Nursing Facility Payment Methodology - Current

- Payment methodology is codified in Chapter 12 of Title 471 of the Nebraska Administrative Code
  - This methodology prevents the Division of Medicaid and Long-Term Care (MLTC) from adapting to marketplace dynamics
  - It also inhibits innovation and flexibility
- Payment methodology is very prescriptive and complicated
  - It can be difficult for stakeholders to understand
  - It can create uncertainty for providers year to year
- Payment methodology is based primarily on facility-specific costs and patient days
  - This unintentionally disincentives efficiency
- The methodology results in a significant variance in payments to providers for Medicaid beneficiaries
  - Varied payments for patients at the same level of care
  - Payments are made without consideration of quality of care or patient experience
  - Current per diem base rate ranges from $116.23 to $238.53
Case Study

- Town of approximately 3,000 people with two Nursing Facilities

<table>
<thead>
<tr>
<th>Measure</th>
<th>Facility A</th>
<th>Facility B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Rate</td>
<td>$123.30</td>
<td>$205.39</td>
</tr>
<tr>
<td>CMS Star Rating</td>
<td>5 Stars</td>
<td>3 Stars</td>
</tr>
<tr>
<td>Occupancy Rate</td>
<td>96%</td>
<td>54%</td>
</tr>
<tr>
<td>% Medicaid</td>
<td>&gt;80%</td>
<td>&lt;50%</td>
</tr>
</tbody>
</table>
MLTC’s Plan for Nursing Facility Payment

- Chapter 12 NAC Title 471 Changes
- New Payment Methodology Concept Development
- New Payment Methodology Modeling
- Stakeholder Engagement
- State Plan Amendment
- Technology Changes, Evaluation, and Implementation
- Program Changes, Evaluation, and Implementation
Chapter 12 NAC Title 471 Changes

• MLTC has begun work to remove significant portions of Chapter 12 from the Regulations
  • Payment Methodology
  • Cost Reports and Instructions
• MLTC plans to issue guidance documents to providers in lieu of Regulations
• MLTC will engage stakeholders via the regulations process
• MLTC is evaluating the information that will replace the current payment language, such as:
  • Assurance to stakeholders on process for feedback for any methodology changes
• Timeline (subject to changes) targets promulgation of regulations by January 2020

• *NO CHANGES PROPOSED AT THIS TIME TO ICF/DD AND CHAPTER 31 REGULATIONS*
New Payment Methodology Concept Development

1. Set a single/standard per diem rate for all providers/facilities for each level of care
   • Ensures consistent payment for services rendered
   • Incentivizes and compensates efficiency
   • Creates transparency
     • Year-to-year provider stability
     • Rate changes applied to per diems
2. Compensate providers who provide quality care to Medicaid beneficiaries
   • Use CMS Star Rating: a nationally recognized rating system
   • Weighting factor to enhance quality facility base rates (4 and 5 Star Facilities)
   • Potential to use a weighting factor to reduce facility base rates (1 and 2 Star Facilities)
   • Prospective in nature – paid in per diems, not “bonus” payments
New Payment Methodology Concept Development

3. Compensate providers who provide a significant amount of care to Medicaid beneficiaries
   - Incentivize and compensate providers who take Medicaid clients as a significant part of business practice
   - Provide providers information that helps to align business strategies, i.e. Medicaid beneficiaries, payment, and incentive-in relation to strategy on payer mix
New Payment Methodology Concept Development

Other Considerations
- Heath Professional Shortage Areas
- Provider Access Shortage Areas
- Phased-In or Immediate Implementation
- QAA data reporting
- Special needs rates (Ventilator, TBI, etc.)
- Case Mix transition (RUGS to PDPM)
- Timeline (subject to change) targeting effective date of July 2020
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