MISSISSIPPI DIVISION OF
MEDICAID

# Nursing Facility Reimbursement Methodology Revision Report

**Mississippi Legislative Session**

January 2014

# Table of Contents

## Recommendations

Pursuant to 2012 Legislation House Bill 421, Section 5,[i] the Division of Medicaid (DOM) requests legislative approval to implement changes to the current reimbursement methodology for nursing facilities, psychiatric residential treatment facilities (PRTFs), and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) effective January 1, 2015. These changes include the reporting of incontinence supplies in the care related cost center; implementing RUG IV[ii] Medicaid classification system as the basis for calculating case mix and discontinuing use of access incentives in the case mix calculation; increasing the capitalization level of new assets to parallel Medicare's level; reducing the Return on Equity (ROE) interest rate; updating the fair rental value (FRV) calculations by increasing the bed value, increasing the depreciation percentage, increasing the maximum allowed depreciation, and decreasing the rental factor while maintaining the current risk premium. The DOM also requests legislative approval to make payment for ventilator dependent residents using an add-on per diem rate. Compositely, these changes are expected to be budget neutral.

## Legislation Requested

MS Code Section 43-13-117

Paragraph (A)(4)(d)

Paragraph (A)(12)

Paragraph (A) (23)

## Specifications of Recommendations

**Incontinence Supplies** - Currently, incontinence supplies (disposable diapers and the like) are considered administrative and operating expenses, but will be more appropriately classified as care related expenses. This change will apply to all long-term care facilities.

**Case Mix Calculations and System Processing** - The DOM recommends implementing the Resource Utilization Grouper (RUG) IV classification system as soon as it is feasible. The RUG IV classification system is designed to work with the Minimum Data Set (MDS) 3.0 assessment record,[iii] which is currently required by Medicare for submission on a regularly scheduled basis to determine nursing facility residents' medical assessment classification. RUG IV represents a refinement of the RUG grouping process over the RUG III grouper currently in use in Mississippi.

The DOM also recommends eliminating the current use of a two percent (2%) access and quality incentive adjustment applied to specific RUG classifications for facilities whose direct care and care related costs are greater than or equal to ninety percent (90%) of the

median. This incentive was approved in the early 1990's to encourage facilities to admit residents that require more skilled nursing care and to deter hospitalization costs to Medicaid. This is no longer necessary as an incentive since most of the nursing facilities now accept more skilled residents.

The current DOM Case Mix system is not capable of using the RUG IV grouper methodology. The DOM is investigating options for incorporating RUG IV into the case mix calculation as soon as possible. The implementation of a new system to accommodate RUG IV is dependent on the development and design of such a system. Timing, level of effort, and cost will be weighed when deciding on the best approach.

**Capitalization Level** - Currently, asset costs are capitalized at $500, but the DOM recommends an increase to the capitalization level to match the Medicare capitalization level, which is currently $5,000. Individual assets that cost less than the capitalization level should be expensed in the year purchased.

**Return on Equity -** The current ROE interest rate, used to encourage facilities to maintain liquid working capital, was set 20 years ago to match the FRV rate; however, interest rates have been significantly lower in recent years, and a reduction in this interest rate is prudent. Therefore, the DOM recommends a reduction to the Return on Equity interest rate from 9.5% to 5.75%. These changes would apply to all long-term care facilities.

**Fair Rental Value** - The Fair Rental Value (FRV) calculation compensates facilities for use of the buildings, grounds and equipment needed to care for Medicaid residents. The FRV method is a common practice among state Medicaid programs to compensate long term care facilities for these costs and includes a number of components. The workgroup recommends updates to the components used in DOM's calculation, as follows:

- Increase the value of a nursing facility bed to $91,200,
- Increase the annual depreciation amount from 1% to 1.75% for all long-term care facilities,
- Increase the maximum allowed depreciation from 30% to 50% for all long term care facilities, and
- Decrease the rental factor from 7.5% to 5.35 % while maintaining the 2% risk premimum for all long-term care facilities.

**Ventilator Dependent Residents** - The DOM is proposing a per diem add-on to the daily rate for small and large nursing facilities that provide the necessary treatment and services for ventilator dependent residents. Moving ventilator dependent individuals to nursing facilities that specialize in caring for ventilator dependent residents will improve the individual's quality of life and potentially result in long-term cost savings to the Medicaid program.

Mississippi has an access to care issue. In Mississippi, there are currently only two nursing facilities that admit ventilator dependent residents – Methodist Specialty Care Center and Baldwyn Nursing Facility. Methodist is legislatively authorized as the only private nursing facility for the severely disabled (PNFSD) and all costs are covered by Medicaid through an all-inclusive rate. This facility not only admits Medicaid residents that are ventilator dependent, but those with spinal cord injuries and closed head injuries. Baldwyn receives only the standard per diem rate without additional compensation for specialized ventilator dependency related costs, such as respiratory therapy.

Historically, these two (2) facilities rarely accept referrals from unrelated acute care facilities. This leaves the state's remaining acute care facilities with no option to discharge stable ventilator dependent patients to an in-state long term care nursing facility. Therefore, these stable ventilator dependent patients stay in hospitals or relocate to another state. Nursing facilities interested in operating a ventilator dependent unit note the challenge of absorbing the related costs and are paralyzed without adequate reimbursement.

