	18,100	17,500
Normalized CMI	**1.0343**	

- Providers reviewed 2 of 4 historical CMI periods
- For non-reviewed periods, the impact of delinquent records was removed

STEP 3: CALCULATE NORMALIZED DC COST PER DAY

- Normalizing DC cost removes the effect of acuity on cost, and creates a uniform cost structure for Median calculations:

Total DC Cost	$	2,650,000
Greater of Total CR Days or Days @ Min. Occupancy		19,710
Total DC Cost Per Day	$	134.45
Normalizing CMI		1.0343
Total Normalized DC Cost Per Day	$	129.99

STEP 4: CALCULATE MEDIANS

- Normalizing DC cost per day for each provider is included in the median data sets
- Each peer group (Fairfield/Non-Fairfield) has the corresponding providers segregated and included only in calculating that specific median.
- From the median data sets, the arithmetic median is calculated.
- Fairfield County Median: $141.15
- Non-Fairfield County Median: $126.90

STEP 5: CALCULATE DC COST LIMIT

- Peer group medians are multiplied by the cost component limit percentage

	Fairfield	Non-Fairfield
Median Value	$ 141.15	$ 126.90
Cost Limit %	135%	135%
DC Cost Limit	$ 190.55	$ 171.32

STEP 6: CALCULATE FACILITY ALLOWABLE DC COST PER DAY

- Normalized facility cost is compared against the DC cost limit
- The lesser of the DC cost limit, or the facility's normalized DC cost is utilized as the allowable facility DC cost value

Facility Normalized DC Cost	$129.99
DC Cost Limit (Non-Fairfield)	$171.32
Lesser of Facility Cost or Limit	$129.99

STEP 7: DETERMINE STATEWIDE CASE MIX NEUTRALITY FACTOR

- To ensure system growth stays within budgetary appropriations during each state fiscal year, a Statewide Case Mix Neutrality Factor will be calculated and applied quarterly as appropriate.
- This case mix neutrality factor will only be applied when the statewide Medicaid CMI exceeds the allowable state fiscal year growth threshold.

Base Statewide Medicaid CMI Value	0.9612
SFY CMI Allowed Growth Factor	0.75%
Max SFY Statewide Medicaid CMI Value	0.9684

Rate Period Statewide Medicaid CMI Value	0.9712
Statewide Medicaid CMI Neutrality Factor	99.71%

STEP 8: CALCULATE MEDICAID CMI

- Reported Medicaid CMI values will be adjusted by any required quarterly Case Mix Neutrality Factor to determine the rate period Medicaid CMI Value.

Reported Quarterly Medicaid CMI	1.018
Statewide Medicaid CMI Neutrality Factor	99.71%
Medicaid CMI for Rate Period	1.015

STEP 9: CALCULATE MEDICAID ALLOWABLE DC COST PER DAY

- The allowable DC cost per day is multiplied by the facility's rate period Medicaid CMI to arrive at the Medicaid allowable DC cost per day
- Medicaid CMI and thereby reimbursement rates are to be updated on a quarterly basis

Allowable Facility DC Cost	$	129.99
Medicaid CMI		1.015
Total Medicaid DC CMI Adj. Cost	$	131.94

QUESTIONS?