DIVISION OF RATE SETTING

MARCH 28, 2014

HOW VERMONT MEDICAID NURSING HOME RATES ARE DETERMINED

THE MEDICAID COST REPORT

Each facility files a Medicaid cost report for each fiscal year. The cost report shows all costs and ties to the facility's audited financial statements. Allowable costs are determined based on Vermont Division of Rate Setting rules (V.D.R.S.R).

The cost report divides reported costs into cost categories. Each category is dealt with individually in the Vermont Division of Rate Setting rules.

COST CATEGORIES

NURSING CARE COSTS - V.D.R.S.R § 6.2

Assistant DON, RNs, LPNs, LNAs and the MDS Coordinator plus fringe benefits for nursing staff

DIRECTOR OF NURSING (DON) - V.D.R.S.R § 6.5

One FTE salary allowed plus fringe benefits

COST CATEGORIES

RESIDENT CARE - V.D.R.S.R. § 6.3

- Activities and Social Work staff salary and fringe
- Contractual Pharmacy, Contractual Medical Director, Contractual
- Contractual Social Worker
- Utilities
- Food
- Activity Supplies and Employee Physicals

COST CATEGORIES

INDIRECT CARE - V.D.R.S.R. §6.4

- Admin and General salary, non-salary and fringe benefits
- Plant Operations salary, non-salary and fringe benefits
- Dietary salary, non-salary (except for food which is in Resident Care) and benefits
- Housekeeping salary, non-salary and fringe benefits

COST CATEGORIES

PROPERTY- V.D.R.S.R. § 6.6

- Property interest
- Depreciation
- Equipment rentals
- Property insurance

ANCILLARY V.D.R.S.R. §6.7

- PT, OT, ST
- Medical Supplies (under current rules all medical supplies are in Ancillary whether or not charges are recorded)

OCCUPANCY LIMITS

Costs are divided by resident days to calculate a per diem cost. Vermont Division of Rate Setting rules state that the divisor/denominator (days) must represent at least 90% of the resident days available during the period.

OCCUPANCY LIMITS

Example:

100 bed facility

365 days

at 100% occupancy would provide 36,500 days of care.

at 90% occupancy 32,850 days of care would be provided.

For the categories with occupancy limits, the 32,850 days would be the lowest number of resident days to be used as the denominator to calculate the per diem.

OCCUPANCY LIMITS

Remember, the larger the divisor (bottom number) the smaller the result.

If you ran at 80% actual occupancy, you would have provided 29,200 actual days of care. However, the divisor which would be used to determine allowable costs per day would be 32,850 or the 90% occupancy figure. Nursing costs are currently exempt from this occupancy limit, as are Ancillary costs.

MINIMUM OCCUPANCY REQUIREMENTS PER V.D.R.S.R. § 5.7

- 90% occupancy limit applied to
  - DON
  - Resident Care Costs
  - Indirect Care Costs
  - Provider Tax
  - Property Costs

LIMITS TO PORTIONS OF THE PER DIEM RATE

CAPS - The maximum amount paid in each cost category.

Nursing per diem – 90th Percentile

DON - No cap

Resident Care - Median plus 5%

Indirect Care – Median plus 5% (One hospital based facility has a cap of median plus 37%.)

Property - No cap

Ancillary - No cap

EXAMPLE OF A MEDIAN LIMIT

What is a median? The median means as many values above a number as below.

Example:

Per diem Resident Care costs from base year for 9 homes arranged in order of magnitude

- Facility A $ 45
- Facility B $ 47
- Facility C $ 49
- Facility D $ 52
- **Facility E $ 58** This is the median because there are the same number of facilities with higher costs as there are with lower costs.
- Facility F $ 62
- Facility G $ 66
- Facility H $ 69
- Facility I $ 71

If the cap is at 105% of the median, the cap would be 105% X $58 or $60.90

The median is not an average and therefore is not affected by very low or very high values in the group.

- The most any per diem could be is the cap on that cost category.

DETAILS ON HOW COSTS IN EACH COST CATEGORY BECOME PART OF THE PER DIEM RATE

Cost categories:

- Nursing
- DON
- Resident Care
- Indirect
- Property
- Ancillary

NURSING CARE COSTS

- Limited by cap at 90th percentile
- No adjustment made to days for low occupancy in this cost category
- Base year costs are inflated to the rate year
- Nursing costs are rebased every two years
- Standardized days are calculated using the All Payer case mix scores (scores for everyone in the home) times the actual resident days in the base year.
- Base year costs are divided by the standardized days to give the base year cost per case mix point.
- Each quarter the inflated cost per case mix point is multiplied by the latest average Medicaid case mix score for that facility to new quarter's nursing per diem.

DIRECTOR OF NURSING (DON)

- Allowable costs divided by actual days or days with assumed 90% occupancy whichever is higher
- No cap
- Base year costs are inflated until the next rebase

EFFECT ON RATE OF CHANGES IN CASE MIX SCORES

Example:

- If a facility's nursing cost per case mix point is \$100 (not untypical) and their Q1 20XX Medicaid average case mix score is .93, then
  - Nursing per diem in the rate is \$100 X .93 = \$93.
- Then for Q2 Medicaid average case mix score is 1.20
  - Nursing per diem in rate is \$100 X 1.20 = \$120
  - Difference is \$27 in the per diem.
- For 80 bed home at 90% occupancy and 60% Medicaid residents the annual cost of this change (assuming score stayed at 1.2 for the next four quarters) for 15,768 annual Medicaid days would be \$425,736.

