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

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Welcome and Introductions

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Agenda

• The Basics of Medicare Skilled Nursing Facilities (SNFs) and Medicaid Nursing Facilities (NFs) and Resident Characteristics
  • Medicare and Medicaid Spending on Dually Eligible Beneficiaries
  • SNF/NF Benefits Under Both Programs
  • Characteristics of SNFs/NFs and Residents

• SNF/NF Payment Basics and Options to Address Coordination, Payment, and Quality Issues
  • Medicaid and Medicare SNF/NF Payment Basics in Fee-for-Service (FFS)
  • State and Health Plan Options to Address SNF/NF Coordination, Payment, and Quality Issues

• Value-Based Purchasing (VBP) for Medicaid NFs

• Questions and Answers
Medicare and Medicaid Spending on Dually Eligible Beneficiaries
Dually Eligible Beneficiaries as a Share of Medicare and Medicaid Enrollment and Spending, CY 2012

Medicare

- Total enrollment: 52.3 million (80% non-dually eligible, 20% dually eligible)
- Total spending: $543.0 billion (66% non-dually eligible, 34% dually eligible)

Medicaid

- Total enrollment: 71.8 million (85% non-dually eligible, 15% dually eligible)
- Total spending: $360.6 billion (67% non-dually eligible, 33% dually eligible)

Note: Enrollment counts include number of beneficiaries ever-enrolled in CY 2012. Spending and enrollment totals include full and partial benefit dually eligible beneficiaries. Spending excludes program administration. Medicaid spending excludes payments by state Medicaid programs for Medicare premiums.

Medicare spending percentages include only Part A and Part B services and do not sum to 100 because spending is shown only for selected services. Medicare Part D spending is not included. Medicaid managed care capitation includes payments to limited-benefit managed care plans for behavioral health, transportation, and/or dental services.

Medicaid and Medicare pay 56% of all nursing facility payments


Note: Total payments include both nursing facilities and continuing care retirement communities.
Nursing Facility Benefits Under Both Programs
Medicare and Medicaid Coverage of Nursing Facility 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
- Requires a 3-day hospital stay to qualify
- 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 Nursing Facility Eligibility in FFS

<table>
<thead>
<tr>
<th>Medicare SNFs</th>
<th>Medicaid NFs</th>
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<tbody>
<tr>
<td><strong>Program Eligibility</strong></td>
<td><strong>Benefit Eligibility</strong></td>
</tr>
<tr>
<td>• Eligible for Medicare Part A because of age (65+) or disability</td>
<td>• Financial eligibility (income and assets)</td>
</tr>
<tr>
<td></td>
<td>• Categorical or medically needy eligibility</td>
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<tr>
<td></td>
<td>• Variation across groups and states</td>
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<td></td>
<td>• Level of care criteria:</td>
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<tr>
<td></td>
<td>• Functional limitations in (ADLs/IADLs)</td>
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<td></td>
<td>• Cognitive capacity</td>
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<td>• Need for supervision</td>
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</tbody>
</table>
**Beneficiary Responsibility for Nursing Facility Costs**

<table>
<thead>
<tr>
<th>Medicare Cost-Sharing for SNF</th>
<th>Medicaid Beneficiary Responsibility for NF</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Days 1-20: $0</td>
<td>• All income (minus personal needs allowance) applied to the cost of care</td>
</tr>
<tr>
<td>• Days 21-100: $164.50 per day (2017)</td>
<td>• Special rules apply to community spouses</td>
</tr>
</tbody>
</table>

**Who Pays These Costs for Dually Eligible Beneficiaries?**

- Medicaid pays Medicare cost-sharing for most dually eligible beneficiaries
- Other payers might include retiree insurance, Medigap, or out-of-pocket

- Beneficiaries’ income may come from a variety of sources such as Social Security, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and pensions
Characteristics of Nursing Facilities and Residents
Medicare & Medicaid Certified Nursing Facility Statistics, 2014

- 14,409 nursing facilities (or 92%) participated in both Medicare and Medicaid
- About 13% had 50 or fewer beds, and 50% had 100+ beds*
  - Combination of SNF and NF beds
- Profit Status
  - For profit: 70% of nursing facilities and 72% of beds
  - Non-profit: 24%; Government: 6%
- Of All Medicare-Certified Facilities (2015)
  - 95% - Free-standing facilities
    - Provide both SNF and NF services
    - Only a limited number of SNF patients on a given day, but higher per diem reimbursement than NF patients. Higher turnover of SNF patients; NF patients stay longer.
  - 5% - Hospital-based facilities
    - Dedicated SNF beds
    - Swing beds in some rural hospitals

