State of Connecticut Nursing Facility Payment Modernization Project: Case Mix Phase-In Methodology

September 2021

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.

Project Overview

NF PAYMENT MODERNIZATION GOALS & OBJECTIVES

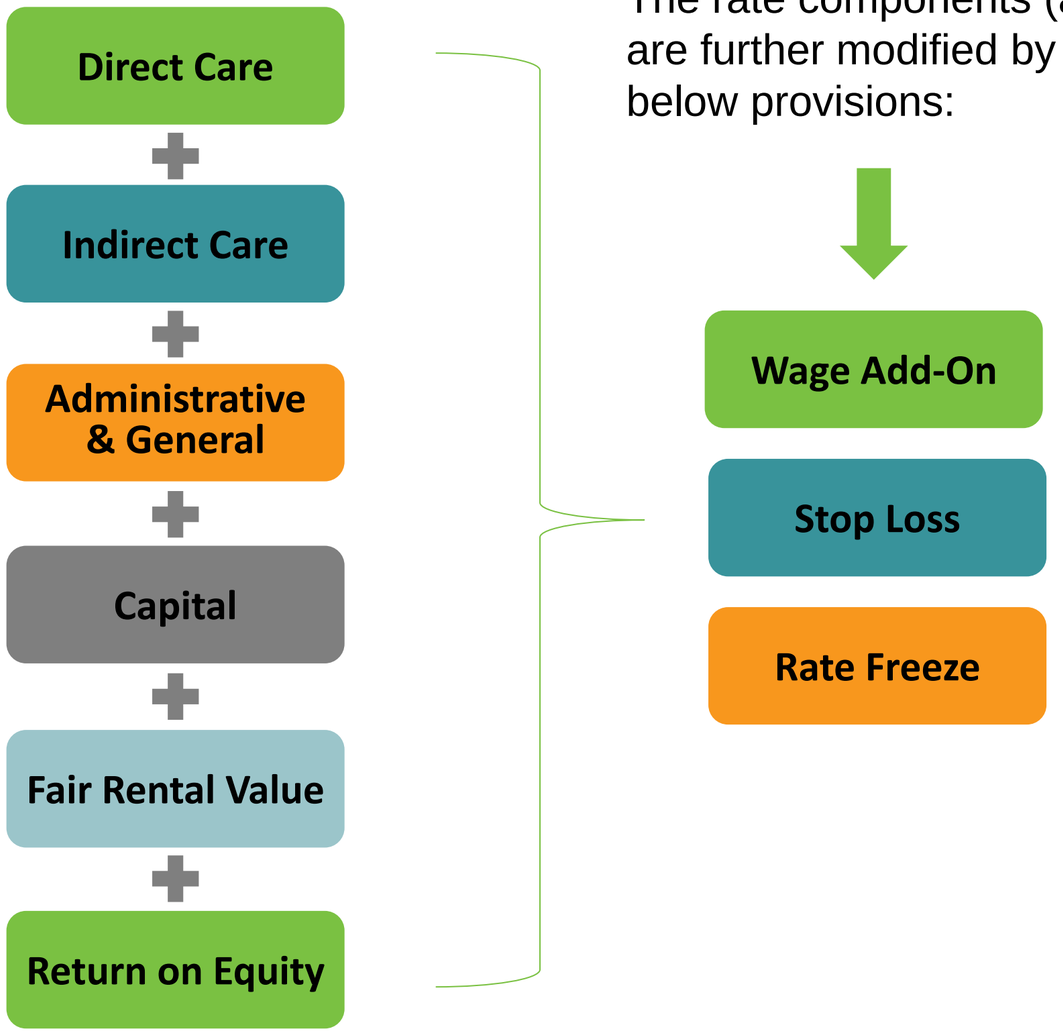
- To reflect the Department’s overall interest and work in modernizing rates.
- Establish a framework to align with value-based payment in the future.
- Align direct care reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents.
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care.

