NURSING FACILITY PAYMENT REVIEW AND REDESIGN

Modeling II: Comprehensive Rate Proposal

March 18, 2021

AGENDA

- Overview
- Recap
  - Exploring role of therapy in current Medicaid payments
  - Considerations in tabulating net income and Medicaid days
  - Missing ownership records
- Summary Case for Change
- Modeling II: comprehensive rate proposal
  - Overview
  - Assessment Fee and Use of Funds
  - Distributional Impact
- Next Steps

PURPOSE STATEMENT

HFS proposes a structured and transparent approach to develop, deliberate, adopt and implement nursing home payments to achieve improved outcomes and increased accountability with an emphasis on patient-centered care. HFS believes the rate mechanism, funding model, assessment, quality metrics, and staffing requirements can and should be updated in conjunction with any new or additional appropriated funding. Further, additional federal funding should be captured to improve these areas through an increase in the current nursing home bed tax.

ORIGINAL OBJECTIVES AND PRINCIPLES FOR REFORM

- Transparent, outcome driven, patient-centered model with increased accountability
- Transition away from RUGS to federal PDPM case-mix nursing component
- Modify the support and capital rate into a set base rate similar to Medicare non-case-mix rate
- End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
- Directly tie funding/rates/incentives to demonstrable and sustained performance on key quality reporting metrics
- Documentation to support, review and validation of level of care coding and appropriateness, outliers, actual patient experiences, etc.
- Align regulation and payment incentives to the same goals
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis, including single-occupancy rooms, certified facilities
- Integrate emerging lessons and federal reforms related to the COVID pandemic
- Improved cooperation, support and follow up, data sharing and cross-agency training from other agencies (OIG, IDPH, DoA)
- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes

STEPS IN THE REVIEW AND REDESIGN PROCESS

Building blocks in a comprehensive NF payment:

- Staffing (3 meetings)
- Quality (2 meetings)
- Physical Infrastructure (2 meetings)
- Rebalancing (2 meetings)
- Capacity (2 meetings)
- Case Mix, Equity and Demographics (3 meetings)
- Modeling (multiple meetings)

Note: COVID has had a profound impact on long term care. Infection control is assumed to be an integral component of each building block.

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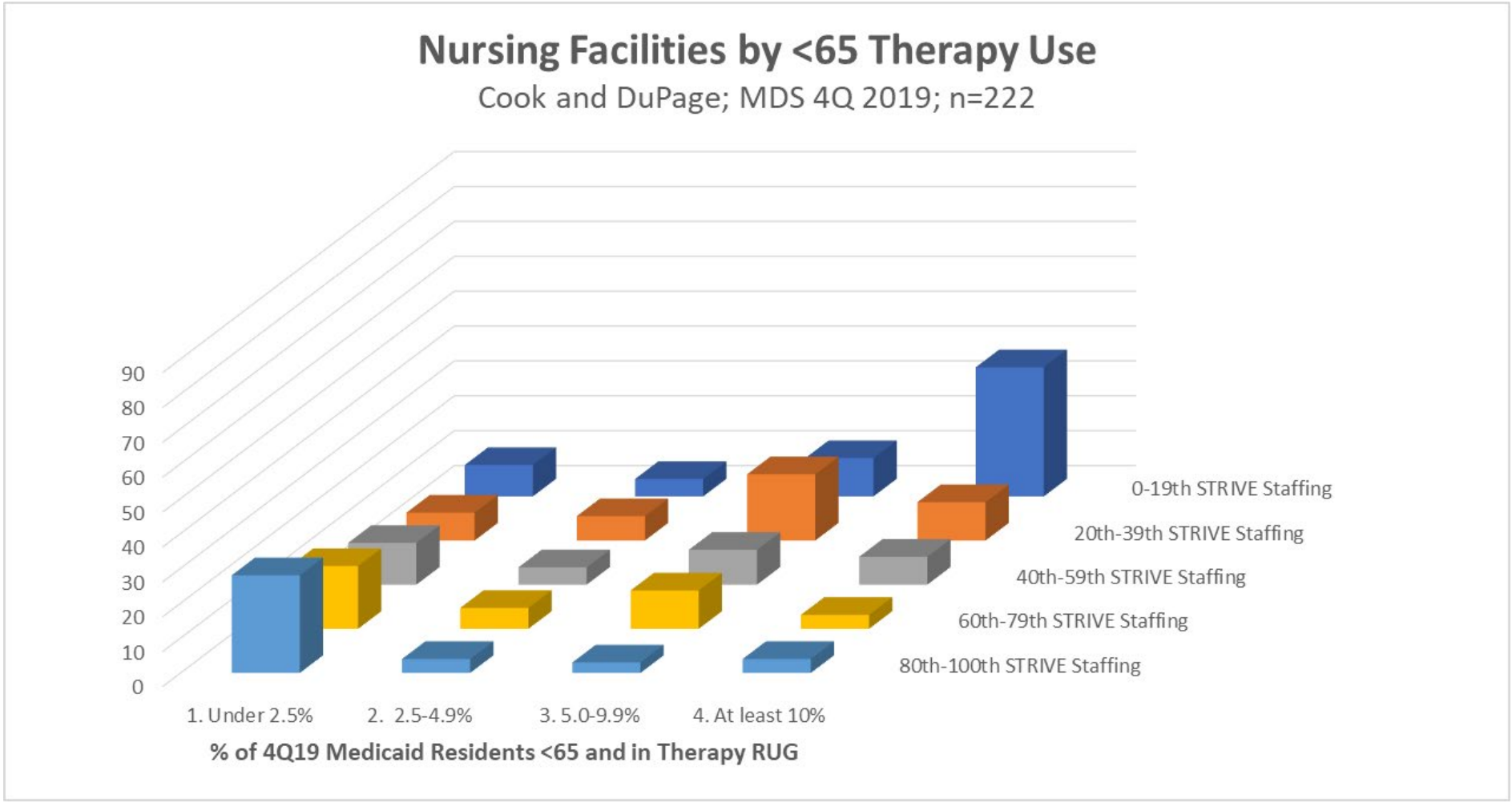
A shift from RUGs 48 to PDPM would collapse 43 non-Rehab groups into 25

