FHCA 2019 Annual Conference & Trade Show

CE Session #39 – Medicaid PPS Campfire Update
Wednesday, August 7 – 10:30 to 11:30 a.m.
Celebration 5-6 – Finance/Development

Upon completion of this presentation, the learner will be able to:

- Explain the relationship between quality metrics and payment incentives
- Identify key projects that are important to include on FRV submissions
- Explain strategies to be successful in the new reimbursement environment

Seminar Description:

Come gather around the campfire and join camp counselor, Florida Health Care Association's own Director of Reimbursement, Tom Parker, as we discuss the first year experience under the Medicaid Prospective Payment System. Hear what providers are doing to maximize their Medicaid rate, achieve higher quality scores and position themselves for future success.

Presenter Bio(s):

Tom Parker is the Director of Reimbursement for Florida Health Care Association. On behalf of Florida Health Care Association, he serves as a liaison to the Florida Legislature, Agency for Health Care Administration, Department of Elder Affairs, Centers for Medicare and Medicaid Services, American Health Care Association and Florida Health Care Association Reimbursement Committees and other relevant state and federal entities regarding issues of reimbursement and health care finance policy.

MEDICAID PPS CAMPFIRE UPDATE

Tom Parker, Director of Reimbursement, Florida Health Care Association

OBJECTIVE

The principle objective of this session is to explain the various components of the Florida Skilled Nursing Facility payment methodology and strategies for success.

OVERVIEW

OVERVIEW

- The Medicaid PPS strikes a balance of financial incentives for high quality care with incentives for efficiency.
- The payment method also attempts to provide fair and equitable payments for similar services.
- The payment method contains nine key components.

OVERVIEW

- Standardized rates, some with pricing floors, for Direct Care, Indirect Care, and Operating components of per diems. This will reward facilities that operate and provide care most efficiently.
- Facility peer groupings, which account for higher costs in South Florida.
- A Quality Incentive Program, which uses quality metrics to increase reimbursement to high performing facilities.

OVERVIEW

- A fair rental value property component, which pays a financial incentive to providers to maintain and update facilities.
- A transition period, that allows facilities to adjust to the new incentive structure.
- There is:
  - Additional payments for specific high cost services to promote access to care.
  - No Case-Mix adjustment

OVERVIEW

- Veteran's Affairs, Government, and Pediatric nursing centers are exempt from the new Prospective Payment System (cost based rates; paid prospectively).
- Current policy for Medicaid portion of the nursing home quality assessment will be maintained
- The final per diem rate will be paid prospectively (in advance) rather than retrospectively based on facility actual costs.

COST BASED COMPONENTS

DIRECT, INDIRECT & OPERATING COMPONENTS

The standardized rates for the Direct, Indirect and Operating components of the per diem are calculated as percentages of the median costs for facilities within each peer group.

Component	Percentage of Median
Direct Care	100%
Indirect Care	92%
Operating	86%

DIRECT CARE

Direct Care Component

Regions	Median DC	% of Median	DC Price	DC Floor
North	$116.96	100%	$116.96	95%
South	$126.47	100%	$126.47	95%

INDIRECT CARE

Indirect Care Component

Regions	Median IDC	% of Median	IDC Price	IDC Floor
North	$37.80	92%	$34.78	92.5%
South	$41.22	92%	$37.92	92.5%

OPERATING

Operating Component

Regions	Median Operating	% of Median	Operating Price	Operating Floor
North	$56.64	86%	$48.71	N/A
South	$65.37	86%	$56.22	N/A

PER DIEM FLOOR

- Per diem floors work in conjunction with the percentage of median value parameters to promote nursing facility investment in areas expected to enhance quality of care.
- Per diem floors are used to reduce the amount of profit a facility can achieve through cost reductions.
- This is important when transitioning to standardized rates versus a method that relies primarily on facility-specific rates.

PER DIEM FLOOR

- A per diem floor reduces a facility's per diem component rate when a facility's cost for that component is below a specific threshold.
- If a facility's cost is below the floor then their rate gets reduced by the difference between the floor and their actual cost.

PER DIEM FLOOR

- Per diem floors:
  - Direct Care Component – 95% of the standardized per diem.
  - Indirect Care Component – 92.5% of the standardized per diem.
  - Operations Component – No Floor

PER DIEM FLOOR

- The policy of no per diem floor for the Operating component is intended to incentivize nursing facilities to do what they can to improve efficiency for administration, housekeeping, and facility operations.
- The absence of a floor will allow facilities the full benefit when maintaining costs below the standardized per diem.

