Navigating Reimbursement Changes: Finding Your Path

FORVIS MAZARS **Senior Living and Long-Term Care Group**

Missouri Health Care Annual Convention – August 2024

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Our Agenda for Today

- Financial Impacts of Rebasing
- Change in CMI Calculation
- Other Incentives
- Clinical Consideration– How is it Changing?
- Supportive Documentation Guidelines for Upcoming Audits
- Strategies for Success
- Q&A

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Questions Forvis Mazars Will Answer Today:

- What big changes go into effect July 1, 2024?
- What does this second rebase mean to your SNF Medicaid rate?
- How does the CMI calculation change?
- What clinical strategies can be addressed that impact your future rates?
- What should providers expect from the supportive documentation reviews that Myers and Stauffer are currently conducting?

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Financial Impacts of Rebasing

Glance At The Basics

Basic Components of Missouri Medicaid Per Diem Prospective Rate:

Cost Components

- Patient Care CMI Adjusted*
- Ancillary*
- Administration*
- Capital – Fair Rental Value “FRV”

Incentives

- Patient Care
- Multiple Component

Add On

- Value Based Purchasing (VBP)
- Mental Illness
- NFRA Bed Tax

**Subject to a ceiling*

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What Will Be Rebased?

Cost Components

- Patient Care*
- Ancillary*
- Administration*
- Capital – Fair Rental Value “FRV”

- ➢ The above cost components will be rebased on 2022 Audited Medicaid Cost Reports
- ➢ Inflation factors will be applied trended to 7.1.24

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How to Estimate Cost Per Diem

- All ceilings will be based on the 2022 audited Medicaid cost reports trended forward to 7.1.24

- Review 2019 Schedule L vs 2022 Schedule L

- Apply inflation factor to your costs if following current plan
  - December 31 YE estimated at 10.5%
  - June 30 YE estimated at 13.60%

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Change in CMI Calculation

Case Mix Index (CMI) Changes

Missouri Medicaid Plan makes the transition to PDPM effective 7/1/24

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Example of Impact of CMI on the Patient Care Component - Not Capped by Ceiling

Patient Care Component Actual Costs PPD:	$100
Cost Report 2022 CMI (All payers):	1.19*

Nursing component CMI can range from .62 to 3.84

Impact on rate:

Medicaid CMI: 1.10	→	$ 92
Medicaid CMI: 1.35	→	$ 113
Medicaid CMI: 2.00	→	$ 167

* *Estimates only – used for example*

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Example of the Impact of CMI on the Patient Care Component – Capped by Ceiling

Patient Care Component Ceiling Normalized:	$160*
Statewide Ave Total CMI-2022 (All payers):	1.19*

Impact on rate:

- Medicaid CMI: 1.10 → $ 148
- Medicaid CMI: 1.35 → $ 181
- Medicaid CMI: 2.00 → $ 269

** Estimates only – used for example*

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Other Incentives – VBP and Mental Health Add Ons

Value Based Purchasing Incentive for Missouri Medicaid

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	<=10.0%	$1.87
Decline in Mobility on Unit	<=8.0%	$1.87
High-Risk Residents w/ Pressure Ulcers	<=2.7%	$1.87
Anti-psychotic Medications	<=6.8%	$1.87
Falls w/ Major Injury	<=1.3%	$1.87
In-dwelling Catheter	<=1.1%	$1.87
Urinary Tract Infection	<=1.9%	$1.87

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Missouri VBP Incentive

A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies based on the total long stay quality measure cores calculated from the Five Star Rating System

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%

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VBP Incentive

What will VBP Look Like 7/1/24?