Between 2008 and 2013, the DOM has placed 14 Mississippi residents in out-of-state facilities to receive the necessary treatment and services (currently four (4) residents are out-of-state). Over the same period, the DOM received thirty-four (34) additional referrals for placement, with no success. Currently, there are two (2) Medicaid ventilator dependent beneficiaries on the waiting list for placement out-of-state and six (6) still residing in an acute care facility. The DOM staff experiences difficulty and delays appropriately placing these higher skilled care residents.

The Ventilator Dependent Workgroup formed by the DOM performed various tasks to gather data and information from states that reimburse for ventilator dependent residents in nursing facilities and was to amass data from six states. The goal of the workgroup was to establish reimbursement for in-state nursing facilities willing to provide ventilator dependent care to prevent placement in out-of-state nursing facilities. Two specific areas of concentration were reviewed:

- The development and implementation of enhanced payment for Medicaid beneficiaries who are ventilator dependent and those in acute care facilities;
- The development of standards of care designed to optimize resident outcomes when nursing facilities provide ventilator dependent care.

The proposed methodology for the ventilator dependent resident considers all costs outside the traditional costs of operating an efficient and economical facility. Utilizing the costs of a facility servicing ventilator dependent residents, another facility's projected costs associated with operating a 10-bed ventilator dependent unit, and considering the requirements of the proposed admission criteria, the DOM extrapolated annual salary costs, equipment costs, and additional costs that can be associated with

ventilator dependent residents to calculate a preliminary add-on rate. The extrapolated annual costs were converted to a per day cost. The preliminary add-on rate is $178.34.

A facility's ventilator dependent related costs will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible beneficiaries. Costs included in the add-on rate will be those necessary to be incurred by an efficiently and economically operated ventilator dependent designated unit/beds. An addendum to the current cost report, to be filed with the cost report on its due date, is required to capture the costs associated with the ventilator dependent designated unit/beds. This worksheet must identify the costs associated with caring for ventilator dependent residents, such as salaries of respiratory therapists, additional registered nurses, training, disposal of medical waste, and rental equipment.

The add-on rate will be rebased every fifth year. The Division of Medicaid will publish the add-on rate in the Medicaid Bulletin.[iv]

## Impact of Recommendations

**Financial –** The proposed changes to the rate setting methodology are expected to be budget neutral. The chart below illustrates payments based on the current methodology and payments if the recommended changes are implemented.

| Mississippi Nursing Facility Project | | |
|---|---|---|
| **Component** | **Baseline Model** | **Industry Model** |
| Total direct care | $328,616,493 | $325,226,307 |
| Total care related | $98,996,385 | $104,800,884 |
| Total property | $64,582,049 | $69,935,525 |
| Total return on equity | $6,581,425 | $3,973,609 |
| Total therapy* | $1,510,550 | $1,510,550 |
| Total administrative & operating | $344,890,181 | $339,855,892 |
| Total payment** | $845,177,084 | $845,302,767 |
| *Applies only to PNFSD. | | |
| **Represents amounts prior to the application of third party liability and patient liability payments. | | |

**Division of Medicaid –** All the recommended changes will require resources to ensure that policy, procedures, and regulations that govern the long-term care program are revised after approval. This may include an increase in personnel, changes to the Administrative Code Title 23, [v] State Plan Amendments, [vi] changes to cost report filing, and changes to the case mix reporting system.

**Providers** – The provider community will receive training prior to implementation of the recommended changes through provider bulletins, workshops and webinars especially as it relates to the RUGs IV classification system and the differences in that grouping process when compared to the RUG III grouper currently in use.

**Beneficiaries** - The recommended changes will greatly enhance treatment and services to long-term care residents. Ventilator dependent beneficiaries will no longer have to relocate to receive the necessary treatment and services. The revisions will maintain stability in the rate system for providers and continuity of care for residents.

## Timeline

In order to meet the target implementation date of January 1, 2015, several milestones are critical as follows:

- Legislative approval – 2014 Regular Session
- State Plan Amendment public notice - July 2014
- State Plan Amendment submission - September 2014
- State Plan Amendment CMS approval – December 2014
- Notice to long-term care providers of changes in cost report requirements - April 2014
- Training/information sessions for providers - 2014
- Change Case Mix system from RUG III to RUG IV – 2014

## Legislative Directive

The 2012 Mississippi Legislature passed House Bill 421, Section 5, with a directive to the DOM to do the following:

> "The division shall develop a plan providing revisions to the current reimbursement methodology for nursing facility services…
>
> The division shall not implement these plans, but shall submit the plans to the Public Health and Welfare Committee of the Senate and the Medicaid Committee of the House no later than October 15, 2012, including necessary legislative recommendations."

A progress report was delivered to legislative committees in October 2012.[vii] This report serves as a final report and supports our request for legislative change.

