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AGENDA

Nursing Home Provider Meeting
Wisconsin Medicaid Nursing Facility Payment Methods

Tuesday, June 18, 2013
1:00 PM - 3:00 PM
Conference Room 630
1 West Wilson St.
Madison, WI 53703

1. Welcome and opening remarks – Tom Lawless & Brian Shoup
2. Preliminary Models and Acuity Analysis – Jim Robinson
3. Proposed changes to the Methods – Dave Varana & Jane Gottwald
    a. Clarifications and Updates
    b. Elimination of obsolete references
    c. Typographical corrections / edits
4. Modernization program update – Dave Varana
5. Workgroup meeting updates – Dave Varana + other participants attending
    a. Vent Rate Workgroup
    b. Beh/Ci Workgroup

SFY14 WI NH Modeling Scenarios

Scen 1: Internal scenario for calibration of model

Scen 2: SFY14 Base Scenario using SFY13 average rates & SFY13 average T19 CMI's, with DHS

Scen 3: Impute 2012 CRs (from available 2011 final CRs) and calculate rates for SFY14 using SFY13 formula and average SFY13 acuity

Scen 4: Apply 2012 R2 cost reports fields (bed count, property valuation, PDs for EMMUA, single occ. rooms, prop. tax, private room affidavit, etc.)

Scen 5: Estimate MDS 3.0/RUG-IV basis for All-Res CMI related to 2011 CR resident population

Scen 6: Medicaid Access Incentive change (if any)

Scen 7: Labor Factors - without Dunn/Dodge/Richland reclassification

Scen 8: Labor Factors - Dunn/Dodge reclassification

Scen 9: Labor Factors - Richland reclassification

Scen 10: Property/Modernization Incentive cost estimates for SFY14

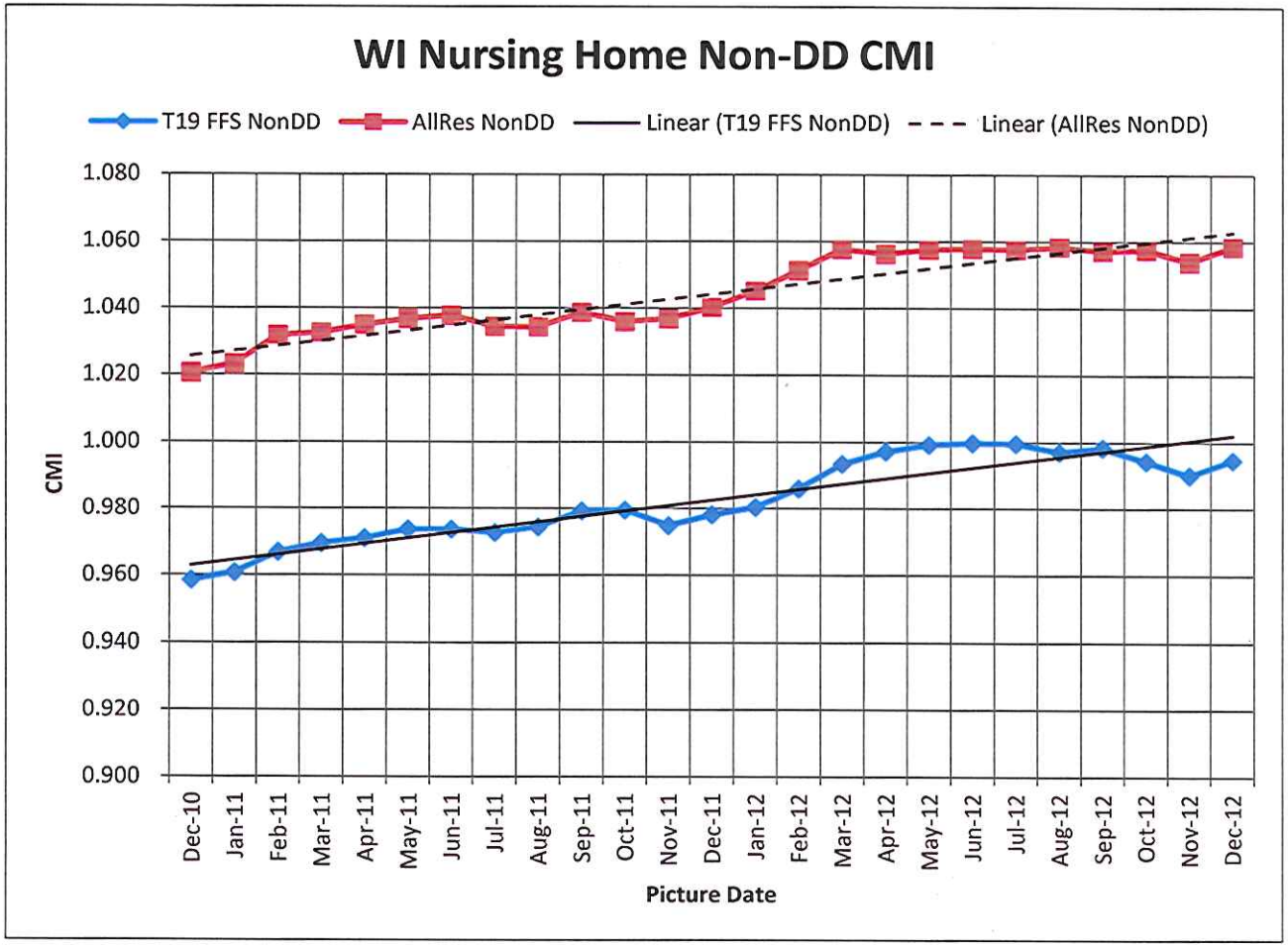
Scen 11: Average SFY14 acuity (using SFY13 Behavior/CI add-on)

