Brian Sandoval
Governor

Richard Whitley
Director

Marta Jensen
Acting Administrator

Division of Health Care Financing & Policy

Medicaid Reimbursement for Nursing Facilities & Community Based Services

Nevada Silver Haired Legislative Forum
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Presented by: Jan Prentice, Chief, Reimbursement Analysis & Payment

Topics of Discussion

- Types of services for post acute care
- Current rate methodologies
- History of rates- revisions to methodology and changes to rates
- Provider tax
- Difference in costs between institutional care and home and community based care

Post Acute Care

- Skilled Nursing Facilities (SNF)
  - Free Standing
  - Hospital Based

- Home and Community Based Services
  - Assisted Living
  - Personal Care Services
  - Home Health/Private Duty Nursing
  - Adult Day Health Care

Rate Methodologies

- SNF Rate Methodologies
  - Hospital Based – Interim rates, then cost settled
  - Free Standing – Facility specific rate, calculated quarterly, based on costs, acuity, and case mix
- Service specific rates, based on type and duration for:
  - Assisted Living
  - Personal Care Services
  - Home Health/Private Duty Nursing
  - Adult Day Health Care

Hospital Based SNF

SNF that are hospital based are paid an interim rate, then cost settled annually

- Defined in Medicaid State Plan 4.19-D (A)
- Paid under Medicare's cost based reimbursement principles, not to exceed the Upper Payment Limit (UPL)
- Cost Reports are audited and the routine cost limit (RCL) is applied to determine the settlement amount

History of Free-Standing SNF Rate

2000

- A study of reimbursement methodologies was completed for nursing facilities. The DHCFP, in partnership with the industry through the Nevada Health Care Association agreed to a rate setting model which is based, in part, on the relative acuity of the mix of patients in each facility.

2001

- SNF operating rates were based on six levels of care to which each facility had a facility-specific capital rate added. A SPA approved April 26, 2002 established the operating rates to be effective October 1, 2001

History of Free-Standing SNF Rate

2002

- The direct health care component was adjusted for the change in their average Medicaid Case Mix Index (CMI).
- The Resource Utilization Group (RUG-III) system was used as the resident classification system to determine the CMI based on the Minimum Data Set (MDS) from each facility.
- Each acuity adjusted quarterly

2003

- New price based nursing facility reimbursement system. Current system.

2011

- Due to budget deficits, the NV State Legislature approved a $5.00 per day reduction to the per diem base rate and the adult vent add-on rate.

Current Reimbursement Calculation For Free Standing SNF

Facility price-based reimbursement system:

- Individual facility rates are developed from prices established for three separate cost centers

- Elements of the Rate Setting System
  - Inflation Factor
  - Base Year Cost Report & Rebasing Frequency
  - Special Care Rates
  - Minimum Direct Care Staffing
  - Rate Adjustment for Changes in State/Federal Laws
  - Budget Adjustment Factor

Current Methodology

The rate methodology for standard SNF rates was established in a SPA approved July 6, 2004 and remains effective today.

- Beginning on July 1, 2003, SNF rates were established using three cost centers: **operating**, **direct health care**, and **capital cost** (fair rental value or FRV).

- Rates are adjusted for inflation annually. A budget adjustment factor is used to reduce rates so total expenditures do not exceed the 2004 base rate plus the provider tax enhancement for the period.

Budget Adjustment Factor

In the event that the reimbursement to nursing facility providers would be greater or less than the funding appropriated by the Nevada legislature, proportional increases or decreases will be made to the rates, so that anticipated payments will equal legislative appropriations

This adjustment to rates will be made as a percentage increase or decrease in each provider's rate. The percentage will be determined in accordance with the following fraction:

(Legislative appropriations / (The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for All Freestanding Nursing Facilities))

Budget Adjustment Factor Reduction

Provider	Medicaid Days	FRV	Operating Statewide Price	Direct Health Price	Total Full Rate	Budget Adjustment Factor	Budget Neutral Per Diem
XXX	2,282	12.44	120.54	78.02	211.00	52.690%	111.17
YYY	1,412	11.99	120.54	66.51	199.04	52.690%	104.87
ZZZ	10,453	23.21	120.54	79.76	223.51	52.690%	117.77

FRV + Operating Statewide Price + Direct Health Price = Total Full Rate

Nursing Facility Equivalent Daily Rate with Supplemental Payment

Provider	Budget Neutral Per Diem Rate	Quarterly Supplemental Payment	Medicaid Days	Supplemental Payment per Day	Equivalent Daily Rate
XXX	111.17	175,518.13	2,282	76.91	188.09
YYY	104.87	164,114.51	1412	116.23	221.10
ZZZ	117.77	844,778.32	10,453	85.04	198.58