PDPM Group	PDPM HIPPS Code Identifier	Comparable RUG Group
ES3	A	ES3
ES2	B	ES2
ES1	C	ES1
HDE2	D	HE2/HD2
HDE1	E	HE1/HD1
HBC2	F	HC2/HB2
HBC1	G	HC1/HB1
LDE2	H	LE2/LD2
LDE1	I	LE1/LD1
LBC2	J	LC2/LB2
LBC1	K	LC1/LB1
CDE2	L	CE2/CD2
CD1	M	CE1/CD1
CBC2	N	CC2/CB2
CA2	O	CA2
CBC1	P	CC1/CB1
CA1	Q	CA1
BAB2	R	BB2/BA2
BAB1	S	BB1/BA1
PDE2	T	PE2/PD2
PDE1	U	PE1/PD1
PBC2	V	PC2/PB2
PA2	W	PA2
PBC1	X	PC1/PB1
PA1	Y	PA1

Exploring the Use of Therapy for Medicaid Residents



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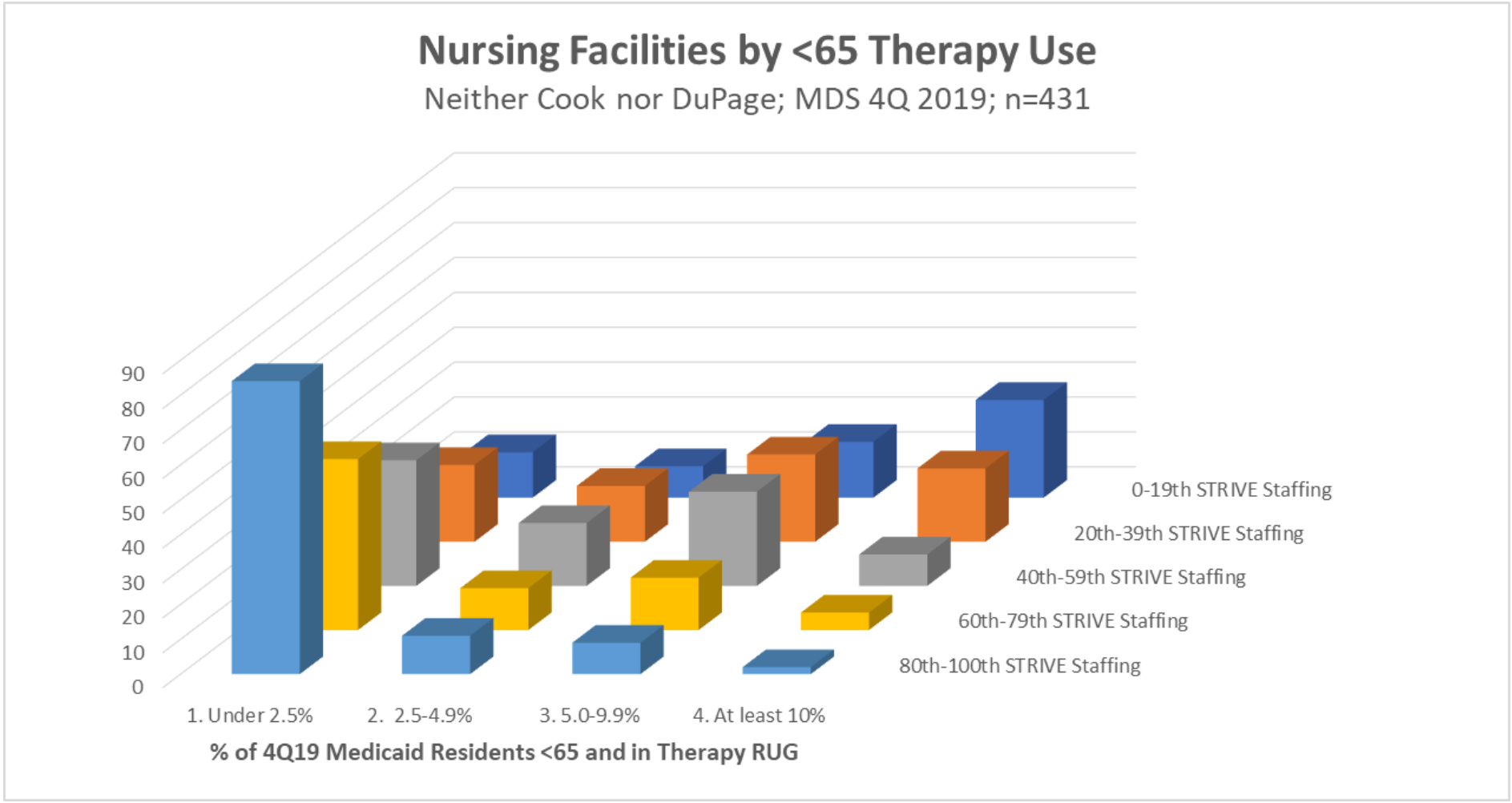

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Considerations in Tabulating Medicaid Days

Source Information

- 2018/2019 Medicaid CR Days
- Medicare CR Medicaid days if neither 2018/2019 Medicaid CR were available (nominal # of providers)

Source Considerations

- Medicaid cost reports were utilized as they better categorize days for the Medicaid program

Source Limitations

- Unknown prevalence of provider reporting of Managed Medicaid days in the "Other/Private" day categories within the Medicaid CR statistical data
  - Prevalence of this issue is larger with Medicare CR reporting
- Impact of COVID on forecasting of Medicaid days
  - Current experienced day decline
  - Projected rebound of Medicaid utilization in forthcoming fiscal year

