Building Block #5: Capacity

Nursing Facility Payment Review and Redesign
Today’s Agenda

• Overview
• Recap
• Capacity
  • Recent trends
  • Recent trends
  • Recent trends
  • Recent trends
  • Recent trends
  • Recent trends
  • Recent trends
• Questions and comments on Capacity

Next steps and request for content
Today's Agenda

Overview

Recap

Capacity

Recent trends

Analysis of emerging policy priorities

Questions and comments on Capacity

Next steps and request for content

Beds (and Rooms)

Staffing
Purpose Statement

HFS proposes a structured and transparent approach to develop, deliberate, adopt and implement nursing home payments to achieve improved outcomes and increased accountability with an emphasis on patient-centered care. HFS believes the rate mechanism, funding model, assessment, quality metrics, and staffing requirements can and should be updated in conjunction with any new or additional appropriated funding. Further, additional federal funding should be captured to improve these areas through an increase in the current nursing home bed tax.
Steps in the Review and Redesign Process

Overview

Note: COVID has had a profound impact on long-term care. Infection control is assumed to be an integral component of each building block.

Building blocks in a comprehensive NF payment:

- Modeling (multiple meetings)
- Case Mix, Equity and Demographics (2 meetings)
- Rebalancing (2 meetings)
- Physical Infrastructure (2 meetings)
- Quality (2 meetings)
- Staffing (3 meetings)

Steps in the Review and Redesign Process

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- Quality (2 meetings)
- Staffing (3 meetings)
Original Objectives and Principles for Reform

Overview

1. Potentially Relevant to Today’s Discussion on Quality:
   - Transparent, outcome driven, patient-centered model with increased accountability
   - Transition away from RUGs to federal PDPM case-mix nursing component
   - Modify the support and capital rate into a set base rate similar to Medicare non-case-mix rate
   - Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis
   - Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
   - Align regulation and payment incentives to the same goals
   - Documenting support, review, and validation of care coding and appropriateness, outliers, actual patient experiences, etc.
   - Directly tying funding/ rates/incentives to demonstrable and sustained performance on key quality reporting metrics
   - End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
   - Modifying the support and capital base rate to better reflect similar to Medicare non-case-mix rate
   - Transition away from RUGs to federal PDPM case-mix nursing component
   - Transparent, outcome driven, patient-centered model with increased accountability

Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new proposed or upcoming changes

Improve cooperation, support, and follow up data sharing and cross-agency training from other agencies (OIG, IDPH, DOA)

Integrate emerging lessons and federal reforms related to the COVID pandemic

including single-occupancy rooms, certified facilities

Reevaluate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis

Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives

Align regulation and payment incentives to the same goals

Documenting support, review, and validation of care coding and appropriateness, outliers, actual patient experiences, etc.

Directly tying funding/ rates/incentives to demonstrable and sustained performance on key quality reporting metrics

End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue

Modifying the support and capital base rate to better reflect similar to Medicare non-case-mix rate

Transition away from RUGs to federal PDPM case-mix nursing component

Transparent, outcome driven, patient-centered model with increased accountability
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    - Beds (and Rooms)
    - Staffing
• Questions and comments on Capacity
• Next steps and request for content
• Recap
• Overview
Therapy in RUGS v. PDPM

- Raises facility's CMI with 2Q lag
- Facility's provision of therapy factors directly into future payment

Assessment of need for therapy

PDPM-based payment

- Need for therapy affects the CMI
- Facility's provision of care does not factor directly into payment

PDPM-based payment

1. Use initial 5-day MDS
2. Determine the resident's PT group using case mix table
3. Calculate the function score using items in GG
4. Calculate the resident's PT clinical category (11 options)

Recap

- Determine the resident's primary diagnosis clinical category using ICD-10 codes AND whether to use default diagnosis instead
- Determine whether the resident received a major joint replacement, spinal surgery, orthopedic surgery, or significant non-orthopedic surgical during prior inpatient stay (several options)

RUGS-based payment

- Two ways to meet RUGS Rehab Category:
  - 3 days AND ≥ 45 minutes in any therapy AND ≥ 2 restorative interventions
  - 5 days AND ≥ 150 minutes in any therapy OR

Recap

- Treatment of need for therapy
New Medicare PDPM Staffing Payment Methodology

Recap

[Diagram showing patient-type + staff-type combinations that contribute to rate development or compliance.]

