Working with Medicare
Medicare and Medicaid Nursing Facility Benefits: The Basics and Opportunities for Integrated Care

April 27, 2016
3:00-4:00 PM Eastern Time
Welcome and Introductions

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Purpose and Goals of This Call

• Draw attention to the significant role nursing facilities (NFs) play in the continuum of services currently used by dually eligible beneficiaries

• Compare and contrast the Medicare and Medicaid NF benefits under fee-for-service (FFS)

• Describe the typical demographic profile of NF residents and highlight their often changing service needs and financial status during the time they engage with NFs

• Summarize Medicare’s and Medicaid’s NF reimbursement methodologies, elements of which are often used by health plans to determine contracted NF rates under capitation

• Identify problems in the current FFS system, such as financial incentives to shift care to hospital settings

• Identify opportunities for states to use managed care to improve care, including:
  • Engaging their health plans in addressing NF quality
  • Leveraging capitation to achieve more effective reimbursement incentives
  • Using policy levers and care models to reduce avoidable hospitalizations
Medicare and Medicaid Spending on Dually Eligible Beneficiaries
Dually Eligible Beneficiaries as a Share of Medicare and Medicaid Enrollment and Spending, CY 2011

Note: Spending totals include full benefit and partial benefit dually eligible beneficiaries. Spending exclude spending on program administration. For Medicaid, spending also excludes payments by state Medicaid programs for Medicare premiums.

SOURCE: MEDPAC –MACPAC Dual Eligible Data Book, January 2016, Exhibit 4
FFS Spending on Full Benefit Dually Eligible Individuals by Type of Service, CY 2011

**MEDICARE**
- Inpatient Hospital, 28%
- Other Outpatient, 30%
- Part D Drugs, 24%
- Home Health, 5%
- Skilled Nursing Facility, 11%

**MEDICAID**
- Institutional LTSS, 50%
- Outpatient, 12%
- HCBS Waiver, 23%
- HCBS State Plan, 8%
- Drugs, 1%
- Managed Care Capitation, 4%
- Inpatient, 2%

Annual Average:
- MEDICARE: $19,467 Per User
- MEDICAID: $41,789 Per User

**SOURCE:** MEDPAC – MACPAC Dual Eligible Data Book, January 2016, Exhibits 14 and 15
Nursing Facility Benefits Under Both Programs
Medicare and Medicaid Coverage of Nursing Facility (NF) Care

Medicare Coverage: Skilled Nursing Facilities (SNFs)
- Short-term skilled nursing care and rehabilitation services
- Up to 100 days of SNF care per spell of illness
- Ordered by a physician
- Includes skilled nursing, rehabilitation, medical social services, drugs/biologicals, durable medical equipment, and bed and board

Medicaid Coverage: Nursing Facilities (NFs)
- Long-term custodial care
- Safety net for persons who cannot afford the cost of NF care
- Mandatory service for ages 21+/optional for under age 21
- Includes room and board, skilled nursing care and related services, rehabilitation, and health-related care
- Optional state coverage of therapies, such as physical therapy, occupational therapy, and speech pathology and audiology services
# Medicare and Medicaid NF Eligibility in FFS

<table>
<thead>
<tr>
<th><strong>Medicare SNFs</strong></th>
<th><strong>Medicaid NFs</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Program Eligibility</strong></td>
<td><strong>Benefit Eligibility</strong></td>
</tr>
<tr>
<td>• 65+ and paid Medicare payroll taxes ≥ 10 yrs</td>
<td>• Financial eligibility (income and assets)</td>
</tr>
<tr>
<td>• &lt; 65 who receive SSDI for at least 24 months</td>
<td>• Categorical or medically needy eligibility</td>
</tr>
<tr>
<td></td>
<td>• Variation across groups and states</td>
</tr>
<tr>
<td><strong>Benefit Eligibility</strong></td>
<td><strong>Benefit Eligibility</strong></td>
</tr>
<tr>
<td>• Must be preceded by a 3+ day hospital stay</td>
<td>• Level of care criteria:</td>
</tr>
<tr>
<td>• Require skilled nursing or skilled rehab daily (e.g., physical therapy following stroke, wound treatment following surgery)</td>
<td>• Functional limitations in (ADLs/IADLs)</td>
</tr>
<tr>
<td></td>
<td>• Cognitive capacity</td>
</tr>
<tr>
<td></td>
<td>• Need for supervision</td>
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</table>
### Beneficiary Responsibility for NF Costs

#### Medicare Cost-Sharing for SNF
- Days 1-20: $0
- Days 21-100: $161 per day (2016)

#### Medicaid Beneficiary Responsibility for NF
- All income (minus personal needs allowance) applied to the cost of care
- Special rules apply to community spouses

