Over the past year, we have been reporting to the membership that MO HealthNet Division (“MHD”) was working with us, and our consultants, to reform the SNF Medicaid rate plan. MHD’s goal is to rebase the SNF Medicaid rates under a new, reformed SNF Medicaidplan.

Throughout this lengthy process, as MHD unveiled their plan and worked through their proposed reforms, they not only listened to our comments but were also willing to make countless adjustments based on concerns we raised or ideas we brought to the table. The plan may not be perfect, we are pleased that the state has finally acted on what we have been asking for so many years and that is, our SNF Medicaid rates need rebased. We were also pleased with the collaboration we had with MHD and their consultants. Their willingness to listen to our ideas/recommendations and their willingness to make changes based on our conversations throughout this journey was refreshing and what negotiation and collaboration should be.

This process has come a long way from where it began. We believe the final product is the best plan possible to reform the SNF Medicaid plan at this time, within a budget the state can afford, and includes the reforms the MHD and the legislature required in order to agree to move forward with a rebase.

MHD had two main priorities that were mandatory in order to move forward with a rate rebase:

* Add a Case Mix Index (“CMI”) or acuity adjustment to the plan; and
* Realign the add-on incentives and incorporate a Value-Based Payment (“VBP”) or quality incentive into the plan.

We are finally in a place to give you a high-level overview of what to expect under the new proposed plan, assuming the money is appropriated through the budget process. We have outlined the information as follows:

* Overview of the proposed new SNF Medicaid plan and rebase.
* Status of the Appropriation of the Money Necessary to Fund the Medicaid Plan and Rebase.
* Implementation and Timing of the Rebase and Reforms

**Overview of the Proposed New SNF Medicaid Plan and Rebase**

**Status of FY22 (July 1, 2021 – June 30, 2022) $10.18 PPD Temporary Rate Increase***:*

The temporary $10.18 PPD rate increase that passed last year is scheduled to expire on June 30, 2022, according to the state plan amendment (“SPA”) approved by CMS last year. Under this SPA, your rate returns to what it was in June 2021 – which is $10.18 PPD lower than your rate today.

We have some good news. In our final discussions with MHD, we were able to negotiate to keep $10.18 PPD in place; therefore, the temporary $10.18 will not be taken away from any facility’s base rate on July 1, 2022. In addition, any facility who has a rebased CMI adjusted rate lower than its current rate (including the $10.18) will be held harmless to the current rate (including the $10.18). Meaning, once every facility’s rate is rebased and the CMI adjustment is applied, no facility will receive a rate lower than what it is getting today.

Throughout our discussions, the $10.18 was set to expire as it was only passed as a temporary increase to help with COVID and to transition to the new rate methodology. Given the financial hardship so many of our facilities are facing today, we approached MHD and asked that the $10.18 be left in place so that no facility’s rate would be reduced on July 1, 2022. This will help avoid additional financial disruption during these uncertain times.

**Rebase of Base Rate**:

Effective July 1, 2022, each facility’s base Medicaid rate will be rebased. This will be based on FY2019 cost reports trended forward to July 1, 2022. As stated above, rates for facilities whose rebased rate is lower than the rate they are receiving today will not be reduced. Facilities whose rebased rate is higher, will be increased accordingly.

The changes to the original Medicaid plan or formula to calculate these base rates were minimal. Following are a few highlights of how the rebase rates will be calculated:

* The rates were rebased on the facility’s 2019 cost report trended forward to July 1, 2022. Also, MHD increased several patient care labor costs in addition to the above noted trend adjustments. While we understand that this does not account for all the increases in costs you have incurred due to COVID, MHD hopes to get a better sense of the ongoing trend factor and increased costs accordingly the next time rates are rebased. In addition, we believe that keeping the $10.18 in place gives additional recognition of the increased costs over and above a normal trend factor.
* The current plan calculates certain cost components of the base rates using 85% occupancy. The occupancy percent in the new plan will be 80%. We understand 80% does not represent the average occupancy before, during and after the pandemic; however, we are pleased MHD agreed to reduce occupancy, based on our request, as it has been at 85% since the inception of the current plan.

The current plan has a few incentives imbedded in the current rate that were revised to accommodate the VBP incentive add-ons.

**Adjust Base Rate to Account for Acuity of Care - Case Mix Index (CMI)**

As stated above, one of MHDs required reforms to the Medicaid plan was to incorporate a CMI (acuity) adjustment to the base rate. Once a facility’s base rate is rebased, each facility’s patient care component of their rate will be adjusted based on its Medicaid CMI. These respective CMI adjustments could be made on either a quarterly or semi-annual basis. We currently do not know MHD’s preference.

Facilities will be held harmless to their current rate, meaning the CMI adjustment will not lower the facility’s rate from what the facility’s rate is today. Below are a couple examples of how a facility’s rate could be adjusted by the facility’s CMI:

**Example #1:** If a facility’s rate is $170 today, its rebased rate is $175, CMI adjustment results in a reduction of $6, the facility’s rate will not be reduced to $169, it will be held harmless at $170.