CMI-adjusted rate formula for each Patient for each component (per diem per day)

VDP Adjustment (stage w/in limited 0-100 day stay)

Staffing Effort (hours/day)

Resident-Specific CMI Formulas

Compliance contributions to rate development or patient-type + staff-type combination that each solid line box represents

How to read this diagram...
### Data Sources for Each PDPM Case Mix Index

<table>
<thead>
<tr>
<th>Nursing CMI</th>
<th>NTA CMI</th>
<th>SLP CMI</th>
<th>OT CMI</th>
<th>PT CMI</th>
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<tbody>
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</table>

- Clinical Category (ICD-10 mapped to 4 PT&OT Categories)
- Functional Score (sum of ten GG item scores)
- Acute Neurologic Condition
- SLP-Related Comorbidity or Cognitive Impairment
- Mechanically-altered Diet
- Swallowing Disorder
- RUGS-IV Category
- NTA Comorbidity Score
CMS' Overall STAR Rating

- **Inspections**
  - Staffing is 1 Star
  - 1 Star if:
    - **Health**
      - Staffing Stars <= 1 Star
      - Staffing Stars OR
      - Staffing Stars 2 or 3
      - 0 Stars if:
    - **Quality**
      - Staffing Stars 3 or 4 Stars; AND
      - Staffing Stars 5 or 5 Stars; AND
      - Quality is 5 Stars; AND
      +1 Star if:
      - Quality is 4 Stars; AND
      - Quality is 3 Stars; AND
      - Quality is 2 Stars; AND
      - Quality is 1 Star; AND
      - Quality is 0 Stars; AND

- **Overall STAR Rating (1-5)**
  - 0 Stars if:
    - **Staffing**
      - Staffing Stars 2 or 3; OR
      - Staffing Stars <= 1 Star
    - 0 Stars if:
      - **Quality**
        - Quality is 2-4 Stars; AND
        - Quality is 5 Stars; AND
        - Quality is 1 Star; AND
        - Quality is 0 Stars; AND

Recap
Developing and Using Outcomes

Implications for new metrics:

• We have less information about them, including validation of their impact, an explanation of that impact, and the mechanisms for moving the needle.

• NFs also know less, and face risk when spending money to move the needle to solve the puzzle.

• In addition, NFs face the economic incentive to wait for others to solve the puzzle, which predictably leads to collective under-investment.

• Risk and this 'tragedy of the commons' predictably lead to the economic incentive to wait for others to solve the puzzle, which predictably leads to collective under-investment.

• So what approach should the state take with new metrics?

Recap
### Evaluating an Outcome Measure

#### Examples of Policy Objectives

<table>
<thead>
<tr>
<th>New</th>
<th>Mature</th>
<th>Mixed</th>
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<tbody>
<tr>
<td><strong>Outcome Maturity</strong></td>
<td><strong>Outcome Recast</strong></td>
<td><strong>Outcome Mission</strong></td>
</tr>
<tr>
<td>Coordinate/motivate broad initial investments by NFS</td>
<td>Motivate rapid improvement &amp; investment by low-performers</td>
<td>Maintain target performance; prevent degradation</td>
</tr>
<tr>
<td>Learn from investments and varying NF initiatives</td>
<td>Improve overall (and top) performance</td>
<td>Bring all performance up at margins across many outcomes</td>
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<tr>
<td>Eliminate remaining under-performance</td>
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**Example policy goals in incentive design:**

- Motivate rapid improvement & investment by low-performers
- Improve overall (and top) performance
- Learn from investments and varying NF initiatives
- Coordinate/motivate broad initial investments by NFS
### Key Questions

#### Matching Available Levers to Outcomes

<table>
<thead>
<tr>
<th>Description</th>
<th>New Outcomes</th>
<th>Mixed Outcomes</th>
<th>Mature Outcomes</th>
<th>Recap</th>
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<tr>
<td>Payment</td>
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<td>Incentive</td>
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<td>Dollar or percentage adjustments to (part of) the per diem</td>
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<td>Are payment incentives fixed?</td>
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<td>What is the remaining potential for improvement?</td>
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<td>What is the residual community v. NF 'A' v. NF 'B' placement?</td>
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*Not a characterization of current Illinois policy. Some options would require policy changes to be deployed.*
How Does CMS Make SNF Quality STAR Ratings?

Metric Selection

• CMS adds or subtracts quality metrics periodically and currently maintains a list of 34 MDS-based and 5 claims-based metrics. Of these, 24 remaining metrics are included in CMS’ Nursing Home Compare public reporting system. 15 of the MDS-based metrics are available only to facilities on CMS’ QIES website. 15 of the MDS-based metrics were selected from this list “based on their validity and reliability, the extent to which nursing home practice may affect the measures, statistical performance, and the importance of the measures.”

• STAR measures were selected from this list “based on their validity and reliability, performance, and the importance of the measures.”

