Ohio | Department of Medicaid

Medicaid Reimbursement for Skilled Nursing Facility Services

Presentation to the Nursing Facility Payment Commission

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Agenda

- Statutory Authorities
- Peer Group Structure
- Funding formula components and formula breakout
- H.B. 110 formula revisions and impacts
- Appendices
  - » Definitions
  - » Cost Center Components
  - » Other payments to nursing facilities
  - » Federal formula changes

Statutory Authorities: Nursing Facility Formula

Ohio Revised Code

- 5165.15
- 5165.151
- 5165.152
- 5165.16
- 5165.17
- 5165.19
- 5165.191
- 5165.192
- 5165.21
- 5165.23
- 5165.26

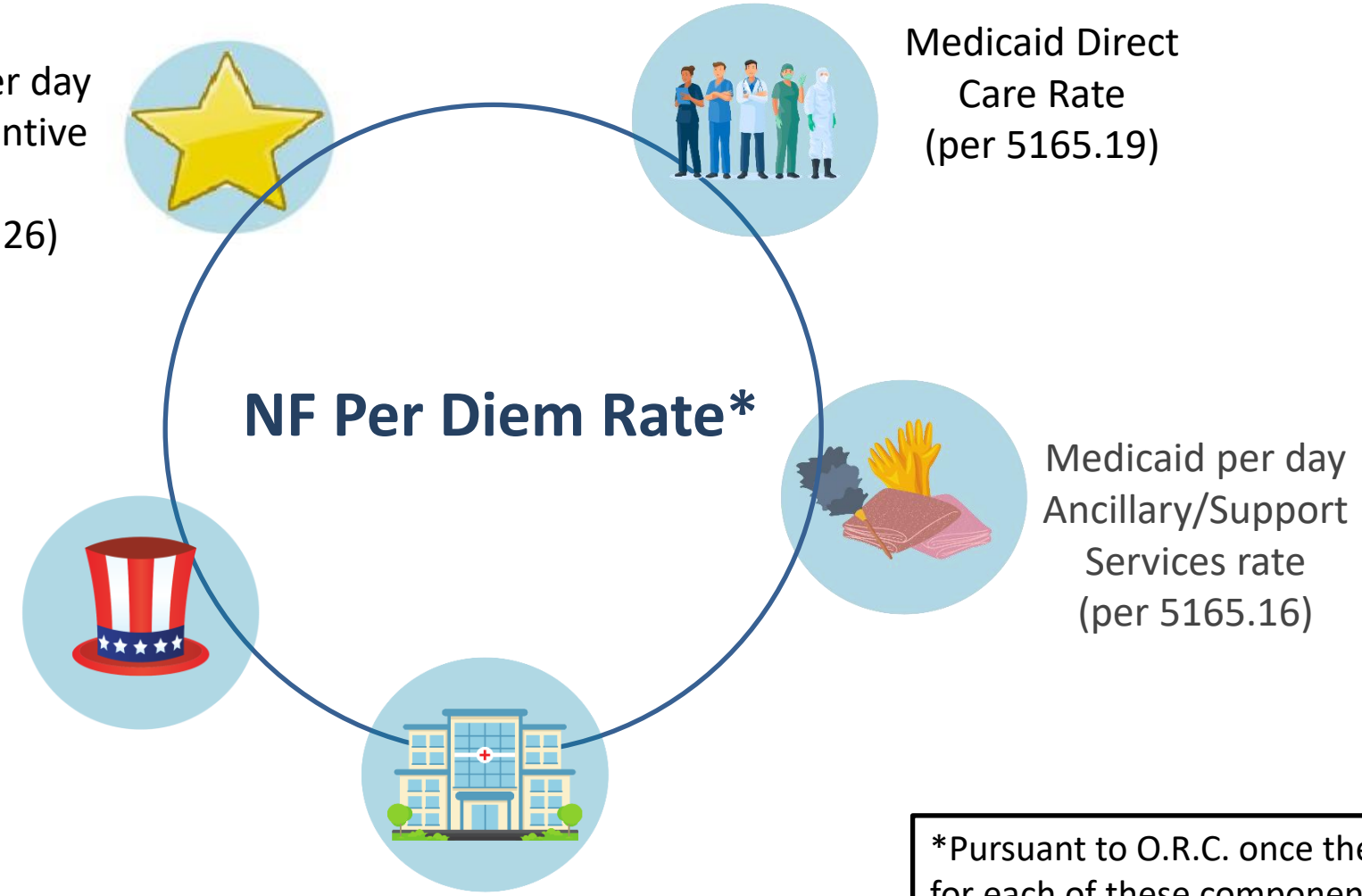
- Ohio's formula for reimbursing skilled nursing facilities is codified across multiple sections of the Ohio Revised Code (ORC)
- What characteristics of each NF determines their reimbursement?
  - Location: urban/rural/ Cincinnati
  - No. of beds in the facility
  - Acuity/population mix
  - Tax rate: profit/non profit; facility specific actual rate