Semi-annual updates:

- The VBP will be re-calculated effective for dates of service beginning January 1 and July 1 of each year
- The QM performance date will be updated based on the most current data available as of November 15th for the January 1 rate adjustment and as of May 15th for the July 1 rate adjustment

Due to the removal of Section G of the below quality measures, these will be frozen until January 2025:

- Decline in ADL
- Decline in Mobility on Unit
- High-Risk Residents with Pressure Ulcers

The State is still working on how they will accommodate the freeze period within the VBP Add-On

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Mental Illness Diagnosis Add-On

If at least 40% of a facility's Medicaid population have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00).

- Schizophrenia: MDS item I6000
- Bi-polar: MDS item I5900

Each facility's mental illness diagnosis data will be re-evaluated semi-annually using data available as of:

- November 15th - January 1 rate adjustment
- May 15th - July 1 rate adjustment

No further detail on if this is going to come from I5900 and I6000 or if there will be additional documentation requirements.

Beginning with the April 1, 2024 Resident Listings

- Residents who qualify for the Mental Illness Diagnosis Add-On will be noted in Column K

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Clinical Considerations

Clinical Components Overview

Medicaid Plan transitions from RUGS CMI to Nursing Component of PDPM effective 7/1/24

- **Six Major Classifications**
  - ❑Extensive Services
  - ❑Special Care High
  - ❑Special Care Low
  - ❑Clinically Complex
  - ❑Behavior Symptoms and Cognitive Performance
  - ❑Reduced Physical Function

- Each Major Classification contains specific qualifiers that include the Nursing Function Score calculated from Section GG of the MDS

- The CMI ranges from .62 to 3.84

- Each provider will continue to have an updated average CMI for their Medicaid population at each “snapshot” on January 1 and July 1

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Extensive Services

Qualifiers:

- Tracheostomy
- Ventilator or Respirator
- Infectious Isolation
- All of the above are required during the look back period while a patient is in the facility

The Nursing Function Score must be 14 or below to qualify for this Major Classification

ES3:	Tracheostomy and Ventilator or Respirator	CMI - 3.84
ES2:	Tracheostomy or Ventilator or Respirator	CMI - 2.90
ES1:	Infectious Isolation	CMI - 2.77

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Special Care High

Qualifiers - Receive one of the following with a Nursing Function Score of 14 or Below:

- Comatose and completely dependent for functional tasks or the functional tasks did not occur
- Septicemia
- Diabetes with both daily insulin injections and two or more days of insulin order changes in the 7-day look back period
- Quadriplegia with a Nursing Function Score of 11 or below
- COPD and shortness of breath while lying flat
- Parenteral/IV feedings
- Respiratory therapy for all 7-days in the look back period
- Fever with one of the following: pneumonia, vomiting, weight loss or feeding tube

The PHQ score also impacts this major classification:

HDE2:	Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI - 2.27
HDE1:	Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI - 1.88
HBC2:	Nursing Function Score 6-14- PHQ total severity score of 10 or greater	CMI - 2.12
HBC1:	Nursing Function Score 6-14- PHQ total severity score of 9 or less	CMI - 1.76

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Special Care Low

Qualifiers: Received one of the following with a Nursing Function Score of 14 or Below:

- Cerebral Palsy, Multiple Sclerosis or Parkinson's with a Nursing Function Score of 11 or less
- Respiratory failure with oxygen therapy while a resident
- Feeding Tube: at least 26% of total calories and 501(cc) via tube daily
- Stage 2, 3, and 4 pressure ulcers with two or more selected skin treatments
- Venous and arterial ulcers with two or more selected skin treatments
- Foot infections, diabetic foot ulcers and other open lesions of the foot with application of a dressing
- Radiation treatment while a resident
- Dialysis treatment while a resident (hemodialysis or peritoneal dialysis)

The PHQ Score impacts this major classification:

LDE2:	Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI -1.97
LDE1:	Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI -1.64
LBC2:	Nursing Function Score 6-14 - PHQ total severity score of 10 or greater	CMI -1.63
LBC1:	Nursing Function Score 6-14 - PHQ total severity score of 9 or less	CMI -1.35