• Note: STAR ratings are the pre-eminent and most sophisticated example found for aggregating NF quality performance into performance indices. Although Medicare does not use STAR ratings in payment, the final step from index to payment would be computationally straightforward.

Recap
How Does CMS Make SNF Quality STAR Ratings?

From Raw Data to a STAR Rating

Collect Data

Make NFs Comparable

Score Raw Claims

Score Raw MDS

** Example to follow

* See next page

** Policy / value judgements, transparent, consistent, complete scoring

Recap

From Raw Data to a STAR Rating

How Does CMS Make SNF Quality STAR Ratings?

Collect Data

Make NFs Comparable

Score Raw Claims

Score Raw MDS

** Example to follow

* See next page

** Policy / value judgements, transparent, consistent, complete scoring

Recap
### COMPARE/STAR Quality Results

### Long Stay Measures

| Percent of LS Residents Who Lose Too Much Weight | 5.5 IL | 6.2 96 |
| Percent of Low Risk LS Residents Who Lose Control of Their Bowel or Bladder | 48.4 IL | 46.1 37 |
| Percent of LS Residents with a Catheter Inserted and Left in Their Bladder | 1.8 IL | 2.1 29 |
| Percent of LS Residents Who Were Physically restrained | 0.23 IL | 0.19 29 |
| Number of outpatient emergency department visits per 1,000 long-stay resident days | 0.96 IL | 0.7 22 |
| Number of hospitalizations per 1,000 long-stay resident days | 2.02 IL | 1.7 29 |
| Percent of LS residents assessed and appropriately given the pneumococcal vaccine | 93.9 IL | 89.2 12 |
| Percent of LS residents assessed and appropriately given the seasonal influenza vaccine | 96 IL | 93.7 12 |
| Percent of LS residents whose ability to move independently worsened | 17.1 IL | 15.8 10 |
| Percent of LS residents whose need for help with daily activities has increased | 14.5 IL | 13.7 10 |
| Percent of LS residents with a urinary tract infection | 2.6 IL | 2.9 10 |
| Percent of LS residents who received an antipsychotic medication | 14.2 IL | 18.3 10 |
| Percent of LS residents who received an antianxiety or hypnotic medication | 19.7 IL | 19.4 10 |
| Percent of high risk LS residents with pressure ulcers | 7.3 IL | 7.6 29 |
| Percent of Low Risk LS Residents Who Lose Control of Their Bowel or Bladder | 46.1 IL | 48.4 37 |

### Source:
COMPARE “State US Averages” as of 9/1/2020 (based on 2019 data)

### Recap
<table>
<thead>
<tr>
<th>Measure</th>
<th>IL Rank</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of SNF residents with pressure ulcers that are new or worsened</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td>Percentage of SS residents who newly received an antipsychotic medication</td>
<td>83</td>
<td>68</td>
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<tr>
<td>Percentage of SS residents who newly received an antipsychotic medication</td>
<td>1.8</td>
<td>2.1</td>
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<td>Percentage of SS residents who newly received an antipsychotic medication</td>
<td>22.8</td>
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Source: COMPARE "State US Averages" as of 9/1/2020 (based on 2019 data)
### 2013 Measure Recommendations for Incentive Program

**HFS nursing advisory group’s prioritized metrics**

<table>
<thead>
<tr>
<th>Very Important</th>
<th>Importance Level</th>
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</thead>
<tbody>
<tr>
<td>• Staff retention / stability</td>
<td></td>
</tr>
<tr>
<td>• Consistent assignments</td>
<td></td>
</tr>
<tr>
<td>• Pressure ulcers (long stay residents)</td>
<td></td>
</tr>
<tr>
<td>• Re-hospitalizations</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Important</th>
<th>Metric Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attendance by Direct Care Staff at Resident Care Plan meetings</td>
<td></td>
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<tr>
<td>• Falls</td>
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<tr>
<td>• Moderate / Severe Pain (QM)</td>
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<tr>
<td>• Restraints</td>
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<tr>
<td>• Unintended weight loss</td>
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<tr>
<td>• Pressure ulcers (short stay residents)</td>
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<tr>
<td>• Psychoactive medication use</td>
<td></td>
</tr>
<tr>
<td>• Resident / family satisfaction</td>
<td></td>
</tr>
<tr>
<td>• Staff satisfaction</td>
<td></td>
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<tr>
<td>• Participation in Advancing Excellence</td>
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</table>

<table>
<thead>
<tr>
<th>Somewhat Important</th>
<th>Metric Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Catheter use</td>
<td></td>
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<tr>
<td>• Person centered approaches (Care, Environment and Community)</td>
<td></td>
</tr>
</tbody>
</table>