Peer Group Structure & Establishing "Prices"

Direct Care Component	Peer Group 1		Peer Group 2		Peer Group 3	
3 Peer groups	Cincinnati		Metropolitan		Rural	
Ancillary, Capital & Tax Components	Peer Group 1		Peer Group 2		Peer Group 3	
6 Peer Groups	Small	Large	Small	Large	Small	Large
	< 100 beds	=>100 beds	< 100 beds	=>100 beds	< 100 beds	=>100 beds

- "Price" established for
  - Direct care: 3 peer groups
  - Ancillary: 6 peer groups
  - Capital: 6 peer groups
- These peer groups were established to reflect differences in provider cost experience, geography and number of beds in a facility; not based on facility specific costs.
- Each facility's rate is dependent upon others in their peer group

Rate Components for NF Reimbursement



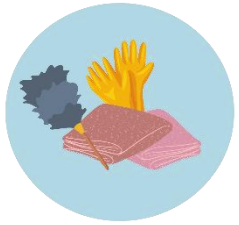
*Pursuant to O.R.C. once the price is set for each of these components, it remains in place until the next rebasing-- with the exception of quality.

1. Direct Care Price Determination (ORC 5165.19)

- Semi-annual adjustments (January and July) to direct care rate based on case mix (i.e., acuity level)
- Per statute, ODM is required to rebase at least once every 5 years

Direct Care Costs[1] ÷ Total inpatient days = **Direct Care Cost Per Day** ÷ Annual case mix score[2] = **Direct Care Cost per Case mix unit (CPCMU)[3]**

Notes:
(1) Derived from facility cost report - includes expenditures for all residents regardless of payer source
(2) All residents case mix score (i.e., acuity level) regardless of payer source
(3) Direct care cost per case mix unit is calculated for each facility in a peer group. The peer group price is then set based on the facility that has a CPCMU that is at the 25th percentile of those in the group. This standardizes the experience of nursing facilities across each peer group to compare cost of caring for residents.
(4) Direct care FY 2023 prices range from $38.51 to $41.76 cost per case mix.



2. Ancillary and Support Services Price (ORC 5165.16)

Ancillary/Support Services Price[1]

÷

Greater of:
Facility's Inpatient days
or
Imputed Occupancy @ 90%

=

Ancillary/Support Services Cost Per Day

Notes:
(1) Derived from facility cost report - includes expenditures for all residents regardless of payer source
(2) Ancillary FY 2023 prices range from $61.85 to $68.12 per diem

3. Capital Services Price (ORC 5165.17)

Capital Price ÷ Total Inpatient Days (100% occupancy) = **Capital Cost Per Diem**

Notes:
(1) Derived from facility cost report - includes expenditures for all residents regardless of payer source
(2) Prices for FY 2023 range from $7.99 to $11.11 per diem

4. Tax Cost Component (ORC 5165.21)

Tax Cost ÷ Total Inpatient Days (100% occupancy) = **Tax Cost Per Day**

5. Quality Rate (ORC 5165.26)

What is the total POOL OF FUNDING available for quality?

Subtract $1.79 from NF rate + Add 5.2% of each NF rate + Supplemental funding = **Quality Funding**

Across how many Medicaid days and points is funding distributed?

NF average quality points* × Annual Medicaid days = **Quality Point Days**

* NF points below the 25th percentile reduced to zero (per 5165.26 (C)(2)(c))

5. Quality Rate (cont.)

What is per diem amount paid per quality point?

Quality Funding ÷ Quality Point Days = **Per Point Add-On**

Note: The per-point add-on increased from $1.32 in FY22 to $1.82 in FY23

Ohio Quality Rate (cont.)