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Clinically Complex

Qualifiers: The Nursing Function Score can be 0-16

- Pneumonia
- Hemiplegia/hemiparesis with a Nursing Function Score of 11 or less
- Surgical wound or open lesions with surgical wound care or application of a dressing or ointment other than to the feet
- Burns – second or third degree thermal or chemical
- Chemotherapy, oxygen therapy, IV medications or transfusion while a resident

The PHQ total severity score impacts this major classification

CDE2:	Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI - 1.77
CDE1:	Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI - 1.53
CBC2:	Nursing Function Score 6-14 - PHQ total severity score of 10 or greater	CMI - 1.47
CBC1:	Nursing Function Score 6-14 - PHQ total severity score of 9 or less	CMI - 1.27
CA2:	Nursing Function Score 15-16 - PHQ total severity score of 10 or greater	CMI - 1.03
CA1:	Nursing Function Score 15-16 - PHQ total severity score of 9 or less	CMI - 0.89

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Behavioral Symptoms & Cognitive Impairment

Qualifiers: Must have a Nursing Function Score of 11-16 and BIMS Summary Score of 9 or Less

One of the following exist:

- Comatose and completely functional task dependent
- Severely impaired cognitive skills for daily decision making
- Difficulty making self understood
- Short term memory impairment – MDS data elements C1000, B0700, C0700 depending on coding.

If none of the cognitive conditions are met, does the resident have the following:

- ✓ Hallucinations
- ✓ Delusions
- ✓ Physical/verbal behaviors directed toward others
- ✓ Other behaviors not directed at others
- ✓ Rejection of care
- ✓ Wandering

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Behavioral Symptoms & Cognitive Impairment

Restorative Nursing Services Impacts this Major Classification:

At least 6 days in the 7-day look back period, two or more programs for at least 15 minutes each per day.

BAB2:	Nursing Function Score 11-16, Restorative Nursing qualifier	CMI value of 0.98
BAB1:	Nursing Function Score 11-16, No Restorative Nursing qualifier	CMI value of 0.94

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Reduced Physical Education

Qualifications: **Residents who do not Meet any Previous Case Mix Group Qualifiers**

Restorative Nursing services impact this major classification:

At least 6 days in the 7-day look back period, two or more programs for at least 15 minutes each per day

- PDE2: Nursing Function Score 0-5 — Restorative Nursing qualifier — CMI - 1.48
- PDE1: Nursing Function Score 0-5 — No Restorative Nursing qualifier — CMI - 1.39
- PBC2: Nursing Function Score 6-14 — Restorative Nursing qualifier — CMI - 1.15
- PBC1: Nursing Function Score 6-14 — No Restorative Nursing qualifier — CMI - 1.07
- PA2: Nursing Function Score 15-16 — Restorative Nursing qualifier — CMI - 0.67
- PA1: Nursing Function Score 15-16 — No Restorative Nursing qualifier — CMI - 0.62

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Supportive Documentation Guidelines for Upcoming Audits

Supportive Documentation Requirements Users Guide

Effective for MDS Assessments with assessment reference dates (ARDs) dated July 1, 2024 and after

These requirements were developed in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS form itself, and the Data Submission Specifications for MDS 3.0.

Providers are encouraged to review these resources thoroughly to accurately understand MDS coding and meet all federal requirements.

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Standard Conventions for MDS Assessment Completion

- The standard look-back period for the MDS 3.0 is 7 days*
- Except for certain items, the look-back period does not extend into the preadmission period*
- In the case of reentry, the look-back period does not extend into time prior to the re-entry*
- When determining the response to items that have a look-back period relating back to the admission/entry, re-entry, or prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to iQIES.
- PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to iQIES and therefore should not be considered when determining the “prior assessment”.

**Unless otherwise stated*

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Documentation Guidelines

Documentation in the clinical record should consistently support the MDS item response and reflect care related to the symptom or problem.

Documentation must apply to the appropriate look-back period and reflect the resident's status on all shifts.