COST OF CHANGES IN CASE MIX SCORES

- Changes in case mix scores may not look large but they have a large effect on the per diem.
  - From .95 to 1.05 is a 10.5% increase
  - From .95 to 1.15 is a 21% increase.

RESIDENT CARE

- Allowable costs divided by actual days or days at 90% occupancy, whichever is higher
- Capped at 105% of the median
- Base year costs are inflated until the next rebase

INDIRECT COSTS

- Allowable costs divided by actual days or days at 90%, whichever is higher
- Capped at 105% of the median (One hospital based facility (Gifford) is capped at 137% of the median)
- Base year costs are inflated until the next rebase

PROPERTY COSTS

- Allowable costs divided by actual days or days at 90% occupancy, whichever is higher
- No caps
- Updated when each review of a facility's Medicaid cost report is completed
- Special Adjustment available for purchase of large assets, large construction projects with prior approval from the Division (V.D.R.S.R §§ 4.11 and 8.1)

ANCILLARY

- PT, OT, ST, RT based on the cost of services provided to Medicaid residents
- Medical supplies divided by actual resident days
- Dialysis transportation for Medicaid residents divided by Medicaid days

What is a Base Year?

- Base year is a very important concept.
- For the following cost components: Nursing, DON, Resident Care and Indirect, a specific year's cost report is used as the basis for the rate components that will be part of the rate for several years.
- These specific rate components will be adjusted by inflation factors each year but will not revisited or changed beyond inflation until the next rebase of cost occurs.

WHAT IS A BASE YEAR?

- Therefore, costs in a base year will affect the rate for many years. If, for some reason, these costs are atypically low, the rate will not include a typical annual cost.

- Base years are not announced in advance. Nursing Care costs must be rebased every two years and all other costs at least every four years.

CASE MIX SCORES

- Facilities receive quarterly notification of their average Medicaid case mix scores from Licensing and Protection before the score is used by Rate Setting.
- The score provided to Rate Setting each quarter is the average score of a facility's Medicaid residents.
- This score is used for quarterly adjustments to the nursing care rate component for that facility.

Base Year Case Mix Scores

- For the base year calculations, the rules state that DRS will use the average case mix scores for **ALL** residents for the same periods/quarters as your fiscal base year period to determine the nursing costs per case mix point.

- If your fiscal year ended on September 30, 2014, we would use the average of the case mix scores for the fourth quarter 2013, first quarter 2013, second quarter 2013, and third quarter 2013. These are the same periods as the costs were accumulating to build the total costs reported on the Medicaid cost report.

- Case Mix Scores are applied only to the Nursing Care component of the rate. The Nursing portion of the rate is the only portion that will change every quarter.

WHAT ABOUT RATES FOR SPECIAL RESIDENTS?

- V.D.R.S.R §14.1
- Vent patients at The Pines at Rutland.
- Huntington's Chorea
- Also has been used for bariatric residents and Traumatic Brain Injury (TBI).
- Must be approved as reasonable for the services provided and signed off by the Director of the Department of Vermont Health Access (DVHA), Medical Director at DVHA and the Director of DAIL Licensing and Protection.

OTHER SPECIAL RATES

- **§ 14.3 Furloughees**
  - Special rate equals 150% of facility's normal rate.
  - Facilities only receive the special rate while resident is on furlough. If sentence ends and resident is still at nursing home, facility reverts back to its normal Medicaid rate.

QUALITY INCENTIVE AWARDS

- Annual awards given pursuant to V.D.R.S.R. § 9.5.
- Payments based on objective standards of quality as determined by DLP and objective standards of cost efficiency determined by DRS.
- Pool of payments based on a pool of $25,000 times number of facilities meeting award criteria, up to a maximum of 5.
- Pool distributed based on ratio of Medicaid days to the total Medicaid days for the group of award winning facilities.

TERMINATING RATES - V.D.R.S.R. § 5.10

- DRS may adjust a facility’s rate when there is a planned closure to ensure protection of the residents of the facility.
- Facility needs DAIL approved transfer plan to accompany application.
- Additional costs can include costs associated with keeping staff on while transferring residents.

EXTRAORDINARY FINANCIAL RELIEF V.D.R.S.R. § 10

- EFR is available in order to protect residents from the unplanned closing of a nursing home. Nursing homes in immediate danger of failure may seek relief under this section.
- EFR is approved by the Secretary of the Agency. Relief is purely discretionary.
- DRS writes recommendation to the Secretary.
- Criteria to be considered listed in § 10.3

Section 8 Rate Adjustments

- Reasons for Rate Adjustments
  - New service or project (compare/contrast to § 4.11(a))
  - CON approved project ($1,500,000 or more)
  - Reduction in number of licensed beds
  - Change in law
  - Receivership
  - Installation of energy conservation devices or other efficiency measures
  - Emergencies and unforeseeable circumstances such as damage from fire or flood (but also note that providers are required to carry sufficient insurance)

ADJUSTMENTS TO RATES

- § 4.11(a) adjustment for large asset acquisition
  - Not for projects, for single asset.
  - Examples: Roof, addition
  - Change to the rate must be at least 1/2 % of the current rate.
  - Must have prior approval.
  - Extra depreciation and interest go into the rate first day of the quarter following the later of date of final order or date asset is placed into service.

THE END