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### The nurse advisory group’s emphasis in 2013:

- They chose not to focus on inspections
  - Because Medicare already did?
  - Because IDPH oversight mechanisms already did?
- Thought long-stay metrics were more relevant to Medicaid
- Staffing was top of mind by this group of expert practitioners
Nursing Facility Infrastructure

Recap
The Medicaid NF census fell with the initial spread and fatal impact of COVID and did not recover during COVID's lull. The drop of ~7.5% represents about 3,500 daily Medicaid residents since the beginning of March.
Occupancy increases with more recent Medicare certification in Illinois—but it's (slightly) the reverse for the U.S. as a whole. The overall Medicare certification age of NH beds in Illinois looks the same as the country's, with more recent Medicare certification increasing occupancy.
For 2019, 622 facilities with 68,210 beds including 2010s and 62,565 without the 2010s.
For 2008, 512 facilities and 48,675 beds.

Recap

Nursing Facility Infrastructure Age

Construction Listed

Cost Report Bed Counts by First (not earliest) Year of

Only Facilities Listed Matching P, 2 and P, 12 Bed Counts Included

Sources: Completed HFS 2019 Cost Reports
Concentration of Residents within Nursing Facilities

Recap
"High" is above-average, "Low" is below. Aggregated IDPH Covid data from 6.26 for facilities and 5.29 for general population. Missing Covid data treated as zeros. Numerator is cumulative cases, not point in time. This chart (only) was prepared before the availability of 2019 resident counts and uses SNF bed counts as denominator instead.

Likelihood of contracting Covid varied by type of residence (E.B.)

Wave 1 COVID's Impact on Illinois Nursing Facility Residents in Recap
COVID Infections in Illinois Nursing Homes:

All Skilled Nursing Facilities

Recap

The average number of residents per room appears to explain Covid's Wave 1 spread somewhat better than total square footage. In additional analysis (not shown), it appears that above an average of ~2.1 residents per room, COVID infection ratios may go back down to about the level observed for facilities with 1.5-1.8 residents per room. In other words, infections may have peaked at 1.8-2.1 residents/room.

Sources: IDPH Aggregated COVID Records 5/2020; IDPH Room Count 9/2020; Preliminary HFS 2019 Cost Reports
Summary of Nursing Home Infrastructure and the Spread of Coronavirus

Based on existing, though incomplete evidence:

- Community rates of infection appear to have had the greatest impact on resident infections
- Physical characteristics of NFs appear to have had significant impact on COVID's spread
- Little is known about airflow, replacement, and filtering in Illinois nursing homes – three presumptive keys to infection control for the airborne Coronavirus

Recent guidance from the CDC/OSHA/EPA and IDPH may provide additional mitigation controls, e.g., prior to effective vaccinations

- Resident density is strongly correlated with NF infections after controlling for each of the rest
- Facility size, multi-floor facilities, and Chicago-area location are all also (individually) related to Wave 1 COVID infections
- All of these facility characteristics are correlated with each other, leaving causation uncertain
- Resident density within nursing homes, especially in the form of residents/room, also appears to have had a very large impact on resident infections

Recap
Summary of Feedback on Infrastructure

Recap

- Allow for the preference some may have for double-occupancy
- Moving towards suite- or neighborhood-type pods or areas with shared homelike infrastructure
- Improvements in the physical environment such as eliminating nursing stations, room-based medication (carts?), and airflow improvements (limiting internal spread)
- Illinois has one of the highest occupancy penalties in the country in its Medicaid rate, so this could be lowered
- Consider potential dilution of targeted funding (for physical infrastructure) due to independent MCO contracting process
- Other infrastructure considerations could include specialized beds, outdoor space and other “homelike” improvements
- Consider tying (formulaic components for) profit and support to infrastructure quality, e.g., different tiers for different levels of density or room occupancy
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Illinois was recognized as one of the top 10 states in making progress on rebalancing in terms of HCBS as a percentage of total LTSS expenditures between 2012-2016. During this period, Illinois leveraged federal incentives to expand access to HCBS. As of 2019, roughly half of LTSS expenditures were dedicated to HCBS as a percentage of total LTSS expenditures. Illinois was recognized as one of the top 10 states in making progress on rebalancing in terms of HCBS. Recipients, NF recipients, Medicare, Medicaid, and LTSS. The Choices for Care program and Coordinated Care Unit (CCU), as well as PASRR, are also designed to screen and deflect institutionally-qualifying individuals to the community. Illinois requires managed care plans to cover nursing facility services, home health services, and some HCBS waiver services. MCO enrollment tends to follow LTC placement since pre-LTSS coverage is more likely through Medicare via Medicare-Medicaid Alignment Initiative (MMAI) Health Plans for duals. Illinois was subject to several lawsuits resulting in consent decrees which require the state to provide the opportunity for care in the most community-integrated setting possible. The choices for care program and coordinated care unit (CCU), as well as PASRR, are also designed to screen and deflect institutionally-qualifying individuals to the community. The Last two decades, Illinois has been subject to several lawsuits resulting in consent decrees which require the state to provide the opportunity for care in the most community-integrated setting possible. MCO enrollment tends to follow LTC placement since pre-LTSS coverage is more likely through Medicare via Medicare-Medicaid Alignment Initiative (MMAI) Health Plans for duals. Illinois requires managed care plans to cover nursing facility services, home health services, and some HCBS waiver services. The Choices for Care program and Coordinated Care Unit (CCU), as well as PASRR, are also designed to screen and deflect institutionally-qualifying individuals to the community. Illinois was subject to several lawsuits resulting in consent decrees which require the state to provide the opportunity for care in the most community-integrated setting possible.
Medicaid’s % of General Nursing Residents Varies
(n=691 Multi-Level Facilities with ≥10 General Nursing Residents; From Health Facilities and Services Review Board 2018 Survey)