Conflicting documentation identified within the observation period shall be deemed as unsupported documentation.

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Results from Recent Supportive Documentation Guideline Reviews:

- Section GG – No documentation of the interdisciplinary discussion or decision making on how functional tasks will be coded on the MDS.
- Untimely patient interviews (on or before the assessment reference date) based on Section Z0400 of when the section(s) is determined to have been completed.
- Active diagnosis based on RAI definition is not supported
  - Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period
- Inaccurate Section GG definitions provided to nursing personnel
- No policy exists or it is outdated for pressure reducing mattresses
- No proof that licensed nursing personnel were provided respiratory training

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Section GG Supportive Documentation Requirements

- **Includes:**
  - Documentation during the observation period to accurately capture resident usual performance
  - Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff or family documented in the medical record during the assessment period
  - CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period
  - The IDT should determine the usual performance based on the data gathered, document the IDT decision, and enter into the medical record
  - SEE RAI manual and Supporting Documentation Guideline User's Guide
- **Does Not Include**
  - Individuals hired, compensated or not, by individuals outside the facility's management and administration
  - Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors

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Definition of Usual Performance

A resident's functional status can be impacted by the environment or situations encountered at the facility.

Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status.

If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather the **resident's usual performance.**

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Section GG Functional Task Definitions

GG0130A Self-Care: Eating	• Tube feedings and parenteral nutrition are not considered when coding this activity
GG0130C Self-Care: Toileting Hygiene	• Managing clothing and perineal cleansing – takes place before or after the use of the toilet, commode, bedpan or urinal
GG0170C Mobility: Sit to lying	• The ability to move from sitting on side of bed to lying flat on the bed
GG0170C Mobility: Lying to sitting on side of bed	• The ability to move from lying to sitting on the side of the bed with no back support
GG0170D Mobility: Sit to Stand	• The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
GG0170E Mobility: Chair/bed to chair transfer	• The ability to transfer to and from a bed to chair or wheelchair
GG0170F Mobility: Toilet Transfer	• The ability to get on and off a toilet or commode

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Section Z0400

Z0400 requires the **signature, title, sections and dated sections completed** by all persons completing any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

Z0400 certification reads as follows:
"I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment for such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

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Active Diagnosis

Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period

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Respiratory Therapy Days

Does Require:

- Physician order including a statement of treatment specific to the resident's needs
- Documentation of actual direct minutes on a daily/shift/occurrence basis
- Associated initials/signature(s) daily to support the total number of minutes of respiratory therapy provided
- Periodic evaluations to ensure the resident receives needed therapies and that treatment plans are effective
- Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function
- Documentation that the respiratory nurse (licensed nurse) has been specifically trained in the modalities provided and may deliver these modalities as allowed under the state Nurse Practice-Act and under applicable state laws.
- Respiratory evaluation during the observation period by a licensed nurse

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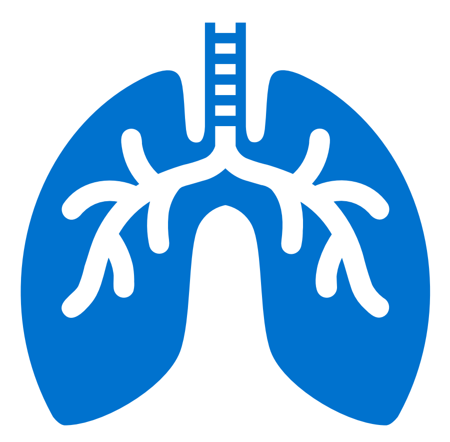
Respiratory Therapy Days

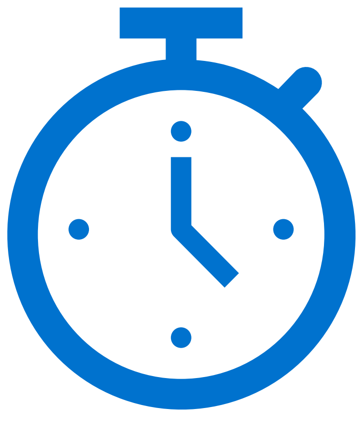


Does Include:

- Coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc.

