

**SUMMARY REPORT
SB 06-131 COMMITTEE
HB 07-1183 COMMITTEE**

Reimbursement Under The Medical Assistance Program For Nursing Facility Providers

BACKGROUND

The Colorado General Assembly passed legislation in 2006 (SB 06-131) directing the Department of Health Care Policy and Financing (Department) to conduct a feasibility study on a new Long Term Care Medicaid reimbursement system for Medicaid recipients residing in Colorado's nursing care facilities. On November 3, 2006, a report was submitted to the House and Senate Health and Human Services Committees as well as the Joint Budget Committee. The report summarized the research conducted by the Department and the Committee on the development of a new reimbursement system. The Committee recommended extending the development period for one year due to the overall complexity and the effects a new system would have on the quality of care and quality of life of nursing facility residents.

The Colorado General Assembly passed legislation in 2007 (HB07-1183) directing the Department to continue the feasibility study with submission of a report detailing recommendations for a new reimbursement system due to the House and Senate Health and Human Services Committees and the Joint Budget Committee by November 1, 2007. In addition, HB07-1183 established a grant program to provide assistance to Medicaid facilities for the purpose of avoiding a decrease in the provider rate as a result of eliminating the 85th percentile floor on reimbursement.

This report is intended to outline the 2007 findings of the SB 06-131 Committee (Committee) as well as detail the recommendations for a new reimbursement system as required by HB 07-1183.

The membership of the Committee includes representatives of both nursing facility associations, Colorado Association of Homes and Services for the Aging (CAHSA) and Colorado Health Care Association (CHCA), an unaffiliated nursing facility representative, ombudsman, the contract auditor and the Department.

CURRENT REIMBURSEMENT SYSTEM

The current Medicaid reimbursement methodology for nursing facility care is facility specific, cost based and adjusted for resident acuity. The current system, modified for resident acuity in 2000, was placed into service sometime in the 1970s and was then considered to be "state-of-the-art." Prior to setting a rate for a facility, costs are subject to ceilings, various caps, and tests of being reasonable, necessary, and patient related. The ceilings and caps referred to are a result of legislative modifications designed to control the rate of growth.

There are three cost components in the current reimbursement system:

(1) Health Care

Health Care is divided into two components:

- a. "Direct" Health Care includes salaries, taxes, benefits and contracted services of Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs). This component is adjusted for acuity to reflect the resource utilization of the Medicaid resident.
- b. "Other," or Indirect Health Care, includes ancillary services such as physical, occupational and speech therapies. It also includes food, social services, activities, medical supplies, medical records department expenses and health care consultants.

(2) Administrative & General

Examples of Administrative and General (A&G) expenses include salaries, taxes and benefits and/or contracted services of the Nursing Home Administrator as well as the Dietary, Housekeeping, Laundry & Linen and Plant Operations Departments. Interest, lease and depreciation expense for movable equipment are also included here.

(3) Fair Rental Value

The property of the facility including land, building and fixed equipment is appraised every four years by an independent contractor. The appraisal value is based on a depreciated cost value. Along with audited asset additions, it is used to calculate a Fair Rental Value component of the rate.

STRENGTHS OF THE CURRENT SYSTEM

Although the current system has significant weaknesses, some inherent strength exists in cost-based systems. Cost-based systems allow a provider to receive reimbursement that is reflective of what they spend. The theory is a dollar spent is a dollar received.

The current system adjusts direct healthcare costs for acuity so facilities are reimbursed for the costs of treating Medicaid residents. In effect, the acuity-based system carves out the nursing costs of other payer groups. (See limitations of current acuity adjusted system in weaknesses of current system section.)

WEAKNESSES OF CURRENT SYSTEM

Over the years, policy decisions were made with budget primarily driving the changes to the system, eroding the strength of the current cost-based system. The ceilings and caps referred to are a result of legislative modifications designed to control the rate of growth.

