

## Office of Health Transformation **Reform Nursing Facility Payments**

### **Governor Kasich's Budget:**

- *Increases nursing facility reimbursement \$61 million over two years.*
- *Links 100 percent of the increase to quality performance.*
- *Removes the nursing facility reimbursement formula from statute.*

### **Background:**

The Kasich Administration continues its efforts to improve the quality of care provided to individuals residing in nursing facilities. Ohio Medicaid supports approximately 50,000 Ohio residents live and receive care in nursing facilities at a cost of \$2.4 billion annually. The Administration's goal is to achieve better health, better care and reduced costs by creating incentives to continuously improve service features and characteristics to meet or exceed customer needs and expectations for quality.

### **First Four Years:**

Beginning in 2011, Ohio Medicaid initiated reforms to rein in costs associated with nursing facility care and improve overall quality. The following reforms created a new approach to caring for some of Ohio's most vulnerable residents:

- ***Converted Medicaid Nursing Facility Reimbursement to a Price Based System.*** Governor Kasich's first budget (enacted in 2011) completed the transition from a cost-based Medicaid payment system for nursing facilities to a price-based system, a change that was initiated by the legislature in 2005 to reward efficiency. The final budget reduced nursing facility rates by 5.8 percent on average in 2012 and saved Ohio taxpayers \$360 million over two years.
- ***Linked Nursing Facility Reimbursement to Quality Outcomes.*** Governor Kasich's first budget strengthened the link between Medicaid payments for care services and quality by increasing Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average Medicaid nursing facility rate in 2011 to 9.7 percent in 2013. A Nursing Facility Quality Measurement Subcommittee was created and achieved consensus recommendations on 20 specific accountability measures, which were enacted by the General Assembly in December 2011.
- ***Integrated Care Delivery through MyCare Ohio.*** In conjunction with the three year demonstration program to better coordinate care for individuals served by both

Medicare and Medicaid, nursing facilities and other health care providers are contracting with health plans to provide long-term services and supports to participating individuals. Prior to the May 1, 2014 launch, dual-eligible individuals had no choice but to receive their Medicaid benefit through the traditional fee-for-service program.

- **Connected veterans residing in nursing facilities to federal benefits.** The Kasich Administration initiated a pilot project to ensure that Ohio veterans living in nursing facilities were provided access to a broader set of benefits and services through the Veterans Administration (VA). Staff from the Ohio Departments of Medicaid, Aging, and Veterans Services made personal contact with veterans identified as eligible for benefits in a VA long-term care facilities. Work is underway to expand the project statewide.

### **Executive Budget Proposal and Impact:**

After several years of flat funding, the Executive Budget proposes to increase nursing facility spending \$60.7 million (\$22.8 million state share) over two years. The net increase is achieved through a combination of reforms that:

- **Rebase Nursing Facility Rates With a Grouper Update.** Current nursing facility rates are based on costs from calendar year 2003. The Executive Budget proposes to update rates beginning in state fiscal year 2017 using calendar year 2013 costs as a basis. The update is required by current law and will result in rates more reflective of current health care costs and service delivery in Ohio's nursing facilities. Rebasing also creates the opportunity to update the resource utilization group (RUGs) methodology used to measure resident acuity in the state's nursing facilities. Ohio uses nationally recognized acuity measurement software that employs clinical data collected by the Centers for Medicare and Medicaid Services (CMS). In 2010, CMS updated the data collection tool and offered states the option of using an updated grouper. At the time, Ohio continued using the older grouper (RUGS III) because it aligned with the years-old rate components in effect, but now will update to RUGS IV to coincide with the calculation of new rate components during the rebasing process. The net impact of the effort to rebase nursing facility rates and implement a new grouper will increase nursing facility spending \$84.1 million (\$31.7 million state share) in 2017, all of which will be applied to a new quality improvement program, described below.
- **Pay for Quality.** The Executive Budget builds on the work of the previous four years and further strengthens the relationship between payment and quality. It requires that all of the spending increase related to rebasing (\$87 million in 2017) be used to support a new quality framework. Under this framework, the current quality component is eliminated and that funding is incorporated into the direct care component of the rate. The payment for quality will be replaced with a "Quality Reserve" that nursing facilities can earn back through objective measures of quality care. The current list of 20 measures is replaced by five measures directly related to outcomes and Medicaid spending. Facilities

will have to meet benchmarks for all five measures to receive the full quality payment. The five measures include two staffing measures and three clinical measures. The staffing measures include minimum staffing levels for nursing and STNA and consistent assignment. The Administration is proposing staffing levels recommended by the Consumer Voice, a national advocacy group representing nursing facility residents and their families. Consistent assignment of nurse aides is widely recognized as a key component of quality care for nursing facility residents and is a goal recognized and measured by the Advancing Excellence in America's Nursing Homes campaign. Two of the clinical measures rely on quality measures established by CMS and are calculated using information from the Minimum Data Set (MDS). Those measures include the rate of pressure ulcers across the facility census (both long-stay and short-stay measures), and the rate of atypical antipsychotic use for both long-stay and short-stay residents. The third clinical measure is the rate of avoidable inpatient admissions from nursing facilities and is the initial step in measuring potentially preventable events in Ohio's nursing facilities. The cost of this provision is already counted in the rebasing provision described earlier.

- **Reduce Reimbursement for Low Acuity Individuals.** Governor Kasich's first budget implemented a reduced rate for low-acuity individuals. The Executive Budget takes the next step in aligning payments across delivery systems based on the care needs of the beneficiary. The daily rate paid for the lowest acuity individuals in Ohio's nursing facilities will be reduced from \$130 per resident day to \$91.70 per resident day, more in line with what it would cost to serve these individuals in a community setting. This provision will save \$23.5 million (\$8.8 state share) in 2017.
- **Remove the Nursing Facility Rate Formula From Statute.** Nursing facilities are the only Medicaid provider group whose reimbursement is guaranteed in the Ohio Revised Code. The Executive Budget puts nursing facilities on the same footing as other provider groups by rescinding statutes which set forth payment methodology.
- **Make Administrative Changes to the Franchise Permit Fee Program.** The Executive budget makes two changes to the administrative operation of the Nursing Facility Franchise Fee Program. The first change gives Ohio Medicaid the authority to utilize electronic alternatives to traditional mail when issuing franchise fee assessments. This creates opportunities to reduce administrative costs related to the franchise fee, improve department efficiency and streamline communications with nursing facility providers. The second change closes a technical loophole in the franchise fee tax base to clarify that only beds that are permanently surrendered are exempt from the fee.

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