RATE METHODOLOGY OVERVIEW

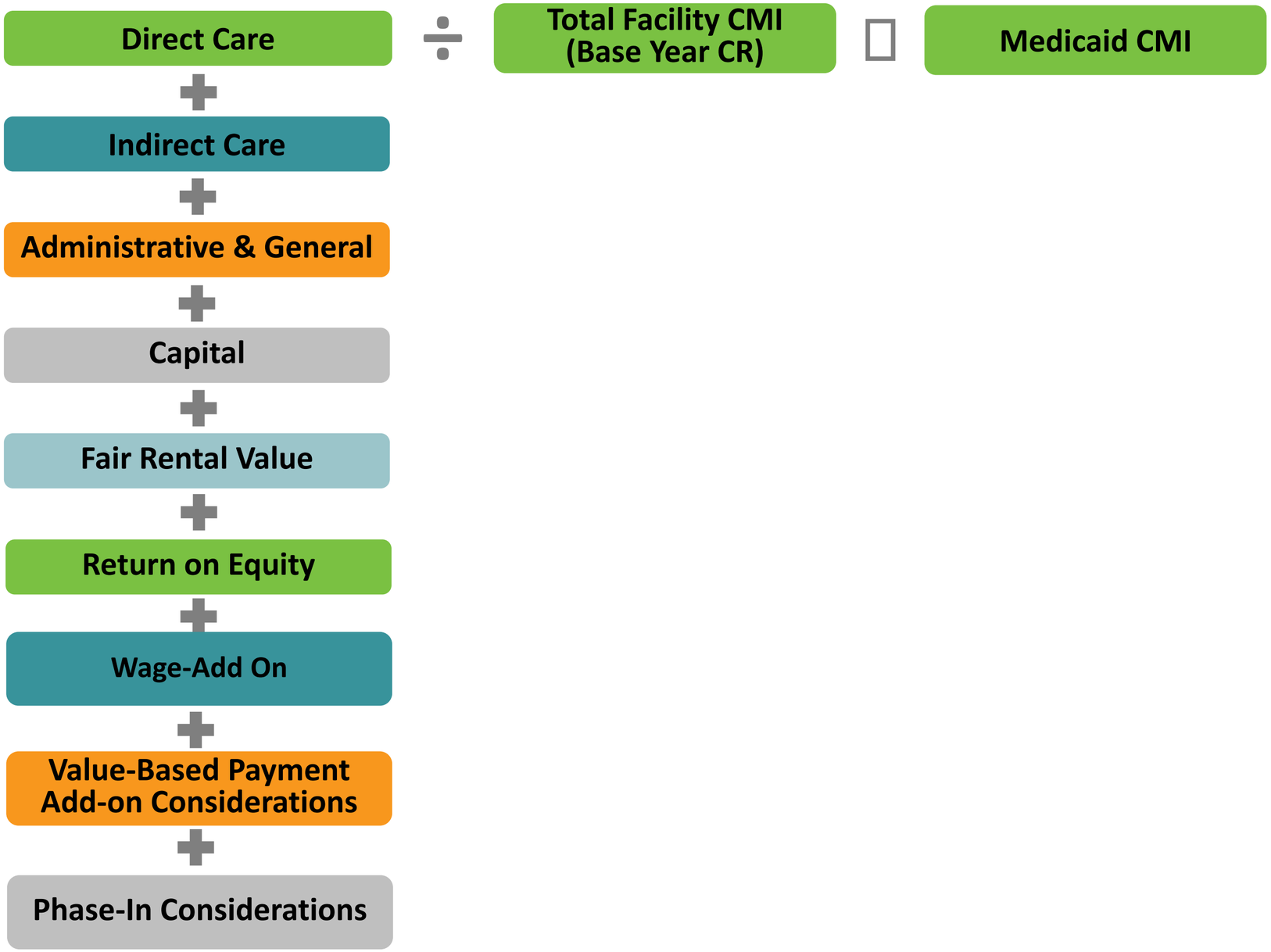
SYSTEM PARAMETERS

- **Case Mix System Implementation Date:** July 1, 2022
- **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
  - A single facility rate for both CCNH and RHNS beds will be determined
  - Vent and AIDS units/facilities will continue to receive a separate reimbursement rate.
  - No change in component cost classifications proposed
- **Base Year Cost Period:** 2019 cost reports will be utilized as basis for rate system