Budget Neutral Per Diem Rate + Supplemental Payment Per Day = Equivalent Daily Rate

Per Diem Equivalent Rate

	Per Diem	Daily Rate
• SFY-11 Qtr 4	190.13	*
• SFY-12 Qtr 4	116.65	188.25
• SFY-13 Qtr 4	117.29	197.67
• SFY-14 Qtr 4	117.07	196.07
• SFY-15 Qtr 4	117.15	200.91

*There is no equivalent rate, as provider tax was built into the per diem rates

Special Care Rates

In a SPA approved April 25, 2006 and effective July 1, 2005, the Medicaid Special Care Rates methodology was defined

a) For adult ventilator beds, $500 is added to the facility-specific FRV. The SPA states, " The ventilator dependent add-on rate is the rounded average of the sum of the daily average ancillary costs plus the skilled nursing level 3 rate in effect as of October 1, 2001 for this recipient population."

b) Behavioral complex recipients receive the facility-specific per diem plus $261.29

c) The facility rate for pediatric patients who are not ventilator dependent is the facility-specific FRV plus $475, also calculated by adding the skilled nursing level 3 rate to average ancillary costs for the recipients on October 1, 2001

d) For ventilator-dependent pediatric patients, the daily rate is the facility-specific FRV plus $600. This special rate was to be calculated the same way as the regular pediatric add-on

Special Care Rates

	2005	2011	2013	2016
Behaviorally Complex add-on Rate	$261.29	i. 1-8 hours ii. 9-16 hours iii. 17-24 hours		Tier I. $111.23 Tier II. $222.45 Tier III. $326.26
Ventilator Add-on Rates 21 and over	$500.00	$495.00		
Pediatric Level I		$475.00	$635.00	
Pediatric Level II		$600.00	$695.00	

Negotiated SNF Rates

- Negotiated rates are sometimes needed in special situations such as access to care or difficult placement
- Both facility specific and patient specific rates can be negotiated
- Facilities with negotiated rates are not eligible for supplemental payments

Increasing Federal Revenue for Nevada (Provider Tax)

Nursing Facility Quality Improvement Tax

- Provider Tax Revenue is received
- This is matched with federal funds
- This is paid back to nursing facilities based on a formula that includes Medicaid bed days, MDS accuracy and quality indicators

Provider Tax

- Per NRS 422.3775, all free-standing nursing facilities in Nevada are assessed a provider tax for all non-Medicare bed days
- Tax rates are calculated quarterly and are collected monthly by DHCFP based on data reported every month by each free-standing nursing facility
- The provider tax collected is calculated at the federal maximum allowable of 6% of net revenues as reported by the Facilities
- Two tax rates are assessed:
    1. Facilities with a Medicaid Occupancy of greater than 65% are assessed the Nominal Tax Rate ($18.58) for every Non-Medicare Bed Day [1]
    2. Facilities with a Medicaid Occupancy of less than 65% are assessed the Uniform Tax Rate ($35.38) for every Non-Medicare Bed Day [1]
- Penalties and interest are charged for overdue tax payments

[1] *Rates effective for SFY 2016 – Q3*

Distribution of Supplemental Payments

1. Acuity Portion of Supplemental Payment = 50%

2. Medicaid Occupancy, MDS & Quality Portions = 50%

    a) Medicaid Occupancy (82%)

    b) Minimum Data Set (MDS) Accuracy (9%)

    c) Quality (9%)

SNF Per Diem Calculation

Provider	Medicaid Days	FRV	Operating Statewide Price	Direct Health Price	Total Full Rate	Budget Adjustment Factor	Budget Neutral Per Diem
XXX	2,282	12.44	120.54	78.02	211.00	52.690%	111.17
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Keeping People in the Community

- 3 Home and Community Based Waivers
  - Frail/Elderly
  - Physically Disabled
  - Intellectual Disabilities and Related Conditions

Community Based Services

- Personal Care Services (in home)
- Home Health/Private Duty Nursing (rate increase as of July 1, 2016, pending public hearing and CMS approval of SPA)
- Adult Day Health Care
- Assisted Living (provided in a group setting, help with activities of daily living)

The 2001 Legislative Session enacted A.B. 513 "Strategic Healthcare Plan for Nevada". Thereafter a Provider Rates Task Force was created. In January 2002 EP&P Consulting Inc. was selected and did research and analysis of Nevada's rate structure for waiver services. Rates paid to private providers were set in 2002 by the Nevada Provider Rates Task Force. Rates for waiver providers were recommended by the Provider Rates Task Force and were adopted by the DHCFP August 15, 2002