Considerations in Tabulating Net Income

Source Information

- 2018/2019 Medicare Cost Reports
  - Gross Revenue
    - SNF/NF Routine Revenue – Wrksht G-2
    - Total SNF/NF Ancillary Revenue (Prorated) – Wrksht G-2
      - Revenues prorated on basis of routine SNF/NF revenue to total revenue
  - Contractual Adjustments
    - SNF/NF Contractual Revenue (Prorated) – Wrksht G-3
      - Contractuals prorated on basis of SNF/NF(ICF) routine and ancillary revenue to total revenue
  - Expenses
    - SNF/NF Routine Cost – B part I
    - SNF/NF Ancillary Cost (Prorated) – B part I
      - Utilized SNF/NF revenue proration factor to more closely align with traditional Medicare costing mechanics
- 2019/2018 Medicaid Cost Reports if Medicare CRs were not present within HCRIS dataset (~30 providers)
  - Net Income (page 19)
  - Adjustments to Net Income:
    - Owner's Compensation Limits (page 7)
    - Related Party Adjustments (page 5)
    - Allowable cost adjustment (page 5)

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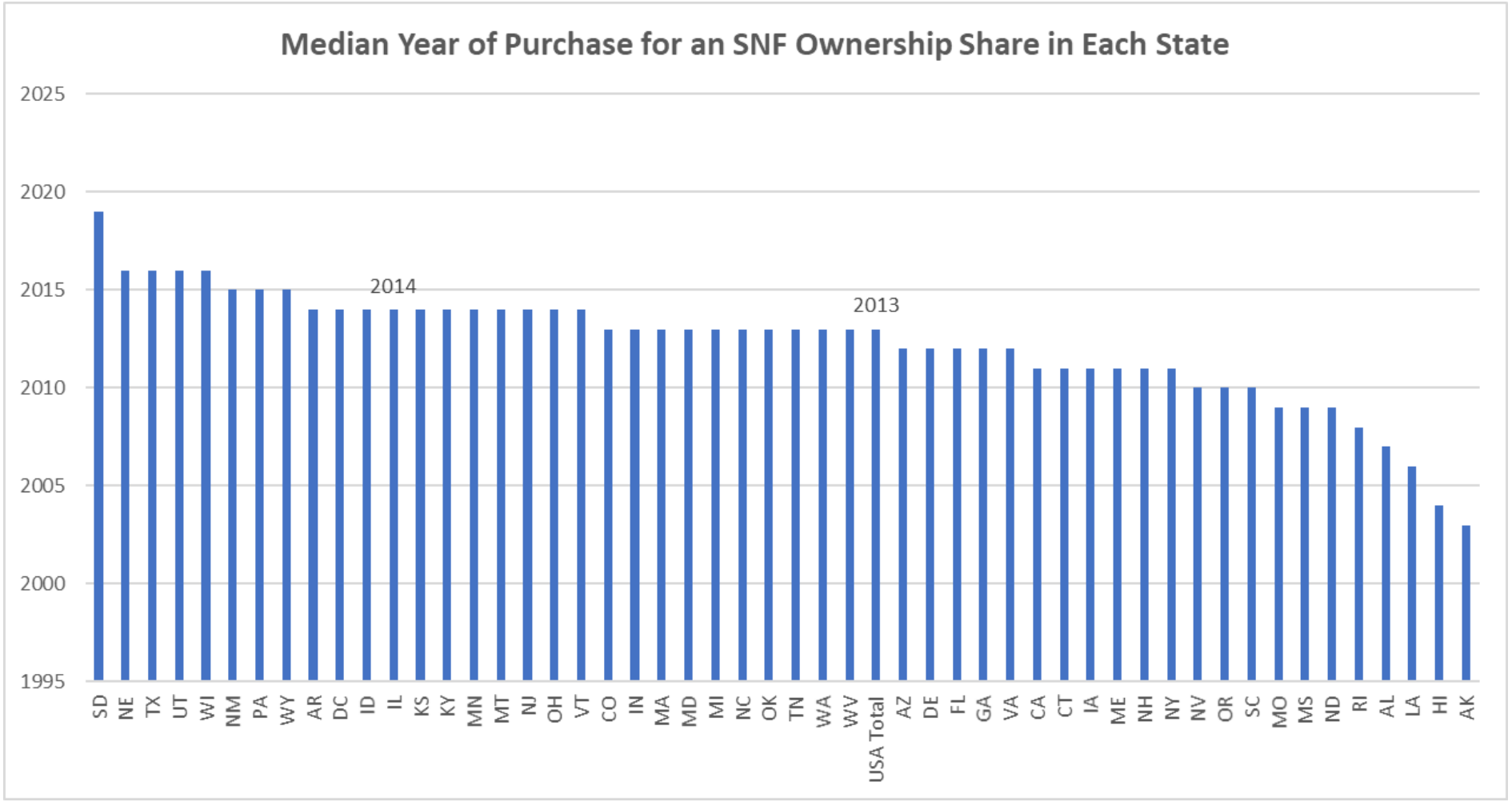
Medicare COMPARE SNF Ownership Records (Feb 2021) N=~500