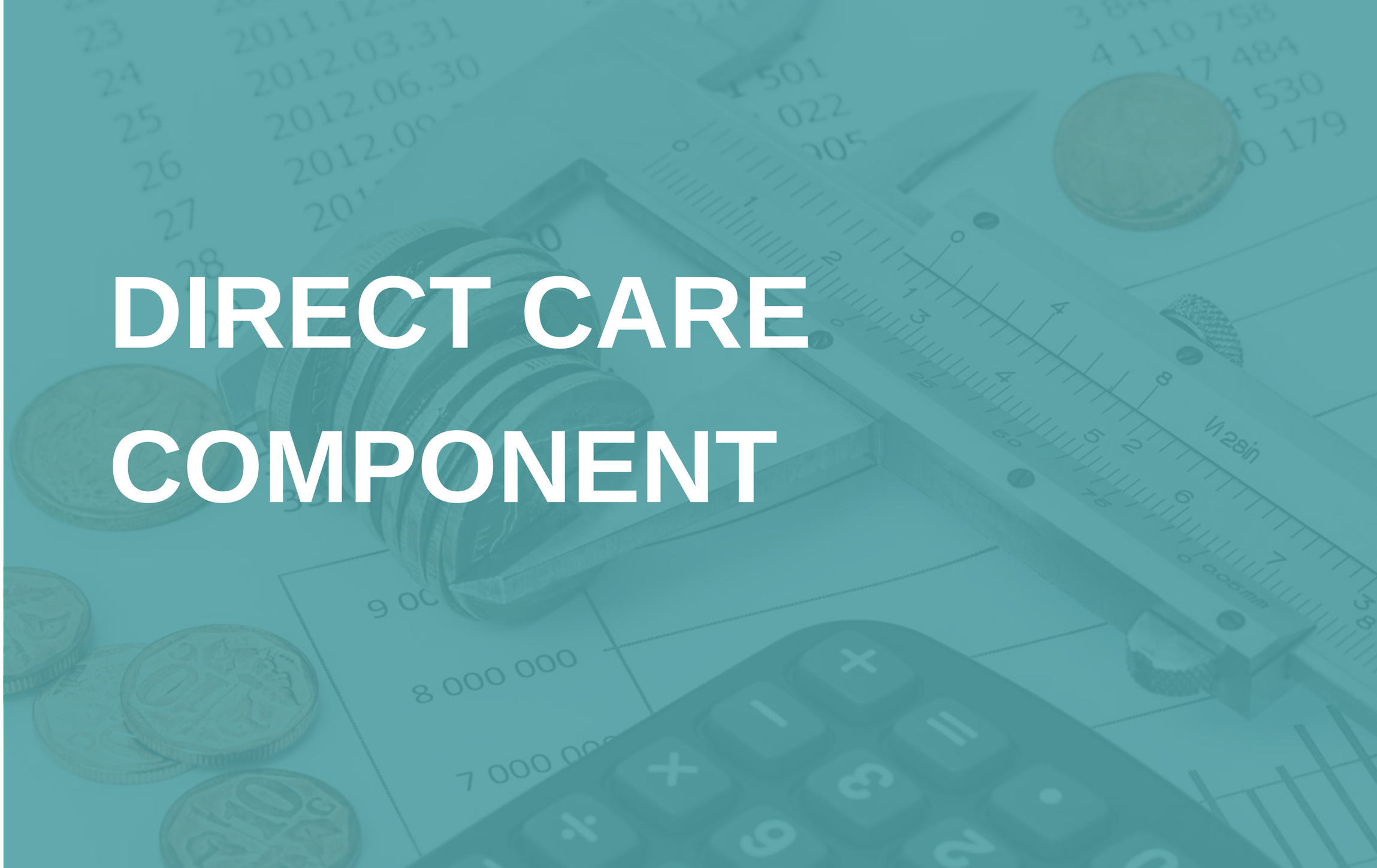
CURRENT RATE METHODOLOGY



CASE MIX METHODOLOGY



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