## Workgroup Process

In response to the directive by the Legislature, DOM held an open-forum meeting in June of 2012 and, as a result, a workgroup was formed comprised of long-term care industry representatives, DOM staff, other state agencies, consultants and other interested parties. See Appendix A for a complete list of the membership of the workgroup.

The workgroup has met multiple times in Jackson, between July 2012 and November 2013. See Appendix B for a full list of workgroup meetings.

Recommendations for improving the current reimbursement methodology were developed by this workgroup. The workgroup based recommendations on data, research and analysis. If the recommended changes are approved, the DOM will develop the logistics to implement the specific processes needed to incorporate these changes in the current reimbursement methodology. During the developmental process, the DOM will continue to collaborate with the long-term care industry, as well as other interested parties.

The workgroup agreed to use nursing facility costs for 2011 and first quarter 2012 MDS 3.0 assessment records as the primary sources of data. The first step taken was to calcuate a baseline model using the current reimbursement methodology (see section on Current Methodology). All subsequent changes to the reimbursement methodology were compared to the baseline model to determine the cost to the DOM and to measure the impact on the nursing facilities.

As different changes to the components of the rate computation were considered, the changes were built into the rate model and the resulting outcomes were analyzed. The process was iterative, so that the final rate computation model was developed and refined over time, by adjusting one component at a time and reviewing the outcomes.

Approximately 20 different models were constructed and reviewed by the workgroup, before arriving at the final combination of rate computation components recommended in this report.

Additional data was considered at various points in the process, including:

- Rate setting information from other states
- Federal Reserve treasury bond rate history
- Commercial prime lending rate history
- National data on nursing facility construction/renovation costs
- National data on nursing facility investment costs
- CMS nursing facility quality data
- Reports from the Medicare Payment Advisory Council on nursing home reimbursement

- CMS Facility Certification survey summary information for Mississippi and other states
- Published literature on the issue of rate-setting for nursing facility services

## Workgroup Goals

The workgroup identified 13 goals as follows:

1. Maintain access to nursing facility care for Medicaid beneficiaries
2. Provide stability and predictability in revenue to the marketplace
3. Provide resources to meet quality of care, quality of life and physical environment expectations of regulators
4. Provide resources to meet quality of care, quality of life and physical environment expectations of consumers
5. Promote quality care for beneficiaries
6. Timely recognition of changing costs; especially those targeted to improve resident care
7. Fairness in payments across facilities
8. Efficiency and ease in administration – Nursing Facilities
9. Efficiency and ease in administration – DOM
10. Purchasing clarity for the State
11. Insure appropriate access to capital markets
12. Keep the nursing facility program affordable for Medicaid, and for the taxpayers of Mississippi
13. Assure the appropriate level of care for Medicaid beneficiaries

These goals are the benchmark against which all potential changes to the nursing facility reimbursement methodology have been compared. The recommended methodology changes also meet the goal of affordability in that they are budget neutral.

## Current Methodology

The DOM pays each nursing facility a facility specific payment rate for all residents, whether the resident is low acuity or high acuity. The rate is derived from the facility's specific costs subject to ceilings, and is adjusted for facility acuity. The current reimbursement system establishes a cost-based prospective per diem payment rate annually at January 1. The per diem payment established for each nursing facility is the sum of per diem rates calculated for the different cost centers, based on cost report data. Rates are computed for:

- Direct care and care related costs
- Administrative and operating costs
- Property fair rental payment, and

- Return on equity capital for non-property related equity

The rates for direct care and care related costs and for administrative and operating costs are based on actual costs as reported on each facility's annual Medicaid cost report trended forward. The trend factor is based on a Mississippi specific market basket index. The direct care costs are case mix adjusted based on the average case mix of the facility for the cost report period. The case mix is calculated based on a resident classification system.

The resident classification system was designed in 1993 based on time studies and assessment information gathered from five (5) states (Kansas, Maine, Mississippi, Nebraska, and South Dakota). The classification system originally designed for the demonstration project contained forty-four (44) classifications of residents and is known as RUG III. Mississippi elected to use the Multi-state Medicare/Medicaid Payment Index ($M^3PI$), which contains thirty-five (35) classifications. Using Mississippi wage data, weights were assigned to each of the classifications. Additionally, different weights were developed and are used for residents in licensed Alzheimer's Units.

The current payment method requires that resident specific data be extracted from the resident assessment tool (the Minimum Data Set or MDS record) and processed through the RUG III grouper to determine the relative acuity of each resident over time. The facility case mix is calculated based on the average case mix of all nursing facility residents during the measurement period (typically one calendar quarter). The rate-setting process uses a historical measure of case mix to adjust direct care costs for each facility, which means that historical case mix affects the facility's future rate. There is a lag of one calendar quarter between changes in case mix and changes to the facility rate.

