NURSING FACILITY PAYMENT REVIEW AND REDESIGN

Modeling II: Comprehensive Rate Proposal

March 18, 2021
AGENDA

• Overview
• Recap
  ➢ Exploring role of therapy in current Medicaid payments
  ➢ Considerations in tabulating net income and Medicaid days
  ➢ Missing ownership records
• Summary Case for Change
• Modeling II: comprehensive rate proposal
  ➢ Overview
  ➢ Assessment Fee and Use of Funds
  ➢ Distributional Impact
• Next Steps
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.
ORIGIINAL OBJECTIVES AND PRINCIPLES FOR REFORM

- 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
- End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
- Directly tie funding/rates/incentives to demonstrable and sustained performance on key quality reporting metrics
- Documentation to support, review and validation of level of care coding and appropriateness, outliers, actual patient experiences, etc.
- Align regulation and payment incentives to the same goals
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis, including single-occupancy rooms, certified facilities
- Integrate emerging lessons and federal reforms related to the COVID pandemic
- Improved cooperation, support and follow up, data sharing and cross-agency training from other agencies (OIG, IDPH, DoA)
- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes
Building blocks in a comprehensive NF payment:

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

Note: COVID has had a profound impact on long term care. Infection control is assumed to be an integral component of each building block.
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A shift from RUGs 48 to PDPM would collapse 43 non-Rehab groups into 25

<table>
<thead>
<tr>
<th>PDPM Group</th>
<th>PDPM HIPPS Code Identifier</th>
<th>Comparable RUG Group</th>
<th>PDPM Group</th>
<th>PDPM HIPPS Code Identifier</th>
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<td>P</td>
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<td>BAB2</td>
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<td>PE2/PD2</td>
</tr>
<tr>
<td>LDE2</td>
<td>H</td>
<td>LE2/LD2</td>
<td>PDE1</td>
<td>U</td>
<td>PE1/PD1</td>
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<tr>
<td>LDE1</td>
<td>I</td>
<td>LE1/LD1</td>
<td>PBC2</td>
<td>V</td>
<td>PC2/PB2</td>
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<tr>
<td>LBC2</td>
<td>J</td>
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<td>PA2</td>
<td>W</td>
<td>PA2</td>
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<tr>
<td>LBC1</td>
<td>K</td>
<td>LC1/LB1</td>
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<td>X</td>
<td>PC1/PB1</td>
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<tr>
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<td>L</td>
<td>CE2/CD2</td>
<td>PA1</td>
<td>Y</td>
<td>PA1</td>
</tr>
<tr>
<td>CD1</td>
<td>M</td>
<td>CE1/CD1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exploring the Use of Therapy for Medicaid Residents

Nursing Facilities by <65 Therapy Use
Neither Cook nor DuPage; MDS 4Q 2019; n=431

% of 4Q19 Medicaid Residents <65 and in Therapy RUG

0-19th STRIVE Staffing
20th-39th STRIVE Staffing
40th-59th STRIVE Staffing
60th-79th STRIVE Staffing
80th-100th STRIVE Staffing
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Next Steps
Considerations in Tabulating Medicaid Days

Source Information

- 2018/2019 Medicaid CR Days
- Medicare CR Medicaid days if neither 2018/2019 Medicaid CR were available (nominal # of providers)

Source Considerations

- Medicaid cost reports were utilized as they better categorize days for the Medicaid program

Source Limitations

- Unknown prevalence of provider reporting of Managed Medicaid days in the “Other/Private” day categories within the Medicaid CR statistical data
  - Prevalence of this issue is larger with Medicare CR reporting
- Impact of COVID on forecasting of Medicaid days
  - Current experienced day decline
  - Projected rebound of Medicaid utilization in forthcoming fiscal year
Considerations in Tabulating Net Income

Source Information

- **2018/2019 Medicare Cost Reports**
  - Gross Revenue
    - SNF/NF Routine Revenue – Wrksht G-2
    - Total SNF/NF Ancillary Revenue (Prorated) – Wrksht G-2
      - Revenues prorated on basis of routine SNF/NF revenue to total revenue
  - Contractual Adjustments
    - SNF/NF Contractual Revenue (Prorated) – Wrksht G-3
      - Contractuals prorated on basis of SNF/NF(ICF) routine and ancillary revenue to total revenue
  - Expenses
    - SNF/NF Routine Cost – B part I
    - SNF/NF Ancillary Cost (Prorated) – B part I
      - Utilized SNF/NF revenue proration factor to more closely align with traditional Medicare costing mechanics

- **2019/2018 Medicaid Cost Reports if Medicare CRs were not present within HCRIS dataset (~30 providers)**
  - Net Income (page 19)
  - Adjustments to Net Income:
    - Owner’s Compensation Limits (page 7)
    - Related Party Adjustments (page 5)
    - Allowable cost adjustment (page 5)
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Medicare COMPARE SNF Ownership Records (Feb 2021)
N=\sim 500

Median Year of Purchase for an SNF Ownership Share in Each State
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Illinois is at the bottom of national rankings on overall nursing hours, driven largely by shortages in Certified Nursing Assistants (CNAs).

