Study: Revised Methodology for Payment of NF Services

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Human Services Committee
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Study overview: scope and output of discussion

Component	Description
Study Scope	▪ **DHS**, with advice from a committee with representatives of the nursing home industry, **will develop an implementation plan for a revised payment methodology for nursing facility services**, which must include recommendations for the following: – Methods of reimbursement for nursing facility cost categories including direct patient care, administrative expenses, and capital assets; – Considerations regarding establishing peer groups for payments based on factors such as geographical location or nursing facility size; – The feasibility and desirability of equalizing payments for nursing facilities in the same peer group, including the time frame for equalization; and – Payment incentives related to care quality or operational efficiency
Study Output	▪ Before October 1, 2020, **the department shall report to the legislative management regarding the plan** to implement the revised payment methodology ▪ **The estimated costs** related to the implementation of the revised payment methodology **must be included in the department's 2021-23 biennium budget request** submitted to the 67th legislative assembly

Source: DHS 2019 SB 2012, Section 19

Guiding principles

- Preserve access to nursing facility services for citizens of state
- Do not reduce aggregate Medicaid reimbursement to providers
- Find balance of interests of 3 key stakeholders - residents, providers, taxpayers - where those interests may collide
  - Interest of resident for more staffing or better facilities may conflict with affordability for provider/ taxpayer
  - Interest of lower-paid provider may conflict with interest of higher-paid provider
  - Interest of resident for lower price may conflict with provider's interest for revenue
- Do not allow anecdotes to drive the system policy; ground generalizations in facts
- Be open to accepting an outcome where some providers receive less money from taxpayers per resident day
- Build in measured, predictable transition periods for any facilities experiencing changes
- Promote choice for citizens in accessing their preferred setting of care
- Consider rate equalization and its implications in evaluating options

Objectives of Payment System

- **Financially sustainable for providers**
  - Providers receive stable and predictable revenue
  - Sufficient to promote safe and high-quality care in an economically run facility
  - Allows providers to benefit from a reasonable margin to incentivize efficient and economical operations
  - Ensures recognition of changing costs, particularly those targeted to improve care
- **Financially sustainable for state, private-pay residents**
  - Growth in rates is reasonable
  - Cost is managed as efficiently as possible
- **Reimbursement is fair and equitable**
  - Reimbursement rates are similar for like services provided in similar facilities (which does not necessarily mean that every facility is paid the same)
- **Encourages quality care**
  - Incentives improvement in care quality
  - Promote choice for consumers in their setting of care
- **Encourages and allows for maintenance and improvement of facilities**
- **Easy to understand and administer**

Operating Payment: List of perceived strengths

- **State pays "fair share"**
  - Rate equalization, coupled with sustained commitment to appropriations funding, supports a system in which private-pay should not subsidize Medicaid enrollees
- **Expansive recognition of costs**
  - Pass-throughs include bad debt, education, technology
  - Property investments produce guaranteed return, as depreciation and interest is full recognized in rates
- **Timely recognition of costs**
  - Annual re-basing and rate-setting process ensures that rates increase as costs increase
  - The 3% operating margin acts as a built-in ~2% inflator, which can be used to cover resident care or other costs
- **Non-profit character of facilities supports focus on resident care**

Operating Payment: List of perceived weaknesses (1/3)

- **As of 3/31/18, two-thirds of providers were operating at a deficit.**
  - This suggests that most providers are in an unstable and unhealthy position.
  - Providers that are in a healthy position this year may not be able to sustain that position given the system.
- **The current quality measures for NFs are incomplete, varied, imprecise, or lacking impact.** This suggests there is an opportunity to expand a holistic understanding of the quality of care in NFs across the system.
- **ND has one of the highest rates of people in nursing facilities per capita.** This suggests there is a lack of awareness, supply, trust, or support for other settings of care.
- **The rate increase per resident day has been ~5% per year over the last decade.** This rate of cost growth could be characterized as unsustainable for residents and taxpayers.
- **There is more than ~83% variation in payment to SNFs per resident day.** The variation in payment could be characterized as an unfair difference given the similarity in services provided.