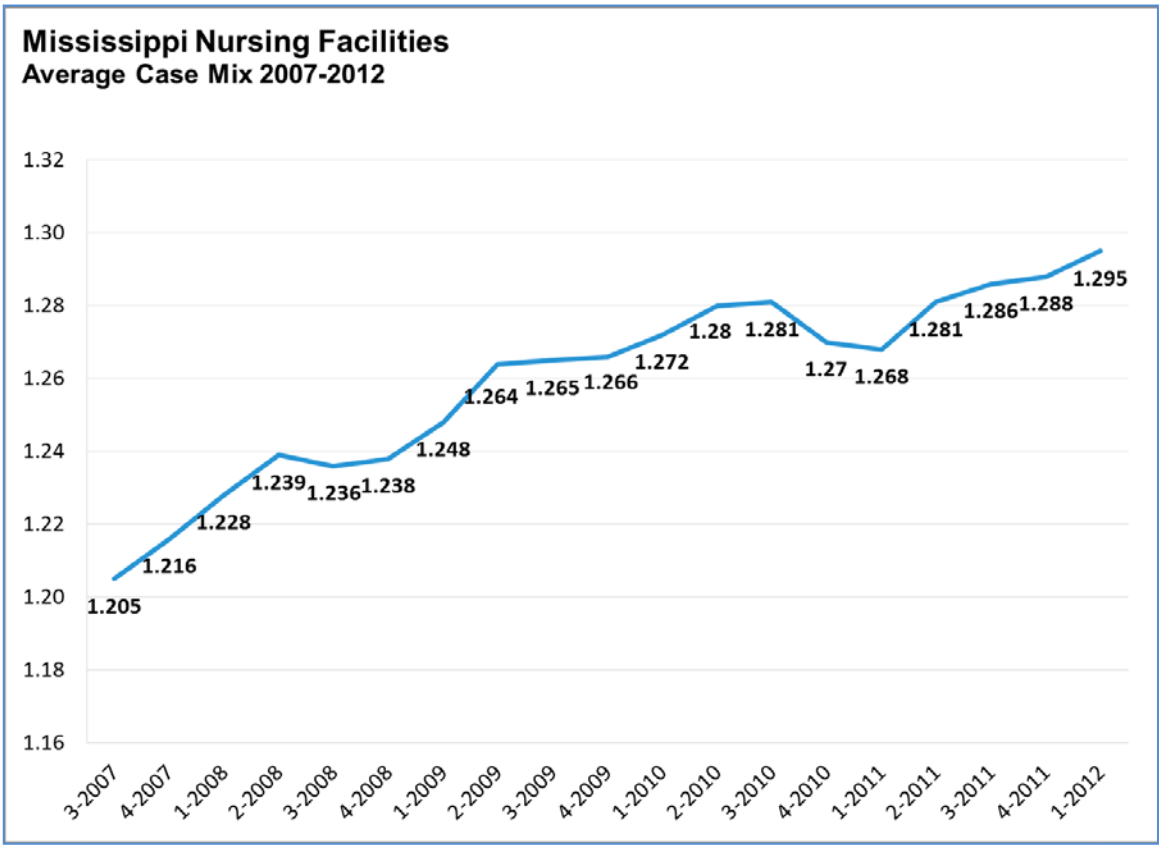
## Medicaid's Role/Impact

It is important to acknowledge Medicaid's role as the most significant payer of nursing facility services. According to the Kaiser Commission on Medicaid and the Uninsured' s October 2011 report,[viii] Medicaid finances nearly half (43 percent) of all spending on long–term care services while sixty-eight percent (68%) of the national nursing facility population are Medicaid beneficiaries. This places a special burden on the Medicaid program to carefully consider reimbursement policy, because of the disproportionate impact on the provider's ability to operate.

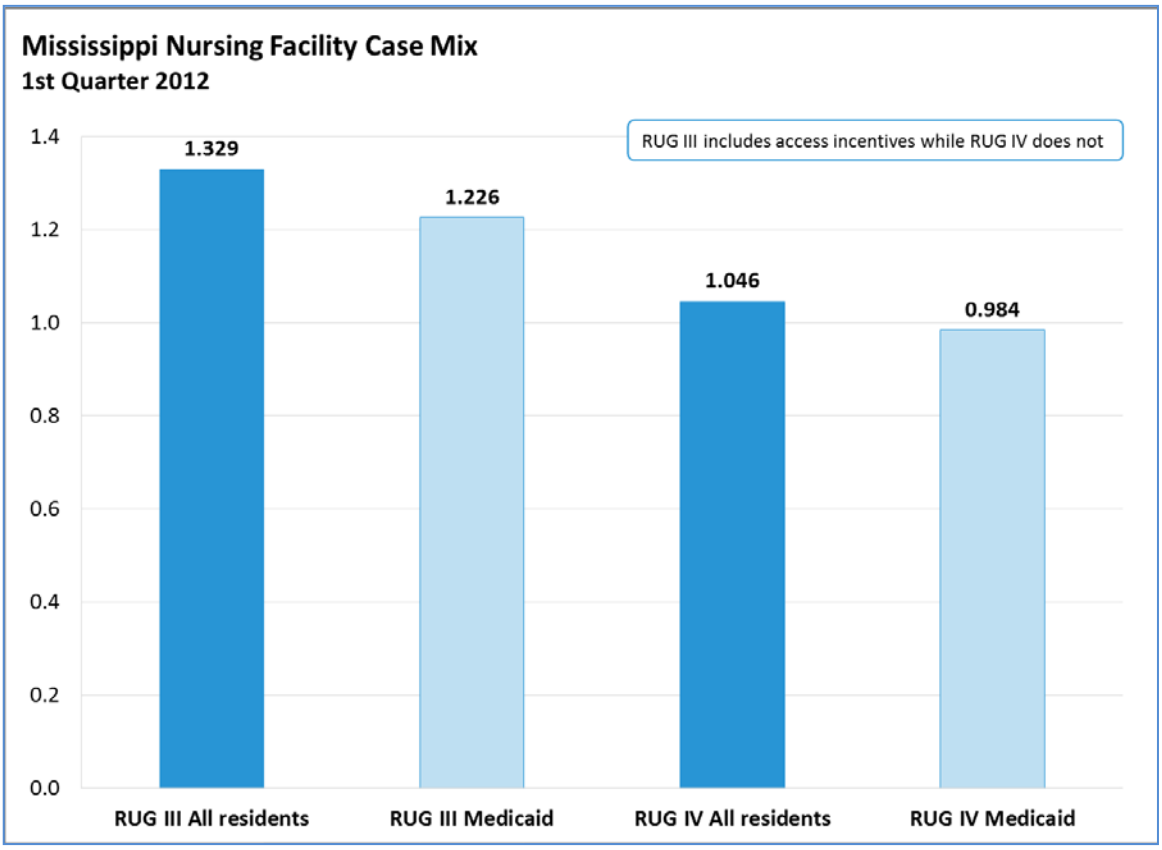
In 2011, Mississippi Medicaid financed approximately seventy-five percent (75%) of nursing facility days of care. Therefore, when Medicaid makes a change in payment policy, it can impact the way nursing facilities do business. It can affect staffing levels, plant maintenance and administrative capabilities. All of these factors can impact access to care and the quality of care experienced by the nursing facility residents.