* Describes all nursing facilities, not just dually Medicare and Medicaid certified.
Characteristics of All Residents in Medicare- and/or Medicaid-Certified Nursing 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 of ≥ 3 days.</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>• Experience ≥ 3 day hospital stay, transferred to community or other post-acute setting, transferred to SNF within 30 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></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>
</tbody>
</table>
Medicare and Medicaid SNF/NF Payment Basics in FFS
### Medicare SNF Prospective Payment System

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

Medicare SNF Payments: Recent Trends

• High and sustained Medicare SNF margins (difference between Medicare payments and provider costs)
  • Over 10% for 16 years in a row
  • 12.6% in 2015
  • In 2015, 9% of facilities (1,007) with relatively low-cost and high-quality care had median Medicare margins of 19.4%

• Costs varied widely among facilities
  • Variation in costs based on ownership and coding practices
  • Variation not attributable to case mix

• Medicare Advantage pays considerably less than FFS
  • Medicare FFS daily payments received in 2016 by four large nursing home companies averaged 23% higher than Medicare Advantage rates
  • May be due to lower payment rates and/or stricter rules than FFS for SNF admissions, lengths of stay, therapies, etc.

Medicaid’s Traditional NF Payment Approach

• States establish reimbursement methodologies and rates within broad federal guidelines
  • §1902(a)(30)(A) of the Social Security Act requires that Medicaid nursing facility payments be “consistent with efficiency, economy, and quality of care and... 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.”
  • Under FFS, NFs are paid directly by states

• Payments are generally developed using provider-reported costs and/or prices of NF goods and services

• Rate setting methodology varies significantly among states
  • Approaches include prospective per diem rates, case-mix acuity-based adjustments, retrospective payments based on costs

• States may pay NFs to hold beds while residents are in the hospital

## 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>43</td>
<td>&lt;10 days</td>
</tr>
<tr>
<td>Price-Based</td>
<td>12</td>
<td>Resident Specific</td>
<td>7</td>
<td>10 – 19 days</td>
</tr>
<tr>
<td>Both</td>
<td>9</td>
<td>Statewide</td>
<td>1</td>
<td>20 – 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not To Exceed Hospitalization Days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No/None Found</td>
</tr>
</tbody>
</table>

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.

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 renew Medicare spell of illness and bring in higher reimbursement
  - State bed hold policies for NFs
    - Pays NFs for empty beds while residents are hospitalized
    - But, helps ensure residents can return to their former residence following hospitalization
  - Insufficient clinical staff in NFs to treat complex residents on site, especially on weekends
    - Can result in avoidable hospitalizations
- Insufficient linkages between SNF/NF care and acute care (physicians, hospitals, prescription drugs)
  - Challenges remain for states to effectively use data on Medicare FFS utilization
State and Health Plan Options to Address SNF and NF Coordination, Payment, and Quality Issues
Health Plan Reimbursement Options for Nursing Facilities

• Under Medicaid and Medicare managed care arrangements, state and CMS pay health plans a per-member, per-month rate (capitation) for all covered services

• Although many plans mimic FFS payment structure when negotiating rates with SNFs and NFs, they have flexibility to design other payment approaches and pay amounts that differ from FFS
Health Plan Reimbursement Options for Nursing Facilities (Cont.)

Health plans can:

• Waive SNF three-day hospital stay requirement
• 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
• Encourage use of HCBS in lieu of institutional care, particularly for lower-need residents
• Make performance-based incentive payments to NFs
Other Tools Available to States and Health Plans

• Provide on-site clinical staff in nursing facilities
• Use state contracted and/or health plan staff and networks to support transitions into the community
• Designate high-performing facilities as “centers of excellence”
• Share quality measures with facilities, even if they are not linked to payment
• Promote evidence-based models of care that raise the bar on quality
• Increase use of electronic e-prescribing or certification
  • Can reduce medication errors, drug and allergy interactions and therapeutic duplication
Strategies to Reduce Avoidable Hospitalizations in NFs: Findings from CMS Initiative

• CMS demonstration selected organizations in seven states (AL, IN, MO, NE, NV, NY, and PA) to work with nursing facilities to reduce avoidable hospitalizations of long-stay residents in FFS

• Results from evaluation covering 2014-2015
  • Decline in all-cause hospitalizations (all 7 states)
  • Decline in Medicare expenditures (6 states)

• Strategies of most successful models (IN, MO, and PA):
  • Strong role of Initiative-funded nurses
    • Consistent, hands-on clinical care led to changes in facility culture, support for reducing avoidable hospitalizations, and buy-in from facility staff
  • Importance of building relationships
    • Strong relationships between nurses and staff, and between nurses and primary care providers
  • Most sustainable initiative components
    • INTERACT tools, medication review focused on reducing antipsychotic medications, quality improvement efforts to reduce avoidable admissions, and use of advance care planning/advance directives