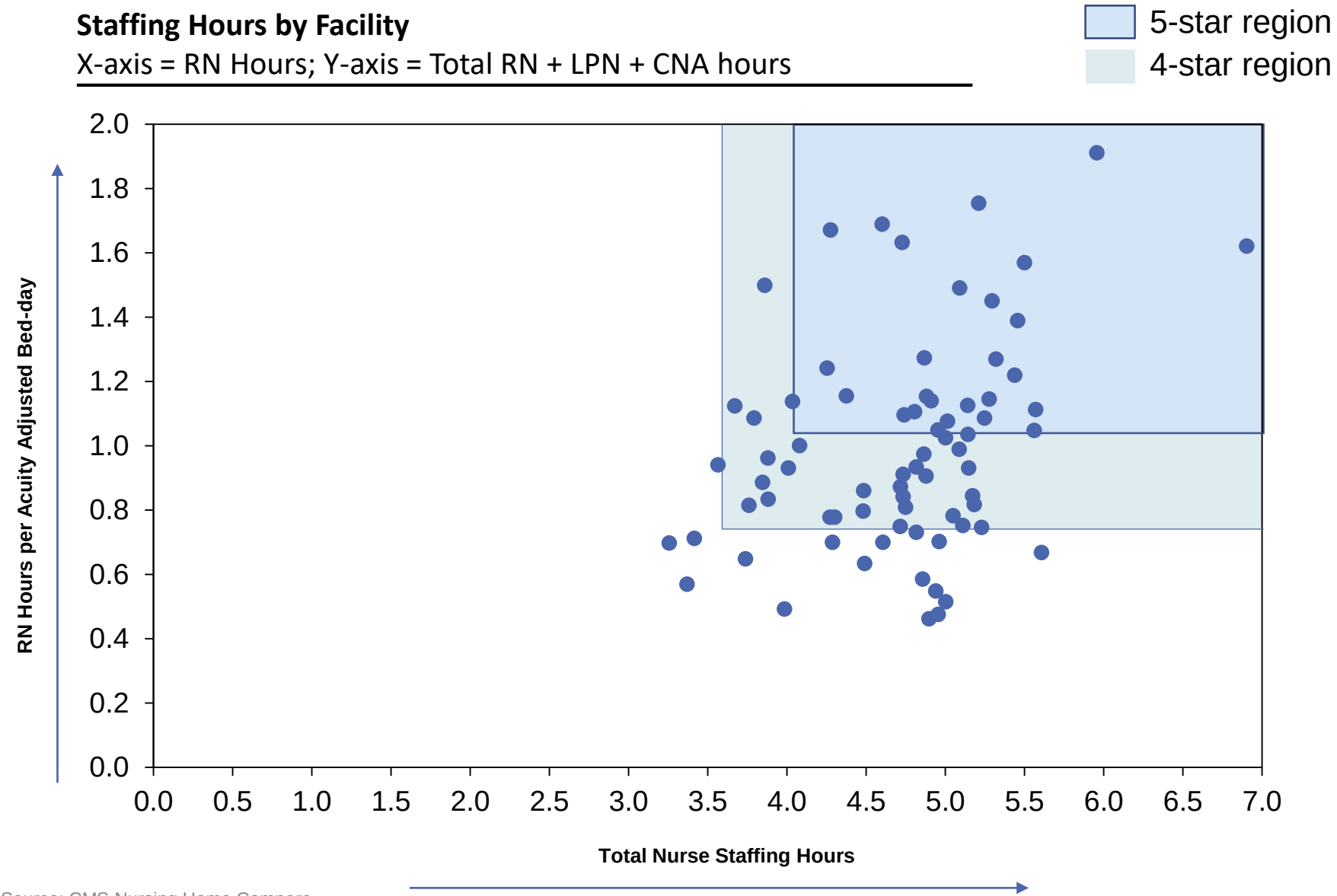
Operating Payment: List of perceived weaknesses (2/3)

- **Providers are stuck in a vicious cycle, worsening their financial position.**
  - Costs increase due to needed staff raises, regulations, tech updates, facility maintenance, etc.
  - Cost increases put pressure on financial health of facilities.
  - Current system provides limited leverage for providers to improve their bottom-line:
    - *Lowering costs by innovating will lead to lower rates the following year, thereby dis-incentivizing innovation or new operating models.*
    - Rate equalization largely prohibits increased rate on self-pay residents, though this does not apply for the ~50% of beds in market that are private rooms (for private rooms, rate increases are under pressure from the market if residents are self-pay).
  - Primary source of leverage to improve financial position is to request increases in reimbursement from the state.
  - And the cycle continues
- **This vicious cycle could have imminent effects on access, quality, and/ or sustainability of care.**
  - Access to care could decline if worsening financial position leads to facilities closing or losing licenses.
  - Safety or quality of care could decline if facilities cannot staff adequately or make required investments given reimbursement.
  - Care could be unsustainable if costs continue to rise significantly year over year.