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

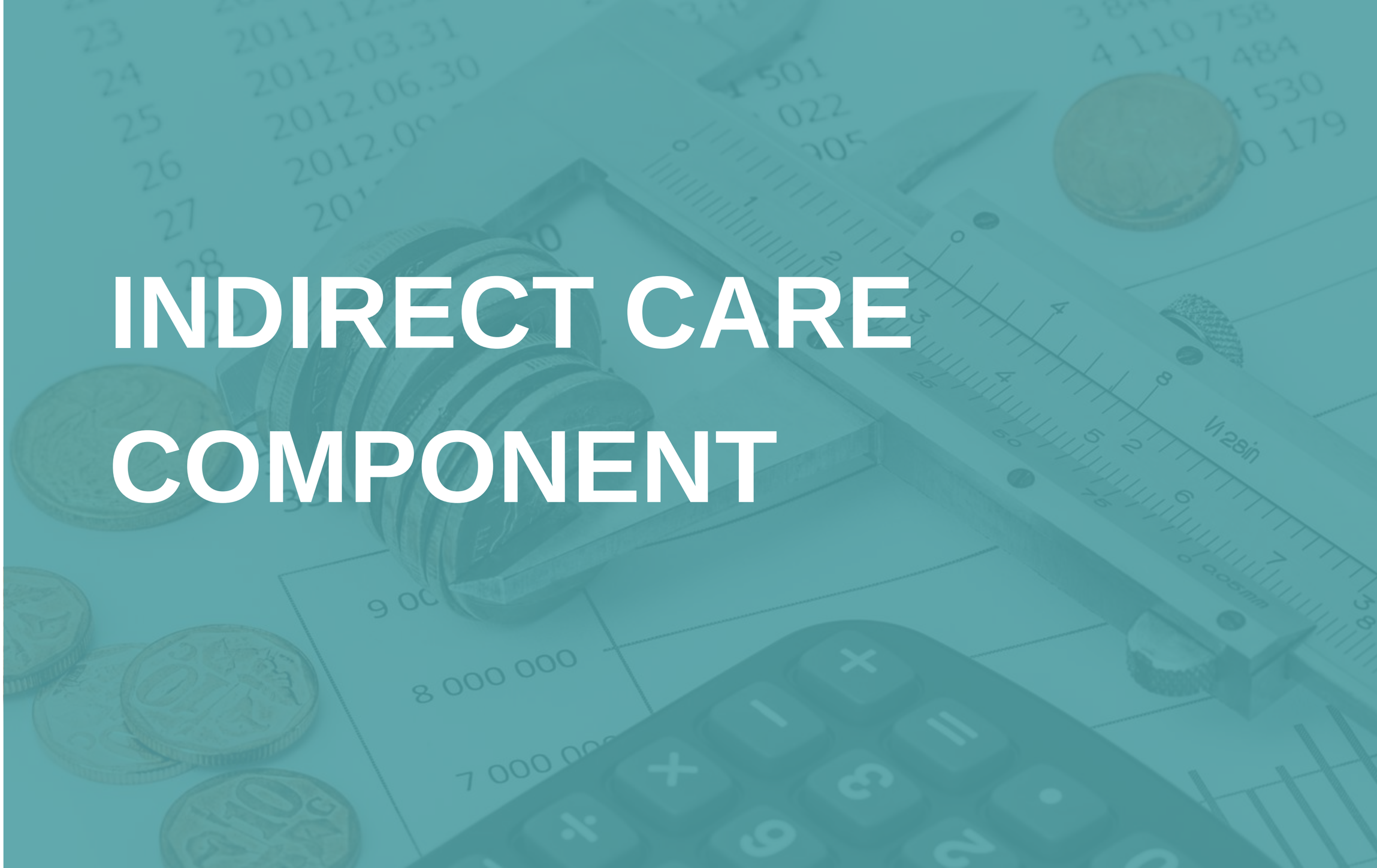
Allowable Facility DC Cost	$	129.99
Medicaid CMI		1.015
Total Medicaid DC CMI Adj. Cost	$	131.94