Scen 12: Proposed SFY14 Behavior/CI add-on

Scen 13: Proposed ventilator rate change

Scen 14: Adjust DC Bases to Hit Expenditure Targets

Month	T19 FFS NonDD Census	AllRes NonDD Census	T19 FFS NonDD CMI	AllRes NonDD CMI
Dec-10	16,978	29,815	0.958	1.020
Jan-11	16,889	29,926	0.961	1.023
Feb-11	16,683	29,835	0.967	1.032
Mar-11	16,637	29,757	0.969	1.033
Apr-11	16,578	29,521	0.971	1.035
May-11	16,562	29,340	0.973	1.037
Jun-11	16,515	29,468	0.973	1.038
Jul-11	16,438	29,235	0.973	1.034
Aug-11	16,499	29,383	0.974	1.034
Sep-11	16,501	29,616	0.979	1.039
Oct-11	16,522	29,475	0.979	1.036
Nov-11	16,483	29,318	0.975	1.037
Dec-11	16,376	29,019	0.978	1.040
Jan-12	16,366	29,464	0.980	1.045
Feb-12	16,283	29,233	0.986	1.051
Mar-12	16,137	29,062	0.993	1.058
Apr-12	16,121	28,922	0.997	1.056
May-12	16,124	28,778	0.999	1.057
Jun-12	16,047	28,574	1.000	1.058
Jul-12	16,012	28,611	1.000	1.058
Aug-12	15,946	28,680	0.997	1.058
Sep-12	15,855	28,471	0.998	1.057
Oct-12	15,820	28,602	0.994	1.057
Nov-12	15,714	28,389	0.990	1.054
Dec-12	15,474	28,042	0.995	1.058
		Annual CMI Slope	0.020	0.019



PROPOSED TEXT CHANGES TO *METHODS OF IMPLEMENTATION*

Department of Health Services
(Medical Assistance Reimbursement of Nursing Homes)
State of Wisconsin Medicaid Nursing Facility Payment Plan:
July 1, 2013 through June 30, 2014

The Department is proposing changes in the methods of payment to nursing homes and, therefore, in the plan describing the nursing home reimbursement system. The changes proposed would be effective July 1, 2013.

The proposed changes are as follows:

1. Modify the methodology to adjust the reimbursement for nursing homes within the parameters of 2013-2015 Biennial Budget Bill. These parameters are divided into two parts. First, the Department will disburse the additional $13,128,600 AF ($7,877,200 FFP) that was appropriated to fund an assumed acuity increase of approximately 2.0% for nursing homes. Second, the number of Medicaid-funded patient days is projected to decline, which generates the overall funding decrease identified above. These modifications will include adjustments to the maximums, per diems, and other payment parameters in Sections 5.400, 5.500, 5.700, 5.800 and 5.900, the inflation and deflation factors in Section 5.300, and targets in Sections 3.000 and 5.000.
2. Modify Sections 3.655 (Nursing Home Modernization Incentive Program) to reflect the Department's enhanced focus on addressing behavioral and cognitive impairment issues, including dementia-related needs, by making the following additions (see *<u>underlined</u>* addition):