**Example #2:** If a facility’s rate is $170 today, its rebased rate is $175, CMI results in a reduction of $3, the facility’s new rate will be $172.

**Example #3:** If a facility’s rate is $170 today, its rebased rate is $175, CMI results in an increase of $3, the facility’s new rate will be $178.

**Example #4:** If a facility’s rate is $170 today, its rebased rate is $165, CMI adjustment is anything below a $5 increase, the facility’s rate will not be reduced, it will be held harmless at $170.

**Example #5:** If a facility’s rate is $170 today, its rebased rate is $165, CMI adjustment is a $7 increase, the facility’s new rate will be $172.

The CMI used in the new Medicaid payment model will be based on RUGS-IV. In the very beginning of this process, we asked that the CMI be based on PDPM rather than RUGS-IV. There are various reasons the state did not implement CMI based on PDPM. PDPM payment model is relatively new and very few states who have a Medicaid case-mix payment methodology have converted to PDPM. There are significant changes to software that have to be implemented in order for the transition to take place. Some states are currently working on this conversion and MHD intends to transition in conjunction with future rebases.

Since the SNF Medicaid rate did not include a CMI in the past to adjust or determine Medicaid rates, we believe that many facilities were and still are not properly capturing acuities on their Medicaid MDS. It is complicated, and because of that and the impact CMI can have on your rate, we have been warning facilities for the past year of how important it is to begin training MDS coordinators in preparation of these reforms.

**Please Note:** **If resident acuity is not properly captured in the Medicaid MDS assessment, facility Medicaid rates may be lower than they should; therefore, we cannot stress enough how important it is that you spend time educating on this topic and ensuring your MDS assessments are properly completed to reflect the acuity of the residents.**

**Adjust Incentives and Add Value Based Incentives:**

In addition to adding the CMI adjustment to the Medicaid rate, MHD wanted to modernize the incentives to the base rate. As a result, MHD will adjust existing incentives and include additional incentives based on a Value Based Payment (VBP”) model. The VBP incentive originally proposed by MHD was extremely complicated and would have been unattainable for most facilities. There is too much detail to explain where this proposal started and the many months of discussions and negotiations that produced the end model; however, below is a brief summary of where the VBP incentive model started and where it ended.

**Where we started-MHD’s Original VBP Proposal**

The original VBP proposal by MHD used the 5-Star Inspection rating as a qualifier for the VBP incentive. Any facility with a 2-Star or below on their health inspection star rating would **not** qualify for the overly complicated and detailed VBP incentive. As you know, due to the forced distribution included in the 5-Star, at any given time, 35% of our facilities are stuck at 2 star or below because of the forced distribution. Forced distribution means that at all times a certain percentage of facilities must always be either a 1, 2, 3, 4 or 5 star. Regardless of any improvements a facility makes, in order to increase your star rating, another facility has to move down in their rating before a facility who has improved can move up in their star rating. Therefore, regardless of your overall star rating or how well your quality measures are, any facility with 2-Star or lower on their health inspection score would not have qualified for a VBP incentive add-on.

Other components of MHD’s initial proposal to determine the VBP incentive included an overly complicated formula that considered overall 5-Star rating, 5-Star Staffing rating, 5-Star Quality rating and Quality Scoring in eight (8) different categories. By nature of the survey process, including the delays in surveys over the past 2 years due to COVID combined with the punitive nature of the short snapshot in time that the survey results are based upon, facilities that made improvements would likely not have been recognized in the VBP. Finally, excluded in the initial VBP proposal, was any recognition of providers with special populations, that by nature of the CMI and various quality measures, would have their rates adversely impacted by these reforms.

The original proposal from MHD was a non-starter for us. MHD agreed to consider changes to the model. After several months of negotiations, we were able to agree to a VBP incentive that was much simpler to understand, was based solely on quality measures and would be attainable by any facility that makes appropriate improvements to the seven (7) quality measures used to determine the VBP.

**Where We Ended-the Revised and Final VBP Model**

As noted above, MHD was adamant that the Health Inspection 5-Star and scoring be part of the VBP model and used as a qualifier for the VBP. In addition, they proposed the VBP must be linked to multiple components of the 5-Star (overall 5-Star, 5-Star Staffing and 5-Star Quality and Scoring). We were able to negotiate and make significant changes to MHD’s proposal by removing any reference to Health Inspection 5-Star and scoring; 5-Star Staffing; and overall 5-Star. However, MHD remained adamant that there be a “qualifier” and the model be tied in some way to 5-Star.

In the end, MHD agreed to a VBP model that 1) applies a per diem VBP add-on based on Quality Measure (“QM”) performance; and 2) a 5-tier methodology based on a provider’s QM scores calculated in the 5-Star that determines the amount of the VBP add-on the provider will receive. The VBP incentive will be adjusted in conjunction with the CMI adjustment (ex. quarterly or twice a year – we are still waiting on final word from MHD). It is important to note, although the “qualifier” for the VBP incentive is based on quality measures, there is nothing (i.e. no forced distribution) that would prevent a facility from being able to qualify.

