



ADVANCING
STATES



Leadership, innovation, collaboration
for state Aging and Disability agencies

Addressing Nursing Facility Financing Challenges during MLTSS Program Development

June 2022

Quick Housekeeping



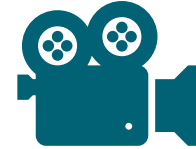
Everyone is muted



Use the "raise hand" button to speak



Ask questions!



We are recording



Closed captioning

Agenda for Meeting



- Welcome and Introductions
- ADvancing States' work on MLTSS
- Considerations when Moving to MLTSS
- Discussion of Key Issues
 - Medicaid Financing
 - Nursing Facility Payments
 - Medicaid Managed Care Reimbursement Regulatory Structure
- Addressing Solutions for Payments for Nursing Facility Services
- Key Takeaways and Questions

Today's Speakers



Camille Dobson is the Deputy Executive Director of ADvancing States and with over 20 years of experience in Medicaid managed care, provides MLTSS and quality subject matter expertise to state members.



Diane Gerrits is the founder and CEO of Innovation Matters in Health. She brings 39 years of health care industry experience – in the private sector as well as Medicaid, Medicare and Marketplace – to her consulting practice.

Today's Speakers

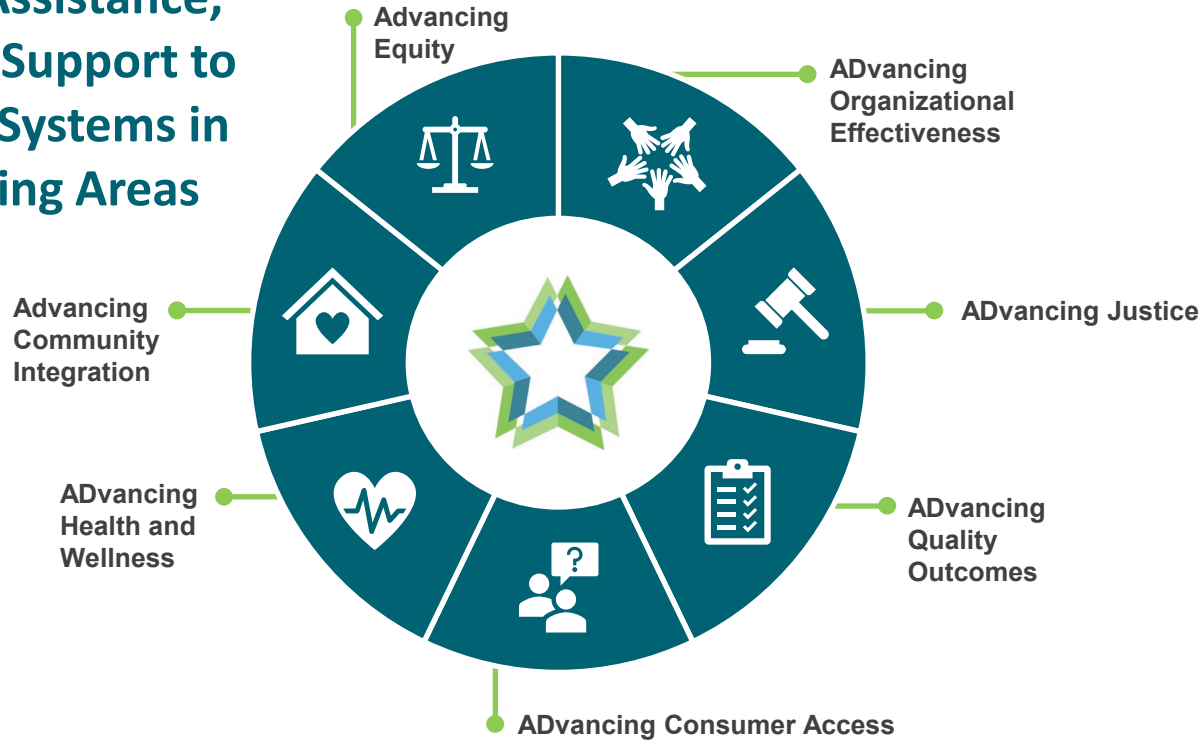


Luke Roth is a Senior Healthcare Consultant who specializes in the development and execution of strategies related to Medicaid program financing and purchasing of healthcare services.