Operating Payment: List of perceived weaknesses (3/3)

- **Legislatively approved inflationary increases often raise admin costs above intended levels**
- **Elevated staffing levels may bring diminishing returns:**
  - ND has the highest avg total staffing levels in the contiguous US
  - In many facilities staffing ratios far exceed 4 or 5-star standards
  - A direct care price around ND median cost would be sufficient to promote high quality care
  - ND direct care rates far exceed MN direct care rates, with ND 25th percentile higher than MN 90th percentile
- In addition to very high staffing levels, **CNA wages far exceed those of other states, running counter to economic logic,** as high wages are typically associated with a shortage of workers
- **Elevated CNA wages & staffing levels could create workforce issues for communities**
  - Other providers/industries may have difficulty competing for staff

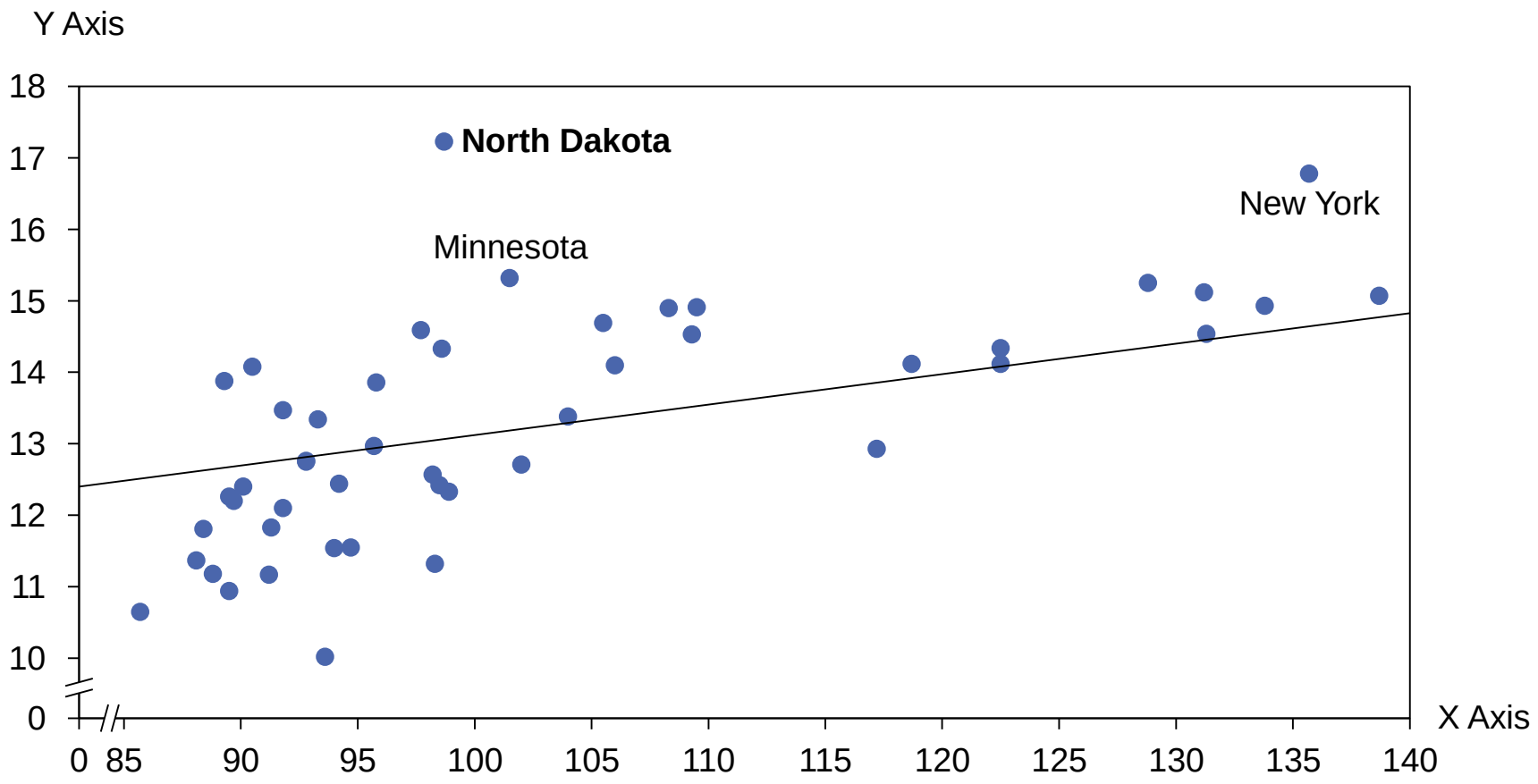
Elevated staffing levels may bring diminishing returns (2/5): In many facilities staffing ratios far exceed 4 or 5-star standards



