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

March 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

AGENDA

- Project Overview
- Project Phases
- Case Mix Overview
- Rate Methodology Comparison
- Implementation Strategy
- Rate Setting Overview
- 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.

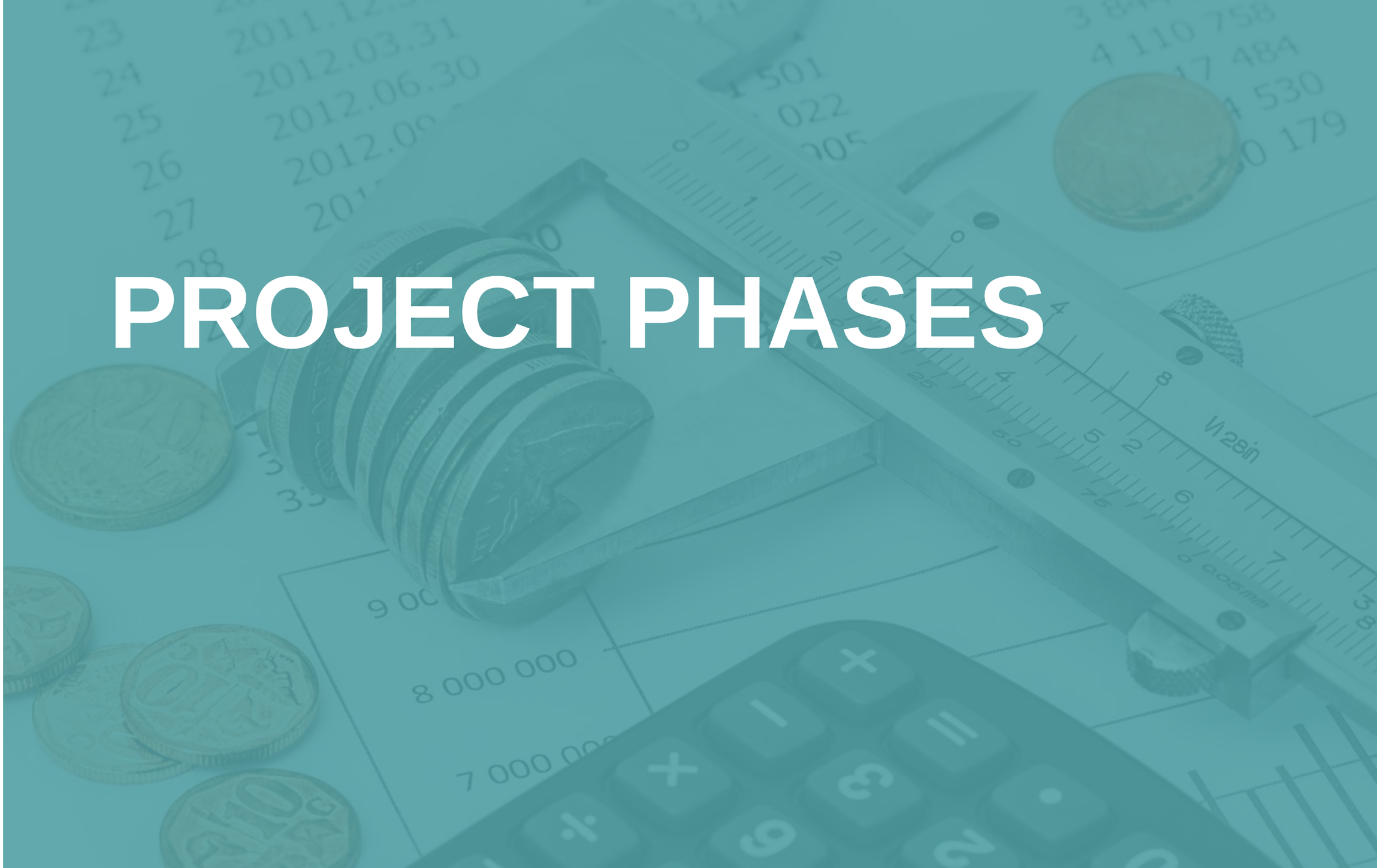
- **FRV** - Fair Rental Value; the fair market value of property while rented out in a lease arrangement.