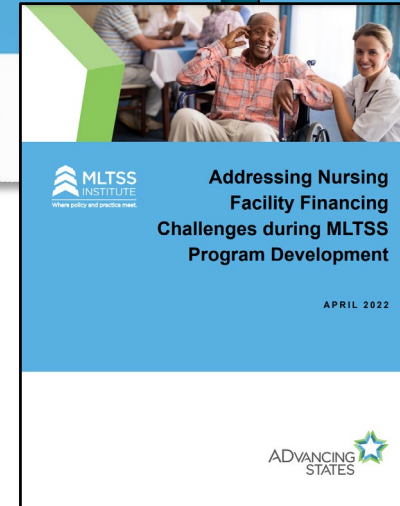
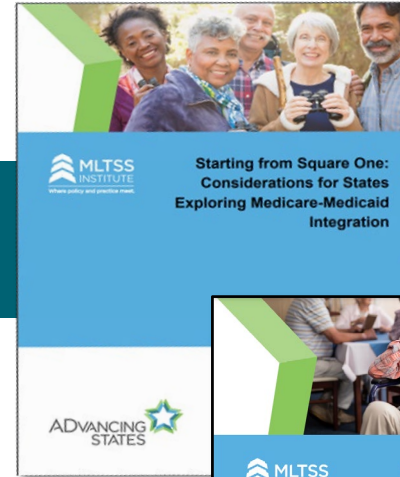
Amanda Schipp, JD is a Senior Healthcare Consultant who specializes in helping clients navigate the complex federal statutory and regulatory landscape of publicly funded healthcare and social services programs.

ADvancing States Provide Leadership, Technical Assistance, and Policy Support to State LTSS Systems in the Following Areas



A collaborative effort between states and health plans to:

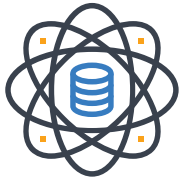
- Drive improvements in key MLTSS policy issues;
- Facilitate sharing and learning among states; and
- Provide direct and intensive technical assistance to states and health plans.



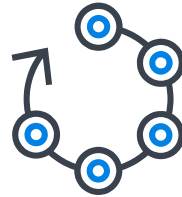
About Milliman



Milliman's mission is to protect the health and financial well-being of people everywhere. With a dedicated team of over 200 professionals specializing in Medicaid actuarial, financial, and policy consulting, we have served as trusted advisors to over 40 state Medicaid agencies and numerous Medicaid providers and health plans.



Industry experts



Creative problem solvers



Trusted advisors

Rationale for Issue Paper

- Medicaid financing is complex and not well understood
- Nursing facility (NF) taxes or provider fees is are a large source of state funds for their long-term services and supports (LTSS) system
- Maintaining those taxes and fees – and the benefits to NFs – has been a significant barrier to delivering LTSS using managed care plans (MLTSS)
- Paper is intended to highlight potential pathways for states to sustain the funding sources historically relied upon while accommodating interest/need to provide a more coordinated holistic approach to LTSS.

Considerations when Moving to MLTSS

Overview



Due to complex federal regulatory requirements, many states may need to make changes in their approaches to funding and reimbursement for NF services to support transitions from LTSS to MLTSS programs.



Multiple options exist to retain robust access to NF services for Medicaid beneficiaries despite any needed funding changes.



States need to engage in extensive stakeholder engagement – both early and often – to ensure that providers and beneficiaries are properly prepared and understand any changes.