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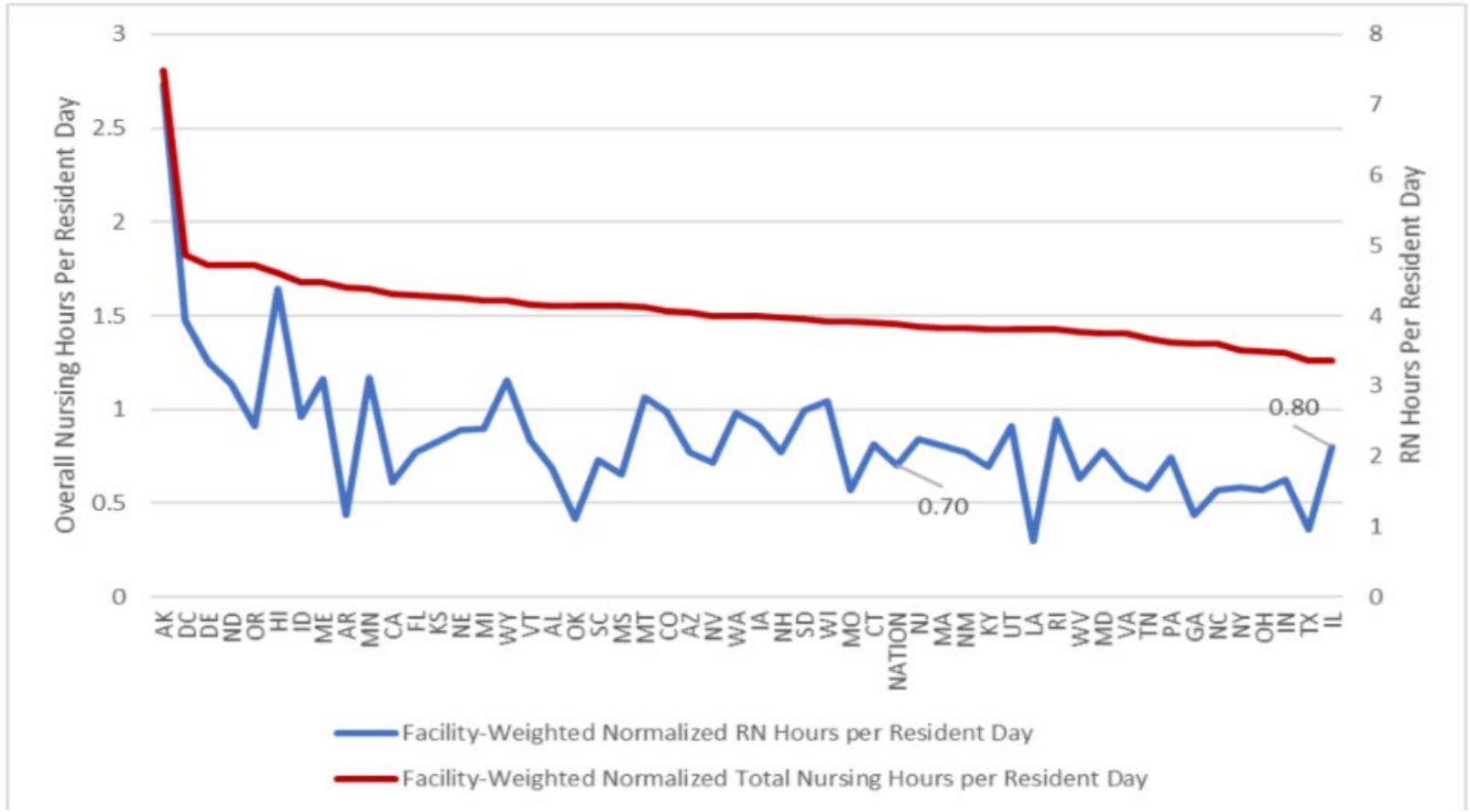
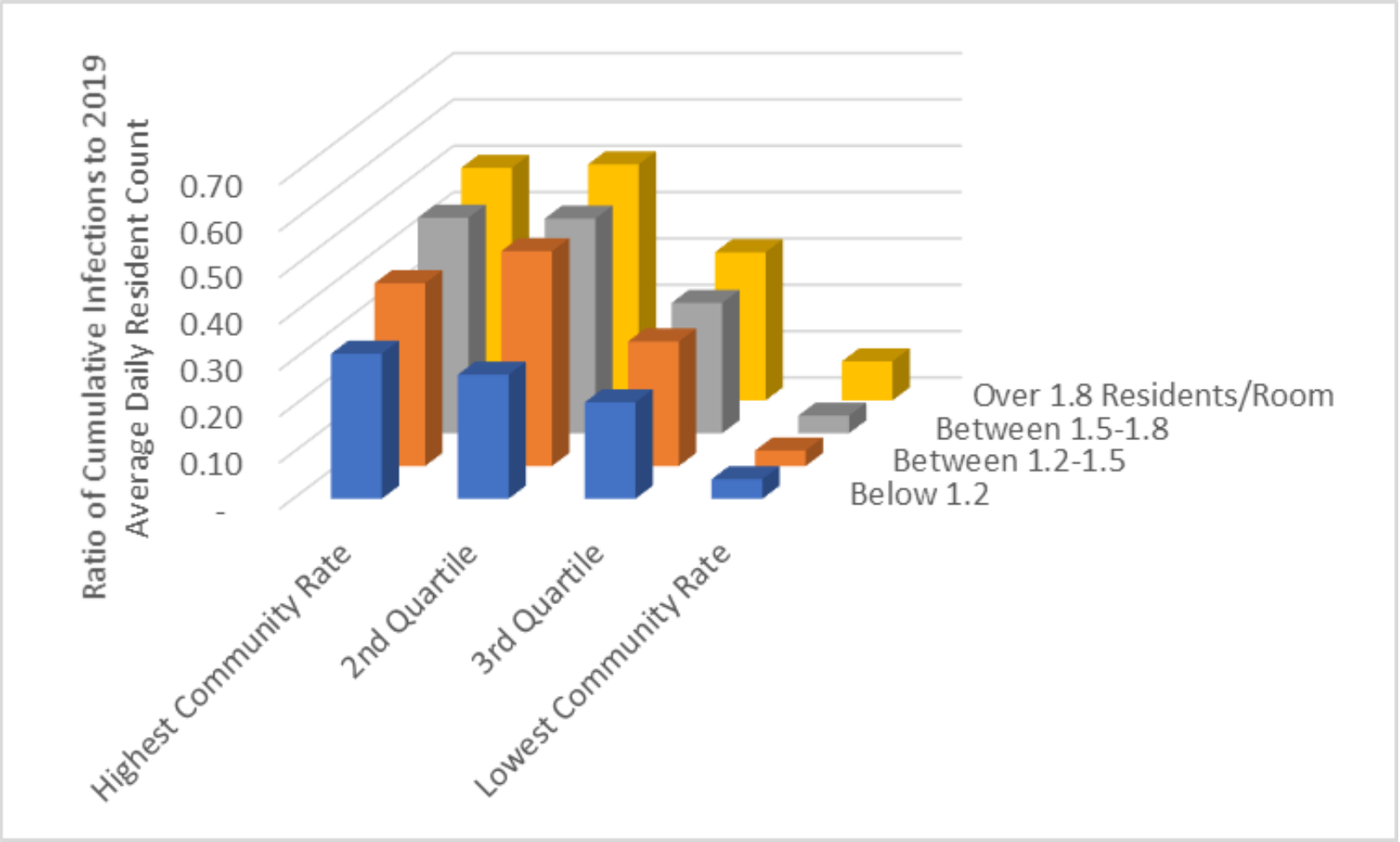
IMPROVE QUALITY STAFFING