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.

PROJECT PHASES



PROJECT PHASES

PHASE 1

- RUG-IV Based Case Mix Transition
- Value-Based Purchasing (VBP)-Quality Measure Reporting

PHASE 2

- MDS Verification Review Program
- Evaluation of the Capital and FRV Components
- VBP Evaluation and Enhancements

PHASE 3

- Transition to Patient Driven Payment Model (PDPM) for Nursing case mix
- Capital and FRV Component Modernization
- VBP Evaluation and Enhancements

CASE MIX OVERVIEW

WHAT IS CASE MIX?

- “Case” refers to residents.
- “Mix” refers to resident differences.
- “Case Mix” describes differences in residents within a population (nursing facility).
- A “Case Mix Reimbursement System” is simply any system that utilizes patient case mix indices (CMI) or acuity during the rate setting process.

WHAT IS CASE MIX INDEX (CMI)?

- “Case Mix Index” is the average numerical value of the resident acuity in a nursing facility based on the applicable resource utilization group weights.
- The higher the CMI, the greater the resource requirements and associated reimbursement for the resident.
    - For example, a resident with a CMI of 2.0 takes twice the nursing resources as a resident assessed with a CMI of 1.0.
- In the case mix reimbursement methodology the CMI is utilized to adjust reimbursement rates on a periodic basis.
- Connecticut is proposing updating provider case mix index on a quarterly basis for reimbursement purposes.

HOW IS CMI CALCULATED?

- All Medicare and/or Medicaid certified facilities must complete periodic status and care planning assessments of each resident within their facility (regardless of payer).
- The Minimum Data Set resident assessment instrument is utilized for these periodic assessments.
- The completed MDS assessments are processed through a resident classification system to calculate the Case Mix Index.
- A RUG IV classification grouper will be used to classify residents and assign a case mix index for reimbursement.

HOW IS CMI CALCULATED?

- 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

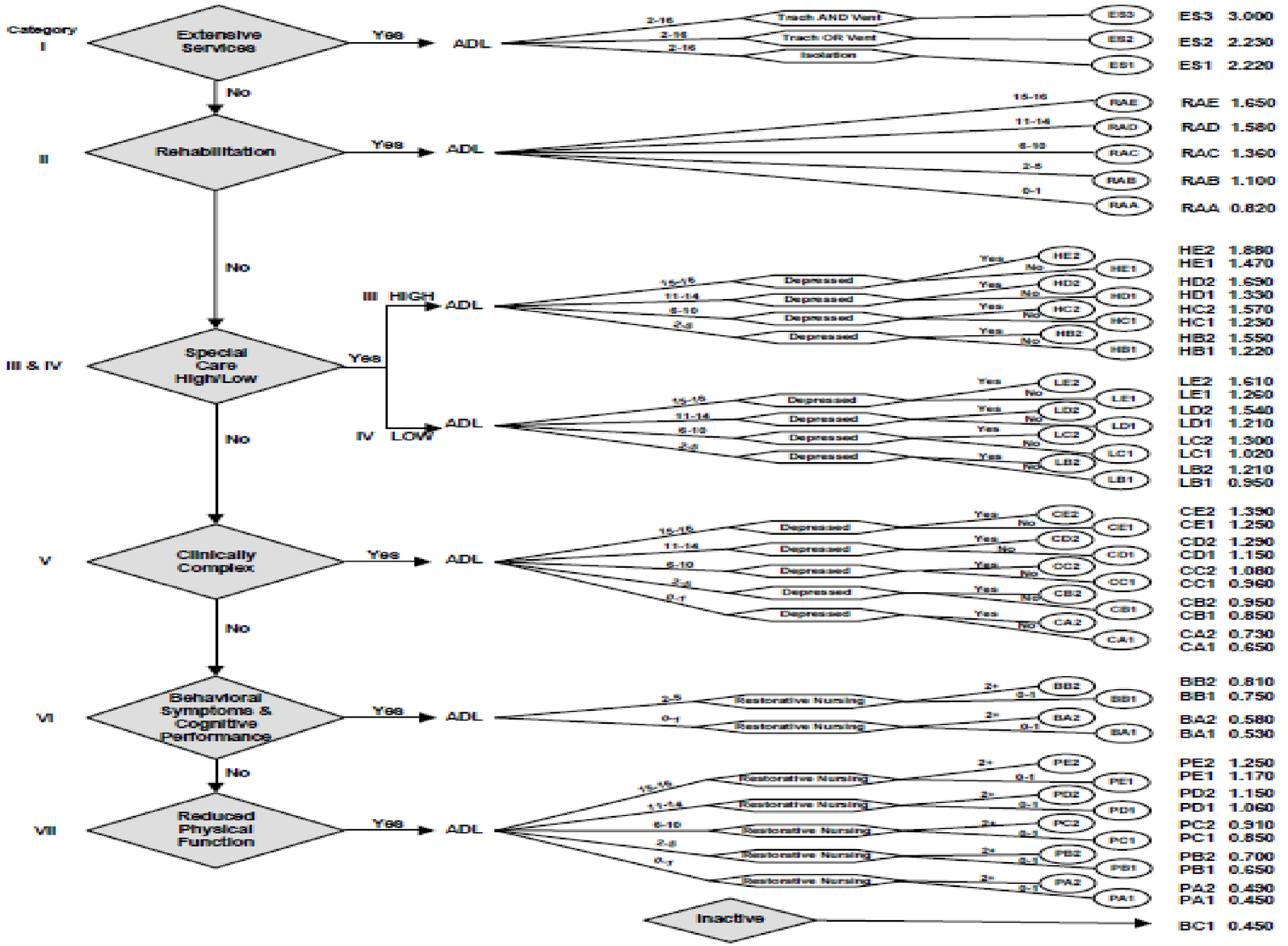
HOW IS CMI CALCULATED?