Recap
Services Review Board 2018 Survey
(n=695 Multi-Level Facilities with ≥ 10 General Nursing Residents; From Health Facilities and Nursing Home Survey)
Where do NF Admissions Come From?

- Hospital or Inpatient Rehab: 87%
- Community: 7%
- Other: 2%
- Hospice, etc.: 4%

MDS All-Payer Data from 3Q 2019; n=38,774 Admissions
Program Choices for Medicaid-Medicare Dual Eligibles

**Recap**

<table>
<thead>
<tr>
<th>Doesn’t Qualify for LTC</th>
<th>Qualifies for LTC (Institutional or HCBS)</th>
<th>Qualifies for LTC (Institutional or HCBS)</th>
<th>Medicaid FFS/MA + MLTSS + Medicare FFS/MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>▲</td>
<td>▲</td>
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<tr>
<td>▲</td>
<td>N/A</td>
<td>▲</td>
<td>▲</td>
</tr>
<tr>
<td>▲</td>
<td>Only until MLTSS/MMAI</td>
<td>N/A</td>
<td>▲</td>
</tr>
</tbody>
</table>

*MLTSS is mandatory for included populations, e.g., those not categorically excluded and who qualify/enroll in institutional or HCBS waiver services. Apart from the MMAI choice, they are auto-enrolled in MLTSS. MLTSS or MMAI. Recaps that duals can be enrolled in is the only types of managed care programs. The only duals, spenddown, others.*
For a Hypothetical Cohort of New Qualifiers

Timeline and Profile of Institutional Qualifiers Over Time

ReCap
Influences on LTC Choice & Placement

Updated 12.18

Focusing on hospital-based decisions
Summary of Feedback on Rebalancing

Recap

• Mental health conditions merit special attention in payment design to ensure appropriate case mix adjustment, though there is not agreement on whether that entails additional payments of some kind.

• Access to NF services for those with mental health conditions or displaying aggressive behavior is mixed.

• Potential analysis: Identifying gaps between an inpatient and NF stay may reflect abandoned attempts to return to the community and potential transition homes are the most consistent potential influence over the course of initial placement.

• Hospitals play a leading role in NF placement at the point of discharge, while nursing homes are the most consistent potential influence over the course of initial placement.

• Consideration should be given to the amount of uncertainty introduced relative to the scope of adoption of PDPM’s 4-5 components (in addition to applicability of each).

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Medicaid & Children’s Health Insurance Program (CHIP) Managed Care Final Rule - CMS-2408-F (5438.68)(2)

Updated November 2020, Network Adequacy Provisions Effective December 2020

Federal Medicaid Managed Care Regulations

Referent Standards of Access and Network Adequacy

Defining Access

Medicaid patients

The numbers of network providers who are not accepting new Medicaid enrollees whose services are specified in the contracts.

Medicaid enrollees

States with MCO, PIHP, or PAHP contracts that may cover LTSS must develop a quantitative network adequacy standard for LTSS provider types. States with MCO, PIHP, or PAHP contracts required to furnish the contracted services.

Other considerations that are in the best interest of the enrollee that need LTSS and support community integration of the enrollee.