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

INDIRECT CARE COMPONENT



INDIRECT CARE PARAMETERS

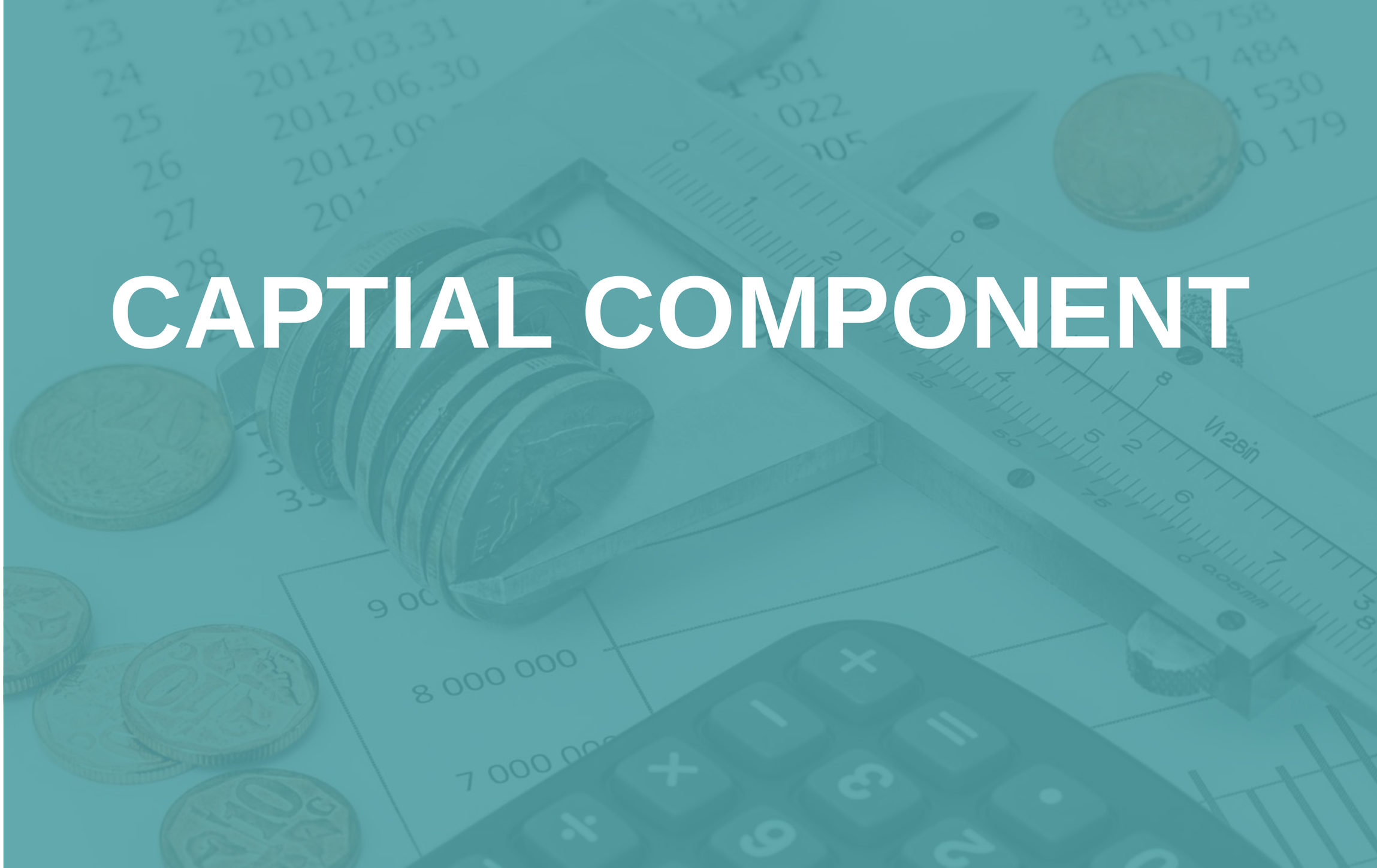
- **Cost Component Limit:** 115% of Median
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** 100%
- **Allowed Efficiency Percentage:** 25%

ADMINISTRATIVE & GENERAL COMPONENT

A&G PARAMETERS

- **Cost Component Limit:** 100% of Median
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** 100%
- **Allowed Efficiency Percentage:** 25%