" *[…]*

- *The facility will clearly demonstrate the improvement in the quality of care and resident life it expects to achieve. The project application will indicate details of how the living environment will be enhanced through specific aspects of the physical environment such as:*
  - *Large % of private rooms per DQA license*
  - *Single loaded corridors-patient rooms on one side, exterior open on the other*
  - *Small household settings including inviting common areas*
  - *Access to the outdoors and outdoor views*

- *Personalized space-enhanced dining, bathing and activity programs*
- *Access for family and community involvement*
- *Design features to enhance relationship between residents and staff*
- *Resident –centered design elements that have a clear focus on improving care outcomes for residents with behavioral and cognitive impairment challenges, including dementia-related needs, will significantly enhance the likelihood of project approval.*
- *The facility will demonstrate the cost savings to the Department that will, at a minimum, equal the additional rate adjustment that is implemented. The facility will demonstrate the total financial impact of the innovative project will not increase overall Medicaid costs. […]"*

3. The methodology will factor in the effect on patient liability of the 1.7% cost of living adjustment (COLA) increases in Social Security and Supplemental Security Income programs, which were effective January 1, 2013.
4. Potentially incorporate changes into the Behavioral/Cognitive Impairment Incentive, as a result of further study the Department is carrying out in this area.
5. Correct an obsolete reference in Section 1.120 relative to the basis for Nursing Home Payment Rates (see deletions indicated in ~~*strikethrough*~~ and additions indicated by *underline*):

"1.120 Basis of the Nursing Home Payment Rates

Allowable payment levels ~~were~~ are determined by the Department through examination of costs actually incurred by ~~a sample of~~ each nursing homes in Wisconsin, as described in these Methods, under the authority granted by, and requirements listed in, s. 49.45(6m)(ag), Wis. Stats. ~~Appropriate adjustments for actual and anticipated inflation levels were taken into account in projecting costs. One provision in these Methods helps assure that necessary and appropriate care continues to be provided by facilities which may not be economically and efficiently operated and which face unique fiscal circumstances.~~

~~*49.45(6m)(c) The department shall establish an appeals mechanism within the department to review petitions from facilities providing skilled, intermediate, limited, personal or residential care or providing care for intellectual disabilities for modifications to any payment under this subsection. The*~~

~~*department may, upon the presentation of facts, modify a payment if demonstrated substantial inequities exist for the period appealed. Upon review of the department's decision the secretary may grant the modifications, which may exceed maximum payment levels allowed under this subsection but may not exceed federal maximum reimbursement levels. The department shall develop specific criteria and standards for granting payment modifications, and shall take into account the following, without limitation because of enumeration, in reviewing petitions for modification:*~~

~~*1. The efficiency and effectiveness of the facility if compared with facilities providing similar services and if valid cost variations are considered.*~~

~~*2. The effect of rate modifications upon compliance with federal regulations authorized under 42 USC1396 to 1396p.*~~

~~*3. The need for additional revenue to correct licensure and certification deficiencies.*~~

~~*4. The relationship between total revenue and total costs for all patients.*~~

~~*5. The existence and effectiveness of specialized programs for the chronically mentally ill or developmentally disabled.*~~

~~*6. Exceptional patient needs.*~~

~~*7. Demonstrated experience in providing high quality patient care.*~~

6. Modify Section 1.134 to provide for the possibility of alternate payment arrangements under certain circumstances by making the following revisions (see underline):

" *[…] If enough Accounts Receivable shall not be generated by the fiscal intermediary to recover 100% of the funds within 60 days, a lump sum payment shall be made to the Department for the difference. In addition, if the Department's fiscal agent cannot determine the amount of the recovery, the amount will be determined by the Department. In these situations, the recovery amount shall also be recovered within 60 days and may either be deducted from current remittances to the provider or repaid by the provider to the Department's fiscal agent. Under certain exceptional and limited circumstances, the provider may request a payment arrangement extending the recovery period beyond 60 days for reasons of financial hardship."*

7. Correct an obsolete reference in Section 1.315 by making the following deletion (see ~~*strikethrough*~~):

" *A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day.* ~~*Patient days will include all of the following types of days:*~~*"*