Staffing varies widely across Illinois nursing facilities.
The average number of residents per room appears to contribute substantially to explain the Wave 1 spread of COVID-19.

Emerging research at the national and international level affirms this insight.
OVERCROWDING INCREASES WITH MEDICAID UTILIZATION

Medicare now only pays for single- and double-occupancy.

In COVID’s devastating wake, researchers, advocates and industry voices alike are focusing increasingly on reducing room occupancy.
Quality of care in nursing facilities is a priority of HFS and sister agencies (DPH, DoA).

Facilities with high proportions of Medicaid residents or racial minorities are currently more likely to receive a lower quality of care. **This must improve.**

The federal Centers for Medicare and Medicaid Services collects and publishes nursing facility quality information, which could be used for quality-based payments in Illinois.

To improve quality, Illinois can tie new funding to the quality of care provided, with incentives to reward high performance and/or improvements:

  - Roughly **half of states** already tie some form of incentive payment to performance for nursing facilities, although payment structure varies widely.
  - Illinois currently has **two unfunded quality incentives** in rule that were agreed to years ago to encourage staff retention as well as continuity of staff assignments to the same residents.
  - **Rebalancing / lower concentration of residents** can be encouraged from many directions.
Our transformation puts a strong new focus on **equity**; prevention and public health;

- Pays for value and outcomes rather than volume and services;
- Proactively uses analytics and data to drive decisions and address health disparities; and

- Works to move individuals from institutions to community, in an effort to keep individuals in the least restrictive environment and to keep them more closely connected with families and communities.
There is robust evidence of persistent disparities in the quality of nursing facility care based on race and source of payment.

- Residents of color and residents whose nursing home care is covered through Medicaid consistently receive care in facilities of lower quality across multiple dimensions compared to other residents, including worse staffing and infection control.

- These disparities exist nationally and in Illinois and remain even after accounting for differences in resident and facility characteristics.

- Facilities with more Medicaid-funded residents provide a lower quality of care, including lower staffing and room crowding; minority residents tend to live in facilities with more Medicaid-funded residents.
What Nursing Facilities are Black or Brown Residents Located In?

- Neither Policy Concern
- Regulatory Staffing Shortfall (Only)
- Dependence of 3+ Person Rooms (Only)
- Room Crowding and Staffing Shortfall
- 0-19th MCD%
- 20th-39th MCD%
- 40th-59th MCD%
- 60th-79th MCD%
- 80th-100th MCD%
What Nursing Facilities are White (only) Residents Located In?

- Neither Policy Concern
- Regulatory Staffing Shortfall (Only)
- Dependence of 3+ Person Rooms (Only)
- Room Crowding and Staffing Shortfall

Categories:
- 0-19th MCD%
- 20th-39th MCD%
- 40th-59th MCD%
- 60th-79th MCD%
- 80th-100th MCD%
Three Main Components:

Modernize Payment Methodology (case mix update)

Transform Nursing Care through Assessment-Driven Increase in Funding (significant enhancements to drive Quality and Staffing)

Improve Payment Accuracy and Integrity
Modernize Payment Methodology

- Adopt transparent, outcome-driven, patient-centered model with increased accountability
- Transition away from RUGS to federal PDPM case-mix nursing component
- Ensure higher rates are geared toward higher acuity residents
- Increase the daily add-on rate for Alzheimer’s services
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
Transform Nursing Care through Assessment-Driven Increase in Funding

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

- Directly tie funding/incentives to demonstrable and sustained performance on key quality reporting metrics

- Align regulation and payment incentives to the same goals [e.g., nurse staffing levels, especially CNAs]

- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 pandemic, including reduced room occupancy

- Integrate emerging lessons and federal reforms related to the COVID-19 crisis
- Institute documentation to support, review and validate level of care coding and appropriateness, outliers, actual patient experiences, etc.