Source: CMS Nursing Home Compare

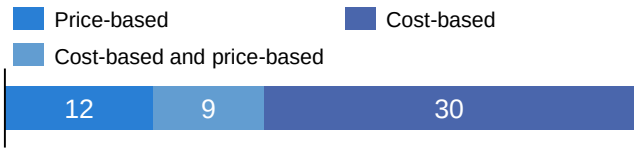
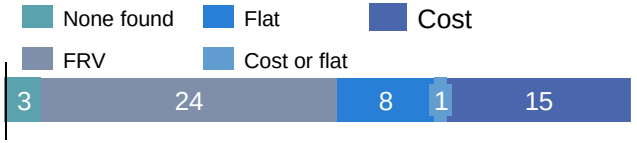
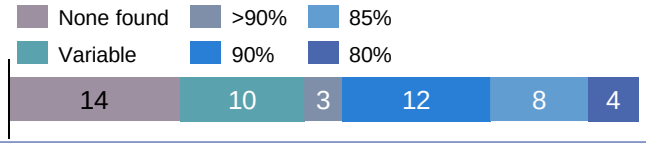
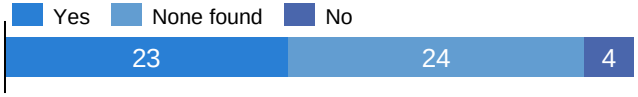
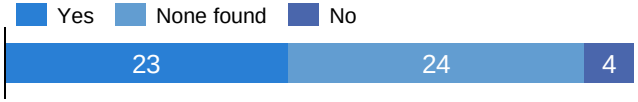
In addition to very high staffing levels, CNA wages far exceed those of other states, running counter to economic logic: high wages are typically associated with a shortage of workers

CNA Wages per Hour in Nursing Facilities versus Cost of Living index for state (2017)



Source: BLS + Cost of living index

Payment methods and policies of other states (as of 2014)

Policy (non-exhaustive)	**Policy Options / Description**	**ND Policy**	**Comparison by state**[1] Number of states	**Comments**
Payment for direct care, indirect care, admin	▪ Cost-based: Rates established based on each facility's costs ▪ Price-based: rates are established based on the costs of a group of facilities & group is paid same price	Cost-based		ND is part of majority of states (30) with primarily cost-based payment for SNF costs
Payment for capital expenditures	▪ Payment for capital falls into 3 categories: cost = pay reported cost; flat = flat rate regardless of cost; FRV = costs paid on fair rental value	Cost		ND is part of minority of states (15) with cost-based method of reimbursement for capital expenditures
Acuity system	▪ Adjustments to payments made based on resident acuity levels using resource utilization groups (RUG) or state-specific classes	RUG-IV		ND is part of majority of states (33) to use RUG-III or RUG-IV case-mix weighting system
Peer grouping	▪ Adjustments to the rate for nursing facilities based on peer groups such as number of beds or geography	None		ND is part of minority of states (18) to not use peer groups in setting rates
Occupancy minimum	▪ Average occupancy must be above minimum to receive full payment ▪ Occupancy minimum can apply to one or more cost categories	90%		ND is part of about half of states (27) with clear occupancy thresholds
Efficiency incentives	▪ Payment incentives for efficient operation or keeping costs below ceilings	Yes; admin costs		ND is part of about half of states (23) with efficiency incentives
Quality incentives	▪ Payment incentive to nursing facilities to encourage improved quality of care to residents	None		ND is part of about half of states (28) without quality incentives

- The **most significant deviations** in ND payment methodology from other states are in **payment for capital expenditures** (most states have FRV or flat payment), the **absence of peer group classification** in rate setting, and the **absence of quality incentives**

1 Includes the District of Columbia (DC) in each comparison

Source: MACPAC Nursing Facility Payment Policy Landscape (data collected 2014, report issued 2016)

Potential benefits and concerns of price-based operating payment for direct care, other direct care, and indirect care

- **Potential benefits:**
  - Providing more predictable and stable revenue than cost-based payment
  - Leveling the playing field: providing fairness of payment to facilities with similar characteristics
  - Removing a disincentive to efficiency: ensures that a reduction in cost leads to savings for facility in the following rate year rather than reduction in revenue
  - Easy to understand and administer
- **Potential concerns:**
  - How to set a price that is “fair”
  - How to avoid a windfall in cash for facilities that don’t have cost-base to support the price being paid
  - Whether price levels will be high enough to support resident care and facility operations
  - How to provide for smooth transition for facilities to consistent rate

Examples of price-based models from other states (as of 2014)

