South Dakota Department of Human Services
Nursing Facility Reimbursement
Decision Points in Developing a New System

	Question		Common Options			
Rate Component Questions						
1.	How will the system redesign be funded?		Budget neutral		Additional funding of $?? is anticipated.	
2.	What will be the basis for determining reimbursement rates?		Current Medicaid Cost Reporting Forms		Medicare Cost Reporting 2540-10, or 2552-10 with supplemental schedules	Other: Modifications to current report, design new report.
3.	What cost centers will there be?		Maintain Current System: Direct Care (CMI Adjusted), Health & Subsistence, Administration, Capital.		Direct Care, Indirect Care, Administrative and General, and Capital	
4.	How will reimbursement levels be determined?		Cost based up to a limit – limit options: % of the Median, % of the Weighted Median.		Price Based – All providers receive the same price for the same service.	Combination – May have a price on non-direct care components and a cost based direct care component subject to CMI adjustment.
5.	How often will rates, the price/cost be updated?		Prices and costs could be updated on an annual basis, based upon more recent cost experience.		Prices and cost established initially and then allowed to grow at some rate of inflation, with a "periodic" rebasing.	
6.	How will Capital/Return on Equity be reimbursed?		Maintain Current System		Fair-Rental Value (FRV) – Based on a periodic appraisal, or a calculated rental rate consistent across all facilities.	Other Options: -Cost up to a limit/threshold -Price for Capital

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	Question		Common Options			
CMI Questions						
7.	How will acuity measurement be continued?		Continue using RUG classifications indefinitely. This will require an alternative data source beginning 10/1/20.		Move to PDPM nursing classifications as soon as feasible.	
8.	Facility Average vs. Beneficiary Specific CMI adjustment?		Maintain Current System: Use beneficiary specific CMI to pay a specific rate by resident.		Facility Average CMI is calculated as the average of the CMI's for all residents or Medicaid only residents. Options for average methodology and frequency of adjustments (Questions 9/10).	
9.	CMI calculation methodology, (for Facility Average methodology only)		Day-Weighted measures the average acuity of the residents over a period of time, takes the CMI per MDS assessment times the number of days assessment covers and weights the CMI for the period.		Point-in-time measures the average acuity of the residents in the facility at a specific point in time (i.e. the first day of the preceding quarter). (See Example)	
10.	Frequency of CMI adjustments? (for Facility Average methodology only)		Quarterly– CMI's would be calculated on a quarterly basis and reflected in the CMI adjustment of the rate quarterly.		Semi-Annually – CMI's would be calculated on a semi-annual basis and reflected in the CMI adjustment of the rate semi-annually	Annually – CMI's would be calculated annually and rates updated based on those revised CMI's.

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Question		Common Options				
CMI Questions Continued						
11.	What costs will be adjusted for Acuity?		Maintain Current System: Use the current cost components that are included in the Direct Care rate and adjusted for acuity.		Make adjustments to try and match the CMI's to the types of costs that were measured through the time studies that developed the CMI's in the first place (i.e. direct nursing, medical supplies, etc). Some states also include costs such as Social Services, Med Director, etc.	

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Question		Common Options				
Value Base Payment Questions						
12.	What VBP areas will be addressed?	Quality of Care (i.e. quality measures, staffing, health survey performance).		Quality of Life (culture change, person-centered care).		Other (efficiency, Medicaid utilization)
13.	Will you include any value based payment incentives that could be impacted by case mix?	Include incentive add-ons determined by value based performance measures such as staffing ratios adjusted for differences in case mix.		Do not include add-ons determined by value based performance measures that would require case mix adjustments.		
14.	Will VBP areas be addressed separately or in total?	Separate payments tied to each VBP area.		One payment tied to total VBP performance.		Combination (some VBP components are grouped together and others stand alone).
15.	How will VBP payments be made?	Per diem add-on to the base rate or percent reduction in rate to be earned similar to Medicare		Lump sum payments made quarterly, semi-annually, or annually.		Combination (some VBP payments made as add-ons, others made as lump sums).
16.	How will VBP payments be funded?	General appropriations.		Alternative funding solutions (provider tax revenue, UPL based supplemental payments, certified public expenditures.		Combination (some general funds and alternative funding will be used).

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Question			Common Options			
Value Base Payment Questions Continued						
17.	Will the revised reimbursement components be phase-in over time?		No phase-in		Changes phased in over ___ years.	
18.	Will any hold harmless provisions be implemented?		No hold harmless provision will be incorporated.		Provider rates will be held to a floor based on previous rates (e.g. new rates will be held to 90% of the old rates)?	

Question			Common Options			
Special Payment Questions						
19.	How will extraordinary care payments be addressed under the new system?		Maintain current system		Addressed through provisions of the revised rate methodology.	

Additional Technical Questions (for facility average CMI methodology only)

1) How will CMI data used for rate setting calculations be distributed to providers (via USPS mail, via secure email, via a web-based portal, or using some other solution)?