Meeting Minutes
SB147 Nursing Home Rate Methodology Meeting
October 10, 2019
Americ Inn, Fort Pierre 10:00 a.m. CST

Members Present in Person: Mark Burket, Avera Platte Health Center; Marty Davis, Empres Health Management; Rhonda Burris, Business Operations, Long Term Services and Supports (LTSS), Department of Human Services (DHS); Greg Evans, Audit Manager, Budget and Finance, DHS; Dave Halferty, Senior Manager, Myers and Stauffer; Denice Houlette, Director Budget and Finance, DHS; Christine Lewis, Manager, Myers and Stauffer; Tom Martinec, Deputy Secretary, DHS; Amy Perry, Partner, Myers and Stauffer; Shawnie Rechtenbaugh, Cabinet Secretary, DHS; Yvette Thomas, Director Long Term Services and Supports, DHS; Lara Williams, Budget Analyst, SD Bureau of Finance and Management.

Members Present Via Teleconference: Brett Hoffman (Mark Deak), South Dakota Health Care Association; Loren Diekman, Jenkins Living Center; Gil Johnson, South Dakota Association of Healthcare Organizations; Kim Kouri, Good Samaritan Society; Mark Lyons, Casey Peterson Associates; Jodie Mitchell, Rapid City Regional Healthcare; Connie Ortega, Legacy Healthcare; Nate Ovenden, Good Samaritan Society; Daryl Reinicke, Westhills Village; Jeff Steggerda, Brighton Consultant Group; Tammy Darnell (Sakura Rohleder), SD Legislative Research Council.

Yvette Thomas welcomed members to the meeting and conducted a roll call of members. Members were asked to always identify themselves before speaking for the benefit of those on the phone and to remember to speak up. All members or their designated representative were present either in person or via teleconference. Following, starting with those present in the room, members were invited to introduce themselves, followed by members on the phone. Any non-members were then offered an opportunity to introduce themselves; none did so.

Thomas then provided some background on the purpose of the meeting:

- Senate Bill 147 passed in 2017 Legislative session calls for the Departments of Human Services (DHS) and Social Services (DSS) to conduct a rate methodology review of community-based providers at least every five years. This review is a part of that process.
- A schedule of review of providers was developed based on specific criteria including delta between cost and current rate, access, dependence on Medicaid.
- A report of activities is made to the Legislature each year.
- A copy of the Steering Committee Consensus document was provided to members as background on the process.
- Nursing home rate methodology was moved up to an earlier review than originally scheduled based on a request from Joint Appropriations in the 2019 Legislative Session.
- Reminder that the focus of this meeting is to review the rate methodology, not a discussion of funding.
    - System established in 1998;
    - Reviewed during the Long-Term Care Continuum meeting in 2007 with no changes;
- Focus in on the methodology and if all relevant factors are included in the current methodology.

Thomas then turned the meeting over to Dave Halferty with Myers and Stauffer to lead the remainder of the meeting.

Goals and Objectives:
This group was put together due to Legislative obligations to review rate methodology on a regular basis. Some topics for consideration in the process include:

- Value based purchasing (VBP). The Centers for Medicare and Medicaid Services (CMS) have established a program to make Medicare SNF incentive payments to those providers who do well with quality as a value-added payment. Consideration of the potential for some sort of value-based payment is a trend South Dakota should consider.
- Original rate methodology was established in 1998. In 2007, during the Continuum of Care study it was reviewed; members at the time agreed the methodology remained valid but disliked the capital restrictions.
- CMS moved to the Patient Driven Payment Method (PDPM) on October 1, 2019 for Medicare payments; this will eventually affect Medicaid reimbursement methodology and must be considered.
- DHS has a methodology to provide additional payment for extraordinary care. This method has placed a great deal of administrative burden on LTSS and provider staff concerning documentation and rate calculations. Factoring this care into the methodology would save time for DHS and providers and should be evaluated.
- Group task will be to evaluate all the rate components.