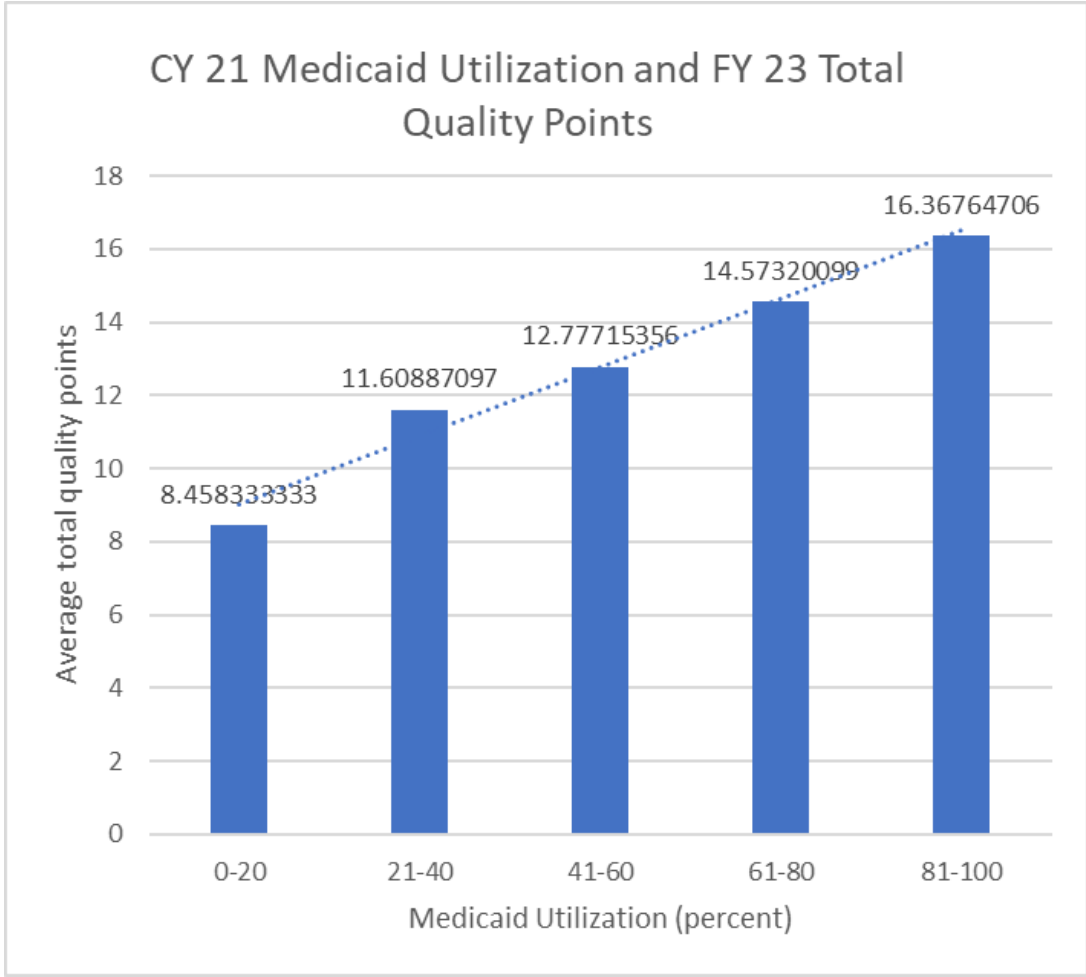
- Ohio's Nursing Facility Quality is calculated based on the following four CMS measures:

  1.) The percentage of the nursing facility's long-stay residents at high risk for **pressure ulcers** who had pressure ulcers

  2.) The percentage of the nursing facility's long-stay residents who had a **urinary tract infection**