#### Who Pays These Costs for Dually Eligible Beneficiaries?
- Medicaid pays Medicare cost-sharing for most dually eligible beneficiaries
- Other payers might include retiree insurance or out-of-pocket
- Beneficiaries’ income may come from a variety of sources such as Supplemental Security Income (SSI), Social Security, pensions, Social Security Disability Insurance (SSDI)
Characteristics of NF Facilities and Residents
Medicare & Medicaid Certified Nursing Facility Statistics (2014)

• 15,005 nursing facilities (or 95%) participated in both Medicare and Medicaid

• Vast majority (83%) had 25+ beds
  • Combination of SNF and NF beds

• Profit Status
  • For profit: 70% of nursing facilities and 72% of beds
  • Non-profit: 24%; Government: 5%

• Of All Medicare-Certified Facilities
  • 95% - Free-standing facilities
    • Medicare SNF services plus custodial Medicaid NF services
    • Generally, SNF patients make up just a small portion of all residents
  • 5% - Hospital-based facilities
    • Dedicated SNF beds
    • Swing beds in some rural hospitals

Characteristics of All Residents in Medicare- and/or Medicaid-Certified Facilities (2014)

Demographics
- 42% ≥ age 85, 16% < age 65
- 66% are women
- 78% are white

Impairments
- 20% - no limitation in ADLs
- 63% - 4-5 ADLs

Cognitive impairment
- 37% severe
- 25% moderate
- 39% mild

Note: Data describe all residents, regardless of payer or program participation.
# Common Scenarios for Entry into Medicare SNF and Medicaid NF

<table>
<thead>
<tr>
<th>Doorways into Medicare SNF Stay</th>
<th>Doorways into Medicaid NF Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience an acute episode that results in an ED visit, followed by a hospital stay</td>
<td>• Prior to NF stay, individual may be receiving home and community-based services at home or in assisted living. Becomes increasingly frail and in need of higher level of care. Admitted to NF.</td>
</tr>
<tr>
<td>of ≥ 3 days.</td>
<td>• Transferred from Medicare SNF stay to extended stay as private pay. Deplete income and assets on care until qualify for Medicaid.</td>
</tr>
<tr>
<td>• Experience ≥ 3 day hospital stay, transferred to community or other post-acute setting,</td>
<td>• Already dually enrolled and residing in NF. NF sends resident to hospital. Return for skilled care as Medicare SNF. Then back to NF.</td>
</tr>
<tr>
<td>transferred to SNF within 30 days.</td>
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Medicaid and Medicare NF/SNF Payment Basics in FFS
Medicaid’s NF Payment Approach

• Federal requirements regarding state payment to NFs must meet the following standards:

  ...assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area.” (§1902(a)(30)(A) of the Social Security Act)

• States are required to implement public process for determining rates (states publish all proposed and final rates for comment)

• Significant variation among states
  • Prospective per diem rates
  • Case-mix acuity-based adjustment
  • Retrospective payments based on reported costs
  • Major features may be specified by state statute

• For state-by-state payment detail, see October 2014 MACPAC Compendium at: https://www.macpac.gov/publication/nursing-facility-payment-policies/

## Some Illustrative Features of Medicaid NF Payment Policies (2014)

<table>
<thead>
<tr>
<th>Basic Payment Policy</th>
<th>Basis of Rates</th>
<th>Duration of Bed Holds During Hospitalizations</th>
<th>Acuity-Based Payment System</th>
<th>Quality/ Pay-for-Performance Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td># of States</td>
<td>Type</td>
<td># of States</td>
<td>Type</td>
</tr>
<tr>
<td>Cost-Based</td>
<td>30</td>
<td>Facility Specific</td>
<td>40</td>
<td>&lt;10 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facility Specific</td>
<td>7</td>
<td>10 – 19 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Statewide</td>
<td>1</td>
<td>20 – 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not To Exceed Hospitalization Days</td>
<td>No/None Found</td>
<td>17</td>
</tr>
<tr>
<td>Price-Based</td>
<td>12</td>
<td>Resident Specific</td>
<td>7</td>
<td>RUGs-Based</td>
</tr>
<tr>
<td>Both</td>
<td>9</td>
<td>Resident Specific</td>
<td>1</td>
<td>State specific</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Statewide</td>
<td>No/None Found</td>
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<td>Not To Exceed Hospitalization Days</td>
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</tr>
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Notes: Cost-based payments are based primarily on reported past facility costs, while price-based payments are based on estimates of future costs. Facility-specific rates are based on a composite estimate of the costs of all residents of a facility, while resident-specific rates vary with individual residents. Bed-hold days are days for which Medicaid pays NFs all or part of the regular per diem rate to keep a bed open for a resident’s return. Resource Utilization Groups (RUGs) are used by Medicare to pay acuity-based rates for SNF residents.