Project Outline:

- The goal is for completion of the study by August, 2020;
- A report of status to date will be prepared for the 2020 Legislative Session;
- Bi-weekly meetings will be scheduled via conference call; with the possibility of one of more in person meetings.
- Development of a rate model with viable options to be prepared.

Review of Current System:

a. Review of Current Rate: Greg Evans provided presentation of the current methodology (see presentation). Evans and Halferty responded to member questions
    - about how many individuals are on the extraordinary care program? Evans: 126
    - what is the current state-wide occupancy? Evans: moratorium is approximately 72%, licensed approximately 85%, Evans will provide the exact report.
    - Beginning October 1st of 2020, there is concern CMS will no longer calculate RUGS III or RUGS IV, and the State will not be ready to convert to PDPM by then. Halferty responded that CMS will continue to calculate the RUGS, but Section G is scheduled to be gone; states will have to move to the Optional State Assessment (OSA) in order to collect data needed to continued RUG-based acuity adjustments. States are pushing back to request retention of Section G. Bottom line is everything is fine for now, but South Dakota may need to require OSAs beginning in October of 2020.

    There was group discussion about the movement to PDPM; which Myers and Stauffer anticipates will be very much like the previous changes to different versions of the RUG classification system. The major problem is that states don't have the data available to model the new system and determine the potential cost impact to Medicaid; this concern has been shared with CMS. As things stand now, it appears that CMS will not start to gather section GG data on Omnibus Budget Reconciliation Act (OBRA) assessments (non-Medicare assessments) until October 1, 2020. Because South Dakota Medicaid cost reports are submitted on facility

fiscal years there will be an 18-24-month period before the state has cost report data for every provider to match to PDPM data. Time will then be needed to analyze this data, model a PDPM based system, develop program revisions and implement changes. It will likely take until 2023 or 2024 to gather enough data for South Dakota and other State Medicaid programs to calculate the fiscal impact of a switch to PDPM and complete a thoughtful implementation process.

Nate Ovenden shared a concern over the additional administrative burden to collect OSA data in addition to OBRA assessment; we would want to avoid this if possible. If CMS is pushed to keep Section G, this would allow continued support of RUGS. A suggestion has been made to add GG to current. Amy Perry shared the GG will probably go on OBRA on 10/1/20 – other items will come off – assume it will be at least Section G that comes off. States are pushing/requesting CMS to keep G on assessment so they can collect parallel data in order to determine fiscal impact. Ovenden agreed this makes sense, wanted to make sure the group was all on the same page.

Jeff Steggerda commented that he understands the current case mix is calculated using RUGS 34, how complex is it going to be to continue to maintain? Will there be a two-step process to get to the case mix? Perry replied that as of 10/1/20 if a state requires use of the OSA, states will be able to use the QIES system and CMS will continue to recalculate the RUG 34.

Evans requested that Ovenden expand on some difficulties experienced with PDPM. Ovenden replied the grouper tool release on 9/27/2019 is not accurate. They have not been able to complete an assessment until yesterday; they have received rejections left and right. The transition has not been smooth. Nate you indicated difficulties with PDPM? Can you expand.

Challenges: Grouper tool released 9/27 not accurate. Not been able to complete a Medicare assessment until yesterday. Rejections left and right. Transition has not been smooth. There was an update this week, and yesterday was the first day to transmit. There is some potential the RUGS submitted since October 1 may not be accurate. Evans shared with the group that SD Medicaid has been receiving documents and calculations for Medicaid residents as per normal since the change over on October 1, 2019.

b. <u>Input on Strengths and Weakness:</u> Halferty shared that one of the strengths Myers and Stauffer sees is the resident specific rate, which is unique to South Dakota and a few other states. They work with 20 states, and all of them use a facility average Medicaid CMI. Using a resident specific rate is as responsive as a system can be. A weakness they see is that most states have implemented some sort of value-based system which can be used to enhance the system. Members were asked to provide input on their perceived strengths and weaknesses of the system:

Strengths:	Weaknesses:	Comments:
Resident specific rate	System based on cost reports; the system is hard to sustain, and the reimbursement methodology needs to align with strategy and address the need for replacement of aging facilities. The average age of	The difference between Medicaid and private pay rates continue to expand; when the methodology was developed in 1998 it was only about $2.

	buildings in 47 years, only two build in previous decade, only a few have been built since.	
On-time payments	Cost Reports, capital costs are not adequately realized.	Value based should be assessed
Bed Hold policy for therapeutic and hospital stay days	Lease costs are not recognized	The bed tax is a viable option that should be considered.
Direct care to incorporate therapy is a strength; over the years the level/extent of therapy has expanded.	Application of limits – limits may be too narrow in some cost components and need to be re-evaluated; the rate is getting further and further away from actual costs.	Rebase that recognizes costs is important.
Individual case mix is a strength if rebase occurs	Individual case mix is a weakness if rebase doesn't occur.	Acuity level and transfers of patients in and out has changed and happens faster.
	Technology costs are not realized, Electronic health record, medication administration record, etc.	
	Not having a provider tax	
	Awkward process for extraordinary care payments; don't really create incentive because they are offset back against the cost, only cover cost.	
	Alzheimer's/memory care patients in nursing facility are almost all Medicaid – private pay stay in Assisted Living. The problem is the staffing level needs to be higher due to need to monitor but the case mix is low because they don't need assistance with Activities of Daily Living (ADLs).	

A member inquired if the 638-facility rate setting will be a part of this discussion; because it is different than most facilities it will not. With these facilities, because additional federal funds can be accessed, ceilings and limitation aren't applied. This was suggested as a strength for the state, with the ability to recognize the full cost of services.

Decision Matrix:

a. Walk through the Decision Matrix. Halferty led the group through a discussion of the items on the Decision Matrix (see handout) to determine if they should be retained as points for further

discussion. Those items that are retained will be discussed in depth on upcoming bi-weekly conference calls:

1. Budget – is a separate issue, not a part of the rate methodology discussion.
2. Cost reports – Keep. The format has been in place 20 years without much for updates or changes.
3. Cost Centers: Some states use Indirect care as a category. Keep this item, it is closely related to #2.
4. How will reimbursement levels be determined: Keep, there was discussion around the consideration to move to a price-based system, so portions of costs are determined on a state-wide basis. Mark Burket indicated that the variety in provider types (corporate, hospital based, free standing), whose cost reports all look different has always been a barrier to price-based in the past. Perry suggested consideration of separate reimbursement schedules for different peer groups may be a consideration. Marty Davis indicated that 7 years ago he and Clint Graybill analyzed the reimbursement at a case mix level of 1.0 across state. From the lowest to highest, the difference was almost $75 per day. They believed the discrepancy shouldn't be that large, and came forward with a hold harmless plan, which ultimately wasn't funded; high costs → higher reimbursements. Halferty responded that there is value to price-based systems, step down costs don't affect direct nearly as much as indirect care costs.
5. How often will rate, the price/cost be updated: Keep.
6. How will Capital/Return on Equity be reimbursed: Keep. Capital was raised by quite a few people. Burket reminded the group that the Abt Associates study researched average cost of capital; it would be good to have the information available to provide to legislature if the opportunity arose considering the age of facilities. A capital reserve fund was suggested in 2008 and might be worth re-considering. If members have additional thoughts comments, send in to Dave Halferty and Cc: Greg Evans. (Contact email on member list).
7. How will acuity measurement be continued: Keep, the group has discussed briefly the upcoming changes with PDPM and options. Myers and Stauffer, along with others will continue to push CMS to continue to support RUGS. Development of precise plan should be a part of this overall plan.
8. Facility average versus beneficiary specific case mix adjustment: The consensus of the group has been that individual specific is a strength. This item will be deleted.
9. Delete: N/A if #8 is removed
10. Delete: N/A if #8 is removed
11. What costs will be adjusted for acuity: Nurses, aides, and therapy are currently included; are there any concerns of what is included. There was good discussion on this topic. Burket raised that EMR cost and IT costs need to be included. The Health and Subsistence part of the rate is where they are now; things have changed, things like EMR, IT, MDS Coordinator should be considered for addition to Direct. Davis remarked that although therapy is included for people supported by Medicaid, it doesn't meet the cost. Evans responded that this wasn't really an issue when rebasing happened every year; now if a facility didn't have therapy costs in 2012, therapy costs are still not recognized in their rate. Jeff Steggerda inquired if this is the place where we try to recognize people with cognitive impairment and how they dilute the overall score due to their low ADL needs, but require additional staffing. Halferty responded that they have seen a similar problem in other states; some states have gone to the use of the cognitive performance scale to adjust the rate. Ovenden replied that the CPS is very complex, and the Brief Interview for Mental Status (BIMS) exam is less