A full outline of the VBP model can be found [**here**](https://nam02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.ne16.com%2Ft%2F3614302%2F46385417%2F3528319%2F0%2F1002542%2F%3Fx%3D5564db10&data=05%7C01%7Cmuellerjes%40missouri.edu%7Cb31f5e51c0df4735eec708da246bcac7%7Ce3fefdbef7e9401ba51a355e01b05a89%7C0%7C0%7C637862342786841620%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=xcHXjZ5ECVgUaHDMatXHPqAt49tzOE1MsnzeBXF0YMw%3D&reserved=0). However, the following is a brief summary of the model:

**Measure Selection** – Seven long-stay QMs were selected - High risk/unstageable pressure ulcers; falls with major injury; antipsychotic medications; urinary tract infections; catheter inserted and left in bladder; increased assistance with ADLs; and moving independently has worsened.

**Performance Assessed** – Provider performance is assessed based on the provider's QM performance being equal or less than the Top National Cut Point.

**Payment is Linked to Performance** – A VBP per diem add-on will be based on the QM performance being equal to or less than the Top National Cut Point. The provider will then earn a percentage of the sum of the VBP add-on which is calculated by applying a 5-tier methodology structured by the level of a provider’s QM scores calculated in the 5-Star Program.

An additional incentive add-on will be allowed based on the percentage of the population a provider cares for with certain chronic mental health conditions. By nature of the CMI, the CMI does not adequately capture chronic mental health conditions due to the clinical differences in these residents versus typical long stay geriatric patients.

**In-Depth Education on New Medicaid Plan**

As soon as we have all the details from MHD we will be doing at least one, if not more, in-depth webinars to explain in detail the rebase, CMI and VBP payment plan.  We hope to be in a position to do that within the next few weeks. However, we felt we needed to share all the details we have at this time so you can start preparing.

**Status of the Appropriation of the Money Necessary to Fund the Medicaid Plan and Rebase**

In order to reform and rebase our SNF Medicaid rate, the money necessary to fund the plan must be appropriated by the legislature. MO HealthNet has forecast it will cost approximately $200 million to fund the reforms and rebase the SNF Medicaid rates. We are only halfway through the legislative session; therefore, we will not have any guarantees the funding will be appropriated until session ends. Below is an update of where we are in this process.

In mid-January, the Governor released his FY23 Budget recommendations. The Governor’s recommendation included the money necessary ($200 million) to fund the SNF Medicaid rebase/reforms.

On April 7, the FY23 budget passed the House. There were no changes to the recommendation of the $200 million to be appropriated for the SNF Medicaid rebase and reforms. Therefore, we have made it through another hurdle. The FY23 budget now lies in the hands of the Senate who began debating the FY23 budget today, April 19. So far, we have received no push back from the Senate budget leaders and have no reason to believe they will not agree with the Governor and the House; however, this process is not over until the budget passes the legislature and heads to the Governor for his signature; therefore, we must not take anything for granted. Pursuant to the Missouri Constitution, the budget must be passed by May 6, 2022. We will continue to update you as this process moves forward.

**Implementation and Timing of the Rebase and Reforms**

We currently do not have many of the implementation details of the new proposed plan except as noted below:

* A State Plan Amendment (“SPA”) will have to be submitted and approved by CMS before the new rates are implemented. MHD understands the necessity to get this approved ASAP; therefore, MHD is currently working to draft the SPA. We hope to have the draft soon to review.
* As mentioned above, the state agreed to make the temporary $10.18 PPD increase permanent; therefore, no facility’s rate will be cut or reduced by $10.18 on July 1, 2022.
* The effective date of the new proposed plan will be July 1, 2022.
* We do not know what any specific facility’s new rate will be at this time. Facilities whose rates will increase due to the rebase and other reforms can expect to receive a retroactive payment back to July 1, 2022, for any increases due to them based on an increase to their rates once CMS gives final approval of the SPA and the regulation is filed.

As we continue to get additional details, we will share them with you.

**Final Comments**

This has been a long journey that evolved significantly from where it started and where it ended. We are very appreciative of the collaboration we had throughout the process with MHD and other consultants. Did we get everything we asked for? NO. Is this plan perfect? Probably not. However, we were able to make significant changes to MHD’s original plan creating one of the most significant reforms to our Medicaid plan and the ONLY full rebase of the plan since the inception of the Medicaid plan decades ago.

We believe these reforms are a work in progress. We will continue to work with MO HealthNet to evaluate this plan over the next year. It is our hope that the state will continue with regular Medicaid rate rebases. Our discussions have suggested rebases are likely every two years. We believe that the Medicaid plan will be reevaluated, and more tweaks will be made with future rebases. In addition, it is the intent of MHD to move to a PDPM CMI rather than RUGs-IV in the future and hopefully in time for the next rebase.

Due to COVID changing our industry, we believe strongly more adjustments need to be made to the Medicaid plan and reflected in future rebases based on changes in the way our sector will operate post-COVID. It is too early to predict the exact costs of those changes, but we are already preparing for those future conversations.

We are sure you will have many additional questions; however, this is what we know at this time. Please be watching for an announcement soon for the webinar that will include an in-depth overview of the rebase and reforms to the Medicaid plan.