- The base year CMI utilized in the cost normalization process for case mix, matches MDS assessments to the applicable cost reporting period as shown in the table below:

MDS Assessment Period	Corresponding CR Period
10/1/2017 – 9/30/2018	10/1/2017 – 9/30/2018

- Providers were given the opportunity to review and modify MDS assessment records from these historical period.

RUG IV-48- GROUP HIERARCHICAL CLASSIFICATION



RATE METHODOLOGY COMPARISON

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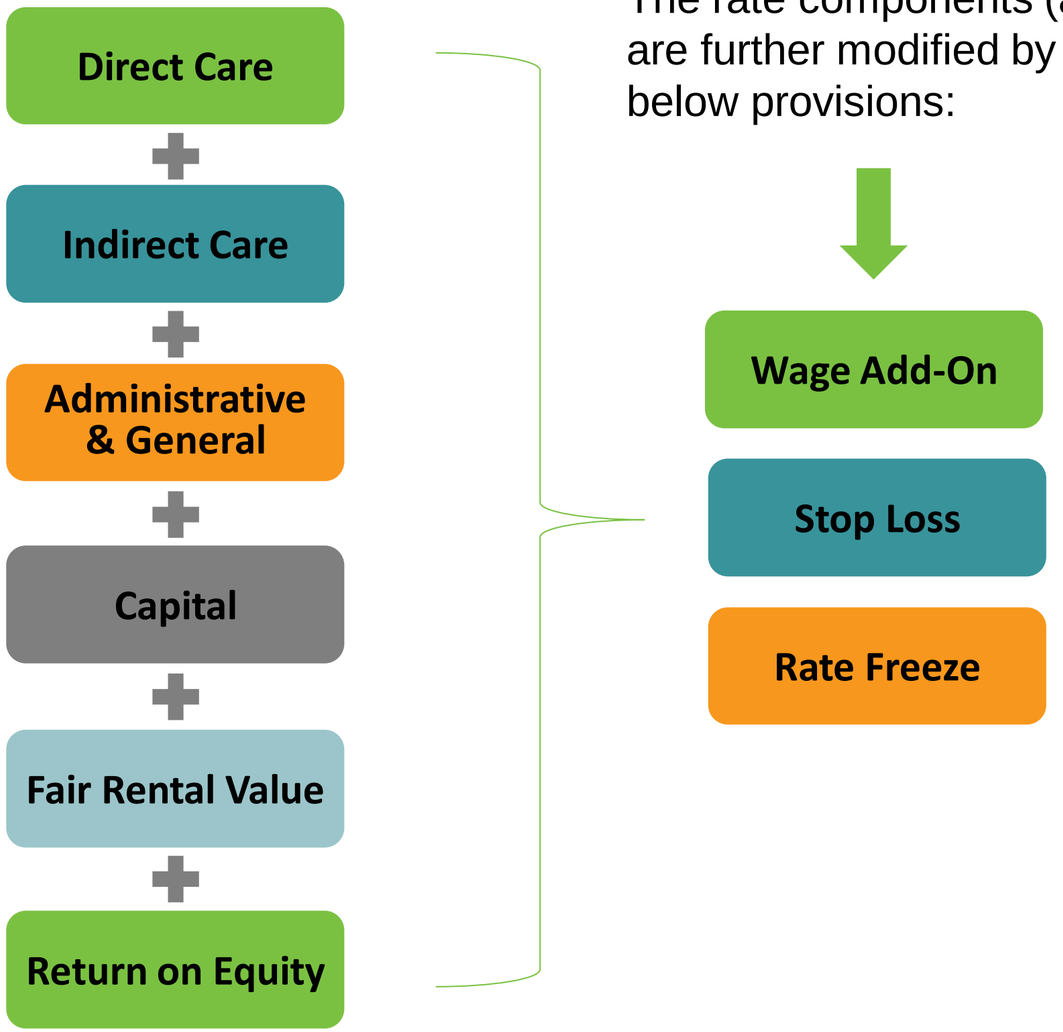
Example