## Trends

As seen in the following chart, the average case mix (measured quarterly) has increased since 2007 by 7.5%. This is a significant increase, resulting in higher payments to nursing facilities. Higher case mix indicates that nursing facilities are caring for more complex residents overall, and incurring greater costs to provide that care. This case mix measure does not tell us whether the more complex residents are Medicaid beneficiaries or not. Mississippi uses a facility wide case mix which includes the acuity of non-Medicaid residents, including Medicare residents who typically have a higher acuity rating than Medicaid residents.

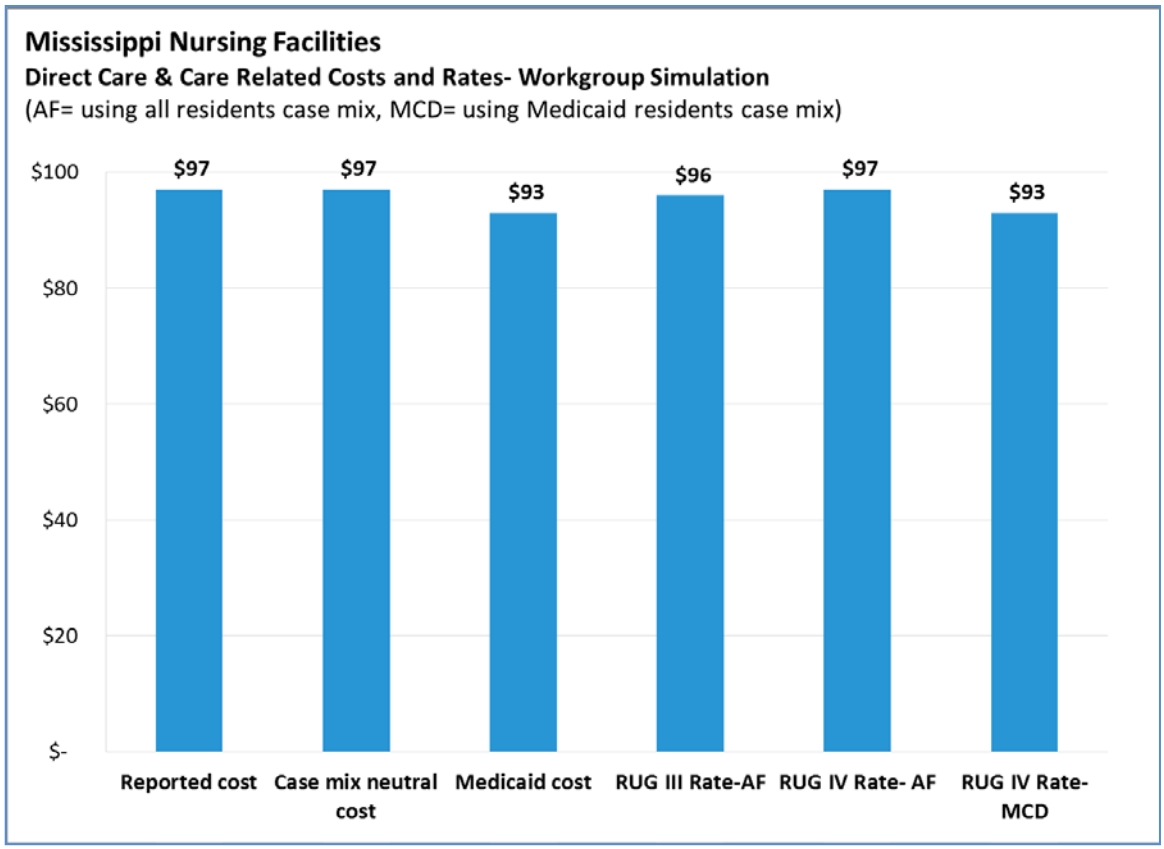


As part of the workgroup process, case mix was recalculated using the RUG IV Medicaid grouper. Using the same set of MDS assessment records, the Medicaid case mix was also calculated. The following chart compares the all-facility case mix to the Medicaid resident case mix, using both RUG III and RUG IV.