## Medicare SNF Prospective Payment System

<table>
<thead>
<tr>
<th>Medicare SNF Payments</th>
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</table>
| **SNF Payment Approach** | Daily “per diem” urban and rural base amounts  
• Covers all services for a day, including room/board, nursing, therapy, and prescription drugs (excludes physician visits, dialysis and certain prosthetics and orthotics) |
| **Payment Adjustments to Base Per Diem** | Case-mix varies by treatment and care needs  
• 66 Resource Utilization Groups (RUGs)  
• Minimum Data Set (MDS)  
• Area wage variation (i.e., hospital wage index) |
| **Annual Updates to Per Diem** | SNF Market Basket  
• National average costs of good and services purchased by SNFs  
• Offset by productivity adjustment (started 2012) |
| **AIDS** | Per diem payment increased by 128% for a SNF resident with AIDS |

Example of Medicare SNF Prospective Payment System

FY 2015 Sample Rates for New York

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>One day for resident with high ADLs in a <strong>high RUG group</strong></td>
<td>$710.07</td>
</tr>
<tr>
<td>Rural</td>
<td>One day for resident with low ADLs in a <strong>medium RUG group</strong></td>
<td>$266.75</td>
</tr>
</tbody>
</table>

Medicare SNF Payments: Recent Trends

• From March 2016 MedPAC Report to the Congress:
  • High and sustained Medicare margins
    • >10% for 15 consecutive years
    • In 2014, 892 facilities with relatively low-cost and high-quality care had margins of 20%
  • Costs varied widely among facilities
    • Variation in costs based on ownership & upcoding
    • Variation not attributed to case mix
  • Medicare Advantage pays considerably less than FFS (in some cases, 23% less)
    • May be due to lower payment rates and/or stricter rules than FFS for SNF admissions, lengths of stay, therapies, etc.

State and Health Plan Options to Address SNF and NF Coordination, Payment, and Quality Issues through Integrated Managed Care
Challenges with FFS Reimbursement System for SNF/NF benefits

- Incentives to hospitalize residents
  - Medicare 3-day hospital stay requirement for SNFs
    - May lead to unnecessary hospitalizations to get higher SNF rate
  - State bed hold policies for NFs
    - Pays NFs for empty beds while residents are hospitalized
  - Insufficient clinical staff in NFs to treat complex residents on site
    - Can result in avoidable hospitalizations
- Insufficient linkages between SNF/NF care and acute care (physicians, hospitals, Rx drugs)
  - States do not have information on acute care service use for dual eligibles in FFS, since services are paid for by Medicare
State Opportunities under Integrated Care Programs

- States with integrated care programs – like those participating in the CMS Financial Alignment Initiative or with linked Medicare D-SNPs and Medicaid MLTSS plans – can work with health plans to:
  - Improve integration of SNF and NF benefits
  - Promote better quality and lower costs
  - Address some of the perverse financial and other incentives in the FFS system
Health Plan SNF/NF Reimbursement Options

• Health plans are not limited by Medicare and Medicaid FFS reimbursement rules, but usually build on them in negotiating rates with nursing facilities.

• Health plans can:
  • Waive SNF three-day hospital stay requirement
  • Determine need for SNF services without being constrained by SNF 100-day limit
  • Limit payment to NFs for “bed-hold days”
  • Use savings from decreased avoidable hospitalizations and SNF stays to fund additional on-site clinical staff at NFs
  • Pay NFs more for high-need residents and less for lower-need residents
    • Can include extra short-term payment for services needed to avoid unnecessary hospitalizations
    • Can reduce payment “cliffs” when residents shift between Medicare and Medicaid benefits
  • Make performance-based incentive payments to NFs
  • Pay NFs directly for Medicare beneficiary cost sharing for dually eligible beneficiaries in SNFs, without the need for “crossover claim” submissions
    • Can reduce SNF “bad debt” for unpaid beneficiary cost sharing
Tying Payment to Facility Performance

• Most publicly available examples of NF/SNF pay-for-performance initiatives are in FFS
  • States and health plans can adapt these approaches for use in managed care
• Tennessee bases a portion of FFS NF payment on quality measures (member/family satisfaction; culture change/QoL; staffing/staff competency; clinical performance)
  • See this link for details: https://www.tn.gov/tenncare/topic/quiltss and http://www.chcs.org/media/CHCS-NASUAD-State-Innovations-in-LTSS.pdf
• MedPAC tracks and reports on five quality measures for SNFs dealing with discharges to the community, avoidable hospital readmissions, and mobility changes
  • Measures could be tied to payment
• CMS is developing a SNF value-based purchasing program for implementation in 2019
  • See this link for details: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
Other SNF Quality and Performance Measurement Options for States and Health Plans