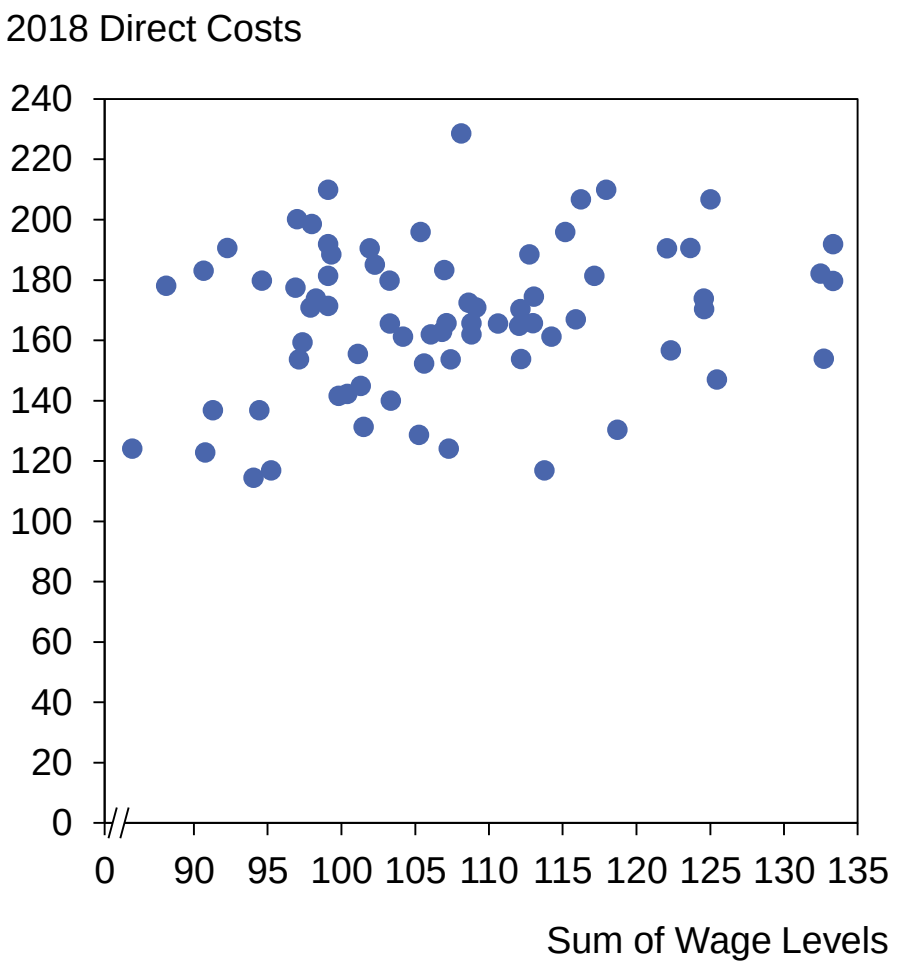
State	Price grouping	Direct care	Indirect care	Administration	Capital
Arizona	▪ Geographic grouping (urban, rural, flagstaff)	Adjusted for wage variation in costs	Statewide mean	Statewide mean	Statewide mean (flat rate)
Hawaii	▪ Statewide; small facilities receive G&A adjustment	110% of median in base yr.	G&A: 103% of median in base yr.		Median in base yr.
Kentucky	▪ Geographic grouping (urban, rural) based on MSA designation	n.a.	n.a.	n.a.	n.a.
Louisiana	▪ After July 1, 2011, price applies statewide	112.4% of median in base yr.	112.4% of median in base yr.	107.5% of median in base yr.	Fair Rental Value (FRV)
Montana	▪ Price applies statewide	20% of statewide price, acuity adjust.	80% of statewide price		
Nevada	▪ Price applies statewide	110% of median costs in base yr.	105% of median costs in base yr.	105% of median costs in base yr.	Fair Rental Value
New York	▪ "Wage equalization factor" applied to 16 geographic regions	n.a.	n.a.	n.a.	n.a.
North Carolina	▪ Price applies statewide	102.6% of median in base yr.	100% of median in base yr.	100% of median in base yr.	Fair Rental Value
Ohio	▪ Grouping into 6 groups by geography & # of beds	102.6% of median in base yr.	100% of median in base yr.	100% of median in base yr.	Fair Rental Value
Oregon	▪ Add-on for complex medical needs	Statewide rate w/ fixed relation to cost	Statewide rate w/ fixed relation to cost	Statewide rate w/ fixed relation to cost	Statewide rate w/ fixed relation to cost
Texas	▪ Statewide, special classes may be established	107% of mean in base year	107% of median in base year	107% of median in base year	FRV, price = 80% of appraised value
Utah	▪ Geographic grouping (urban, rural)	96% of median, adjusted for labor	Median in base yr.	Median in base yr.	Fair Rental Value

