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
Two Main DSS Topics

1. Nursing home policy update:
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2. Inventory of DSS/Medicaid Projects
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. Review Inventory of DSS/Medicaid Projects

   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 financing (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. Regulating (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
  • 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

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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 Department of Social Services
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.
4. **Property (Fair Rent)**
5. **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and depreciation.

**Unallowable Costs:**
1. Disallowed salaries and fees and those over reasonable cost caps
2. Disallowed managerial administrative compensation over reasonable cost caps
3. Disallowed rent
4. Building interest, depreciation, amortization
5. Physical therapy, speech therapy, and occupational therapy expenses (paid by Medicare)
6. 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
(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
   - Use Minimum Data Set (MDS) data from nursing homes

2. Develop resident-specific “needs” score
   - Using MDS + others: develop a “needs” score for each, known as a case mix index

3. Calculate payments
   - Translate these scores into reimbursement rates for each home

4. Adjust over time
   - Over time, repeat steps (1) – (3) to ensure payments reflect residents’ needs

A version of this system is used by most states
[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**
Example questions from the Minimum Data Set

B2. Hearing
- Ability to hear (with hearing aid or hearing appliances if normally used) in last 5 days:
  1. Adequate—no difficulty in normal conversation, social interaction, listening to TV
  2. Minimal difficulty—difficulty in some environments (e.g., when person speaks softly or setting is noisy)
  3. Moderate difficulty—speaker has to increase volume and speak distinctly
  4. Highly impaired—absence of useful hearing

B3. Hearing Aid
- Hearing aid or other hearing appliance used in above 5-day assessment.
  0. No
  1. Yes

B4. Speech Clarity
- 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

J1. Pain Management (answer for all residents, regardless of current pain level)
- At any time in the last 5 days, has the resident:
  a. Been on a scheduled pain medication regimen?
    0. No
    1. Yes
  b. Received PRN pain medications?
    0. No
    1. Yes
  c. Received non-medication intervention for pain?
    0. No
    1. Yes
[Step (2)]. Definition: Case Mix Index

<table>
<thead>
<tr>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reflects the fact that not all residents are alike</td>
<td>Low CMI: fewer care needs</td>
</tr>
<tr>
<td>• Case refers to residents</td>
<td>High CMI: greater care needs</td>
</tr>
<tr>
<td>• Mix refers to differences in care needs among those residents</td>
<td></td>
</tr>
<tr>
<td>• Case Mix Index (CMI): amount of direct care staff resources each resident is expected to need</td>
<td>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.</td>
</tr>
</tbody>
</table>
### [Step (3)]. High-level overview: How acuity influences payment calculations

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

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
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

- 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.

<table>
<thead>
<tr>
<th>Before acuity</th>
<th>After acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid reimbursement would remain fixed until next comprehensive rebasing period</td>
<td>Medicaid reimbursement adjusts quarterly to reflect higher acuity</td>
</tr>
<tr>
<td>At that point, Medicaid reimbursement would increase...but not enough to reflect higher level of Medicaid needs:</td>
<td>Medicaid rates would increase by 50%, reflecting higher needs of Medicaid residents</td>
</tr>
<tr>
<td>• All-payer average acuity: 1.0 -&gt; 1.33: +33%</td>
<td></td>
</tr>
<tr>
<td>• Medicaid average acuity: 1.0 → 1.5  +50%</td>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Selected Parameters</th>
<th>SFY 2023</th>
<th>SFY 2024</th>
<th>SFY 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost report year</td>
<td>2019</td>
<td>2019</td>
<td>2019</td>
</tr>
<tr>
<td>Case mix neutrality limit</td>
<td>0.75%</td>
<td>1.51%</td>
<td>2.27%</td>
</tr>
<tr>
<td>Stop gain</td>
<td>$6.50</td>
<td>$20</td>
<td>None</td>
</tr>
<tr>
<td>Stop loss</td>
<td>$0</td>
<td>$5</td>
<td>None</td>
</tr>
</tbody>
</table>
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

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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description of Preventive Interventions</th>
<th>Participant Population</th>
<th>No. of RCTs/No. of Participants</th>
<th>Pressure Ulcers, RR (95% CI)</th>
<th>Randomization</th>
<th>Allocation Concealment</th>
<th>Blinding of Outcome</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pressure redistribution foam (e.g., cubed foams, foam, visco-elastic foam, and high-density foams) vs standard hospital mattresses</td>
<td>Medical, surgical, and rehabilitation patients</td>
<td>5/2016</td>
<td>0.40 (0.21-0.74)</td>
<td>4 RCTs</td>
<td>2 RCTs</td>
<td>None</td>
<td>McIntosh et al11</td>
</tr>
<tr>
<td>2</td>
<td>Oral nutritional supplements (e.g., daily drinks of 237 mL, 2 kcal/mL and standard hospital diet vs standard hospital diet)</td>
<td>Elderly hospital patients</td>
<td>4/124</td>
<td>0.85 (0.73-0.99)</td>
<td>4 RCTs</td>
<td>None</td>
<td>1 RCT</td>
<td>Stratton et al12</td>
</tr>
<tr>
<td>3</td>
<td>A hyperosmolar fatty and regimen for skin dryness, applied twice per day to the sacrum, trochanter, and heels (MeaPhin, Laboratories Bama-Geve SA, Barceloneta, Spain) vs matched gowny placebo</td>
<td>Patients from home care and/or geriatric centers</td>
<td>1/380</td>
<td>0.42 (0.22-0.80)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Reddy et al13</td>
</tr>
<tr>
<td>4</td>
<td>A foam cleanser combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Cleansid, Shiloh Health Care, Northampton, England) vs soap and water for incontinence care</td>
<td>Residents of long-term care sites</td>
<td>1/93</td>
<td>0.32 (0.13-0.82)</td>
<td>1 RCT</td>
<td>None</td>
<td>1 RCT</td>
<td>Hodgkinson et al14</td>
</tr>
</tbody>
</table>

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

CT Department of Social Services
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
   Finalize initial list of quality measures + adjustments (e.g. risk adjustment / numerator / denominators)

2. Finalize financial calculations
   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

3. Begin payment adjustments 7/1/23
   • DSS and the industry are working collaboratively
   • Reimbursement adjusted for quality will begin 7/1/23
   Note: CMS state plan amendment (SPA) approval required

4. Revise / test and learn
   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

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

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