• CMS Medicare Nursing Home Compare, includes Star Ratings
  • Quality measures
  • Deficiencies from survey results
  • Self-reported staffing levels

• CMS SNF Quality Reporting Program
  • Starts in FY 2018
  • Includes measures of pressure ulcers, falls, functional assessments and care plans, and proposed measures of discharges to the community, per-beneficiary spending, preventable readmissions, and drug regimen reviews
    • See April 21, 2016 Fact Sheet for details: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-21-2.html

• States and health plans could consider using these measures to adjust payment to Medicaid NFs

• Could also be adapted for use in Medicaid managed care quality rating system required in new Medicaid managed care regulations
  • See 42 CFR secs. 438.334 and 438.330(b)(5) and (c)(1)(ii) (LTSS measures)

SOURCES: Nursing Home Compare, see http://www.medicare.gov/nursinghomecompare/search.html, Access to data at https://data.medicare.gov/data/nursing-home-compare ProPublica, ProPublica Nursing Home Inspect
Reducing Avoidable Hospitalizations for Dually Eligible Individuals in Nursing Facilities
ICRC TA Brief and Study Hall Call

  - Illustrates what states and health plans, working together, can do to address a long-standing problem for Medicare-Medicaid enrollees

- **Reducing Avoidable Hospitalizations Among Nursing Facility Residents: Three Perspectives** (June 2015)
  - Study Hall Call slides and recording available at: [http://www.integratedcareresourcecenter.net/PDFs/ICRC-SHC_NFAvoidableHospitalizations_508.pdf](http://www.integratedcareresourcecenter.net/PDFs/ICRC-SHC_NFAvoidableHospitalizations_508.pdf)
  - Features health plans in MN and AZ and CMS FFS demonstration in MO
State Options to Reduce Avoidable Hospitalizations: Capitated Managed Care

- Include performance measures in health plan contracts
  - Plan all-cause readmissions within 30 days
  - Percent of plan members using high-risk medications
  - Nursing facility urinary tract infection hospital admission rate
  - Emergency department utilization rate
- Focus health plan performance and quality improvement projects
  - Work with state External Quality Review Organization and Medicare Quality Improvement Organization to coordinate performance and quality improvement projects
- Encourage and facilitate specific health plan efforts
  - Waiving requirement for three-day hospital stay to qualify for SNF-level reimbursement
  - Making greater use of nurse practitioners in nursing facilities
  - Encouraging more appropriate prescription drug use
  - Contracting with selected nursing facilities
State Options to Reduce Avoidable Hospitalizations: Medicaid Fee-for-Service

- **Modify bed-hold policies**
  - Pays nursing facilities to reserve beds of hospitalized residents
  - In early 2014, 33 states and DC had a bed-hold policy for Medicaid beneficiaries (MACPAC, 2014)
  - Eliminating bed-hold policies or making them less generous is likely to reduce hospitalizations and readmissions (Cai et al., 2010; Grabowski et al., 2010; Intrator et al., 2007; Unruh et al. 2013)

- **Use case mix reimbursement system**
  - Reimbursement system that pays Medicaid nursing facilities higher amounts per day for residents with higher needs
  - In early 2014, 39 states and DC had some form of acuity-base case mix reimbursement system (MACPAC, 2014)
  - Can make it more financially feasible for facilities to treat higher-acuity residents rather than hospitalizing them
CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in FFS

• Organizations in seven states (AL, IN, MO, NE, NV, NY, and PA) are providing education and clinical support to nursing facility partners

• *Phase One* evaluation report found promising effects on all-cause hospitalizations, potentially avoidable hospitalizations, and Medicare expenditures, and noted some early lessons that may be useful to states and health plans

• *Phase Two* (payment phase) will test the addition of extra payments to support the training and clinical initiatives in Phase One
  • Practitioners will receive new payments for multidisciplinary care planning activities, and participating skilled nursing facilities will receive payments to provide additional treatment for common medical conditions that often lead to avoidable hospitalizations.

Links to Main Sources Cited


- Nursing Home Compare: http://www.medicare.gov/nursinghomecompare/search.html
Additional Resources

• CMS Medicare-Medicaid Coordination Office

• Integrated Care Resource Center
  • Contains resources, including briefs and practical tools to help address implementation, design, and policy challenges
  • [http://www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com)
About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries

- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies

- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges

- Send additional questions to: integratedcareresourcecenter@chcs.org
Questions and Answers
Next Steps

• MMCO/ICRC goal is to help states improve integration of services for dually eligible beneficiaries

• Tell us what Medicare issues you would like more information on

• Send additional questions to: ICRC@chcs.org