- Of the price-based payment systems,
  - **7 of the 12 establish one price group statewide for all facilities**, though 3 of those 7 may make adjustments to the price in the case of facility size (Hawaii) or special medical care (Oregon, Texas)
  - **5 of the 12 leverage a geography-based classification** (i.e., urban versus rural) **to create price groups** for the purposes of rate-setting, and 1 of those 5 (Ohio) also applies a facility-size grouping as well
- In all the price-based systems with information available, **direct, indirect, and admin prices have fixed relation to costs** (i.e., mean or median) **for facilities in the price group in a base year**, often with an adjustment between 0-10%

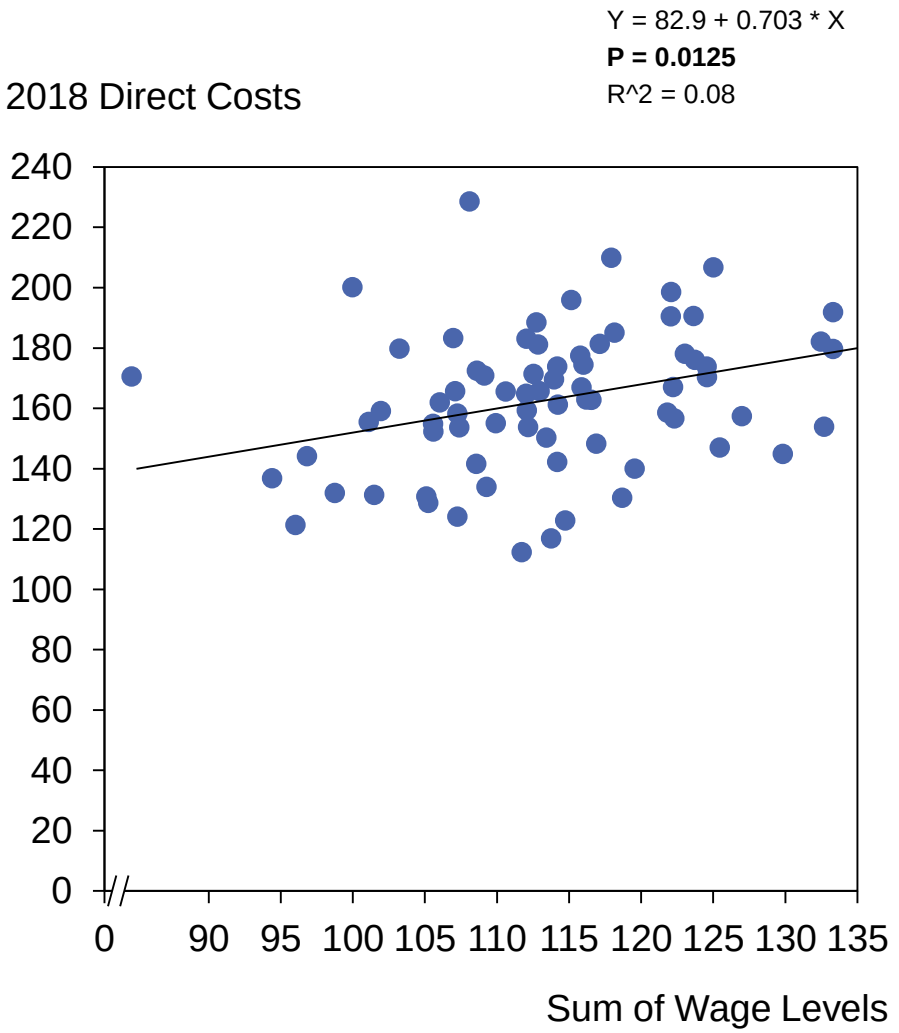
Note: payment methods are as reported in MACPAC review and do not include rate adjustments made to accommodate legislative appropriations
Source: MACPAC Nursing Facility Payment Policy Landscape (data collected 2014, report issued 2016)

Direct care costs are weakly correlated with aggregate wages

Direct costs per bed-day versus composite mid-point wage index developed from LTCA survey
(RN/LPN/CNA weighted at 1.1/0.7/3)



