South Dakota Nursing Facility Rate Review Project

Stakeholder Meeting #3 - Minutes

November 13, 2019 11:00 AM CT – 12:30 PM CT via Webinar and Conference Call

Participants: The following individuals participated in the stakeholder meeting organized by the South Dakota Department of Health (DHS).

Name		**Position**
Mark	Burkett	CEO, Avera Platte Health Care
Rhonda	Burris	Program Specialist, Long Term Services and Supports, DHS
Marty	Davis	Divisional VP of Operations, EmpRes Healthcare Management
Mark	Deak	Executive Director, South Dakota Health Care Association
Loren	Diekman	CEO/President, Jenkins Living Center
Greg	Evans	Audit Manager, Budget and Finance, DHS
Dave	Halferty	Senior Manager, Myers and Stauffer
Gil	Johnson	VP Business Development, South Dakota Assoc. of Healthcare Org.
Kim	Kouri	Manager Cost Reporting, Good Samaritan Society
Christine	Lewis	Manager, Myers and Stauffer
Tom	Martinec	Deputy Secretary, DHS
Jodie	Mitchell	Finance Manager/Community Controller, Rapid City Regional
Nate	Ovenden	Lead Reimbursement Advisor, Good Samaritan Society
Amy	Perry	Partner, Myers and Stauffer
Daryl	Reinicke	CEO, Westhills Village
Jeff	Steggerda	Consultant, Brighton Consulting Group
Yvette	Thomas	Director, Long Term Services and Supports, DHS

Agenda and Notes:

1. Welcome/Roll Call
    a. Dave Halferty welcomed participants and conducted a roll call

2. Minutes from November 6, 2019 meeting
    - Minutes were distributed prior to the meeting.
    - Halferty asked members for any comments to the Second Meeting Notes shared via email. Members were asked to reply on the call or send comment in an email by close of business November 14.
        - No comments were received during or after the meeting.
        - Final minutes will be posted to the DHS website.

3. Revisit the Purpose/Goal of the Rate Study and Workgroup
    - It's a required process every five years (SB147).
    - First look at rates if rebased with current methodology as a basis.
    - Work through options to address out-of-date methodology that is no longer relevant.
    - Not sure how it will be used with the funding issue.
        - Greg added that down the road, the Centers for Medicare and Medicaid Services (CMS) won't support current case mix and will need to decide if want to use Patient Driven Payment Model (PDPM) or something different for October 2020 and beyond
        - Yvette commented they want an honest review of the methodology.
        - Greg added to take advantage of the opportunity
        - Dave commented that things could be changed even without funding being addressed.
        - Halferty asked for comments on the purpose/goal of the rate study workgroup. No comments. Any comments may be sent via email and incorporated into the modeling.

4. Base Modeling Updates/Base Rates for Comparison/Proposed Alternatives

    a. General
        - New information was added to the Summary sheet.
        - In the General box, is 2018 cost data, using the current methodology, Consumer Price Index (CPI) inflation to 12/31/2019 can see the number facilities identified by grouping type.
            - 19 Hospital Based (HB) are defined by shared cost with a hospital.
            - 87 Free Standing (FS)

- 28 Urban (U) and 78 Rural (R). Using the Office of Management and Budget (OMB) Core Based Statistical Areas (CBSA) that are used by Medicare
- 39 Large (L) and 67 small (S). Small is set to less than or equal to 60 beds. Seems to be a good cut point. There is a pretty big jump after 60 beds.

b. Direct Care
- Used current methodology with two ceilings.
- Maximum with 125% of the median is $107.10 and Minimum 115% of median is $93.50.
- There is 80% of the gap paid between the two ceilings, resulting in a maximum Direct Care rate of $105.39.
- The Weighted average rate for all facilities is $85.21.
- Minimum rate is $53.37 and Maximum rate is $105.39.
- Average cost coverage is 97.86%
- 15 facilities impacted by the maximum ceiling and 25 by the minimum ceiling.
- The same analysis is shown for each group. (HB, FS, U,R,S,L)
- Hospital Based has a higher average rate. The other groups' average rate is fairly consistent.