Illinois is at the bottom of national rankings on overall nursing hours, driven largely by shortages in Certified Nursing Assistants (CNAs).

Staffing varies widely across Illinois nursing facilities.



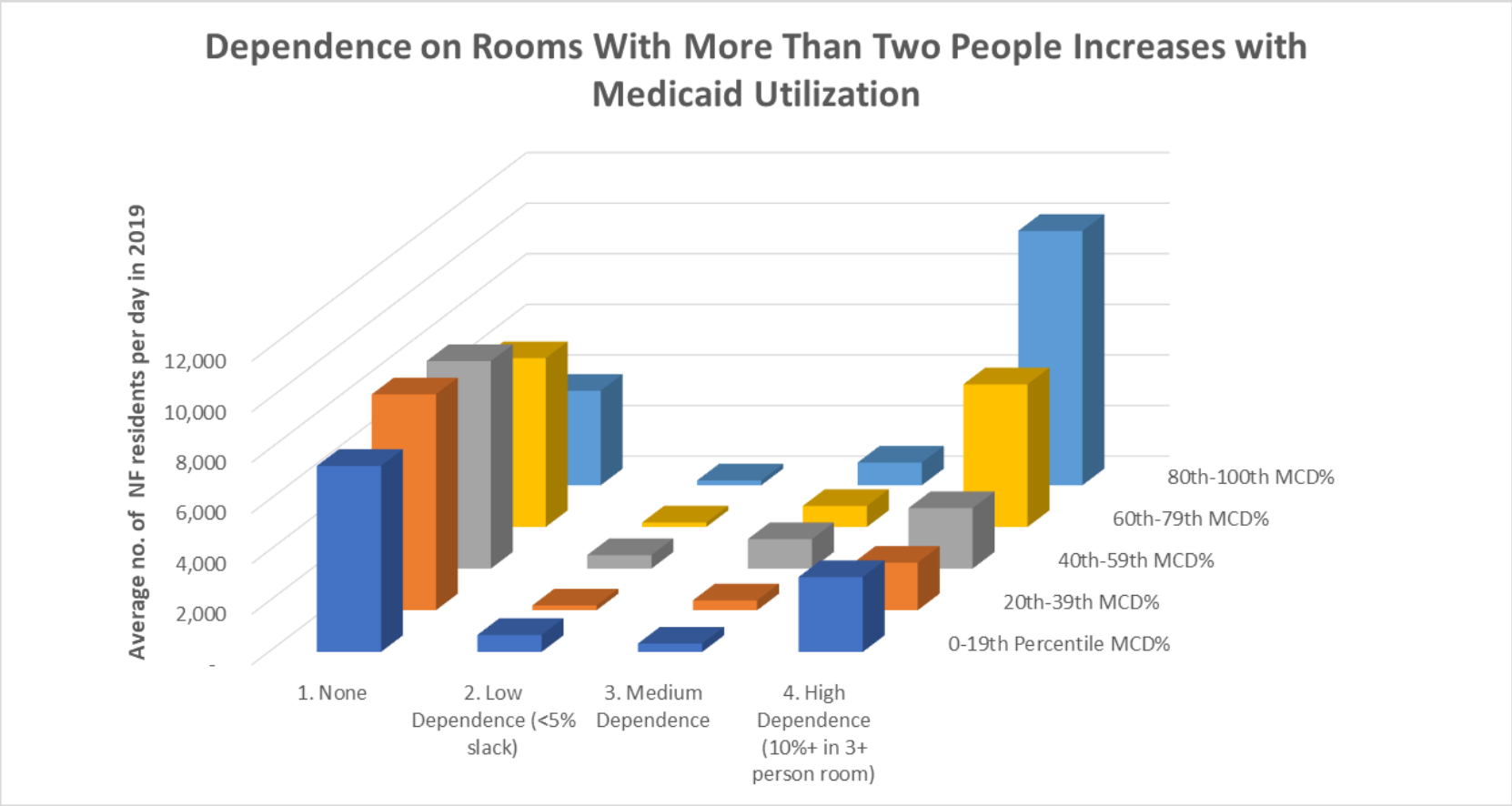
RESIDENT OVERCROWDING CONTRIBUTED TO COVID IMPACT



The average number of residents per room appears to contribute substantially to explain the Wave 1 spread of COVID-19.

Emerging research at the national and international level affirms this insight.

OVERCROWDING INCREASES WITH MEDICAID UTILIZATION



Medicare now only pays for single- and double-occupancy.

In COVID's devastating wake, researchers, advocates and industry voices alike are focusing increasingly on reducing room occupancy.