PER DIEM FLOOR EXAMPLE

Calculation Item	Value	Calculation
Example Facility with Cost Below Floor		
Direct Care Rate	$100.00	
Floor Percentage	95%	
Floor Value	$95.00	($100.00*95%)
Facility Direct Care Costs	$93.00	
Amount facility's cost is below the floor	$2.00	($95.00-$93.00)
Facility's Assigned Direct Care Rate	$98.00	($100.00-$2.00)

PER DIEM FLOOR EXAMPLE

Calculation Item	Value	Calculation
Example Facility with Cost Between the Floor and the Rate		
Direct Care Rate	$100.00	
Floor Percentage	95%	
Floor Value	$95.00	($100.00*95%)
Facility Direct Care Costs	$97.00	
Amount facility's cost is below the floor	$0	
Facility's Assigned Direct Care Rate	$100.00	

PER DIEM FLOOR EXAMPLE

Calculation Item	Value	Calculation
Example Facility with Cost Greater than the Rate		
Direct Care Rate	$100.00	
Floor Percentage	95%	
Floor Value	$95.00	($100.00*95%)
Facility Direct Care Costs	$105.00	
Amount facility's cost is below the floor	$0	
Facility's Assigned Direct Care Rate	$100.00	

MAPPING OF COST CENTERS

- Therapy costs have historically been split between indirect and operating, now all are going to direct
- Dietary Costs were in indirect and also moving to direct
- Complex Medical Equipment, Medical Supplies, and other allowable ancillary costs were split between indirect and operating, now all are in indirect
- Medical Records costs have been in indirect but are now in operating

RATE SETTING AND COST REPORTS

RATE SETTING & TIMING FREQUENCY

- Under PPS, the initial direct care, indirect care and operation per diem values are calculated based upon the cost reports submitted to AHCA prior to the 2016 rate year.
- These components will rebased at the end of the 3rd fiscal year using newer cost and patient utilization information as reported in the latest "audited" cost report.

RATE SETTING & TIMING FREQUENCY

- Individual provider quality points will be updated annually. Plan is for quality "cut points" to be frozen in between rebasing years.
- Provider's will have an opportunity to report new projects and changes for FRVS annually.
  - Property Insurance and Taxes updated annually.

COST REPORTS

- Medicaid cost reports will continue annually and audited cost reports will be used in the rate rebasing process performed once every three years.
- Using audited cost reports will ensure accuracy of the data used to determine the median costs for each per diem component and will ensure that the adjustment in individual facility rates based on per diem floors is applied accurately.

COST REPORTS

- To enable use of audited cost reports in rebasing once every three years, AHCA would need to audit every nursing facilities' cost reports at least once every three years (currently AHCA audits cost reports at least once every five years).
- Procuring an new audit contractor in order to accomplish this

COST REPORTS

- With cost reports being submitted annually, cost reports will be modified to be used as the vehicle for communicating facility renovation information in the future.
- Process is still being worked out within the Agency and we continue to have ongoing conversations.

PROVIDER QUALITY ASESSMENT

- PPS does not impact the requirement of providers to submit a monthly provider assessment.
- Funds will continue to flow through the rates as a Medicaid Share Return, and Federal Matching dollars enhancing the overall budget
- The operating add-on dollars are used to fund the quality incentive payments.

SPECIFIC SERVICE ADD-ON PAYMENTS

- Includes a $200 per day increase in nursing facility per diem for care of Medicaid residents on ventilators.
- Profession has voiced concerns over program growth like when Florida last had a ventilator add-on
- A cap is placed at the 40,000 annual patient days and any additional Medicaid ventilator patients would be wait listed for the payment not services
- Currently using around 40% of this money

SPECIFIC SERVICE ADD-ON PAYMENTS

- High Medicaid, High Staffing Add-on
- An add-on of up to $20 a day paid to facilities that staff at some of the highest levels and have a high Medicaid volume of patients.
- Must staff at the 80th percentile and have a Medicaid utilization greater than the state average.
- Ensure that those providers are not harmed by a PPS model.

NEW FACILITIES

- A provisional rate will be paid to a provider who constructs a new facility.
- For the Direct Care, Indirect Care and Operating portions of the per diem, the provisional rate will be the standard per diem for facilities in the same peer group.
- No per diem floor will be applied. This will be true until an initial cost report is received by AHCA.