complex, would the BIMS be a possibility? Halferty indicated that the BIMS could be another option.

12. – 18. What VBP areas will be addressed: Keep, good to discuss. Some states include staffing ratios as an example. Members indicate a need to dig in and determine what is reasonable to include. CMS is pushing VBP more and more, and there is merit but need more discussion on the matrix and what is measured. Ovenden remarked that from a Medicare perspective it is more based on a readmission penalty, is the goal to replicate the Medicare process? Halferty responded they were thinking much more broadly. Readmission is not the best criteria, especially if you only have one. Kim Kouri raised concern that quality add-on incentives without funding just reduces the overall reimbursement. Developing ideas and suggestions to bring forward is possible; funding is determined at the Legislative level. A couple of the bi-weekly calls will be focused on this overall topic.
13. Extraordinary Care Payments. Keep.

Halferty indicated they will be developing a schedule for future focused calls, estimating 2 calls each for rate components, case mix, value-based performance, analysis of plan (impact) and a meeting for extraordinary care payments. Halferty offered the group the opportunity to raise items for inclusion in the Decision Matrix.

Steggerda commented it is hard to come up with questions without seeing the components and cost vs reimbursement. Experience has been that not every facility is a winner when you do a recalibration and we need to have a scope of what it might look like. Halferty responded the plan is to develop a framework – what items should we include, are their others, any that need to be deleted – then dig deeper.

Davis remarked that a hold harmless policy would be a good discussion.

Burket commented that he hopes there is a phase 1, and a phase 2. Is the intent to move to phase 2 and apply the methodology developed? We need to address access critical, vulnerable facilities and how this work might affect the landscape of the industry. Evans replied that the Department knows from cost reports who is struggling. Staff haven't dug down into the details at this point but could. Burket again expressed concern that the recommendations of the workgroup not initiate closures of facilities. Perry indicated the plan is to create a detailed rate model that will allow the ability to assess winner and losers and Halferty indicated they will plan a couple of meetings to talk about base parameters and discuss impact.

b. Review of the South Dakota Quality Measures (QM) Report: Regarding the Nursing Home Compare Report, there isn't a lot of detail you can easily digest to determine how the rating was calculated on the surface. CMS assigns each facility into a quintile for each of the quality measures and states can use the Quality Measures to drive VBP programs. Some states choose to focus on specific quality measures and develop an add on payment based on top performers.

OTHER: Halferty offered the opportunity for members to bring up other topics.

Davis commented that the landscape of SD is changing; nursing homes are changing ownership and we need to capitalize on the expertise that is coming into the state as new providers expand into South Dakota.

Halferty provided a recap of the follow up plan:

- Set up additional bi-weekly calls
- Schedule an additional in-person meeting further into the process
- Myers and Stauffer will continue to develop rate model
- Minutes will be prepared for distribution
- Report to Legislature of progress and plan during Legislative Session
- Prepare a full report by August, of 2021 prior to the FY22 budget request.

SCHEDULE FOR FUTURE MEETINGS:
The group reached consensus to hold bi-weekly conference calls on Wednesdays from 11-12:30 Central Standard Time. First meeting will be Wednesday, October 23 and will focus on base parameters.

Meeting adjourned at 12:30.