c. General Administrative
- Used current methodology with two ceilings.
- Maximum with 110% of the median is $20.16 and Minimum 105% of the median is $19.25/
- There is 80% of the gap paid between the two ceilings allowing for a maximum GA rate of $19.98.
- For all facilities the maximum rate is $19.98 and the minimum rate is $10.66.
- Average cost coverage is 73.23%.
- 75 facilities impacted by the maximum ceiling and 81 by the minimum ceiling.
- Hospital Based has lower weighted average and better cost coverage.
- Urban and Large have lower cost coverage.
  - Mark – 2008-2012 rebase, did they have that many piercing the cap? Probably electronic medical records (EMR) costs is the driving factor. Moving forward where should the cost fall, in Direct Care?
  - Greg – They should go in something not impacted by the ceiling so we don't prevent folks from investing.
  - Amy – If it's in Direct Care, would want to make sure it isn't acuity adjusted.
  - Greg – Patient care limits don't have much impact.
  - Daryl Reinicke – There is real value to know what that cost historically is. To have a number we are talking about would be helpful.
  - Greg Evans – Could set up a survey to see what is spent on the last two years.

        - Yvette Thomas – Could use Survey Monkey. Everyone would have to participate to make it useful.
        - Would have to be very clear what type of costs (Clinical, Financial, Equipment, etc.) so we know what's being included in the numbers.
        - Greg Evans will work with a couple people to see what the survey should look like.
        - Daryl Reinicke – Identify costs for Physician services, Medical Director fees, Long term Care.
        - Survey Monkey would be easy to set up and get info back.
        - Jeff Steggerda – Cost report lines. Ask them to identify lines on the cost report. Other Direct patient care, what are they including in other areas of the cost report.
        - Greg Evans – Try to get everybody on the same page.
        - Jeff Steggerda – First know where they are and where's the best place to put them?
        - Dave Halferty – EMR, Physician Services. Could make revisions to the cost report to get more detail.
    - Follow up plan: Develop survey to make adjustments to cost report going forward. Two weeks is enough to pull data.

d. Combined Non-Direct Care
    - Contains Health and Subsistence, Other operating and Plant Operating grouped together.
    - Current methodology with two ceilings.
    - Maximum with 110% of the median is $76.58 and Minimum 105% of median is $73.10.
    - There is 80% of the gap paid between the two ceilings allowing for a maximum NDC rate of $75.88.
    - The Weighted average rate for all facilities is $66.81.
    - Minimum rate is $40.68 and Maximum rate is $75.88.
    - Average cost coverage is 96.40%
    - 24 facilities impacted by the maximum ceiling and 37 by the minimum ceiling.
    - The same analysis is shown for each group. (HB, FS, U,R,S,L)
    - Hospital Based is a little higher average rate with lower cost coverage.

e. Capital
    - The model is set up with the limit at $17.62.
    - May have a flaw in the way the limit is applied and will revisit it.
    - Minimum is $0.54 and is really small for each group.
        - Lease costs, landlords aren't putting money into buildings.
        - Lease costs and included in the facility rent.
        - Maybe another question to add to the survey.
        - Greg Evans – Might be a quick way to identify costs and who's under a lease.

- Jeff Steggerda – Look at actual vs. allowable costs would be good to look at.
- Greg will try to get costs that have been adjusted for next call.

f. Overall Analysis
   - Weighted average rate $155.08 using Medicaid days.
   - Pro forma of what the costs would look like.
   - An 8% limit is imposed. Compared to the FY 2019 rate.
   - Maximum rate is $201.15 and Minimum rate $115.70.
   - The average cost coverage isn't correct and will be corrected for next call.
   - 101 facilities are impacted by the rate increase limit.
   - Hospital Based has a higher weighted average rate and lower cost coverage.
     - Few things can do
       a. Include all providers in limit calculations for general administrative, and non-direct care
       b. Use actual days and not impose occupancy rule.
       c. Use all case mix index (CMI) data to determine Direct Care. Currently doesn't use Medicare CMI.
     - Please share via email any ideas. Could run multiple scenarios and stack them side-by-side to see difference.
     - Mark – On occupancy, are there patterns to bed changes?
     - Greg – Yes, still have to play the game. Moratorium beds stay consistent to the 85% rule. The State didn't want to have to pay for empty beds.
     - Mark - Does it make sense to continue to do the occupancy rule?
     - Greg – It's a lot of extra work that doesn't have much impact. Isn't doing its intended purpose.
     - Daryl – Where are additional dollars not being recognized? Maybe recategorize Direct Care 97% of allowed costs, where is the system most off?
     - What's allowable? Regulations or Ceilings. We can get to the number on the ceilings easy. Audit would be required of the other. Maybe set a number and extrapolate out.
     - Greg – Most costs are unaudited. Some costs are non-allowable. Can look at the adjustments and see what's not allowable.
     - Halferty – requested suggestions be sent via email.