Does NOT Include:

- Treatments for less than 15 direct minutes per day
- Time that a resident self-administers a nebulizer treatment without the supervision of the respiratory therapist or respiratory nurse
- Metered-dose or dry powder inhalers



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Pressure Reducing Device/Chair

Requires:

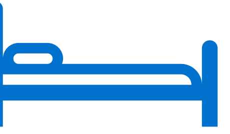
Documentation of use of equipment aimed at reducing pressure away from areas of high risk during the observation period

A facility policy identifying use of pressure reducing, relieving, redistributing mattresses on each resident bed will be considered sufficient documentation of the bed

Does Include:

Foam, air, water, gel, or other cushioning

Pressure relieving, reducing, redistributing devices



Does NOT Include:

Egg crate cushions of any type

Doughnut or ring devices

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Strategies for Supportive Documentation Requirements

Education

Monitoring

Process development for physician documentation requirements

Process development or refinement regarding MDS completion and signing of section Z0400

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Supportive Documentation Requirements Down the Road

This first round of supportive documentation reviews are developed to be an education process

In the future reviews will result in changes to Medicaid CMI for data elements that are not supported by documentation in the medical record.

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Strategies for Success

Strategies for Success

MDS Accuracy

- Interdisciplinary team involvement with OBRA assessments just as if they were PPS assessments
- Strategic scheduling of assessments when approaching a “snapshot date”:

January 1	MDS assessments with assessment reference dates October 1 – December 31
April 1	MDS assessments with assessment reference dates January 1 – March 31
July 1	MDS assessments with assessment reference dates April 1 – June 30
October 1	MDS assessments with assessment reference dates July 1 – September 30

- Monitor for changes in resident conditions that can impact CMI values:
  - Isolation
  - COPD with shortness of breath while lying flat
  - IV fluid administration in the facility or in the ER
  - Changes in skin conditions and treatments
  - PRN oxygen use
  - Changes in functional abilities that would impact the Nursing Function Score

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Strategies for Success

- Use clinical software to run reports when approaching a snapshot date to see the Nursing Component calculated from each resident's prior MDS assessment.

- Schedule a weekly meeting to discuss Medicaid patients and any changes in condition that would impact the CMI value from their prior MDS assessment. This could be in conjunction with care planning or an add on to the weekly Medicare Meeting.

- Use your MDS scheduler in the clinical software package to determine who will be discussed each week, just as used for care planning purposes.

- Become familiar with the Nursing Component major categories and the case mix groups and what items from the MDS are impactful to the case mix index values.