8. Clarify Section 1.530 regarding the proper calculation of the Bed Hold billing threshold by including the following language (see *underlined*):

" *[…] Licensed beds may be reduced for (a) certain code violations and (b) renovations in order to calculate the occupancy for bed hold billings. The occupancy calculation for bed hold billings must include all beds except for the exceptions outlined below. Any beds designated by the facility as "seclusion", "isolation," "restraint," or similar or related terminology, shall be included in the occupancy calculation. Excluded beds must meet one of the following criteria: […]"*

9. Clarify the status of new resident admissions and re-admissions in the CMI by making the following addition to Section 2.140 (see *underlined*):

" *[…] Providers are required to complete MDS assessments for each resident. The assessment for each resident that is RUG-able, dated on or before the picture date, and correctly included in the WI MDS data base by the "as of date" will determine the case mix grouping for that resident for that picture date. New admissions will not be included in the CMI unless they have received a RUG-able MDS assessment on or before the picture date. Re-entries will be included in the CMI with their last valid RUG classification from their prior stay, if they were discharged "with return expected" and actually returned to the facility, if there is no more recent valid RUG classification. […]"*

10. Correct an obsolete reference to certain types of equipment rental expenses in Section 2.251 by making the following deletion (see ~~*strikethrough*~~):

" *[…] Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses.* ~~*A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment.*~~ *(In-service training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)"*

11. Correct obsolete references to "Bed Banks" in Sections 3.040, 3.060, 3.061, and 3.062 by deleting the sections (see ~~strikethrough~~):

" ~~*3.040 Beds for Rate Setting*~~

~~*The beds for rate setting will be calculated as follows:*~~

~~• *Licensed beds on the last day of the base cost reporting period in Section 1.302;*~~

~~• *Less the beds in the bed bank on the last day of the base cost reporting period in Section 1.302; and*~~

~~• *Less any additional beds deposited after the close of the base cost reporting period in Section 1.302 but before July 1, 2012.*~~

~~*3.060 Bed Bank*~~

~~*The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040).*~~

~~*For bed bank requests submitted after June 30, 2012, the bed adjustment will be effective July 1, 2013, subject to the Methods then in effect.*~~

~~*If a bed license is split after the end of the cost report period, causing a transfer of beds between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2013, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.*~~

~~*3.061 Bed Bank Reductions and Resumption*~~

~~*The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.*~~

~~*3.062 Bed Bank Restrictions*~~

~~*1. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.*~~

~~*2. The total beds for rate setting and banked beds cannot exceed the total licensed beds.*~~

~~*3. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.*~~

~~*If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.*~~

~~*4. If banked beds are part of a phase down, the beds will be expunged from the bed bank."*~~

12. Clarify the time period in which corrections to a facility's case mix index are allowable by making the following addition to Section 3.150 (see underlined):

" *[…] The facility may request resident level data from the calculation of the CMIs. The facility may request corrections supported by resident level data for the period. Any correction will result in a recalculation of the RUGs CMI and the behavior/cognitive impairment score for the period. The Department may apply the material adjustment standard in section 4.120 to corrections in the CMI. Allowable corrections to the CMI are only accepted by the "Date Available" listed in Section 5.422. See Section 2.140 for further limitations. Any information exchanged with the Department and the facility under this process will be considered protected medical information. […]"*

13. Clarify that the final rate determination is the sum of calculations made for each cost center by adding the following language to Section 3.700 (see *underlined*):

" *A facility's current Methods rate shall be the sum of the payment allowances resulting from Sections 3.100, 3.200, 3.400, 3.500, and 3.600.* "

14. Merge two duplicative sections relating to separately billable ancillary items by moving portions of Section 6.310 into Section 3.801 and Section 3.802, and a portion of Section 6.320 into Section 3.803, and deleting Section 6.300 (see *underlined for additions and ~~strikethrough~~ for deletions*):

"3.800 SEPARATELY BILLABLE ANCILLARY ~~BILLABLE~~ ITEMS

3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed $10 per day for a resident when a ride is provided plus $1.00 per mile. Medical

Transportation is transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by other carriers, such as bus or taxi. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

3.802 Oxygen

A nursing home may bill for oxygen and oxygen generators at a daily rate as described in the Medicaid Update series. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident. Ancillaries mentioned in this section cannot be paid as part of the rate but can be billed by the facilities.