The RUG IV Medicaid grouper results in a lower case mix measure for both all residents and Medicaid residents only, but the relationship between Medicaid case mix and overall case mix is closer.

The workgroup also did extensive analysis and comparison of the cost of direct nursing care and care related costs for Medicaid residents. This is relevant because the two cost centers are combined to determine a cost ceiling for rate setting. The following chart summarizes the findings of that analysis. The chart uses per patient day costs and simulated Medicaid rates.




The recommended reimbursement methodology model uses the rate calculated with the all facility case mix, as shown in the second bar from the right in the chart above.[ix]

## Comparison to Other States

Mississippi has more nursing facility residents per capita than the national average. Compared to other states in the region, Mississippi's average ranks number three (3).

| Nursing Home Residents by State- Comparison 2011 | | | | |
|---|---|---|---|---|
| | Population* | Nursing Facility Residents* | Percentage of Population | Per Thousand Residents |
| Arkansas | 2,894,000 | 18,033 | 0.62% | 6.2 |
| Louisiana | 4,455,000 | 25,522 | 0.57% | 5.7 |
| **Mississippi** | **2,919,000** | **16,342** | **0.56%** | **5.6** |
| Kentucky | 4,291,000 | 22,680 | 0.53% | 5.3 |
| Tennessee | 6,294,000 | 29,910 | 0.48% | 4.8 |
| Alabama | 4,727,000 | 22,759 | 0.48% | 4.8 |
| North Carolina | 9,377,000 | 37,399 | 0.40% | 4.0 |
| South Carolina | 4,580,000 | 17,143 | 0.37% | 3.7 |
| Georgia | 9,587,000 | 27,564 | 0.29% | 2.9 |
| **US** | **307,892,000** | **1,366,390** | **0.44%** | **4.4** |
| * Kaiser State Health Facts 2011 (kff.org/statedata) | | | | |

Nursing hours per resident day are comparable to other regional states and the national average. Compared to these states and the national average, Mississippi has the highest percentage of nursing home residents dependent on Medicaid as the primary payer.

| Nursing Home Staffing- Comparison 2011 | | | |
|---|---|---|---|
| | Total Nursing Hours per Resident Day* | Licensed Nursing Hours per Resident Day* | Percentage of Residents Medicaid Primary* |
| Alabama | 4.3 | 1.7 | 67% |
| Arkansas | 4.3 | 1.5 | 68% |
| Kentucky | 4.2 | 1.7 | 66% |
| South Carolina | 4.2 | 1.8 | 63% |
| **Mississippi** | **4.1** | **1.7** | **76%** |
| North Carolina | 4.0 | 1.6 | 67% |
| Tennessee | 3.9 | 1.6 | 64% |
| Georgia | 3.7 | 1.5 | 71% |
| Louisiana | 3.7 | 1.5 | 73% |
| **US** | 4.0 | 1.6 | 64% |
| * Kaiser State Health Facts 2011 (kff.org/statedata) | | | |

The property per diem rate is based on a fair rental system. The fair rental system establishes the value of a facility based on its age. This method is used by a variety of states with varying components. A comparison to other states reveals that Mississippi has the lowest depreciation rate and the lowest maximum depreciation.

| Summary of State Methods for Calculating Fair Rental Value (or the equivalent) for Nursing Facility Ratesetting | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Federal Medicaid Match Rate 2014 | Depreciation Rate | Maximum Depreciable Period | Maximum Depreciation | Rental Rate Floor | Rental Rate Ceiling | Minimum Occupancy | Method of Determining Gross Rental Value | Bed Value | Cost per Square Foot | Notes |
| California | 50.00% | 1.80% | 34 years | 61.20% | 7.00% | 10.00% | Statewide avg OCC rate | Per square foot | | $123psf + $4,000 per bed for equipment + 10% of building value for land | |
| Colorado | 50.00% | Appraiser determined | Asset life | 100.00% | 8.25% | 10.75% | 90% | Bed value | 93,079 | | |
| Georgia | 65.93% | 2.00% | | | 9.00% | 9.00% | 85% | Per square foot | | 141.10psf + RS Means annual update + $6,000 per bed for equipment, plus 15% for land value | |
| Kentucky | 69.83% | Appraiser determined | Asset life | 100.00% | 9.00% | 12.00% | 90% | Bed value | 55,836 | | |
| Louisiana | 60.98% | 1.25% | 30 years | 37.50% | 9.25% | 10.75% | 70% | Per square foot | | 149.44psf bldg / 14.96psf land / 6,132 per bed equip | |
| **Mississippi** | **73.05%** | **1.00%** | **30 years** | **30.00%** | **9.50%** | **10.00%** | **80%** | **Bed value** | **52,954** | | |
| Missouri | 62.03% | | | | 12.00% | 12.00% | 93% | | | | Building and equipment rate |