Medicaid enrollees

The following criteria must be minimally considered in setting network adequacy standards for LTSS:

- The numbers and types (in terms of training, experience, and population covered in the MCO, PIHP, or PAHP contract)
- The characteristics and health care needs of specific Medicaid enrollees
- The expected utilization of services
- The anticipated Medicaid enrollment
- Other considerations that are in the best interest of the enrollee
- Medical and non-medical equipment and technological solutions that would support an enrollee’s choice of provider
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Referent Standards of Access and Network Adequacy

State LTSS Network Adequacy Standards

• States may use network adequacy standards such as minimum provider ratios, service initiation time, and maximum time and distance of travel.

Wisconsin – minimum provider ratios (1:25:1 in rural areas, 3:50:1 in metro areas, 6:8:1 for non-specialty nursing homes per specified county)

New York – minimum provider number (e.g., 8 non-specialty nursing homes per county)

A 2017 contracted study for CMS found that among 26 MLTSS programs (some with the same state) that meet federal Medicaid Managed Care Requirements:

• Appointment time and service initiation time (38%), travel distance (50%), travel time (50%), appointment waiting time (e.g., within 7 business days of request in medium counties for SNFs)

For example, within Medicaid MCOs:

• California – appointment waiting time (e.g., within 7 business days of request in medium counties for SNFs)

• New York – minimum provider number (e.g., 8 non-specialty nursing homes per county)

• Wisconsin – minimum provider ratios (1:25:1 in rural areas, 3:50:1 in metro areas, 6:8:1 for non-specialty nursing homes per specified county)

Defining Access
## Defining Access

<table>
<thead>
<tr>
<th>Time and Distance Standards by County Size</th>
<th>Timely Access</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Services</td>
<td>Available</td>
<td>Support (LTS)</td>
</tr>
</tbody>
</table>

Referent Standards of Access and Network Adequacy

Medicare Advantage Plans

Defining Access

42 CFR §422.16 Network adequacy. [For the Medicare Advantage Program; in minutes and miles]

<table>
<thead>
<tr>
<th>Provider/Facility type</th>
<th>Max time</th>
<th>Max distance</th>
<th>Max time</th>
<th>Max distance</th>
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<td>Rural</td>
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Table 1 to Paragraph (c)(2)

Source: https://www.ecfr.gov/cgi-bin/text-idx?SID=01e17c6fc24c47eb9d413417b3424e12&mc=true&node=se42.3.422_1116&rgn=div8

Note on website:  “e-CFR data is current as of December 15, 2020”
For NFs and SLFs, Contractor must maintain the adequacy of its Provider Network sufficient to provide Enrollees with reasonable choice within each county of the Contracting Area, provided that each Network Provider meets all applicable state and federal requirements for participation in the HFS Medical Program. Contractor may require as a condition for participation in its network that a NF agree to provide access to Contractor’s or Subcontractor’s Care Management team to permit qualified members of the team to write medication and lab orders, to access Enrollees to conduct physical examinations, and to serve as PCP for an Enrollee.

Section 5.7.1.4 For Providers of each of the Covered Services identified in this section 5.7.1.4 under an HCBS Waiver, Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county. Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county. Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county. Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county. Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county. Contractor must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Network Providers served at least eighty percent (80%) of the number of Participants in each county who received such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) such Providers, so long as such Providers accept Contractor’s rates, even if one (1) Provider served more than eighty percent (80%) of the Participants in each county.

Covered Services include:
- adult day care; home care/in-home services; day habilitation; supported employment; home-delivered meals; home health aides; nursing services; Occupational Therapy; Speech Therapy; and Physical Therapy.

Defining Access
General Long-Term Nursing Care Category of Service

a) Planning Areas

95 general long-term nursing care planning areas are located within 11 Health Services Areas (HSAs).

b) Age Groups

For general long-term nursing care, age groups are 0-64, 65-74, and 75 and over.

c) Utilization Target

Facilities providing a general long-term nursing care service should operate those beds at a minimum annual average occupancy of 90% or higher.

d) Bed Capacity

General Long-Term Nursing Care bed capacity is the licensed capacity for facilities subject to the Nursing Home Care Act and the total number of LTC beds for facilities not subject to the Nursing Home Care Act.

The following methodology is utilized to determine the projected number of nursing care beds needed in a planning area:

1. Establish minimum and maximum planning area use rates for the 0-64, the 65-74, and the 75 and over age groups as follows:

   A. Divide the HSA’s base year experienced nursing care patient days for each age group by the base year population estimate for each age group to determine the HSA experienced use rate for each age group.

   B. The minimum planning area use rate for each age group is 60% of the HSA experienced use rate for each age group, and the maximum planning area use rate for each age group is 160% of the HSA experienced use rate for each age group.