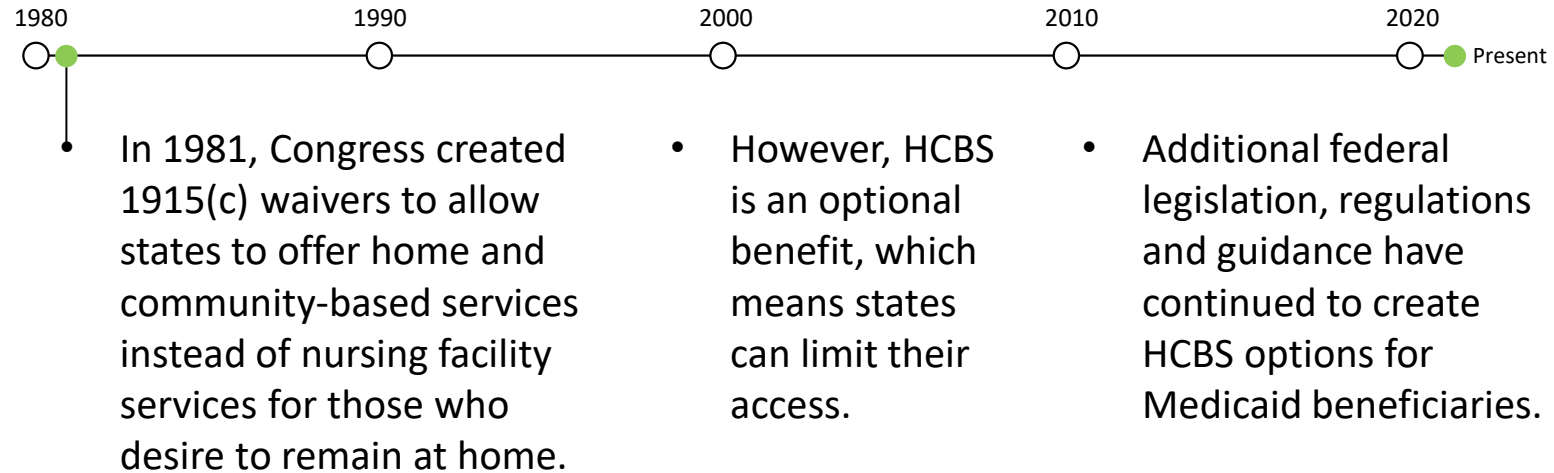
National Landscape

- The most recent KFF data shows that 45 states and DC (all except AK, ND, SC, SD, TX and VA) used provider taxes to generate funding for the state share of Medicaid expenditures
- Many states are using these tax revenues to support base and/or supplemental payments to NFs and other providers in their fee-for-service programs.
- Most states also reimburse NFs using cost-based per diem rates.
- As regulations have continued to evolve over the last few years, there are new considerations that must be accounted for implementing an MLTSS program.



Brief History of LTSS

Medicaid from inception has required states to provide NF services to beneficiaries generally without limits.



Brief History of LTSS

- Many states have worked to rebalance their LTSS system: shifting utilization and spending from NF to HCBS, as appropriate.
 - HCBS is typically less expensive
 - Consumers want to age in place
- MLTSS programs have proven to be an effective tool in moving the needle on rebalancing.
- However, a significant portion of state funds for LTSS in Medicaid programs come from nursing facilities, so its rebalancing is may be a funding concern for Medicaid programs.
 - Decreased NF utilization could result in decreased non-federal funds available to support LTSS

Discussion of Key Issues

Medicaid Financing



- Medicaid programs are jointly financed by the state and federal government in partnership.
- Federal financing of Medicaid (called Federal financial participation or FFP) is determined by using the States' federal medical assistance percentage (FMAP).
 - FMAP is calculated based upon the state's per capita income relative to the national per capita income.
 - The FMAP provides a statutory minimum of 50% and a maximum of 83% in Federal funds for total Medicaid spending.
 - There are exceptions to this general rule for specified populations, services, and provider types (e.g., enhanced FMAP for expansion adults, CHIP, public health emergency, etc.)

Allowable Sources for the State's Portion of Medicaid Expenditures

- Federal law allows states to finance up to 60% of the non-federal share of Medicaid expenditures with sources other than state general funds.
- In state fiscal year 2018, states financed approximately \$63 billion (28%) of \$224 billion in total non-federal spending on Medicaid program expenditures using revenues from providers and local governments.
- States use four common mechanisms to finance the non-federal share of Medicaid program expenditures:



Provider assessments



Certified Public Expenditures



Inter-Governmental Transfers



Bona Fide Donations

The non-federal share of Medicaid expenditures can be comprised of up to 60% of non-state sourced funds.

Healthcare Related Tax

- States may impose a fee or tax to finance the non-federal share
- Must be broad-based and uniform across provider class
- Limited to 6% of net revenues for the provider class

Certified Public Expenditures

- A state may certify expenditures of local government entities
- Only Medicaid-covered services for beneficiaries
- CPEs pose challenges in a managed care delivery system

Intergovernmental Transfer

- States may receive funds directly from government owned or operated entities
- Sometimes private entities enter legal relationships for transfer purposes