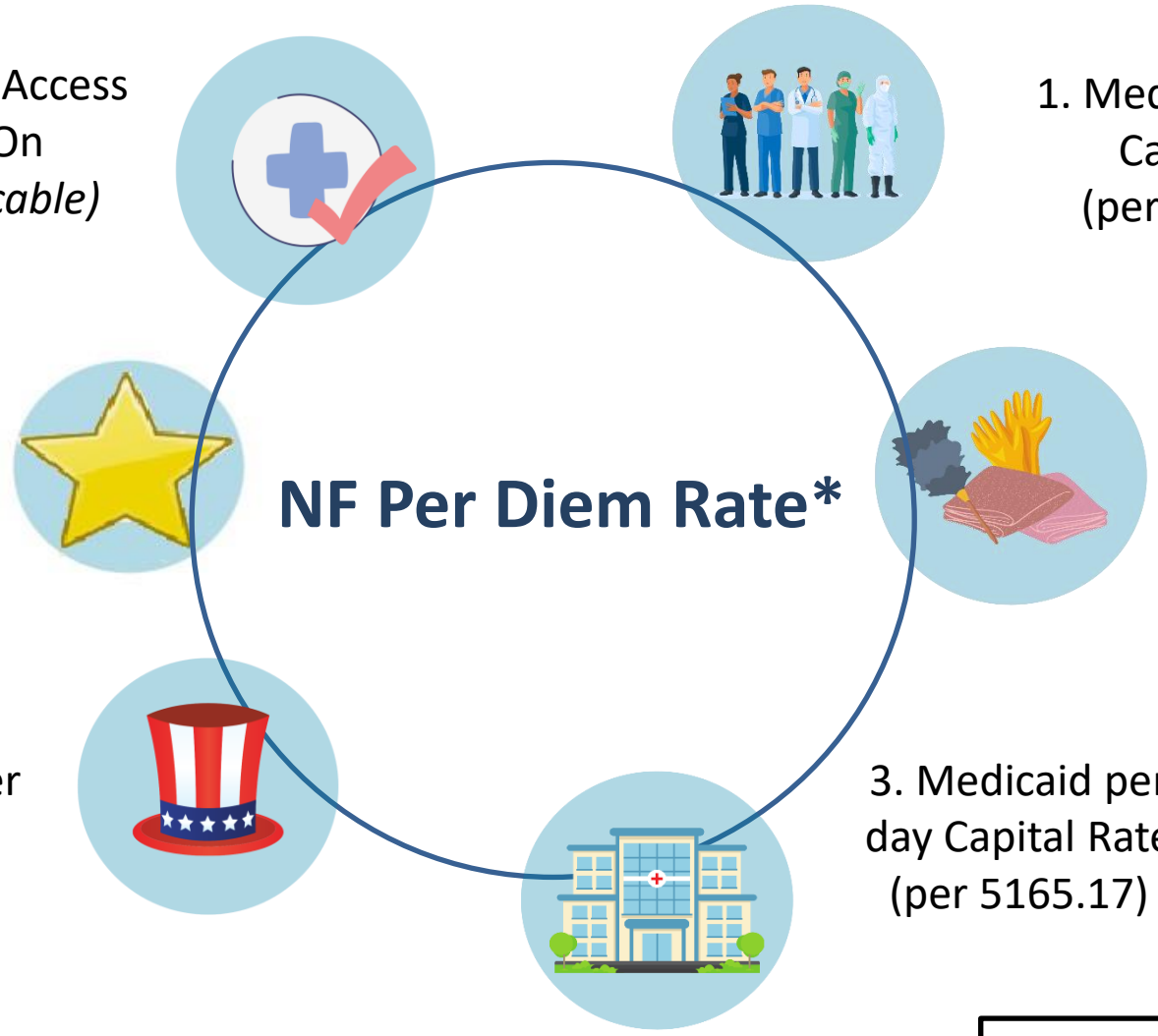
  3.) The percentage of the nursing facility's long-stay residents whose **ability to move independently worsened**

  4.) The percentage of the nursing facility's long-stay residents who had a **catheter inserted and left in their bladder**



CMS has metrics for short stays & long stays. Medicaid is typically "long stay".

Put It All Together...



1. Medicaid Direct Care Rate (per 5165.19)

2. Medicaid per day Ancillary/Support Services rate (per 5165.16)

3. Medicaid per day Capital Rate (per 5165.17)

4. Medicaid per day Tax Rate (per 5165.21)

5. Medicaid per day Quality Incentive Rate (per 5165.26)

6. Critical Access Add-On *(if applicable)*

* Medicaid payment from state is reduced to account for patient contribution toward cost of care (patient liability).