- In 1997, the legislature attempted to control the rate of increase in the cost of nursing facility care for Medicaid residents. In doing so, they set a cap on the rate of increase in the A&G and DHC components of the Medicaid rate. As a result, the facility's rate component for A&G costs can increase by the lower of actual cost or 6%, and the rate component for DHC costs can increase by the lower of actual cost or 8%. The legislature established these caps on the July 1, 1997 rate based upon audited costs incurred in 1996. In addition, each provider is limited to a ceiling of 120% of the state-wide weighted average cost for A&G and 125% of the state-wide weighted average cost for DHC. A&G costs have never been re-based since the base year was

set in 1997 (similar to TABOR prior to Referendum C), resulting in a system where many providers are unable to ever recover their costs. In fact, not including those facilities whose A&G costs are over the ceiling, 120 out of 185 facilities, or 65%, are limited by the 6% prior period cap. Note that these figures are based on unaudited data from cost reports that set the July 1, 2007 rate. In addition, if a facility spends less in the A&G cost center than the previous year, the facility will never be reimbursed at its previous spending level since A&G costs are limited to “actual” or inflated 6% Prior Period Per Diem Cost. The average increase in A&G reimbursable per diem over the past several years for all nursing homes is an approximate 4.3% increase, not a 6% increase as determined by a review of the data by the Department’s contract auditor.

Health care costs (direct and indirect combined) may increase by no more than 8% from one year to the next for the purpose of calculating a rate. The rate is based on the audited and allowable costs and represents the lower of their actual cost increase or 8%.

- Under a full cost-based system, high Medicaid utilization facilities have their cash flow restricted by the prior year’s costs and caps resulting in an inability to reinvest in nursing, infection control, dietary staff, administrators and plant operations and maintenance. See Appendix #1 for itemization of all costs under DHC and A&G.
- Cost-based systems can result in the lack of budgetary predictability for the State and the provider.
- The current system determines the resource utilization of the Medicaid resident for the purpose of adjusting the rate. This mechanism is referred to as the Case Mix Index (CMI) adjustment. However, the tool used to determine resource utilization is a functional assessment that may not adequately capture the challenging behaviors of this population and the additional resources that must be provided from staff including, but not limited to, nursing and social workers to keep these individuals safe and involved in facility activities and programs.
- The current system has no incentives for performance in relation to quality care.

DEVELOPING THE NEW SYSTEM

GOALS

During deliberations, the Committee and the Department agreed that a new system must build on the strengths of the current system while compensating for the weaknesses. As a result, the Committee established several goals to use as guiding principles in the development of the new system.

- Create a system that promotes enhanced outcomes and quality of care for the elderly and infirm.

- Recognize resource utilization for behavior populations and reimburse for those services.
- Achieve predictability in budget forecasting for the State and the provider.
- Reduce litigation (Informal Reconsiderations and Appeals.)
- Avoid disincentives for providers to care for Medicaid residents.
- Recognize and reward delivery of high quality of life and care for the resident.

MODEL

The original discussion regarding a new system focused on the advantages and disadvantages of a full pricing model as opposed to a cost-based system. Under a full pricing model, average costs are determined for all Medicaid providers and a median is determined. A price is then set based upon the median plus a percentage (i.e. 105% or 110% of the median) and that price is intended to pay for the care of the resident regardless of actual cost. The price can be geographically and acuity adjusted. After considerable discussion about a full pricing model, the Committee unanimously agreed to retain the current system for direct and indirect health care without the 8% cap and enhance this system with additional incentives to increase quality and care for behaviorally challenged residents.

The Committee then recognized that other states have successfully implemented a hybrid reimbursement system that combines a cost system with a pricing system. The Committee recommends that Colorado also adopt a hybrid model that combines cost-based and price-based reimbursement. The fundamentals of the system recommended include the following:

- Cost-based reimbursement for direct and indirect health care
 - Acuity adjust direct portion of DHC to reflect Medicaid resource utilization
 - Actual cost reimbursement for the indirect portion of DHC
 - Implement an additional payment relating to resource utilization for the behaviorally challenged resident
 - Implement a “pay for performance” incentive
- A set price for A&G costs established at 105% of the un-imputed median for all facilities. An exception to this price is applied to small facilities of 60 beds or less. The price for these facilities is established at 110% of the un-imputed median.
- Property reimbursement under a Fair Rental Value concept remains unchanged.