CURRENT SYSTEM	
1. Direct Care Costs	$2,500,000
2. Resident Days [All Payers]	20,200
3. **Average Direct Care Costs**	**$123.76**

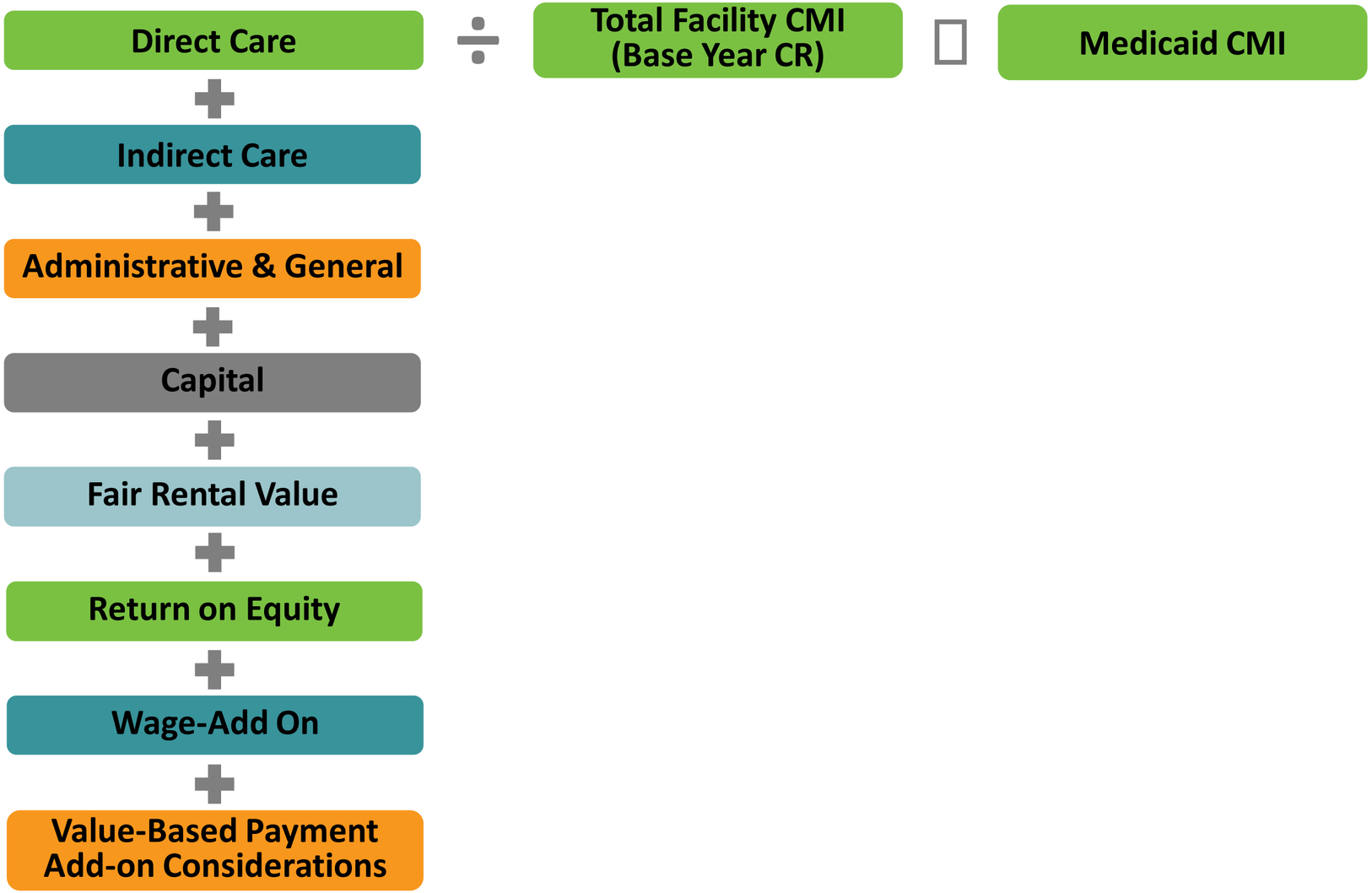
CASE MIX	
1. Direct Care Costs	$2,500,000
2. Resident Days [All Payers]	20,200
3. **Average Direct Care Costs**	**$123.76**
4. Facility Case Mix Index (CMI) [All Payers]	1.02
5. Direct Care Cost Net of Acuity Effects [Ln 3 / Ln 4]	$121.33
6. Medicaid Case Mix Index (CMI)	0.95
7. **Medicaid Case Mix Adjusted Average Direct Care Cost [Ln 5 x Ln 6]**	**$115.26**