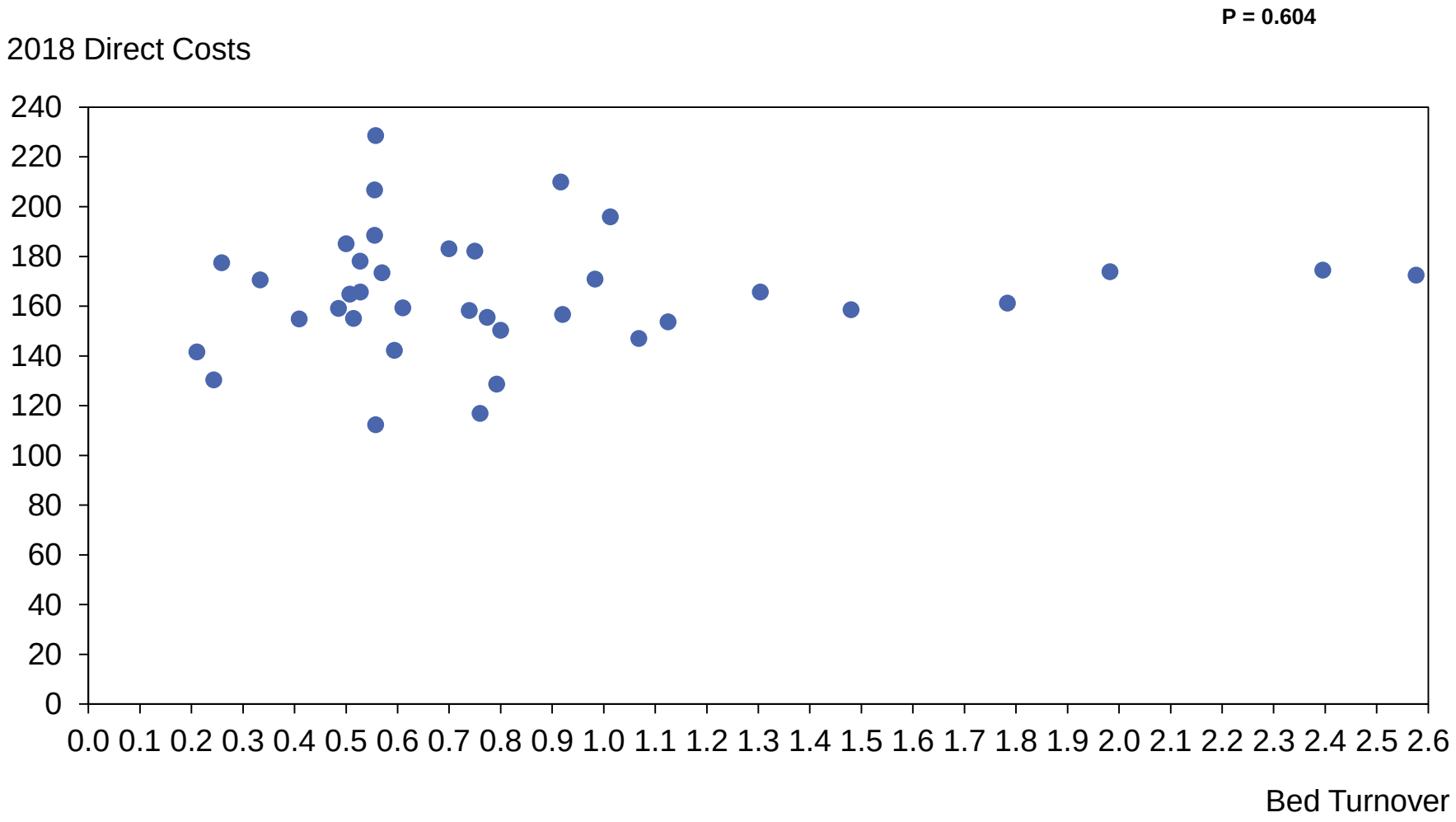
Direct costs per bed-day versus composite wage index developed from Sch P
(RN/LPN/CNA weighted at 1.1/0.7/3)