Based on the foundation of the new system, several decisions were required prior to finalizing the model.

- 1) Administrative and General (A&G)
 - a. Identify the costs that should be included in Health Care vs. Administrative and General. Since the system is changing from cost-based reimbursement to a set price for A&G, it was necessary to specifically and consistently identify the costs that would be reimbursed on the health care cost side and the costs that would be covered by the A&G price (Appendix #1).

- b. Determine the method of setting the price for A&G in order to promote efficiency and economy for the Medicaid program as well as allowing for the provider to meet the needs of the Medicaid resident.
 - c. Determine appropriate future indexing and re-basing calculations for the A&G price.
- 2) Effective measurement of resource utilization for behaviorally challenged residents.
 - 3) Quality factors as they relate to the delivery of nursing facility care and how to properly capture those quality factors with a payment that is associated with performance.
 - 4) Phase-in
 - Due to changes of the rate calculation in the new reimbursement system (e.g. A&G changes from a cost- to a price-based system), there will be winners and losers. As a result, mitigating large swings in one direction or another without harming the ability of a provider to deliver the service needs to be addressed. In addition, re-basing costs to determine an appropriate price will result in an increased cost to the program. The Committee discussed how to phase in the overall cost of the system change to make it affordable for the State Medicaid program.

RECOMMENDATIONS

ADMINISTRATIVE AND GENERAL

Determine the median of the actual cost of all providers for A&G. In determining these costs, no imputed occupancy or caps will be applied. The rate should be set at the median plus 105% of the un-imputed median for all except small facilities with 60 or fewer beds, who will receive 110% of the median. This becomes the price that will cover the A&G costs that are outlined in Appendix 1. For the purpose of updating the original set price, costs will be re-based every four years. During the years when there is no re-basing, the price will be adjusted by the Consumer Price Index at 7/1 of each year.

Dissenting opinion: CAHSA Board of Directors voted to oppose the recommendation. The stated opposition was that the proposed pricing methodology creates “winners” at the expense of “losers,” even with the hold harmless provision. The mechanism for the hold harmless provision is that a facility’s historical A&G rate that is higher than the price will keep that historical rate until either the price rises to meet it or the four-year phase-in period elapses, whichever is sooner. Under this mechanism, a facility with a higher historical A&G rate experiences neither a decrease nor an increase during the phase-in. A full statement of CAHSA’s concerns is included at Appendix 7.

Committee response: The present system has winners and losers as well. The new reimbursement system redistributes reimbursement to those facilities that under the current system receive less than their cost. These facilities are typically most dependent upon Medicaid funds for their residents.

HEALTH CARE

The health care component of the system remains relatively the same. Direct and indirect health care will be cost-based with the direct health care component being acuity adjusted. This acuity adjustment continues to allow the State to identify the resource utilization of the Medicaid resident to assure that payments made reflect care given to the Medicaid recipient. The current cap of 8% on growth in costs is eliminated. Ceilings will remain at 125% of the weighted average cost for all providers.

BEHAVIORAL

Please reference the “Behavior Subcommittee Report and Recommendations” for further details regarding these recommendations in Appendix # 2.

Two types of residents require additional staff resources and training:

(1) Severe Mental Health Diagnosis

The State Medicaid program currently conducts a Pre-Admission Screening and Resident Review (PASRR), as required by Federal law. The PASRR program requires pre-screening of all clients who apply to or reside in a Medicaid certified nursing facility. There are two levels of evaluations in the PASRR program. The purpose of Level I is to identify for further review clients for whom it appears a diagnosis of a major mental illness or developmental disability is likely. The purpose of Level II evaluation is to determine whether an individual has a major mental illness or developmental disabilities and whether specialized services are needed. This particular population is not captured in the current CMI. The Committee recommends that the provider be reimbursed \$3.58 per day for each identified PASRR Level II resident. Of the approximate 9,800 total Medicaid nursing facility residents in the State, there are an estimated 1,828 that fit into this category. Facilities with specialized programs would receive an additional \$3.58 per day for each identified PASRR Level II resident. Appendix #3 provides program criteria for the specialized programs.