Example A (Hamilton County)

- 130 Beds
- 16.25 Quality Points

Direct Care	$103.54
	+
Ancillary	$63.11
	+
Capital	$11.11
	+
Tax	$2.38
	+
Rate Add On – Quality Pool	$16.44 - 1.79
	+
QUALITY ADD ON	$29.58
	+
Critical Access	$0.00
	=
TOTAL Per Day	**$224.37**

$224.37 X 130 beds X Medicaid days 70% occupancy x 365 = Total Medicaid Reimbursement $7,452,450

Example B (Another Metropolitan County)

- 99 Beds
- 0 Quality Points

Direct Care	$122.73
	+
Ancillary	$67.01
	+
Capital	$10.79
	+
Tax	$5.58
	+
Rate Add On – Quality Pool	$16.44 - 1.79
	+
QUALITY ADD ON	$0.00
	+
Critical Access	$0.00
	=
TOTAL Per Day	**$220.76**

$220.76 X 99 beds X 70% Medicaid days occupancy x 365 days = Total Medicaid Reimbursement $5,584,014

Example C (Rural County)

- 23 Beds
- 15.5 Quality Points

Direct Care	$127.20
	+
Ancillary	$61.85
	+
Capital	$9.54
	+
Tax	$0.69
	+
Rate Add On – Quality Pool	$16.44 - 1.79
	+
QUALITY ADD ON	$28.21
	+
Critical Access	$0.00
	=
TOTAL Per Day	**$242.14**

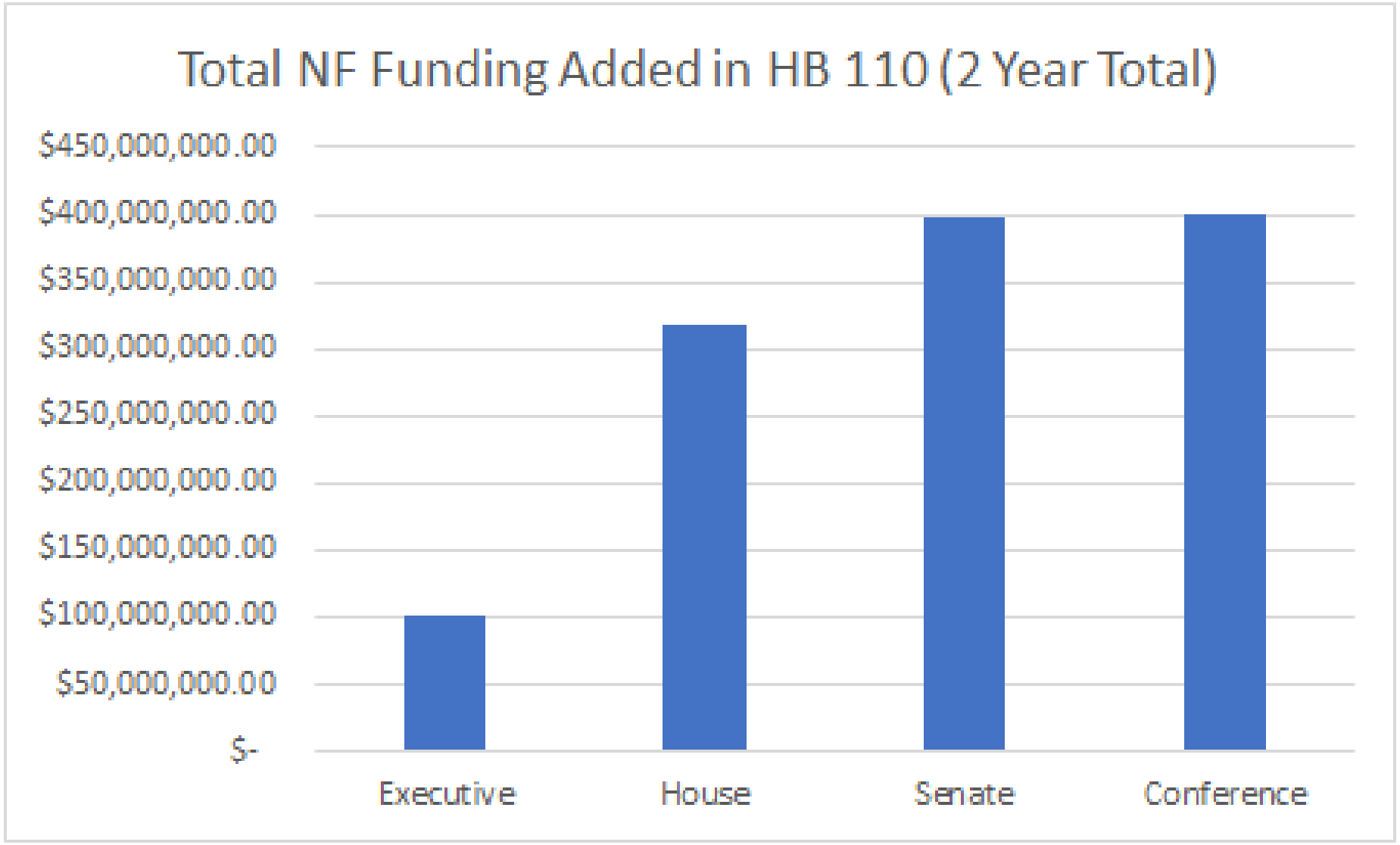
$242.14 X 23 beds X Medicaid days 70% occupancy x 365 = Total Medicaid Reimbursement $1,422,936