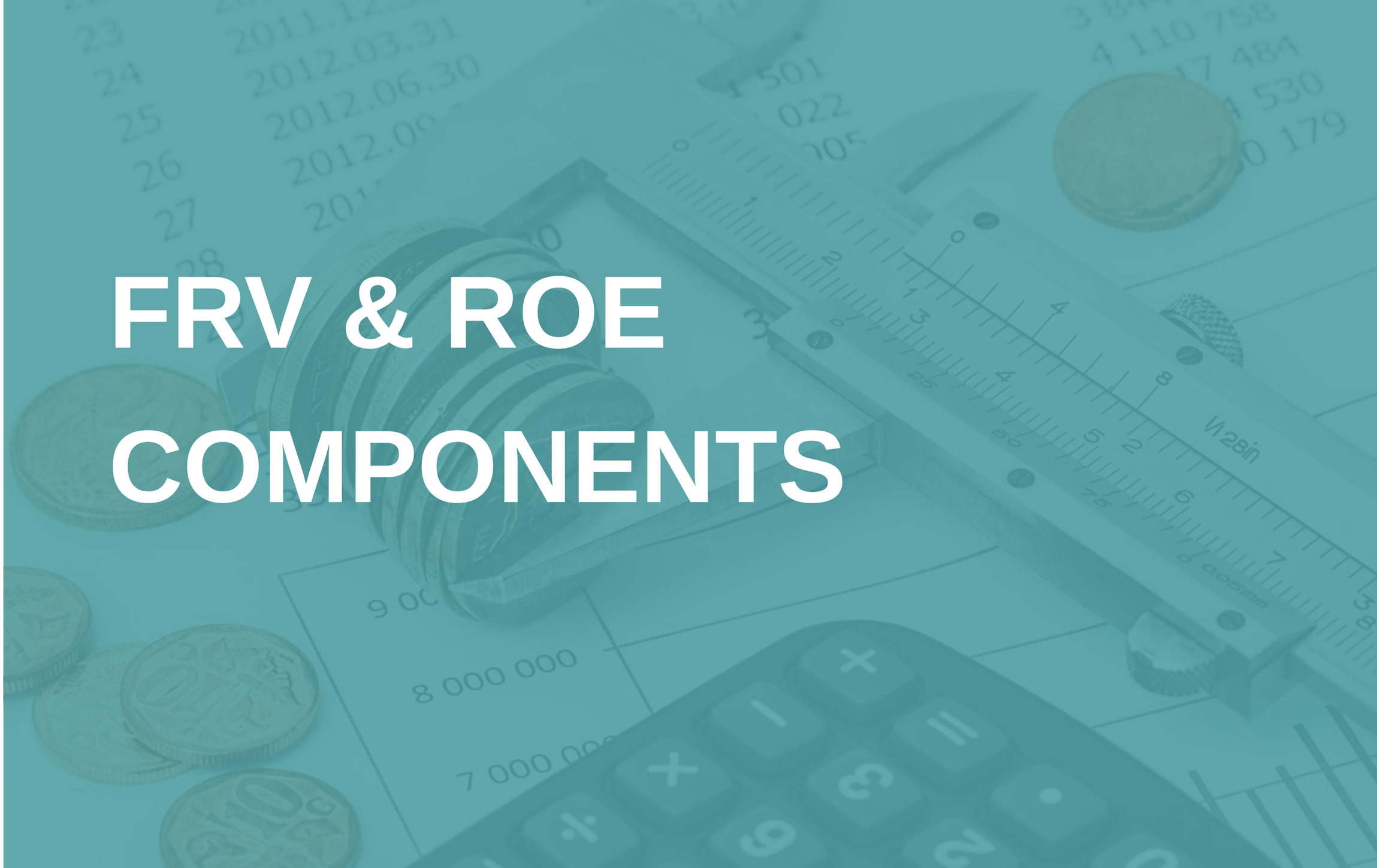
CAPTIAL COMPONENT



CAPITAL PARAMETERS

- **Cost Component Limit:** None
- **Minimum Occupancy Percentage:** 90%
- **Threshold for Efficiency Payment as Percentage of Median:** None
- **Allowed Efficiency Percentage:** None