(2) Cognitive Loss/Dementia

Researchers used components of the Minimum Data Set (MDS) to design a Cognitive Performance Scale (CPS). The scale ranges from 0-6 where 0 is an individual who is intact cognitively and 6 is a comatose individual. Additional staffing is needed for residents with a score of 4, 5 or 6 (moderate to severe impairment). The Committee recommends that a state-wide average be calculated every year for Medicaid residents with a 4, 5 or 6 CPS score. The state-wide average is computed by calculating a per facility percentage by taking the number of Medicaid residents with a CPS score of 4, 5 or 6 divided by the number of total Medicaid residents in each nursing facility. The average of the resulting percents is the state-wide average. The nursing facilities that are one, two or three standard deviations above the state-wide average would then respectively receive an additional \$1.00, \$2.00 or \$3.00 CPS payment per day for each qualifying Medicaid resident.

PAY FOR PERFORMANCE

A “Pay for Performance” component will be included to recognize those facilities that are providing services that ultimately result in better care and higher quality of life for the residents. In addition, the Pay for Performance piece will create an incentive for other providers to enhance their delivery of care. The system will be weighted on a point basis with points being assigned to those areas that are universally recognized for having a positive impact on the lives of residents. There are three domains:

- Quality of Life
 - Resident-Directed Care and Activities
 - Home Environment
 - Relationships with Staff, Family, Resident and Community
 - Staff Empowerment
- Quality of Care
 - Staff Stability
- Facility Management

Please reference Appendix #4 for the “Pay for Performance Subcommittee Report and Recommendations” for further detail regarding these recommendations and Appendix #5 for program criteria.

PROPERTY

Reimbursement for the cost of property including land, building, and fixed equipment has long been reimbursed under a depreciated replacement cost value. This system controls the rate of growth in reimbursement for this cost center and the Committee recommends this system does not change.

PHASE-IN

Several issues require a phase-in approach to this model. First, when we pay a price for the A&G component, and the 8% cap is lifted, there will be an increase in the cost to the Medicaid program. In addition, the acuity adjustment for the behaviorally challenged patient and the pay for performance piece are new pieces to the program and carry with them a cost. The Committee recommends that all components of the new reimbursement system be implemented the first year with the exception of the A&G price. There will be winners and losers when moving from a cost-based system to a pricing system, and to mitigate the effect for providers with high costs those providers will be held harmless by freezing the A&G rate they currently receive for four years or until the A&G price reaches their current rate through inflation adjustments. Providers with low costs will recognize an increase. The Committee recommends that there be a four year phase-in approach that will allow all providers to move toward the new pricing system at the rate of 25% per year. Rates for A&G will increase by not more than 25% of the net change in the first year, 50% in the second year, 75% in the third year and fully converted to the new system in four years. The estimated fiscal impact of the new reimbursement methodology as calculated by the Department’s contract auditor is summarized in Appendix 6.

OTHER IMPLEMENTATION CONSIDERATIONS

PAY FOR PERFORMANCE COMPLIANCE VALIDATION

Options on finalizing the process whereby compliance with the criteria under the pay for performance piece is measured and validated are being explored.

SPENDING FLOORS

Pricing models are not based on individual facility costs. Therefore, there is some concern that if an increase in the rate occurs without regard to costs there should be a requirement that the provider use the increase to deliver or enhance services. If a provider fails to provide or enhance those services then the provider should not be able to keep 100% of the rate. As a result, some states have implemented spending floors on their price-based components. The Committee agrees that this is an appropriate safeguard for the system and recommends that Colorado establish an A&G spending floor of 85% of the price.

DEPARTMENT RECOMMENDATION

The Department supports the recommendations of the Committee for a hybrid reimbursement system having a price-based A&G component, a cost-based health care component that is case-mix adjusted for acuity, a quality allowance based on well-defined measures and an adjustment for facilities who serve clients with cognitive loss/dementia and/or major mental illness. The proposed methodology will meet the Department's goals of fairness to all clients and reduced litigation.