QUALITY IS A PRIORITY

- Quality of care in nursing facilities is a priority of HFS and sister agencies (DPH, DoA).
- Facilities with high proportions of Medicaid residents or racial minorities are currently more likely to receive a lower quality of care. **This must improve**.
- The federal Centers for Medicare and Medicaid Services collects and publishes nursing facility quality information, which could be used for quality-based payments in Illinois.
- To improve quality, Illinois can tie new funding to the quality of care provided, with incentives to reward high performance and/or improvements:
  - Roughly **half of states** already tie some form of incentive payment to performance for nursing facilities, although payment structure varies widely.
  - Illinois currently has **two unfunded quality incentives** in rule that were agreed to years ago to encourage staff retention as well as continuity of staff assignments to the same residents.
  - **Rebalancing / lower concentration of residents** can be encouraged from many directions.

Quality Strategy Objectives

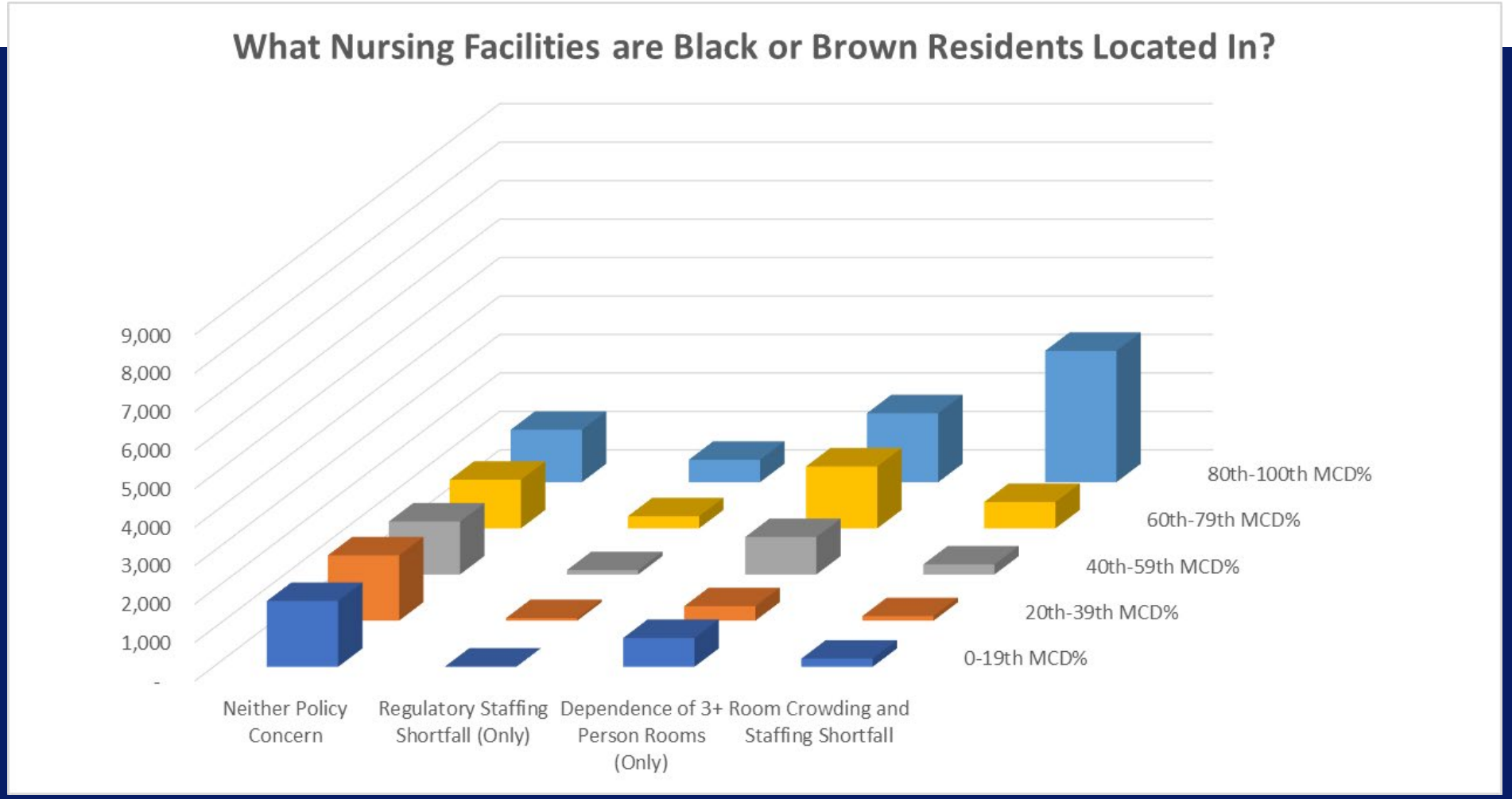
- Our transformation puts a strong new focus on **equity**; prevention and public health;
- Pays for value and outcomes rather than volume and services;
- Proactively uses analytics and data to drive decisions and address health disparities; and
- Works to move individuals from institutions to community, in an effort to keep individuals in the least restrictive environment and to keep them more closely connected with families and communities.