NEW FACILITIES

- The FRVS, property taxes and insurance pass through payments will be determined from information reported in the facility's budgeted cost report.
- Quality Incentive payments will be applied at a value equal to the 50th percentile quality score calculated for all facilities in Florida.

NEW FACILITIES

- The initial cost report will affect rates for the facility until rates can be updated with results of an audited cost report.
- For the first year of operation, minimum occupancy value to be used in the FRVS calculation be 75 percent, and then increase to the standard value in all subsequent years.

CHANGE OF OWNERSHIP

- During a change of ownership, the new owner will receive the same rate as previous owner including quality and FRV.
- The new owner's costs wont come into play until the next rebase.
- FRV and Quality will be updated annually on the same schedule as other providers

BUDGET NEUTRAL ADJUSTMENT

- AHCA is limited by the budget passed by the legislature every year on the total amount of funding available to set nursing home rates.
- After they complete setting the PPS rates all the way through they apply an overall adjustment to the rates to stay within that allocation.
- For October this percentage is 8.9%
- Adjustment does not apply to quality component

TRANSITION

- For the first 3 years a "hold harmless" provision exists that providers can not receive any rate lower than their most recent September 2016 rate
- In years 4 and 5 providers will receive the greater of their PPS rate or their "rebased" cost rate

TRANSITION

- In order to fund the hold harmless provision a limit has to be placed on the gains of providers seeing a rate increase.
- This is the final step applied by AHCA in the rate process
- For October 1, 2019 rates the cap is 1.89%

FAIR RENTAL VALUE

FAIR RENTAL VALUE

- The FRVS approach recognizes the value of a nursing facility property in today's dollars using a standardized approach that takes into account the age and size of the facility.
- It then establishes a reasonable rate of return for the operator based on that value.
- Adds significant incentives for providers to renovate existing buildings.

FAIR RENTAL VALUE

- The new FRVS method is one that utilizes an estimate of construction costs for building value and uses standardized parameters for other elements, such as land and equipment values.
- The standardized parameters are less accurate than determination of individual provider values.

FAIR RENTAL VALUE

- However, the standardized parameters define values for which Medicaid is willing to reimburse, avoids the need to apply limits or ceilings, and is administratively simple to determine.

FRVS PARAMETER VALUES

Parameter	Value
RS Means Cost per Square Foot	$222.05
Land Allocation Percentage	10%
Equipment Cost per Bed	$8,000
Depreciation Factor	1.5%
Fair Rental Rate	8.0%

FRVS PARAMETER VALUES

Parameter	Value
Minimum Occupancy	90% (except for New Facility 75% for 12 months
Maximum Facility Age	40
Minimum Square Footage per Bed	350
Maximum Square Footage per Bed	500

RENOVATION ADJUSTMENTS

- This model uses a relatively standard approach to incentivizing physical facility updates.
- This method adjusts the age of the facility for use in the calculation of depreciation.
- In this approach, the cost of the renovation is compared to the annual depreciation amount to determine an adjusted age of the facility for renovations which do not add new beds.

RENOVATION ADJUSTMENTS

- For renovations that do add beds, the adjusted age of the facility is calculated as a weighted average of the age of the old beds and the age of the new beds.
- Final adjusted age of the facility is calculated as the lowest adjusted facility age determined for each individual renovation.
- Important to remember you can do a renovation project that may not reduce age if the project isn't large enough

PASS THROUGH PAYMENTS

- The PPS maintains pass through payments for property taxes and property insurance.
- Property tax, in particular, and property insurance to a lesser degree, are oftentimes outside of nursing facility operators control and may vary based on region within the state.
- Thus, allowing these costs to be reimbursed as pass through payments promotes equity.

PASS THROUGH PAYMENTS

- The PPS does <u>not</u> continue pass through payments for home office costs, under the assumption that the method for establishing facility square footage under the FRVS reasonably accounts for the administrative property requirements for each facility.
- The $9.6 million spend for home office property costs for SFY 2016 were included in the total budget for the FRVS calculations.

QUALITY COMPONENT

QUALITY OVERVIEW

- The Quality Component uses quality metrics to increase reimbursement to high performing facilities. For example, low infection rates, high star ratings, Governor Gold Seal status, and/or external industry quality accreditation can earn higher rates.
- 6.5% of non-property reimbursement is allocated to fund the QIP.