**Note: The above examples are simplified for illustrative purposes only, and do not reflect the impact of cost component limitations, stop/loss, wage add-ons, rate freezes, or other rate mechanics.*

CURRENT RATE METHODOLOGY



CASE MIX METHODOLOGY



Implementation Strategy Discussion

Case Mix System Phase-In

- 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 adjust operations to fit the new reimbursement system
- A phase-in will be applied with the implementation of the case mix system

RATE SETTING OVERVIEW

RATE SETTING OVERVIEW

- Case Mix System Implementation scheduled for July 1, 2021.
- Rates to be calculated generally in accordance with Connecticut Regulations 17-311-52 and 17b-340.
  - Main differential is inclusion of applying a case mix adjustment to the direct care component of the rate.
- Rates were rebased on 7/1/2019 utilizing cost year 2018 as the base year. Cost year 2018 will continue to be used as the base year for 7/1/2021 rates, as we transition to a case mix system.
- The consumer price index is used to inflate costs from the cost year to the rate year.

RATE SETTING OVERVIEW

- For rate setting purposes, allowable costs are divided by the higher of reported total resident days for the base year or facility occupancy at 90% of licensed capacity.
- Allowable cost maximums are applied to Medicaid allowable costs.
- The system provides an adjustment increasing allowable cost to facilities having lower costs in the Indirect, and Administrative cost categories. The incentive is 25% of the difference between the facility’s cost per day and the state-wide median cost per day in the component category.
- Proprietary facilities receive a return on equity, determined by multiplying the Medicare rate of return for the cost year by the average current equity and non-current equity for the cost year.

ALLOWABLE COST MAXIMUMS

- Facility costs, calculated on a per diem basis by category, are limited to maximums established as a percentage of median costs in the Direct, Indirect and Administrative and General categories.
- The separate peer groupings within the Direct category for facilities in Fairfield County will be maintained.
- There is no maximum applied to the Capital component of the rate.

Allowable Cost Maximum Percentages By Category (% of median)		
Direct	**Indirect**	**Admin./Gen.**
130%	115%	100%

FAIR RENT

- 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.

QUESTIONS?