3.803 Reimbursement Manner

The costs of services and materials identified above may be billed separately by the nursing home, and thus are not included in the calculation of the daily payment rate of the nursing home. These costs shall be reimbursed in the following manner:

1. Claims shall be submitted under the nursing home's National Provider Identifier (NPI.

2. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious.

3. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing.

4. Reimbursement for questionable materials and services shall be decided by the Department.

6. The amount charged for transportation may not include the cost the facility's staff time and shall be for an actual mileage amount.

7. Reimbursement will be limited to the amounts set per Sections 3.801 and 3.802."

~~*"6.300 SEPARATELY BILLABLE ANCILLARY ITEMS*~~

~~*6.310 Items*~~

~~*The costs for the following items may be billed separately by the nursing home and, thus, are not included in the calculation of the daily payment rate of the nursing home:*~~

~~*1. Transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by other carriers, such as bus or taxi.*~~

~~*2. Oxygen, or the daily rental of oxygen concentrators. (The nursing home will be subject to maximum fees for these services, and prior authorization is required for more than 30 days rental of an oxygen concentrator.)*~~

~~*6.320 Reimbursement Manner*~~

~~*The costs of services and materials identified above which are provided to patient recipients shall be reimbursed in the following manner:*~~

~~*1. Claims shall be submitted under the nursing home's National Provider Identifier (NPI), and shall appear on the same claim form used for claiming reimbursement at the daily nursing home rate.*~~

~~*2. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious.*~~

~~*3. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing.*~~

~~*4. Reimbursement for questionable materials and services shall be decided by the Department.*~~

~~*5. Claims for transportation shall show the name and address of any treatment center to which the patient recipient was transported and the total number of miles to and from the treatment center. Claims must be submitted on a form other than the rate claim form.*~~

~~*6. The amount charged for transportation may not include the cost the facility's staff time and shall be for an actual mileage amount.*~~

~~*7. Reimbursement will be limited to the amount set per Section 3.801.*~~"

15. Update the ventilator rate for SFY14 and correct obsolete references to a rate for extensive care patients by adding the updated rate and deleting the following portions of Section 4.691 (see ~~strikethrough~~ for deletions and underlined for additions):

" *4.691 Ventilator Dependent ~~and Extensive Care~~ Patients*

Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of ~~$550~~ $561 per in-house day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Bed-hold day, if qualified, will be paid under Section 1.500. ~~Payment for related extensive care patients prior authorized for care at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.~~ The costs of exceptional supplies related to care of ventilator-dependent residents are include in the above rates and cannot be billed separately after December 31, 2011."

16. Correct an obsolete reference to a special fixed rate for residents with HIV/AIDS in Section 4.694 by making the following deletion (see ~~strikethrough~~):

" *4.694 Residents with AIDS*

~~For requests received prior to October 1, 1993, subject to prior authorization from the Department, a provider accepting a resident diagnosed with AIDS or ARC may receive a payment of $150 per day in lieu of the facility's daily rate.~~ A facility may claim bed hold for ~~the~~ an empty bed in a semi-private room occupied by an AIDS patient, even if the facility does not meet the occupancy requirements for bed hold described in Section 1.500. […]"

17. Correct an obsolete reference to approval of uniform chart of accounts in Section 6.110 by making the following deletion (see ~~strikethrough~~):

" *[…] The cost reports~~, which will be based on the uniform chart of accounts approved by the Department~~, must be completed in accordance with the published cost report written instructions, as well as generally accepted accounting principles (GAAP) and the accrual method of accounting. […]"*

18. Modify Sections 3.775 and 3.780 to reflect possible changes in the Medicare Upper Payment Limit (UPL) calculations. This shall reflect any potential changes to bring the State's approach to calculating the UPL into alignment with the requirements of the recently-released SMD# 13-003.
19. Update the Reporting Period, Picture Dates, and Dates Available in Sections 4.720, 5.421, and 5.422
20. Modify contact names and addresses, as necessary.
21. Modify references to previous years for descriptive reasons, and correct typographical errors as necessary.
22. Modify the labor factors listed in Section 5.410.
23. Modify the case mix weight listed in Section 5.420.
24. Change the dates of the definitions of base cost reporting period.
25. Make any potential changes required by findings of an ongoing federal audit of ICF-IID rate-setting by the Office of Inspector General of the Department of Health and Human Services.
26. Make any potential changes to individual county assignments to labor regions, as required by Wisconsin law.