| Summary of State Methods for Calculating Fair Rental Value (or the equivalent) for Nursing Facility Ratesetting | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State | Federal Medicaid Match Rate 2014 | Depreciation Rate | Maximum Depreciable Period | Maximum Depreciation | Rental Rate Floor | Rental Rate Ceiling | Minimum Occupancy | Method of Determining Gross Rental Value | Bed Value | Cost per Square Foot | Notes |
| New Jersey | 50.00% | 2.00% | 40 years | 80.00% | 8.00% | 8.00% | 95% | Bed value | 89,000 | | |
| North Carolina | 65.78% | 2.00% | 32.5 years | 65.00% | 7.50% | 9.50% | 90% | Per square foot | | 127psf + 15% for land + 5,000 per bed | |
| Nevada | 63.10% | 1.50% | 40 years | 60.00% | 9.00% | 9.00% | 92% | Bed value | 106,016 | | |
| Rhode Island | 50.11% | 1.50% | 35 years | 52.50% | 9.00% | 12.00% | 98% of statewide average | Bed value | 82,201 | | |
| South Carolina | 70.57% | Appraiser determined | Asset life | 100.00% | 3 yr average of 30yr TBR (4.4% in 2010) | None | 96% | Bed value | 48,564 (2010)+ annual CPI | | "Deemed Asset Value" calculation |
| Utah | 70.34% | 1.50% | 35 years | 52.50% | 9.00% | 12.00% | | Bed value | 67,527.28 + 10% for equipment | | |
| Virginia | 50.00% | 2.86% | | | 8.50% | 11.00% | | | | 148 – 177psf + 1.43 land/soft cost factor | |
| Table created by Xerox using data from state government specific websites. | | | | | | | | | | | |

## Other Considerations

**Medicaid residents only case mix** - Mississippi considers the acuity of all residents in the nursing facility when measuring the cost of nursing care (Direct Care). The DOM considered the more standard approach of using the Medicaid case mix to set Medicaid payment rates. The Medicaid case mix reflects the acuity and the care needs of only the Medicaid residents. The Medicaid case mix is typically lower than the "all-facility" case mix, which includes Medicare and private pay residents.

The review of all models for this project using the Medicaid case mix indicated that Direct Care payments to facilities could potentially be reduced by $20 million, or about 6%. DOM considered the concept of a transition process, to ease the short-term impact on facilities. The basic concept was to take the savings made possible by the use of a Medicaid case mix and return those savings to the facilities, based in part on the cost of maintaining nursing staff, and in part on performance on certain quality measures.

This approach was not pursued based on insight from the workgroup's nursing facility industry representatives' that payments to nursing facilities for nursing care would be reduced, likely resulting in facilities reducing nurse staffing. While facilities could possibly earn back some or all of their rate reduction in direct care through the performance measures, the end result would be a considerable redistribution of direct patient care funding among providers, which could negatively impact patient care and nurse staffing in many facilities. In addition, to date, there is little evidence that pay-for-performance systems have resulted in improved quality in the states that have implemented them. Therefore, the details of a transition process were not finalized, once the decision was made to continue using the all-facility case mix in the rate setting methodology.

**Resident-specific case mix** – DOM considered transitioning from an all facility case mix to a resident-specific payment methdology. The position is to only reimburse nursing facilities for the acuity of specific Medicaid residents, rather than using an average case mix for all facility residents. All other payment sources would be paid according to their eligibility before Medicaid is considered in the case mix. Time did not allow for this consideration to be modeled to determine the cost impact. However, the payment change impact is expected to be similar to the Medicaid residents only case mix. This methodology would require extensive revisions to the current Medicaid claims payment system.

**Other changes to FRV** - When considering changes to the FRV calculation, the DOM considered data from several sources. FRV calculations from other states were reviewed; the history of the Treasury Bond Index and the commercial Prime Lending Rate were

considered; and the cost of obtaining investment capital was reviewed. The FRV calculation was modeled using various combinations of components, including:

- Different depreciation levels (from 1% to 1.75%)
- Different maximum depreciation levels (from 30% to 52.5%)
- Different rental rates (from 5.25% to 8%)

Modeling these changes did not significantly alter the property payment.

**Price Based Methodology** - DOM briefly reviewed the concept of using a price based rate setting methodology for nursing facilities. A price based methodology sets a price for each designated cost center component. Medicare and a few states use a price based method to reimburse nursing facilities.

Given the long history of cost based methods in Mississippi, it was determined that a price based methodology would not be feasible at this time.

**Pay for Performance –** Also known as P4P, it is an incentive paid based on the quality of care delivered by the provider. This initiative has had mixed success in States where it has been implemented. It has been discontinued by some. Based on the workgroup research, it will be best to delay further consideration of this topic until experience in other states is adequately successful and easily followed.