RACE & ETHNICITY

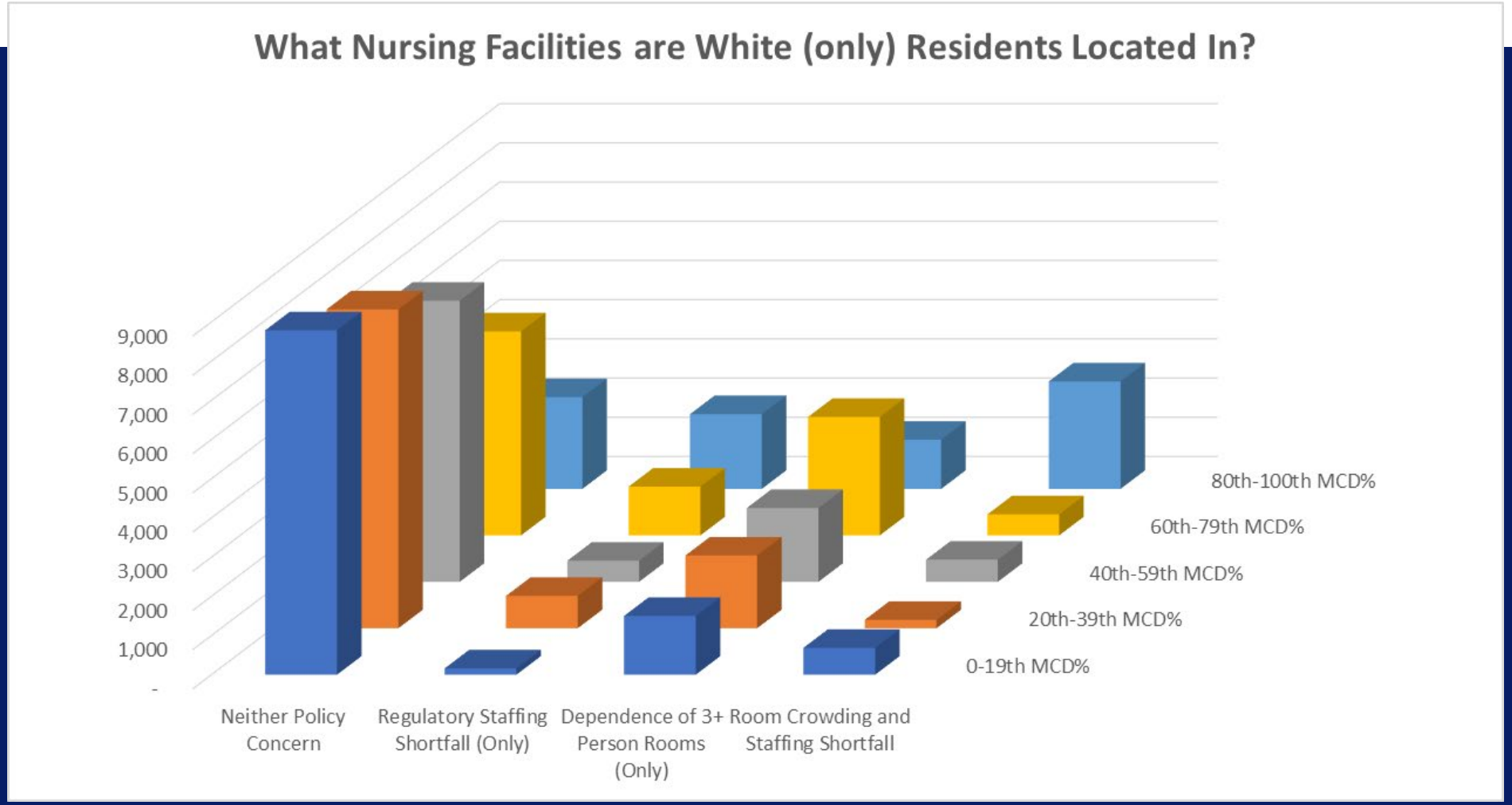
There is robust evidence of persistent disparities in the quality of nursing facility care based on race and source of payment.

- Residents of color and residents whose nursing home care is covered through Medicaid consistently receive care in facilities of lower quality across multiple dimensions compared to other residents, including worse staffing and infection control.
- These disparities exist nationally and in Illinois and remain even after accounting for differences in resident and facility characteristics.
- Facilities with more Medicaid-funded residents provide a lower quality of care, including lower staffing and room crowding; minority residents tend to live in facilities with more Medicaid-funded residents.

RACE & ETHNICITY



RACE & ETHNICITY



Three Main Components:

Modernize Payment Methodology (case mix update)

Transform Nursing Care through Assessment-Driven Increase in Funding (significant enhancements to drive Quality and Staffing)

Improve Payment Accuracy and Integrity

Modernize Payment Methodology

- Adopt transparent, outcome-driven, patient-centered model with increased accountability
- Transition away from RUGS to federal PDPM case-mix nursing component
- Ensure higher rates are geared toward higher acuity residents
- Increase the daily add-on rate for Alzheimer's services
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives

Transform Nursing Care through Assessment-Driven Increase in Funding

- End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
- Directly tie funding/incentives to demonstrable and sustained performance on key quality reporting metrics
- Align regulation and payment incentives to the same goals *[e.g., nurse staffing levels, especially CNAs]*
- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 pandemic, including reduced room occupancy
- Integrate emerging lessons and federal reforms related to the COVID-19 crisis

Improve Payment Accuracy and Integrity

- Institute documentation to support, review and validate level of care coding and appropriateness, outliers, actual patient experiences, etc.
- Improve cooperation, support and follow up, data sharing and cross-agency training from other agencies (IDPH, DoA, Ombudsman)
- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes
- Dedicate resources for consistent data collection, analysis, and oversight of facilities by HFS

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Transition to federal PDPM

- Resident-centric
- Aligns with Medicare
- Higher cost coverage for higher acuity residents

Increase Staffing

- Adequate at all times
- Major staffing bonuses
- Additional funds for CNA training

Focus on Equity

- Equity for all customers
- Decrease the burden for Black & Brown communities
- Person-centered care

Quality Incentives

- Bonuses for consistent assignment and tenure
- Outcome metrics emphasizing Medicaid's longer-stay residents
- Infection control

Maximize Federal Funding

- Increase assessment
- New funding toward enhancements that mirror priorities (equity, quality)

Reduce Overcrowding

- Shift over time to 1 or 2 persons per room
- Dignity of living
- Physical improvements

IMPROVING HEALTH & QUALITY OF LIFE

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Proposed Assessment Fee

	Current Fees	Proposed Fee	Difference
Estimated Revenue - Licensed Bed Fee	$ 50,368,245	$ -	$ (50,368,245)
Estimated Revenue - Occupied Bed Fee	$ 113,864,568	$ 318,895,826	$ 205,031,258
Total Estimated Fee Revenue	$ 164,232,814	$ 318,895,826	$ 154,663,012