QUALITY OVERVIEW

- Based on three broad QM categories
  - Process Measures – Flu Vaccine, Antipsychotic, Restraint (all long-stay measures).
  - Outcome Measures – UTI's, Pressure Ulcers, Falls, Incontinence, Decline in ADLs (all long-stay measures).

QUALITY OVERVIEW

- Structural Measures –
  - Combined Direct Care Staffing (RN, LPN, CNA); Social Work and Activity Staff
  - CMS 5 Star
  - Credentialing Options
    - ✓ Florida Gold Seal
    - ✓ Joint Commission Accreditation
    - ✓ AHCA National Quality Award

QUALITY OVERVIEW

- The proposed system allows a maximum of 40 Total Quality Points for all four domains.
- Only facilities that score above the 20th percentile will be eligible for a Quality Per Diem Add-On.
- The Quality Per Diem Add-On is calculated by using the Total Quality Points as a basis in a three-step formula.

QUALITY MODEL

Process Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points per Facility
Flu Vaccine	20% improvement	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
Antipsychotic	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Restraints	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3

QUALITY MODEL

Outcome Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points per Facility
UTI	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Pressure Ulcers	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Falls	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Incontinence	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
ADLs	20% improvement	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3

QUALITY MODEL

Structure Measures	1 Point	2 Points	3 Points	Max Points per Facility
Combined Direct Care Staff	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
Social Work and Activity Staff	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
	1 Point	**3 Points**	**5 Points**	**Max Points per Facility**
CMS 5-Star Rating	3 Stars	4 Stars	5 Stars	5
Awards/Accreditations	Governor's Gold Seal, Joint Commission, or AHCA Silver or Gold Award all worth 5 points			5
Total Quality Points Possible				40

TIMING OF UPDATES

- Timing of updates to quality measures:
  - Provider scores will be updated annually.
  - However, AHCA will freeze benchmarks for the Process and Outcome measures in the interim years between rebasing periods.
  - This allows lower performing facilities to see finite benchmarks they can strive to attain as opposed to benchmarks that are recalculated annually, thus making them moving targets.

TIMING OF UPDATES

- Quality improvement percentages are calculated based on the percent change from the previous year to the current year.
- Additionally the process will be to update staffing data as well as credentialing (i.e. CMS Five Star Rating, Florida Gold Seal, etc.) annually.

EXAMPLE

- ABC facility has a Total Quality Score of 15 points. This estimated Quality Payment Per Point is $0.86. ABC has 25,830 Annualized Medicaid days.
- Q: What is the estimated quality incentive per diem add-on amount?
- A: $12.90 = (15 X $0.86).
- Q: What is the estimated annual QIP impact for ABC?
- A: $333,207 = ($12.90 X 25,830).

DATA SOURCES

Measure	Data Source
CMS Long Stay Measures	https://www.medicare.gov/nursinghomecompare/search.html?
Direct Care Staff	Most Recently Filed Medicaid Cost Report
Activity and Social Work	https://data.cms.gov/
CMS 5-Star	https://www.medicare.gov/nursinghomecompare/search.html?
Joint Commission	https://www.jointcommission.org/accreditation/nursing_care_centers.aspx
Governor's Gold Seal	https://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx
American Health Care Association	https://www.ahcancal.org/quality_improvement/quality_award/Pages/default.aspx

EXAMPLES

FHCA PPS Summary

Provider Info					
Medicaid #		Provider Name			
Region	Actual	Annualized Medicaid Days			
Cost Report Type	South	Medicaid Utilization			62.75%

Cost Components	Cost	Floor	Price	Rate	After Budget Neutral Cut
Direct Care	$ 112.35	$ 120.15	$ 126.47	$ 118.88	$ 108.13
Indirect Care	$ 37.61	$ 35.08	$ 37.92	$ 37.92	$ 34.55
Operating	$ 54.57	$ -	$ 56.22	$ 56.22	$ 51.23