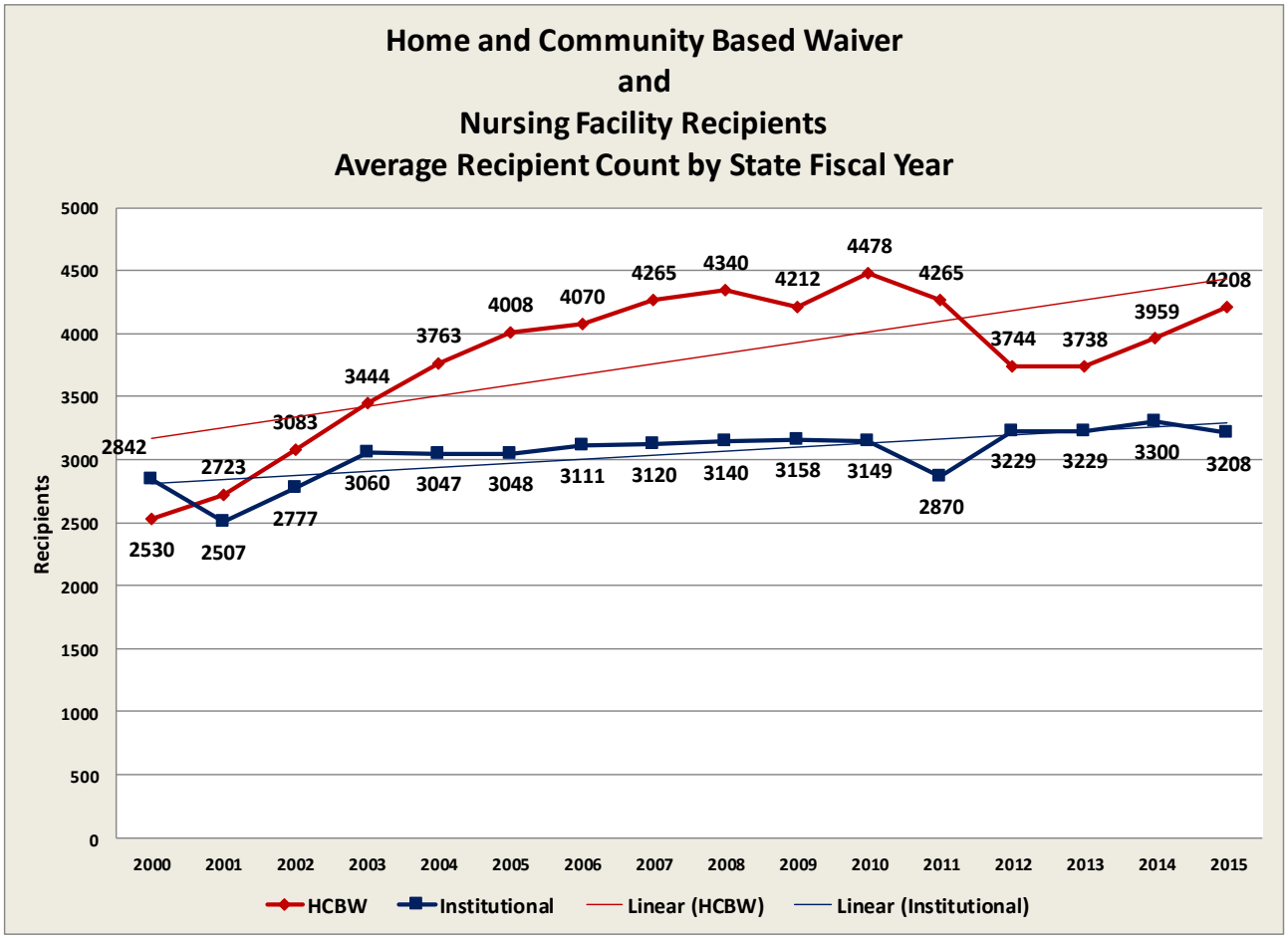
Rates are reviewed, at a minimum, on a rotating 5 year basis