# Appendix A

In June of 2012 a workgroup was formed comprised of long-term care industry representatives, DOM staff, other state agencies, consultants and other interested parties. See below for a complete list of the workgroup.

| Nursing Facility Reimbursement Methodology Revision Committee Members |
|---|
| **Mississippi Division of Medicaid** |
| Charissa Wilson |
| Margaret King |
| Robert Carter |
| Eric Everett |
| Louanne Holman |
| Patricia Holton |
| Evelyn Silas |
| Brian Smith |
| T.J. Walker |
| **Xerox State Healthcare** |
| Kathleen Martin |
| Susan Ryan |
| Wayne Akins |
| **Mississippi Department of Health** |
| Marilynn Winborne |
| Lynn Cox |
| **Independent Nursing Home Association** |
| Brian Cain, Owner |
| Troy Griffin, Owner |
| Benny Hubbard, Owner |
| **Mississippi Healthcare Association** |
| Bobby Beebe, Facility Manager |
| Harold Beebe, Owner |
| Bobby Rotolo, Owner |
| Joe Lubarsky, Consultant |
| Shane Hariel, Cost Report Preparer, Horne, LLP |
| Margaret Leverette, Case Mix Nurse |
| Tammy Martin, Administrator, West Point Community Living Center |
| Diane Platt, Administrator, Cedars Health Center |
| Stan Maynard, Methodist Senior Services |
| John Reed, Shearer Richardson Nursing Facility |

| Nursing Facility Reimbursement Methodology Revision Committee Members |
|---|
| Gary Gardner, Director of Reimbursement, Community Eldercare |
| Jamie Collier, Director of Reimbursement, Preferred Care Partners Management Group |
| **Mississippi Healthcare Association** |
| Margaret Stept, Administrator, Millcreek Facilities |
| J.W. Stewart, Cost Report Preparer, Millcreek Facilities |
| Charles Shearer, Son Valley |
| Dan Estes, Covenant Dove |
| **Attendees not affiliated with an association** |
| Todd Jones, Administrator, Oak Grove Nursing Home |
| Thomas Kuluz, CFO, Corporate Management |
| Paul Black, CFO, Winston Medical Center |
| Aubrey Holder, CPA, Watkins, Ward & Stafford |
| Danny Lamier, Alexander Milne Home for Women |
| Jay Massey, Cognos Consultants |
| David Stewart, Stewart & Barnett |
| **Attendees, but not active participants** |
| David Dzielak, Executive Director, Division of Medicaid |
| Richard Roberson, Division of Medicaid |
| Will Crump, Division of Medicaid |
| Douglas Stewart, Executive Account Manager, Xerox State Healthcare |
| Alice Mitchell, Executive Director, Independent Nursing Home Association |
| Vanessa Phipps Henderson, Executive Director, Mississippi Healthcare Association |
| Melzana Fuller, Mississippi Healthcare Association |
| Karyn Thornhill, Inzinna Consulting |

## Appendix B

In our effort to keep this an open and transparent process, the workgroup met multiple times between July 2012 and November 2013. See below for a list of workgroup meetings.

| Workgroup Meetings | |
|---|---|
| **Location** | **Dates** |
| Jackson, MS | 7/13/2012 |
| Jackson, MS | 8/9/2012 |
| Jackson, MS | 9/6/2012 |
| Jackson, MS | 10/4/2012 |
| Jackson, MS | 11/5/2012 |
| Jackson, MS | 2/7/2013 |
| Jackson, MS | 4/11/2013 |
| Jackson, MS | 5/9/2013 |
| Jackson, MS | 6/13/2013 |
| Jackson, MS | 9/19/2013 |
| By phone | 10/22/2013 |
| Jackson, MS | 11/21/2013 |

## Bibliography

[i] Mississippi Legislature; http://billstatus.ls.state.ms.us/2012/pdf/history/HB/HB0421.xml

[ii] Centers for Medicare & Medicaid Services; http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGRefinement.html

[iii] Centers for Medicare & Medicaid Services; http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

[iv] Mississippi Division of Medicaid, Mississippi Envision Medicaid Bulletins; https://msmedicaid.acs-inc.com/msenvision/index.do

[v] Mississippi Division of Medicaid Administrative Code; http://www.medicaid.ms.gov/manuals/Title%2023%20Part%20200%20General%20Provider%20Information.pdf

[vi] Mississippi Division of Medicaid State Plan Attachment 4.19-D; Mississippi Division of Medicaid State Plan

[vii] Mississippi Division of Medicaid, Legislative Budget Report; http://www.medicaid.ms.gov/Documents/LegislativeBudgetReport.pdf

[viii] The Henry J. Kaiser Family Foundation; http://kff.org/

[ix] The allocation of nursing cost to Medicaid residents is based upon their case mix score in relation to the case mix score of all residents. These case mix scores are based upon national time studies of resident-specific nursing time. However the studies revealed that resident-specific time only represents a little over 50% of total nursing time. The remainder of the nursing time was non-resident specific and benefited all residents, regardless of payer source. This non-resident specific nursing time is not taken into account in the cost allocation formula.