Source: LTCA survey, Sch P of Nursing Facility Cost Reports

Direct care costs are not correlated with bed turnover

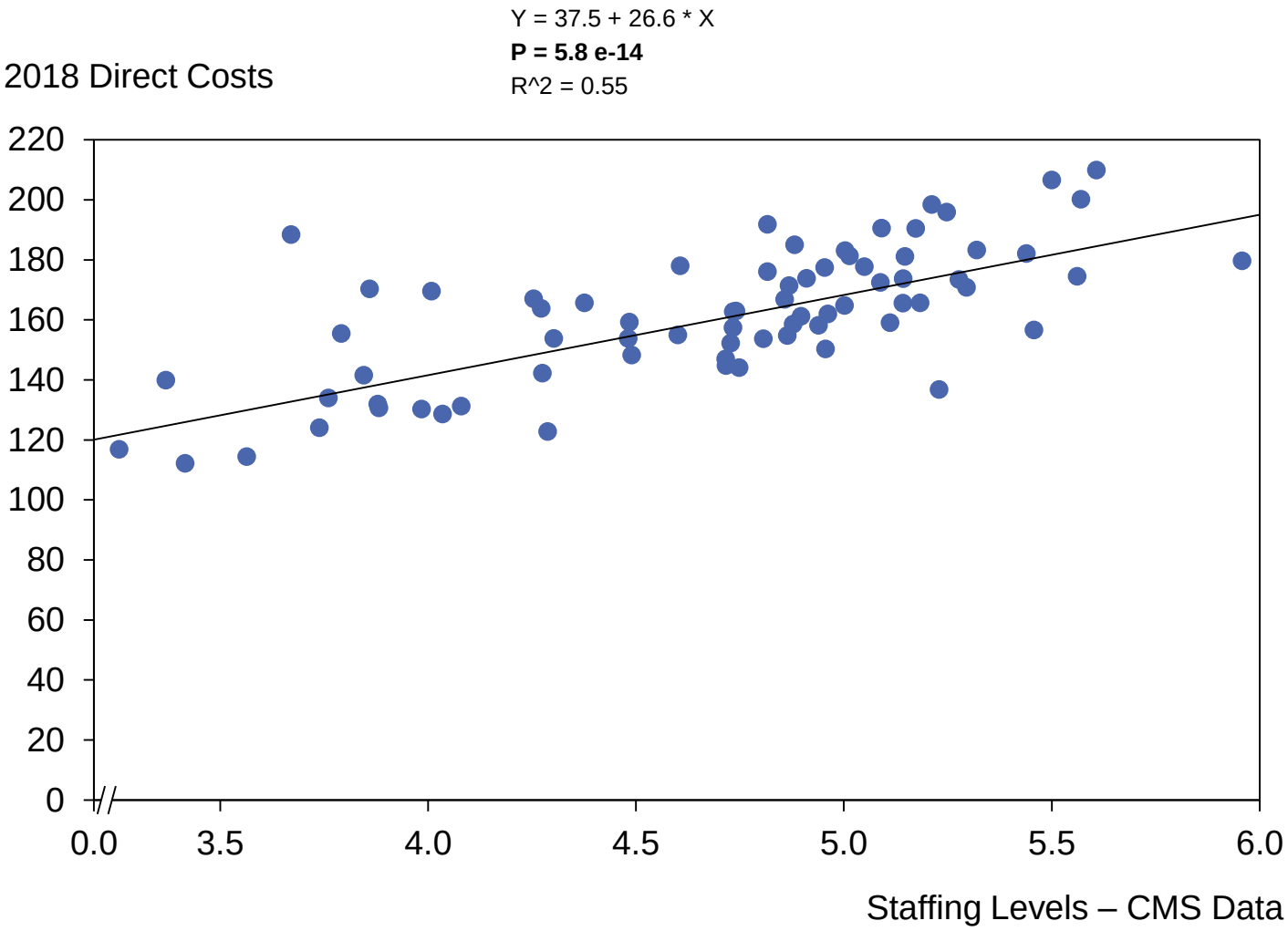
Direct costs per bed-day versus bed turnover (discharges over number of beds)



Source: LTCA Bed Turnover and Private Room Differential Survey – July 2019; Nursing Facility Cost Reports

Direct care costs are strongly correlated with staffing levels

Direct costs per bed-day versus CMS acuity-adjusted staffing levels



Source: CMS Nursing Home Compare, Nursing Facility Cost Reports

Conclusions of peer group analysis

Category	A. Urban v Rural	B. East v West	C. Large v Small
1. Direct costs	▪ While there is a difference in average direct care rates, the difference is not statistically significant ▪ Differences can be attributed to nurse staffing ▪ Bed turnover is higher in urban facilities but is not correlated with higher costs across all facilities	▪ There is not a significant difference in direct costs per bed-day ▪ There is slightly elevated wage level in the West, due to higher CNA costs	▪ There is not a significant difference in direct costs per bed-day
2. Other direct costs	▪ No significant difference	▪ No significant difference	▪ No significant difference
3. Indirect costs	▪ There is a significant difference of ~$5 per bed-day in cost between urban and rural facilities	▪ There is a significant difference of ~$10 per bed-day in cost between eastern and western facilities	▪ There is a significant difference of ~$10 per bed-day in costs between facilities above 55 beds and those 55 beds or smaller

- **Variation** in direct costs is **much more strongly correlated with staffing levels** than wages or bed turnover, but a **slight correlation with wages** exists **when contract staffing is considered**

- **Variation still exists after adjusting for** differences in **occupancy** levels between large and small facilities
- The **most logical underlying driver is large v small distinctions**

Top 3 scenarios to model

		Payment Options				
		Cost w/o limit (pass-through)	Cost-based w/ limit	Price	Price w/ margin floor	Peer Groups
Scenario 1	Direct			✖		
	Other direct			✖		
	Indirect			✖		▪ Large (>55 beds) and small (<=55 beds)
Scenario 2	Direct				✖	
	Other direct				✖	
	Indirect			✖		▪ Large (>55 beds) and small (<=55 beds)
Scenario 3	Direct				✖	
	Other direct				✖	
	Indirect				✖	▪ Large (>55 beds) and small (<=55 beds)