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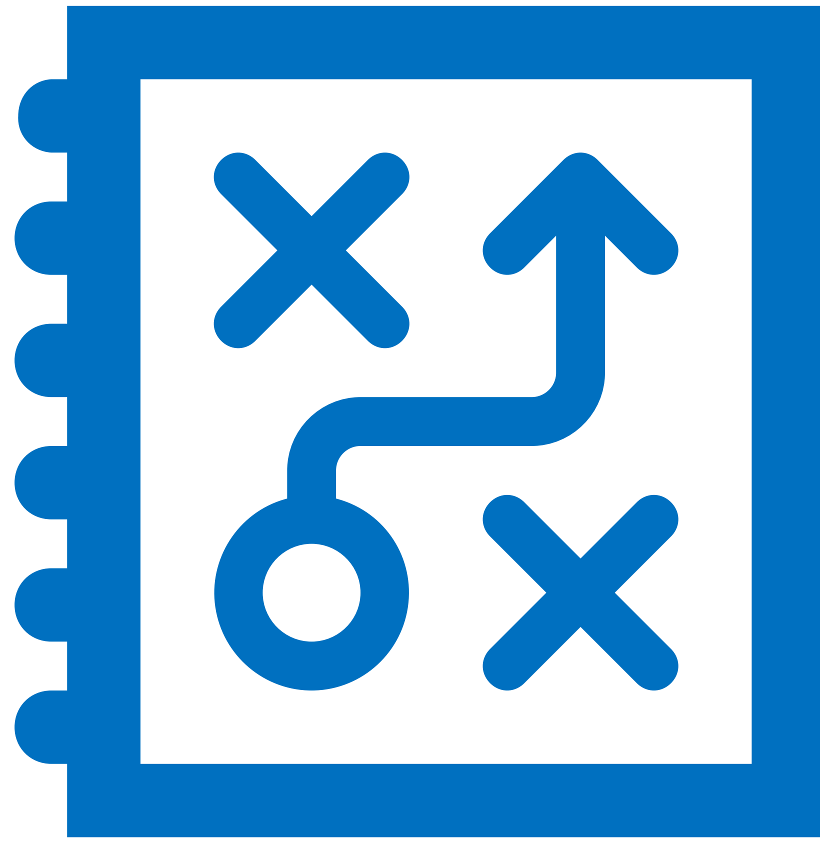
Strategies for Success

- Educate the licensed nursing staff to provide more quality documentation for Medicaid residents especially with changes in condition or when approaching an ARD for OBRA assessments (admission, quarterly, annual and significant change in status).

- Determine if scheduled documentation for Medicaid residents would be beneficial to capturing information that impacts the CMI values

- Determine if developing a Medicaid documentation assessment would be beneficial to assist licensed nursing personnel to capture pertinent information that impacts the MDS data elements that impacts the case mix groups and subsequent case mix index values



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Resident Listings for Missouri Medicaid

- Do not miss this opportunity each quarter!
- Make it a routine practice in your operations to review for accuracy
- Inaccuracies of CMI calculations will impact your Medicaid rate every 6 months
- Registered portal users will be notified by the Missouri Department of Social Services when the Resident Listings are posted for their facility at:

  https://mocostreports.mslc.com *Select NF_MDS Only*

- The roster will be accompanied by a message explaining the “internal” review process and timeline for corrections.
- Providers must complete this review in order to verify the accuracy of the information

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REMEMBER!!!

- The results of the CMIs calculated from the Resident Listing adjusts the patient care component of your Medicaid rate.
- The resident listing information is based on MDS information transmitted to iQIES for each individual provider and will include the most recent MDS assessment for each resident in that snapshot look-back period.

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Questions?

Tools

- Scan the QR Code for access to Forvis Mazars Clinical Tools

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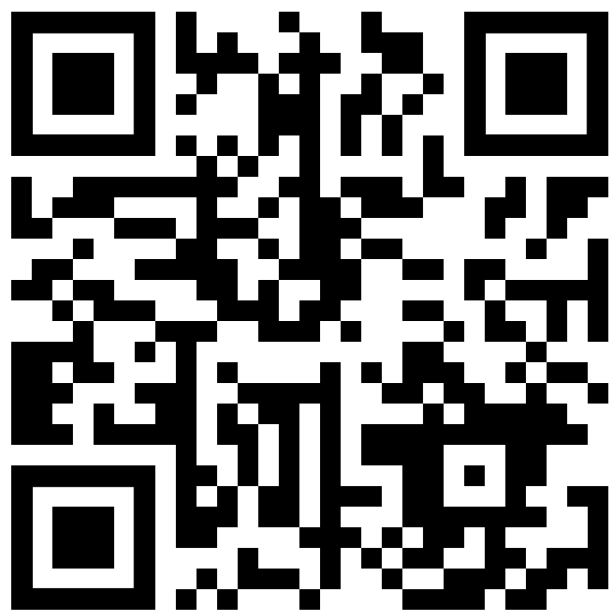

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Let’s Continue the Conversation!

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