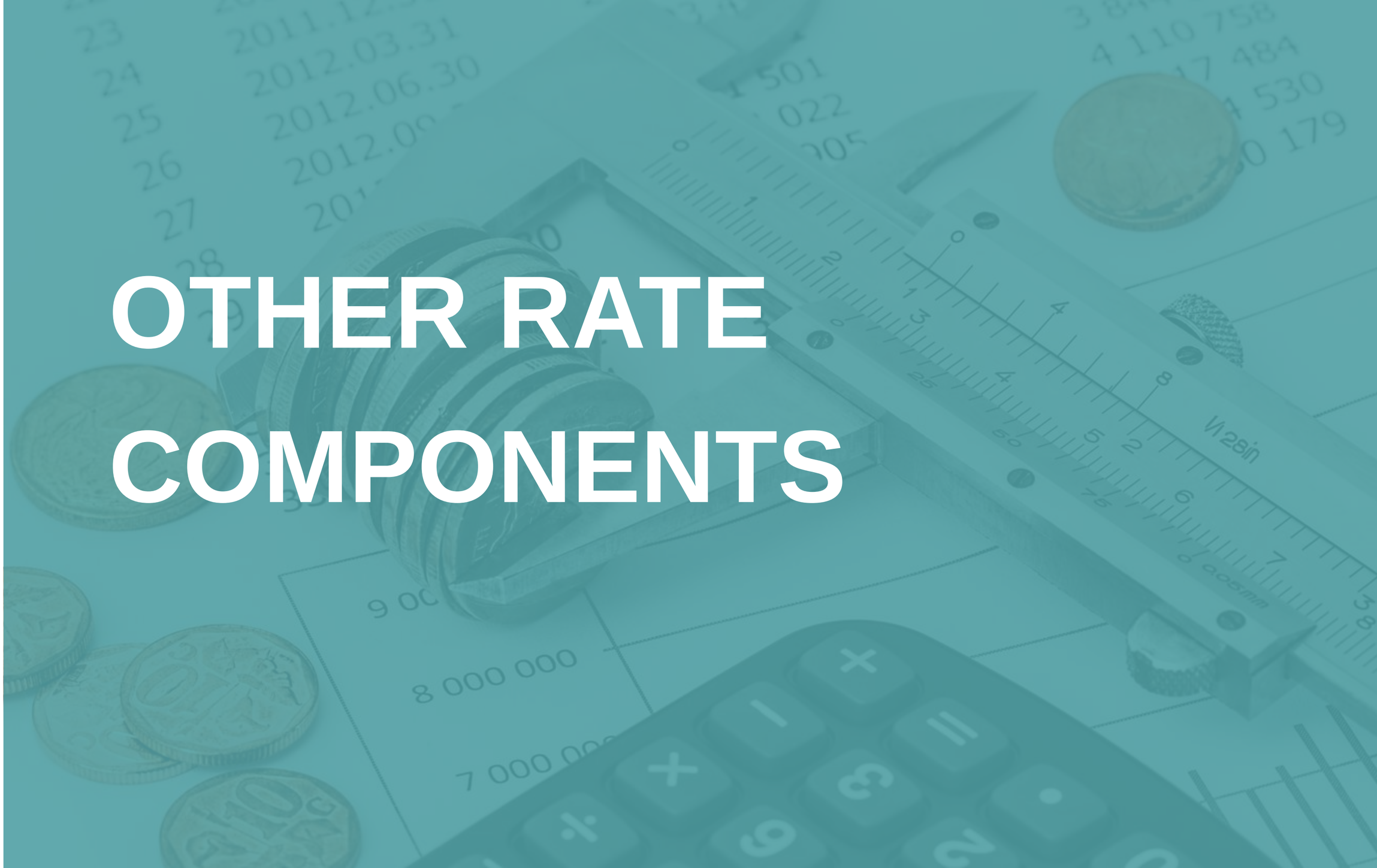
FRV & ROE COMPONENTS



FAIR RENT & ROE OVERVIEW

- A fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs. The allowance for the use of real property other than land is determined by amortizing the base value of property over its useful life.
- The useful life assigned to fair rental additions is based on the American Hospital Association guidelines.
- The rate of return applied to fair rent additions is based on the Medicare Rate of Return.
- Non-profit facilities receive the lower of the fair rental value allowance or actual interest and depreciation plus certain disallowed costs