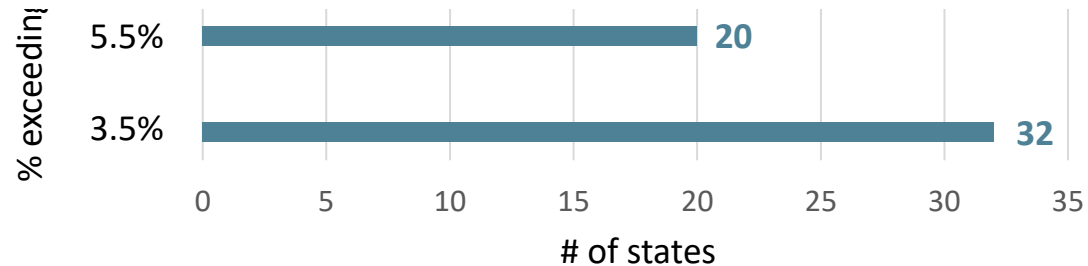
Bona Fide Donations

- Rarely used by states
- Defined as a provider-related donation that does not have direct or indirect relationship to Medicaid payments made to the health care provider

NF Participation in Medicaid Financing Strategies

- Most NF providers are private, for-profit entities, with only 7% of NFs nationwide being government-owned
 - Only local government entities or providers that are government-owned or operated may participate in IGT or CPE arrangements.
 - States need to focus on other funding mechanisms
- Provider taxes are the primary mechanism used to generate non-federal share of Medicaid program expenditures from NFs.

State Medicaid Agencies with a NF Tax Exceeding a NF's Net Patient Revenue



NF Reimbursement

- Most state Medicaid programs use cost-based per diem payment methodologies to provide reimbursement for NF services.
- The use of cost-based payment methodologies—with little change over the years—has historically afforded a high level of financial stability to NFs.
- Nursing facilities' willingness to participate in provider taxes, CPEs, and IGTs suggests they support these mechanisms for the financing of Medicaid program expenditures for NF services:
 - Historically, many states have used supplemental payments to provide additional funding to NFs
 - These payments typically lack a direct connection to the quality and utilization of services rendered

Managed Care Implications for Supplemental Payments

- States can't make payments directly to providers under managed care delivery system for services that are the responsibility of managed care plan
 - 42 CFR § 438.60: Prohibition of additional payments for services covered under MCO, PIHP or PAHP contracts
- In MLTSS, any supplemental payments that were previously made to NFs by state would need to flow through managed care plans
- States using managed care plans to deliver LTSS benefits (MLTSS) faced a problem
 - Historically, states 'told' managed care plans how much and how often they needed to make these supplemental payments to their contracted NFs
 - This approach is called a 'pass-through' payment.

Managed Care Implications for Pass-Through Payments

- In 2016, the Medicaid and CHIP managed care regulations were updated (the Final Rule).
- As part of that update, CMS is phasing out pass-through payments
 - For states currently using pass-through payments, CMS provided for a transition period to move those payments to utilization and quality-based payments. Phase out of pass-through payments for nursing facilities must be complete for rating periods beginning on or after **July 1, 2022**
 - For states moving new services or populations to managed care, CMS provided for the utilization of a **new pass-through payment** for up to three years from the managed care implementation.

Managed Care Implications on State Directed Payments

- The Final Rule prohibited states from directing the expenditures of MCOs except in limited circumstances (called ‘state-directed payments’), including:
 - Fee Schedule Approach: Mandating payment of minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules.
 - Value-based Purchasing Models: Bundled payments, episode-based payments, shared savings/risk arrangements, and other models that reward providers for delivering greater value and achieving better outcomes.
 - Delivery System Reform: Multi-payer or Medicaid-specific delivery system reform or other performance improvement initiatives such as pay for performance arrangements, quality-based payments, and population-based payment models.
- States wishing to direct payments through managed care plans must submit a preprint for CMS review and approval.

Managed Care Implications on State Directed Payments

- The state-directed payment preprint requires a state to:
 - Demonstrate that the payment is tied to utilization;
 - Direct payments equally using same terms across a “class” of providers;
 - Ensure that the payments advance one or more quality goals;
 - Evaluate the effectiveness of the arrangement through an evaluation plan;
 - Ensure payments are not conditioned upon receipt of intergovernmental transfers (IGTs);
 - Renew the arrangement on a periodic basis (may not be renewed automatically).
- Since 2020, CMS no longer requires completion of a preprint IF the state is implementing a directed payment using state plan minimum fee schedule.
 - However, these arrangements must comply with all the requirements above.
- States’ use of state-directed payments has grown substantially since 2016, with more than 200 as of 2020 (up from 65).