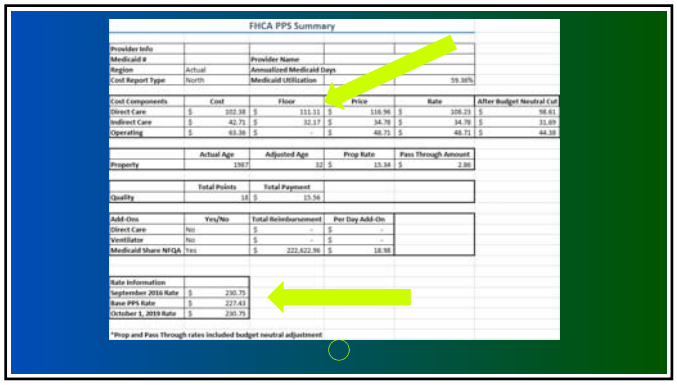
	Actual Age	Adjusted Age	Prop Rate	Pass Through Amount
Property	1988	31	$ 18.44	$ 4.22

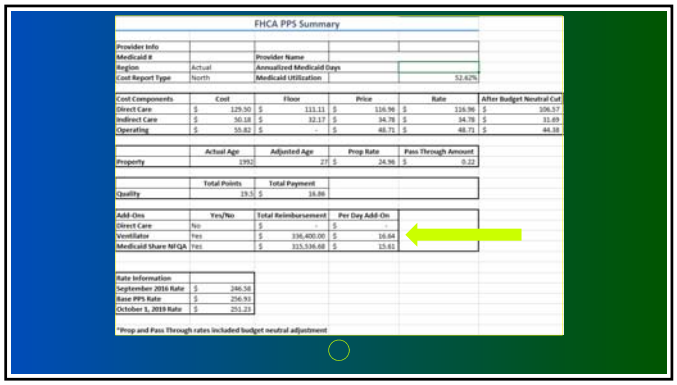
	Total Points	Total Payment
Quality	15.5	$ 13.40

Add-Ons	Yes/No	Total Reimbursement	Per Day Add-On
Direct Care	No	$ -	$ -
Ventilator	No	$ -	$ -
Medicaid Share NFQA	Yes	$ 669,823.61	$ 18.42

Rate Information	
September 2016 Rate	$ 223.17
Base PPS Rate	$ 240.38
October 1, 2019 Rate	$ 227.38

*Prop and Pass Through rates included budget neutral adjustment


FHCA PPS Summary
Provider Info
Medicaid #
Provider Name
Region
Actual
Annualized Medicaid Days
Cost Report Type
North
Medicaid Utilization
59.36%
Cost Components
Cost
Floor
Price
Rate
After Budget Neutral Cut
Direct Care
$ 102.38
$ 111.11
$ 116.96
$ 108.23
$ 98.41
Indirect Care
$ 42.71
$ 32.17
$ 34.78
$ 34.78
$ 31.69
Operating
$ 63.36
$ -
$ 48.71
$ 48.71
$ 44.38
Actual Age
Adjusted Age
Prop Rate
Pass Through Amount
Property
1987
32
$ 15.34
$ 2.86
Total Points
Total Payment
Quality
18
$ 13.56
Add-Ons
Yes/No
Total Reimbursement
Per Day Add-On
Direct Care
No
$ -
$ -
Ventilator
No
$ -
$ -
Medicaid Share NFQA
Yes
$ 222,622.96
$ 18.98
Rate Information
September 2016 Rate
$ 230.75
Base PPS Rate
$ 227.43
October 1, 2019 Rate
$ 230.75
*Prop and Pass Through rates included budget neutral adjustment


FHCA PPS Summary
Provider Info
Medicaid #
Provider Name
Region
Actual
Annualized Medicaid Days
Cost Report Type
North
Medicaid Utilization
52.62%
Cost Components
Cost
Floor
Price
Rate
After Budget Neutral Cut
Direct Care
$ 129.50
$ 111.11
$ 116.96
$ 116.96
$ 106.57
Indirect Care
$ 50.18
$ 32.17
$ 34.78
$ 34.78
$ 31.69
Operating
$ 55.82
$ -
$ 48.71
$ 48.71
$ 44.38
Actual Age
Adjusted Age
Prop Rate
Pass Through Amount
Property
1992
27
$ 24.96
$ 0.22
Total Points
Total Payment
Quality
19.5
$ 16.86
Add-Ons
Yes/No
Total Reimbursement
Per Day Add-On
Direct Care
No
$ -
$ -
Ventilator
Yes
$ 336,400.00
$ 16.64
Medicaid Share NFQA
Yes
$ 315,536.68
$ 15.61
Rate Information
September 2016 Rate
$ 246.58
Base PPS Rate
$ 256.93
October 1, 2019 Rate
$ 251.23
*Prop and Pass Through rates included budget neutral adjustment

Questions

THANK YOU!

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