   C. Determine the HSA’s base year experienced nursing care patient days for each age group by the base year population estimate for each age group.

   D. Divide the HSA’s base year experienced nursing care patient days for each age group by the base year population estimate for each age group.

2. Subtract the number of existing beds in the planning area from the projected planning area need to determine the projected number of excess (surplus) beds or the projected need for additional (deficit) beds in an area.

3. Referent Standards of Access and Network Adequacy

Facilities and Services Review Board Standards for Access and Need
Section 1125.540 Service Demand

Establishment of General Long-Term Care Facilities and Services Review Board Standards for Access and Need

Defining Access

Referent Standards of Access and Network Adequacy

Service Demand

Section 1125.540 Service Demand – Establishment of General Long-Term Care Facilities and Services Review Board Standards for Access and Need

Defining Access
Identifying Policy Goals for Capacity and Access

- Ensuring adequate capacity entails characterizing (i.e., choosing a measure of) how nursing facilities across Illinois might meet the needs of current and future nursing facility residents.
- Access goals may need to evolve to reflect changing expectations for resident quality of available care inside them.
- Capacity extends beyond the geographic accessibility of facilities to consider the availability of care inside them.
- Access goals may need to evolve to reflect changing expectations for resident quality of life and a new emphasis on infection control.
- Defining Access

While there is no universally accepted metric, existing standards for LTSS provider accessibility and insurance network adequacy provide at least an initial framework for evaluating capacity.

Ensuring adequate capacity entails characterizing (i.e., choosing a measure of) how nursing facilities across Illinois might meet the needs of current and future nursing facility residents.

Defining Access
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• Capacity
  - Recent trends
  - Analysis of emerging policy priorities
  - Beds (and Rooms)
  - Staffing
• Questions and comments on Capacity
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Recap

Capacity
There are 26 fewer NFs in the 2019 CR Tally due to a substantial increase in ownership, which delays CR submission to HFS. The spike upward in 2018 remains unexplained, as 2018 remains slow.

(Source: HFS Cost Reports)

Industry Trends in Beds and Occupancy

State NF Bed Counts and Census 2004-2019
Recent Decline in Occupancy 2014-2020

Medicare COMPARE data identifies a different trend in 2018-2020 than HFS reports.

( Measured in January of each year, Source: COMPARE)
Comparison of Trends in Illinois v. the US
(measured in January of each year, Source: COMPARE)

* Indicates positive IL trend (for all others, IL trend was negative)
** Indicates positive US trend (for all others, US trend was negative)

• With two exceptions (US Total Population and IL beds per facility) all trends at both US and IL levels were negative.
• The current market trend in Illinois is for smaller facilities to drop out. Occupancy is dropping at both levels, but faster in Illinois.

Industry Trends in Beds, Occupancy and Population

(Comparison of Trends in Illinois v. the US)
(measured in January of each year, Source: COMPARE)
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  • Recent trends

  • Recent trends

  • Recent trends

  • Recent trends

  • Recent trends

  • Recent trends

  • Recent trends

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Characterizing Staffing Capacity

- Extreme under-staffing v. the regulatory standard (Category 1. Under 75%) is concentrated in 2 or 3 regions.
- All 11 regions appear to have a meaningful 5% - 25% below regulatory minimums (Category 2. 75% - 94% below).
- This analysis may be biased due to missing data.

(5=n=593, Source: 4Q2019 MDS and PBJ; RUGS-based)
Staffing capacity can further be described by isolating those facilities falling below the regulatory threshold (here described as at least 5% below those minimums) and tabulating the total number of FTE represented by the regulatory shortfall in those facilities.

Statewide, the shortfall amounts to more than 1,500 FTE for the subset of NFs included in this analysis, and subject to the simple assumption of a 40-hour work week. This analysis underestimates the nursing shortfall by an unknown amount due to missing data (unmatched providers).

Distriibution of Nurse Shortfall by Region (includes NFs with shortfall only n=123, Sources: 4Q2019 MDS and PBJ)
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Describing Bed & Room Capacity in IL Nursing Facilities

Bed Capacity

This analysis characterizes NF bed capacity in terms of a key potential policy objective discussed in this reform process -- reducing the number of residents sharing NF rooms.

Illinois has fewer than 43,000 licensed rooms but in 2019 had an average daily census of well over 60,000 CF and SNF residents. As a result, this describes

This analysis characterizes NF bed capacity in terms of a key potential policy objective discussed in this reform process -- reducing the number of residents sharing NF rooms.

Double occupancy is estimated by comparing a facility's average daily census in 2019 to the facility's maximum possible census at double room occupancy requirements assumpions about underlying occupancy rates (currently closer to 70%).