• Potential challenges to implementation
  • Staff turnover, consistent buy-in among physicians, pressure from family for hospitalizations, difficulty with new technology, facility leadership support, time of initiative implementation
  • Health plans: limited resident count could impact NF willingness to participate

• Next phase of the initiative will begin using payment as an additional tool

State Opportunities Under Integrated Care Programs

States in which one managed care entity is at risk for hospitalizations, SNF/NF stays, and other Medicare and Medicaid benefits for dually eligible enrollees – as in the CMS Financial Alignment Initiative or in states with Fully Integrated D-SNPs (FIDE SNPs) – can work with these health plans to:

• Reduce avoidable hospitalizations and emergency room use for SNF/NF residents
• Operate SNF and NF benefits more seamlessly
• Improve care transitions between SNFs/NFs, hospitals, and the community
• Increase use of home-and community-based services as alternatives to SNF/NF services
• Improve monitoring and utilization of Part D prescription drugs, especially in NFs
Value-Based Purchasing (VBP) for Medicaid Nursing Facilities (NFs)
Motivation for States and Managed Care Plans to Change the Status Quo

• Improved quality of care in NFs can:
  • Lead to improved health outcomes and quality of life for individuals
  • Contain spending for states and health plans

• Mechanisms:
  • Reduce triggers for avoidable hospitalizations (including the health and financial risks associated with such stays)
  • Support care management for SNF/NF residents
  • Increase individuals’ quality of life in SNF/NFs
  • Reduce avoidable costs associated with SNF/NF care
Efforts to Date

• Promote transparency through public reporting on quality measures
  • CMS’ Nursing Home Compare Star Rating System
  • California’s LTSS provider quality website*

• States and managed care plans increasingly link financial rewards to demonstrated value
  • MACPAC identified 23 states using VBP programs to incentivize quality in nursing homes, in 2014
  • ICRC interviewed 6 states and 5 managed care plans in early 2017
    • Findings will be presented in a forthcoming brief

*CalQualityCare.org is managed by the University of California, San Francisco. Available at: [http://www.calqualitycare.org/](http://www.calqualitycare.org/)
Approaches for VBP for NFs

• States can either:
  • Design their own VBP approach, or
  • Encourage managed care plans to do so

• Most states or plan VBP approaches use a defined set of measures and benchmarks that reward quality with specified payment
  • Some allow managed care plans or providers to identify a strategy that fits their needs and earn payment relative to the proposed design

• Amount available to NFs that participate in VBP varies by state
  • In Ohio, top-scoring facilities can earn up to $2.40/member day
  • In Indiana, facilities can receive up to $14.30/member day (representing ~10% of a facility’s Medicaid daily rate)
Measuring Quality in VBP

• VBP initiatives distribute payment based on measures of:
  • Clinical care quality (e.g., vaccination rates, use of antipsychotics, use of restraints, pressure ulcers, falls, and urinary tract infections)
  • Resident and family experience (from surveys on quality of life)
  • Staffing (e.g., staff time devoted to care, staff retention rate)
  • Utilization (e.g., avoidable inpatient admissions, readmissions within 30 days)
  • Administrative compliance (e.g., submitting accurate data or payment)

• Source data can include:
  • Claims, encounters, state surveys, or other administrative data (e.g., compliance reports)
  • CMS’ CASPER/OSCAR, Minimum Data Set (MDS), or Nursing Home Compare Star Ratings
  • State NF quality report cards
Lessons for States Designing VBP for NFs

• Payment:
  • Over time, continue to increase the size of payments available under VBP
  • Consider adjustments to the structure of NF reimbursement

• Quality measures:
  • Align measures in VBP programs with those reported in Nursing Home Compare Star Ratings or used in the Medicare SNF VBP program
  • Standardize data collection methods or instruments across facilities
  • Approach the quality measures that inform VBP as a work in progress and adjust over time as needed

• Administration:
  • Carefully select stakeholders to be involved in designing the program
  • Provide technical assistance to participating facilities
  • Evaluate program outcomes
Opportunity for States to Lead the Way on VBP

• VBP for NFs is relatively recent, and models are likely to undergo change
  • Many unknowns about most effective program designs, including most effective reward structures
  • Supply of tested and validated measures still limited, especially for NF care
  • Additional measures needed to assess quality of life across NFs for dual eligibles

• Better alignment of measure use across payers could reduce reporting burdens on nursing homes

• Need for states to evaluate their programs and continually refine them to ensure they are delivering on their potential

• ICRC TA brief scheduled for this summer will outline state options
Links to Main Sources Cited


• Nursing Home Compare: http://www.medicare.gov/nursinghomecompare/search.html

**Additional Resources**


- CMS Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP): [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html)
Questions and Answers
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