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

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

- Dedicate resources for consistent data collection, analysis, and oversight of facilities by HFS
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Transition to federal PDPM
• Resident-centric
• Aligns with Medicare
• Higher cost coverage for higher acuity residents

Increase Staffing
• Adequate at all times
• Major staffing bonuses
• Additional funds for CNA training

Focus on Equity
• Equity for all customers
• Decrease the burden for Black & Brown communities
• Person-centered care

Quality Incentives
• Bonuses for consistent assignment and tenure
• Outcome metrics emphasizing Medicaid's longer-stay residents
• Infection control

Maximize Federal Funding
• Increase assessment
• New funding toward enhancements that mirror priorities (equity, quality)

Reduce Overcrowding
• Shift over time to 1 or 2 persons per room
• Dignity of living
• Physical improvements

IMPROVING HEALTH & QUALITY OF LIFE
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## Proposed Assessment Fee

<table>
<thead>
<tr>
<th></th>
<th>Current Fees</th>
<th>Proposed Fee</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Revenue - Licensed Bed Fee</td>
<td>$50,368,245</td>
<td>$-</td>
<td>$(50,368,245)</td>
</tr>
<tr>
<td>Estimated Revenue - Occupied Bed Fee</td>
<td>$113,864,568</td>
<td>$318,895,826</td>
<td>$205,031,258</td>
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<tr>
<td>Total Estimated Fee Revenue</td>
<td>$164,232,814</td>
<td>$318,895,826</td>
<td>$154,663,012</td>
</tr>
</tbody>
</table>

| Provider Participation Fee per Licensed Bed | $1.50 | $- |
| Provider Participation Fee per Occupied Bed  | $6.07 | $17.00 |
| Estimated Fees as % of applicable revenue  | 2.8%  | 5.3%  |
Use of Additional Funds

**Use of increase in assessment fees ($millions, state share)**

- Nursing incentives* ** $ 4
- Quality improvement* $ 66
- CNA tenure, promotion and training $ 20
- Infection control and room conversion $ 10
- Unallocated $ 6
- Community based long term care alternatives $ 49
- Total new spend (=new fee revenue) $ 155

*Model incorporates expected impact at the facility-level, e.g., in overall cost coverage

**In addition, the $4.55 staffing add-on is now distributed through the incentive
### Nursing Care Incentive Structure

#### Incentive Tier Structure

<table>
<thead>
<tr>
<th>Incentive tier</th>
<th>Facility staffing performance as a % of STRIVE</th>
<th>Incentive as % of direct care component</th>
<th># of Providers as of Q3 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (&gt;=)</td>
<td>105%</td>
<td>15%</td>
<td>243</td>
</tr>
<tr>
<td>Tier 2 (&gt;=)</td>
<td>100%</td>
<td>10%</td>
<td>55</td>
</tr>
<tr>
<td>Tier 3 (&lt;)</td>
<td>100%</td>
<td>5%</td>
<td>73</td>
</tr>
<tr>
<td>Tier 4 (&lt;)</td>
<td>92%</td>
<td>0%</td>
<td>288</td>
</tr>
</tbody>
</table>
New Quality Improvement Incentive Program

• Quality payments would launch alongside other rate reforms using the most recent available data
• Begin with more mature metrics that have well understood score distributions to reduce initial uncertainty over the impact of the full package of rate reforms, e.g.:
  • Long Stay Quality STAR rating (composite; nationally normed)
  • Inspection STAR rating (composite; state normed)
• Include newer metrics to capture Medicaid program priorities, e.g.:
  • Staffing continuity (HFS rule)
  • Staffing turnover (HFS rule; forthcoming on Care Compare)
• Allocation of $135 million in incentive payments
  • Reflect program priorities and improvement opportunity
  • Maintain a level of continuity to offer facilities meaningful gain from their QI investments
• Reflect HFS commitment to accuracy and transparency as with the P4P program
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Distributional Analysis of Potential Rate Changes

Key Comparisons
- Cost-neutral comparison of CMI
- CMI versus allocated Medicaid nursing costs
- Overall net income

Demographics
- Regional shifts
- Medicaid payer mix

Special Conditions
- Alzheimer’s
- SMI
- TBI
- Overall case mix

Emerging Policy Priorities
- Nurse staffing levels
- Room crowding
### Impact of Rate Proposal: by Region

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).

<table>
<thead>
<tr>
<th>HSA Region</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 NW Galena</td>
<td>48</td>
<td>57%</td>
<td>90.7%</td>
<td>95.1%</td>
</tr>
<tr>
<td>2 NC Peoria</td>
<td>59</td>
<td>51%</td>
<td>92.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>3 WC Springfield</td>
<td>52</td>
<td>54%</td>
<td>95.8%</td>
<td>100.2%</td>
</tr>
<tr>
<td>4 EC Decatur Champaign</td>
<td>64</td>
<td>54%</td>
<td>93.1%</td>
<td>96.6%</td>
</tr>
<tr>
<td>5 S Cairo</td>
<td>64</td>
<td>56%</td>
<td>100.5%</td>
<td>105.2%</td>
</tr>
<tr>
<td>6 CHI City</td>
<td>76</td>
<td>74%</td>
<td>95.6%</td>
<td>96.1%</td>
</tr>
<tr>
<td>7 CHI Outer Cook DuPage</td>
<td>147</td>
<td>53%</td>
<td>86.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td>8 CHI Lake Kane McHenry</td>
<td>54</td>
<td>49%</td>
<td>84.9%</td>
<td>89.7%</td>
</tr>
<tr>
<td>9 CHI SW and Will</td>
<td>26</td>
<td>50%</td>
<td>84.9%</td>
<td>86.8%</td>
</tr>
<tr>
<td>10 W Rock Island</td>
<td>14</td>
<td>54%</td>
<td>86.3%</td>
<td>91.7%</td>
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<tr>
<td>11 SW East St. Louis</td>
<td>42</td>
<td>57%</td>
<td>91.4%</td>
<td>93.7%</td>
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</table>
## Impact of Rate Proposal: by Medicaid Utilization