Provider Participation Fee per Licensed Bed	$ 1.50	$ -
Provider Participation Fee per Occupied Bed	$ 6.07	$ 17.00
Estimated Fees as % of applicable revenue	2.8%	5.3%

Use of Additional Funds

Use of increase in assessment fees ($millions, state share)

Nursing incentives*, **	$	4
Quality improvement*	$	66
CNA tenure, promotion and training	$	20
Infection control and room conversion	$	10
Unallocated	$	6
Community based long term care alternatives	$	49
Total new spend (=new fee revenue)	$	155

*Model incorporates expected impact at the facility-level, e.g., in overall cost coverage

**In addition, the $4.55 staffing add-on is now distributed through the incentive

Nursing Care Incentive Structure

Incentive tier		Facility staffing performance as a % of STRIVE	Incentive as % of direct care component	# of Providers as of Q3 2020
Tier 1	(>/=)	105%	15%	243
Tier 2	(>/=)	100%	10%	55
Tier 3	(<)	100%	5%	73
Tier 4	(<)	92%	0%	288

New Quality Improvement Incentive Program

- Quality payments would launch alongside other rate reforms using the most recent available data
- Begin with more mature metrics that have well understood score distributions to reduce initial uncertainty over the impact of the full package of rate reforms, e.g.:
  - Long Stay Quality STAR rating (composite; nationally normed)
  - Inspection STAR rating (composite; state normed)
- Include newer metrics to capture Medicaid program priorities, e.g.:
  - Staffing continuity (HFS rule)
  - Staffing turnover (HFS rule; forthcoming on Care Compare)
- Allocation of $135 million in incentive payments
  - Reflect program priorities and improvement opportunity
  - Maintain a level of continuity to offer facilities meaningful gain from their QI investments
- Reflect HFS commitment to accuracy and transparency as with the P4P program

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Distributional Analysis of Potential Rate Changes

Key Comparisons

- Cost-neutral comparison of CMIs
- CMIs versus allocated Medicaid nursing costs
- Overall net income

Demographics

- Regional shifts
- Medicaid payer mix

Special Conditions

- Alzheimer's
- SMI
- TBI
- Overall case mix

Emerging Policy Priorities

- Nurse staffing levels
- Room crowding

Impact of Rate Proposal: by Region

HSA Region	Count of Facilities	Medicaid Utilization	Facility Cost Coverage	
			Current Rates	Proposed Rates
1 NW Galena	48	57%	90.7%	95.1%
2 NC Peoria	59	51%	92.0%	97.1%
3 WC Springfield	52	54%	95.8%	100.2%
4 EC Decatur Champaign	64	54%	93.1%	96.6%
5 S Cairo	64	56%	100.5%	105.2%
6 CHI City	76	74%	95.6%	96.1%
7 CHI Outer Cook DuPage	147	53%	86.2%	89.0%
8 CHI Lake Kane McHenry	54	49%	84.9%	89.7%
9 CHI SW and Will	26	50%	84.9%	86.8%
10 W Rock Island	14	54%	86.3%	91.7%
11 SW East St. Louis	42	57%	91.4%	93.7%

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).

Impact of Rate Proposal: by Medicaid Utilization

Medicaid Utilization	Count of Facilities	Medicaid Utilization	Facility Cost Coverage	
			Current Rates	Proposed Rates
90%-100%	67	95%	106%	102%
80-89%	79	86%	104%	102%
70-79%	85	75%	95%	96%
60-69%	71	65%	93%	97%
50-59%	71	55%	92%	97%
40-49%	85	45%	89%	94%
30-39%	67	35%	86%	93%
20-29%	48	25%	81%	89%
10-19%	41	16%	80%	88%
0-9%	32	3%	62%	68%

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).

Impact of Rate Proposal: by Facility Average Case Mix

Facility Case Mix Average	Count of Facilities	Medicaid Utilization	Facility Cost Coverage	
			Current Rates	Proposed Rates
80th - 100th Percentile	130	58%	96%	99%
60th-79th Percentile	129	60%	96%	96%
40th-59th Percentile	130	58%	91%	93%
20th-39th Percentile	128	54%	90%	93%
0-19th Percentile	129	49%	84%	92%

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).

Impact of Rate Proposal: by Special Populations Alzheimer's, Serious Mental Illness, Traumatic Brain Injury

			Facility Cost Coverage	
% of Medicaid Residents with Alzheimers	Count of Facilities	Medicaid Utilization	Current Rates	Proposed Rates
80-100%	21	26%	74%	80%
60-79%	131	50%	88%	94%
40-59%	247	55%	92%	96%
20-39%	194	63%	95%	96%
0-19%	53	60%	89%	91%

% of Medicaid Residents with SMI	Count of Facilities	Medicaid Utilization	Current Rates	Proposed Rates
10-100%	49	84%	101%	102%
8-9.9%	11	66%	100%	98%
6-7.9%	22	75%	99%	96%
4-5.9%	37	67%	97%	97%
0-3.9%	527	51%	89%	94%

% of Medicaid Residents with TBI	Count of Facilities	Medicaid Utilization	Current Rates	Proposed Rates
Greater than 0%	17	68%	93%	98%
None	639	56%	91%	95%

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).

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TIMELINE

- PDPM has been on the horizon for years.
- Been working with the Nursing Home industry to understand data / our proposal (since August 2020)
- Collaborate with General Assembly on imperatives to change (Spring 2021)
- Begin seeking federal approval for increased assessment summer 2021
- Promulgate Administrative Rules for new rates (keep consistent with federal approval)
- Implement redesigned rate system January 1, 2022
- Continue monitoring and transparency around all aspects – such as costs, staffing, and quality outcomes