H.B. 110 Formula Revisions and Impact

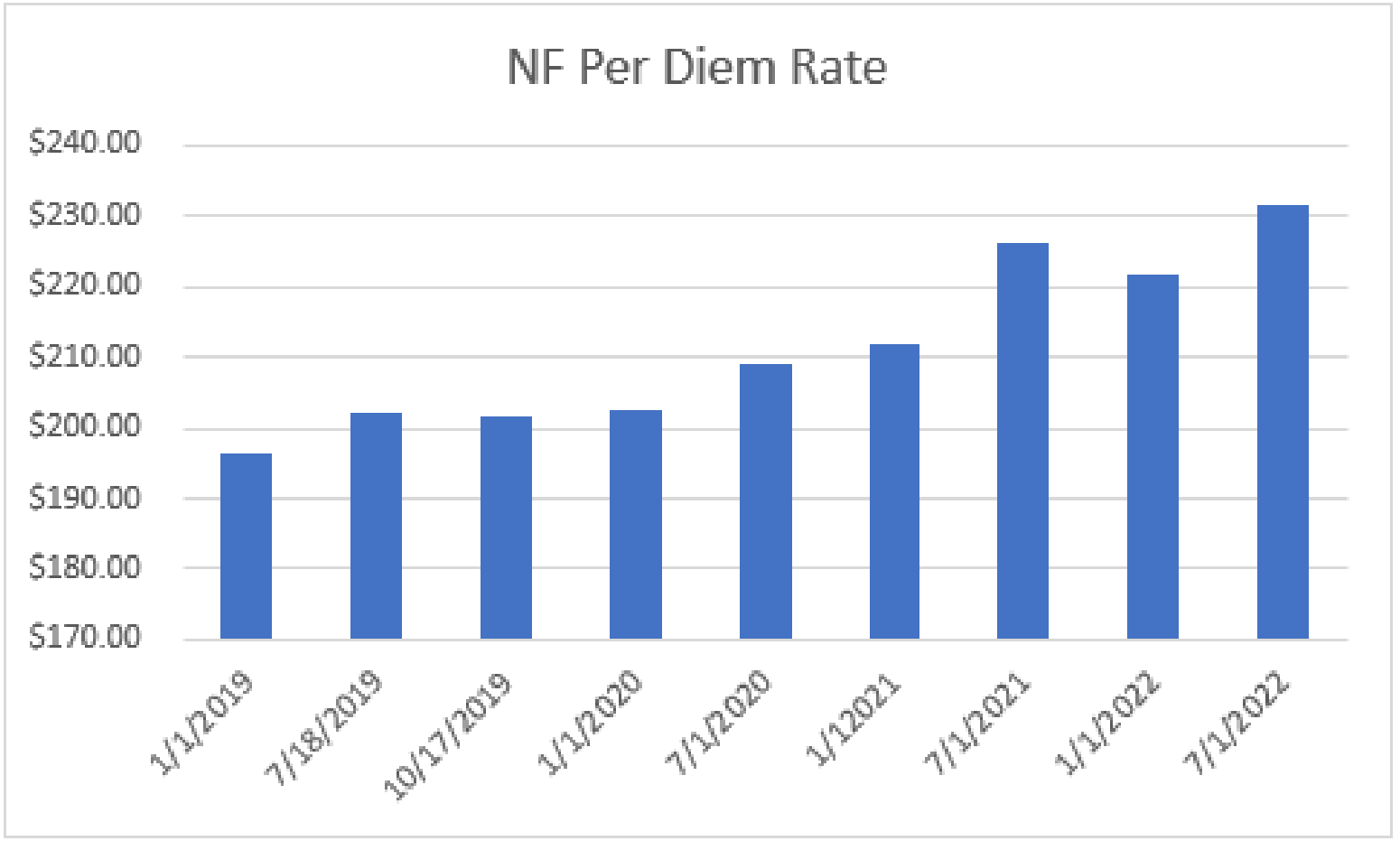
- Rebasing (ORC 5165.36 & Sec. 333.240)
  - » Required ODM to conduct a rebasing using CY19 cost report data
  - » Earmarked $125 million each FY for rebasing
    - Excluded capital costs from rebasing
    - This earmark was enough to cover all of direct care and most of ancillary care
  - » Required NFs to use 70% of rebasing increase on direct care costs, including salaries