<table>
<thead>
<tr>
<th>Medicaid Utilization</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%-100%</td>
<td>67</td>
<td>95%</td>
<td>106%</td>
<td>102%</td>
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<tr>
<td>80-89%</td>
<td>79</td>
<td>86%</td>
<td>104%</td>
<td>102%</td>
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<td>70-79%</td>
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<td>20-29%</td>
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<tr>
<td>10-19%</td>
<td>41</td>
<td>16%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>0-9%</td>
<td>32</td>
<td>3%</td>
<td>62%</td>
<td>68%</td>
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</table>

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).
## Impact of Rate Proposal: by Facility Average Case Mix

<table>
<thead>
<tr>
<th>Facility Case Mix Average</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>80th - 100th Percentile</td>
<td>130</td>
<td>58%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>60th-79th Percentile</td>
<td>129</td>
<td>60%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>40th-59th Percentile</td>
<td>130</td>
<td>58%</td>
<td>91%</td>
<td>93%</td>
</tr>
<tr>
<td>20th-39th Percentile</td>
<td>128</td>
<td>54%</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>0-19th Percentile</td>
<td>129</td>
<td>49%</td>
<td>84%</td>
<td>92%</td>
</tr>
</tbody>
</table>

**Facility Cost Coverage**

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).
## Impact of Rate Proposal: by Special Populations

**Alzheimer's, Serious Mental Illness, Traumatic Brain Injury**

### Facility Cost Coverage

<table>
<thead>
<tr>
<th>% of Medicaid Residents with Alzheimers</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>80-100%</td>
<td>21</td>
<td>26%</td>
<td>74%</td>
<td>80%</td>
</tr>
<tr>
<td>60-79%</td>
<td>131</td>
<td>50%</td>
<td>88%</td>
<td>94%</td>
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<tr>
<td>40-59%</td>
<td>247</td>
<td>55%</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>20-39%</td>
<td>194</td>
<td>63%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>0-19%</td>
<td>53</td>
<td>60%</td>
<td>89%</td>
<td>91%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Medicaid Residents with SMI</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-100%</td>
<td>49</td>
<td>84%</td>
<td>101%</td>
<td>102%</td>
</tr>
<tr>
<td>8-9.9%</td>
<td>11</td>
<td>66%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>6-7.9%</td>
<td>22</td>
<td>75%</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>4-5.9%</td>
<td>37</td>
<td>67%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>0-3.9%</td>
<td>527</td>
<td>51%</td>
<td>89%</td>
<td>94%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Medicaid Residents with TBI</th>
<th>Count of Facilities</th>
<th>Medicaid Utilization</th>
<th>Current Rates</th>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 0%</td>
<td>17</td>
<td>68%</td>
<td>93%</td>
<td>98%</td>
</tr>
<tr>
<td>None</td>
<td>639</td>
<td>56%</td>
<td>91%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Note: Estimates incorporate facility-level impacts of a switch to PDPM, an increase and consolidation of the assessment fee, and incentives for staffing performance and quality (based on recent performance obtained through the federal Care Compare website).
AGENDA

• Overview

• Recap
  ➢ Exploring role of therapy in current Medicaid payments
  ➢ Considerations in tabulating net income and Medicaid days
  ➢ Missing ownership records

• Summary Case for Change

• Modeling II: comprehensive rate proposal
  ➢ Overview
  ➢ Assessment Fee and Use of Funds
  ➢ Distributional Impact

• Next Steps
• PDPM has been on the horizon for years.
• Been working with the Nursing Home industry to understand data / our proposal (since August 2020)
• Collaborate with General Assembly on imperatives to change (Spring 2021)
• Begin seeking federal approval for increased assessment summer 2021
• Promulgate Administrative Rules for new rates (keep consistent with federal approval)
• Implement redesigned rate system January 1, 2022
• Continue monitoring and transparency around all aspects – such as costs, staffing, and quality outcomes