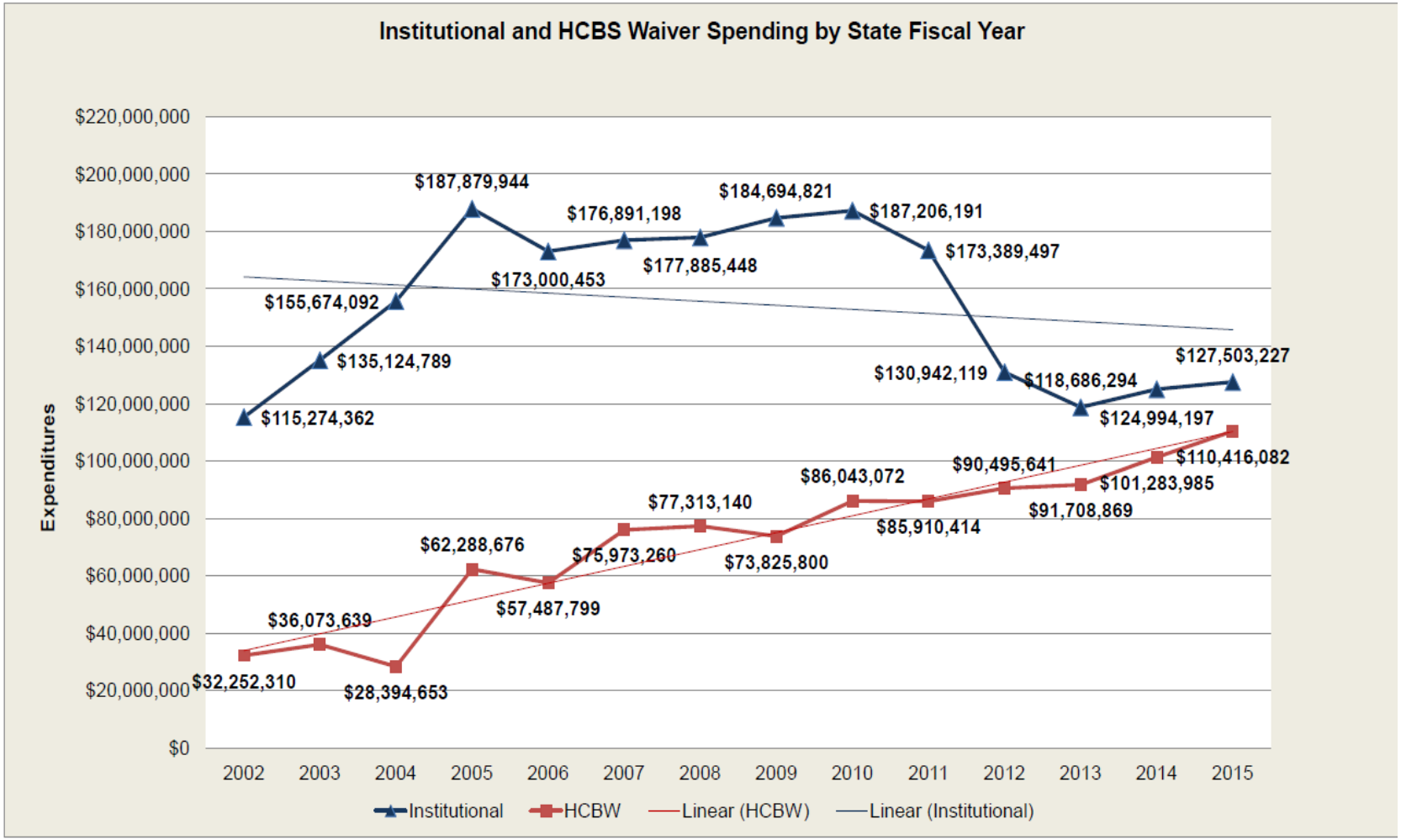
Community Based Services (cont)

Due to service type and intensity, the rates vary. Detailed reimbursement methodology for these services can be found in the Medicaid State Plan Attachment 4.19-B at the following link: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSP/Sec4/Section4-19AttachmentB(1).pdf.

Rates can be found on the DHCFP website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Nursing Facility vs. HCBS Recipients




Institutional and HCBS Waiver Spending by State Fiscal Year
Expenditures
$220,000,000
$200,000,000
$180,000,000
$160,000,000
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
$115,274,362
$135,124,789
$155,674,092
$187,879,944
$173,000,453
$176,891,198
$177,885,448
$184,694,821
$187,206,191
$173,389,497
$130,942,119
$118,686,294
$124,994,197
$127,503,227
$32,252,310
$36,073,639
$28,394,653
$62,288,676
$57,487,799
$75,973,260
$77,313,140
$73,825,800
$86,043,072
$85,910,414
$90,495,641
$91,708,869
$101,283,985
$110,416,082
Institutional
HCBW
Linear (HCBW)
Linear (Institutional)

All statistics are estimates only and must be referred to as such whether used verbally or in written form.