5. Value Based Purchasing (VBP) Options/Discussion
   a. Handout is a comprehensive list of nursing facility VBP options. VBP measures are divided into three categories; quality of care, quality of life, and other. There are also sections on payment options and funding arrangements.
      - Referring to Quality of Care Measurement section
        - Nursing Home Compare Quality Measures is the first option listed
        - Information provided for each option includes:
          a. General Description

b. Measurement Options.
c. Data Sources
d. Available (availability of data)
    i. Question mark means not sure
e. Review
    i. Indicates if it is reviewed and who performs a review of the data
f. Examples
    i. Examples of States that use it in their systems

- Three sections for type of Measure
    - Quality of Care
    - Quality of Life
    - Other Measures
- Our recommendation is to rely on data that is available.
    - 5 star rating or pulling out pieces.
- Last section is the Funding Options Method
    - NSGO is intergovernmental transfer
        a. Don't know if any use withhold.
    - Jeff Steggerda – two key components to consider; predictability (2-5 measures) and potential of component (2% or greater share of reimb.). He also noted that patient satisfaction is likely to become a more significant aspect of VBP programs and is likely to be added to the CMS 5 Star rating system.
    - Jeff added via email -
        a. I believe the existing system is manageable, however, the refinement you pointed out on the application of the occupancy limitation could be important to adequately recognize Direct Care costs. There is a separate limit on Admin Costs too – right? The impact on cost coverage in that area is notable, however, it's probably not a huge amount in the overall cost/rate analysis.
        b. In most things simple is better, but the cost report detail could be broadened for better analytics and documentation. For example, in other analysis I do for South Dakota companies, more than 7% of direct care staffing is provided by Agency staff. If the report captured that more clearly the real cost effect could be demonstrated. I think this MIGHT be an underlying reason why the Direct care costs in rural vs. urban are not significantly different.
        c. There is a lot of correlative data in the 5 Star / Payroll Based Journal (PBJ) system. I would be glad to talk about this further, however, it may not be completely relevant. I'm flexible.
    - Halferty – Agreed.

a. Limit it
b. Available, predictable, and understandable
c. Patient statistic or experience in future efforts.

- We can take the long term measures that we shared and use it. CMS to date has used in their five star rating system. Divide providers into quintiles and assigned points to each quality measure.
  We total scores up a get a total score. Can put more emphasis on a certain area. Use 75th percentile so that the top 25 receive an incentive for performance.
- Gil Johnson – Wouldn't want to add Administrative burden to facilities or State.

- Halferty requested any thoughts on Value Base Purchasing can be sent via email.

6. Other Discussion
   - Halferty asked if any other items we haven't discussed would anyone like to bring up. No comments.

7. Follow up Plan/Next Meeting
   - Review of the rate model.
     - A few things to tweak.
     - Model and alternative and compare to the benchmark.
       a. Jeff Steggerda (also via email) – Can you provide the "summary" without the 8% overall increase limit. It may also be helpful for the group to see the complete range or quartiles of these rates without the limit applied. Possibly a "before and after" type of analysis?
       b. Greg – Agreed Myers & Stauffer can incorporate into the model.
     - Minutes will be sent out as soon as possible.
     - Members should provide feedback by the end of the day via email on last meeting minutes.
     - Next meeting will be Wednesday, November 20 from 11:00-12:30 Central Standard Time.

   - Meeting adjourned at 12:27pm Central Time.