OTHER RATE COMPONENTS



OTHER RATE COMPONENTS

- Legislative Wage Add-Ons

RATE PHASE-IN

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

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

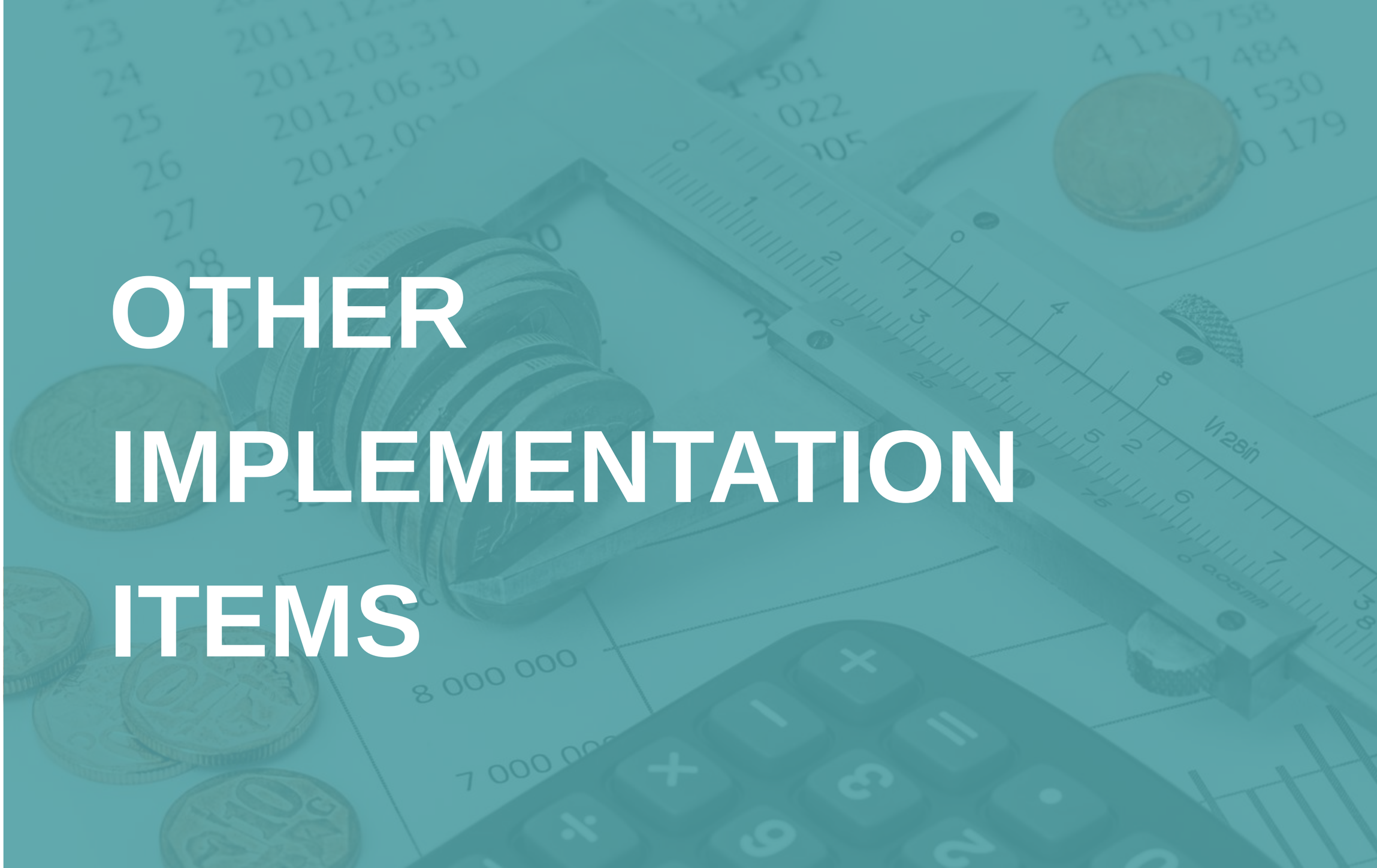
	SFY 2023	SFY 2024	SFY 2025
Case Mix Rate	$ 235.00	$ 235.00	$ 235.00
Issued Rate	$ 245.00	$ 245.00	$ 245.00
Initial Gain/(Loss)	$ (10.00)	$ (10.00)	$ (10.00)
Phase-In Adjustment	$ 10.00	$ 5.00	None
Total Case Mix Rate After Phase-In	**$ 245.00**	**$ 240.00**	**$ 235.00**
Gain/(Loss) After Phase-In	$ -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

VALUE BASED PURCHASING

VBP INCORPORATION

- VBP program will be “Reporting Only” for initial implementation
- For the period after initial reporting-only phase (year 2 and beyond), 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

OTHER IMPLEMENTATION ITEMS



SHADOW RATES

- Shadow Rates will be issued to all Medicaid providers on or before October 1, 2021
- Shadow Rates will communicate the impact of the case mix reimbursement system to each individual provider
  - The impact of the phase-in process will be incorporated and displayed
- Shadow Rates will be distributed to providers on a quarterly basis until the implementation of the case mix system

SHADOW RATES CAVEATS AND ASSUMPTIONS

- Shadow Rates will be based on the most currently available Case Mix Index and Cost Report Information
- Case Mix Index information will continue to be updated on a quarterly basis in line with the preliminary and final resident roster process
- Shadow Rates are for illustrative purposes only, and will not be utilized for reimbursement purposes
- Base cost assumptions in Shadow Rates are subject to additional review/audit adjustment as those processes are completed
- Rates may continue to be adjusted for other factors such as additional wage add-ons or other factors prior to system implementation

QUESTIONS?