Addressing Solutions in Payments for NFs

Overview

- To transition to MLTSS, state Medicaid programs need to carefully plan to transition funding and reimbursement for NF services to conform to Medicaid managed care regulations.
- There are several viable approaches available to address funding and reimbursement challenges.



Transition supplemental payments to short-term pass-through payments



Standardize and update NF reimbursement



Diversify services provided by NFs



State directed payment arrangements



Provide value-based payment strategies

Solutions to Address Nursing Facility Payments in MLTSS

- Options were identified and expanded through structured interviews with representatives from five states Medicaid agencies.
- All five states agreed on one key theme – the importance of early and ongoing stakeholder engagement:
 - Building consensus regarding the overall goals and objectives of the reform
 - Determining how reforms will be operationalized
 - Determining how progress toward those goals and objectives will be measured and evaluated

State Medicaid Agencies

- Arizona
- Delaware
- Kansas
- Tennessee
- Virginia

Solutions to Address Nursing Facility Payments in MLTSS



1. ***Transition Supplemental Payments to Short-term Pass-through Payments***

- The Final Rule provided for a fixed transition period for states to phase out their supplemental payments to hospitals by July 1, 2027, and to physicians and NFs by July 1, 2022.
- In late 2020, CMS updated the Final Rule to permit a three-year transition period for any state transitioning new services or populations into managed care, beginning when the services or populations were transitioned.
- With this new flexibility, states that are newly implementing MLTSS can transition existing supplemental payments into managed care gradually to reduce potential disruption.

Solutions to Address Nursing Facility Payments in MLTSS



2. ***State Directed Payment Arrangements - 42 CFR 438.6(c)***

- The Final Rule allows states to direct MCO expenditures in limited circumstances.
- All five states interviewed reported using state-directed payment arrangements to help maintain historic FFS state plan reimbursement rates under managed care, mostly through minimum fee schedule arrangements.
- States are no longer required to submit a preprint for state-directed payments seeking to adopt minimum fee schedules using state plan approved rates.

Solutions to Address Nursing Facility Payments in MLTSS

3. *Standardize and Update NF Reimbursement*

- Particularly during the transition to MLTSS, state oversight and management of NF fee schedules can provide financial predictability and stability to NFs.
- Based on interviews and a review of approved 438.6(c) preprints for select states with relatively mature MLTSS programs, we found that many continue to maintain fee schedules for NFs in their Medicaid state plans and require their managed care plans to reimburse NFs no less than the state plan fee schedule amounts.
- Additionally, the states interviewed have successfully preserved payment enhancements financed via provider taxes through a combined strategy of maintaining the state plan fee schedule and establishing the state's fee schedule as a minimum for the MLTSS program.

Solutions to Address Nursing Facility Payments in MLTSS



4. *Value-Based Payment Strategies*

- They can incentivize providers to support the state's overall quality goals, such as providing financial incentives to NFs for contributions to achieving rebalancing goals (i.e., through the identification and transitioning of enrollees to HCBS).
- Some states have incorporated value-based payment strategies directly as a component of the state-plan approved reimbursement methodology to reward providers meeting targeted quality metrics, such as resident satisfaction and staffing ratios.
- They can be implemented through state-directed payment arrangements that incorporate value-based payments as fee schedule adjustments or, integrated more generally into MCO-driven VBP-related contract requirements

Solutions to Address Nursing Facility Payments in MLTSS

5. ***Support Diversification of Services Provided by Nursing Facilities***

- Diversification of NF services could support NF fiscal stability in state healthcare markets that increasingly value HCBS and help states continue to leverage NF revenue via provider taxes.
- Diversification strategies could include allowing NFs and hospital systems to provide HCBS, such as adult day health services or meal provision for individuals living in the community. However, state and federal regulations could pose a challenge to those efforts.

Key Takeaways

Key Takeaways

- A thorough understanding of how the state is currently financing and paying for NF services is key to successfully implementing a MLTSS delivery system.
- Because NF payments in MLTSS must be made by the managed care plan and must be linked to utilization of services, many states may need to change the mechanisms used to pay for NF services as they transition to managed care.
- States have used state-directed payments to ensure that payments for NF services is compliant with Federal regulations and maintains robust access to NF services for Medicaid beneficiaries.
- Success will require extensive stakeholder engagement.

Questions



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