- Supplemental NF Quality Payments (Sec. 333.220)
  - » Provided a $25 million add-on quality incentive payment for FY 22
  - » Provided a $125 million add-on quality incentive payment for FY 23
  - » Quality measures were maintained

H.B. 110 Formula Revisions and Impact



NF Per Diem Rates 2019-2022



Nursing Facility Additional Funds & Timeline

Bill	Fiscal Year Funding Received	Amount Received During the Bill's Biennium	Type of Payment
HB 166	2020-2021	$125M	Quality
HB 481	2020-2021	$0*	Quality
CFR CARES Act	2021	$204.9M	Provider Relief + Infection Control
Targeted Federal NF Relief	2020-2021	$491.2M**	Direct Federal Nursing Home Relief
HB 110	2022-2023	$150M	Quality
HB 110	2022-2023	$250M	Rebasing
HB 169	2022	$300M	Provider Relief

*HB 481 moved FY20 quality payment to FY21, increasing the base from 2.4% to 5.2%. It was originally intended to be sunset in FY21 but was continued into the current biennium at the higher rate (plus additional investments in HB 110).
**These payments were targeted specifically to nursing facilities and skilled nursing facilities by the federal government. Nursing facilities may have also applied for additional Provider Relief Funds.

Note: The quality and rebasing increases were not one time but added to the prior year base funding. The average NF per diem in 2019 was **$196.32**. It currently is **$231.72**, an increase of 18%**.**

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Appendix

Definitions

- **Ancillary/Support Services** - cost center for all reasonable costs incurred by a nursing facility other than direct care costs, tax costs, or capital costs
- **Capital** - cost center for depreciation and interest on any capital assets that cost five hundred dollars or more per item, amortization and interest on land improvements and leasehold improvements, amortization of financing costs, lease and rent of land, buildings, and equipment
- **Case mix score** – facility average acuity score based on resident assessment data
- **Cost Report –** annual submission to ODM
- **Direct Care** – cost center for registered nurses, licensed practical nurses, and nurse aides, direct care staff, administrative nursing staff, medical directors, respiratory therapists, purchased nursing services, quality assurance
- **Peer Group** – for purposes of establishing prices, nursing facilities are assigned to a peer group based on geography and bed size
- **Per Diem** - nursing facility's actual, allowable costs in a given cost center in a cost reporting period, divided by the nursing facility's inpatient days for that cost reporting period
- **Taxes** - cost center for taxes imposed under Chapter 5751. of the Revised Code, real estate taxes, personal property taxes, and corporate franchise taxes

Cost Center Components

Direct Care

- Medical Directors
- Director of Nursing
- RN Charge Nurse
- LPNs
- Nurse Aids
- Habilitation Staff
- Respiratory Therapists
- Purchased Nursing Services
- Other Direct Care

Ancillary/Support

- Activity Director/Staff
- Recreational Therapists
- Psychologists
- Social Worker/Counselor
- All dietary costs
- Incontinence supplies
- Payroll taxes, fringe benefits and staff development

Capital

- Cost of Ownership
  - Depreciation and interest on any capital asses that costs five hundred dollars or more per item
  - Amortization and in terest on land improvements and leasehold improvements
- Nonextensive Renovations

Other

- Real Estate Taxes
- Personal Property Taxes
- Franchise Tax
- Quality
- Franchise Permit Fee

Additional Policy Consideration: Federal Formula Changes: RUGS-IV to PDPM

- The current model for reimbursing nursing facilities is known as Resource Utilization Groups, Version IV (RUGS-IV)
- CMS replaced RUGS-IV with a new methodology – the Patient Driven Payment Model (PDPM) in 2020.
  - » This shift places more of an emphasis on an individual patient's unique characteristics, as opposed to paying based on the volume of therapy services they receive.
- ODM has begun the analysis for the transition from RUGS-IV to PDPM
- This shift is intended to be budget neutral in terms of *total aggregate payments* to skilled nursing facilities (SNFs).