No estimate of statewide dependence on 3+ person rooms is offered as the state lacks a clear policy target for reduced room occupancy.

In this analysis, "low," "medium" and "high" levels of dependence on 3+ person rooms were determined by dividing facilities with any dependence on 3+ person rooms into 3 groups with 60-65 facilities each. This objective determines selection of cut-points at 0%, 5% and 12.5% dependence.

The LTC industry will likely be reexamined as Covid’s impact wanes and the nation takes stock of the implicit risk that residents face for such pandemics.

Identifying a precise policy target for the physical design of nursing facilities, including room occupancy, may be beyond the reach of this Medicaid payment design process, though identifying opportunities for improvement may not.

Identifying a precise policy target for the physical design of nursing facilities, including room occupancy, may be beyond the reach of this Medicaid payment design process, though identifying opportunities for improvement may not.
Facilities with dependence on 3+ person rooms are concentrated primarily in two Chicago-area HSA:

- Chicago City
- Chicago SW and Will County

Distribution of Bed Capacity by Planning Region (n=689, Sources: 2019 CRS; IDPH Licensure Records; Review Board HSA's)
• 49% of Medicaid patient days are in facilities with some dependence on 3+ person rooms.

• 74% of Medicaid patient days in facilities with some dependence on 3+ person rooms are in two Review Board HSAs: Chicago City and Chicago SW and Will.

• 91% of Medicaid patient days in facilities with the highest level of dependence on 3+ person rooms are in these two HSAs.
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Bed v. Staffing Capacity in IL Nursing Facilities

Emerging Policy Priorities

- 29% had some dependence on rooms with 3+ beds
- 17% had >95% of required staffing
- 62% of facilities had exposure to neither under-staffing nor 3+ person rooms in 2019.

(1) n=650, Sources: 402019 PB18 MDS, 2019 CRs, IDPH Licensure Records

Sources: 4Q2019 PBJ&MDS; 2019 CRs; IDPH Licensure Records
Nearly half of Medicaid patient days (47%) were in facilities with some dependence on 3+ person rooms in 2019, and about one-fifth (22%) were in facilities with 3+ person rooms in 2019.

One-quarter of 2019 Medicaid resident days (26%) were in facilities averaging >95% of required staffing for the year.

Nearly half of Medicaid resident days (44%) had exposure to neither 3+ person rooms nor under-staffing (<95% of minimum).

Emerging Policy Priorities
About one-third of non-Medicaid patient days (33.8%) were in facilities with some dependence on rooms with 3+ beds in 2019, and one-tenth (9%) were in facilities averaging >95% of required staffing.

Nearly two-thirds of non-Medicaid residents (63%) had exposure to neither 3+ person rooms nor under-staffing (>95% of minimum).

Emerging Policy Priorities:

- Nearly two-thirds of non-Medicaid residents (63%) had exposure to neither 3+ person rooms nor under-staffing (>95% of minimum).
- One-tenth of non-Medicaid resident days (10%) were in facilities averaging >95% of required staffing.
- About one-third of non-Medicaid patient days (33.8%) were in facilities with some dependence on rooms with 3+ beds in 2019.

Payment Reform Objectives:

Distribution of all Non-Medicaid Patient Days by Potential Medicaid Patient Days in 2019

(n=650, Sources: 402210 PB/S, MD; 2019 CSL; IDPH Licensee Records)

Emerging Policy Priorities
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Questions for Discussion

NF Access Goals / Standards for Illinois Medicaid

• How should the Federal Medicaid (i.e., MCO MLTSS) access objectives of "health and welfare" and "best interest of the enrollee" be applied in Illinois going forward?

• How might the most effective strategies be in reducing room occupancy?

• What are your observations about the mid-to-long-term impact of COVID on NF demand?

• What are your observations about the mid-to-long-term impact of COVID on NF attributes like HVAC and other non-structural infection control?

• What might the most effective strategies be in accelerating reductions in room occupancy?

• How might we operationalize incentives for accelerating reductions in room occupancy?

• Should we assume that single occupancy will become the policy objective in the near future?

• Should we ask/survey NFs individually given the wide range of potential interests?

• Quality of Life

• Infection control

• How might we operationalize incentives for accelerating reductions in room occupancy?

• What might the most effective strategies be in accelerating reductions in room occupancy?

• How is the industry responding to reduced occupancy now, and over the last few years?

• Welfare and "best interest of the enrollee" be applied in Illinois going forward?

• How should the Federal Medicaid (i.e., MCO MLTSS) access objectives of "health and welfare" and "best interest of the enrollee" be applied in Illinois going forward?
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