

Combined Questions & Answers on HFS Nursing Home Update Proposal Originally presented on March 18, 2021

Note: Questions were submitted by Matt Werner and Donna Ginther – some overlap in questions is accounted for. Page number references are to HFS' March 18 presentation "Nursing Facility payment Review and Redesign, Modeling II: Comprehensive Rate Proposal."

Not all submitted questions are addressed in this set of responses and several will need to be discussed in more detail at a future meeting.

Data

Q1: How did HFS count staffing? Did you use the Illinois regulatory crosswalk? [Section 300 \(ilga.gov\)](#) Or did you use Federal CMS 5 Star tabulation?

A: We calculated the ratio of "Reported Total Nursing Hours" (RNs/LPNs/CNAs) to the STRIVE expected nurse staffing targets ("Case-Mix Total Nurse Staffing Hours"), relying on the "Provider Information" file posted to the Care Compare website in January. The basis of these hours stems from PBJ data collection for Q3 2020.

Q2: Is HFS going to share the baseline data? Specifically, we were asked to about the following: Medicaid days for spending, Taxable occupied days, Revenue data used to set 6% limit on tax, Cost coverage data, Which Federal 5 start file are you using?, facility level modeling (blind or identified), raw data files for Medicaid rates, raw data file for staffing and star rating

A: In general, we are planning to share key data supporting the rate modeling. A separate workbook accompanying this set of responses was sent around after the meeting on 3.25.2021.

Rates

Q3: Is HFS keeping the existing wage adjusters?

A: Yes, in the proposal.

Q4: Is HFS keeping the 3 small rate add-ons?

A: Funding for the SMI adjuster would be redirected to the Alzheimer's adjuster, raising it from \$0.63 to \$0.89

Q5: Is HFS keeping the two resident specific add-ons for vent care and TBI?

A: Yes, in the proposal.

Q6: HFS presented on the PDPM nursing weights and showed them being neutral.

A: New funding will accompany the switch from RUGS to PDPM in the agency's proposal. The reforms are depicted in two parts to enable a clearer accounting of the use of new funds: the first part showing the switch in a budget neutral fashion and the second showing the use of new funds.

Q7: Does this mean HFS is presenting weights that in and of themselves do not change spending?

A: To promote continued rebalancing four low-acuity PDPM groupings are held to the absolute weights they held under RUGs, while the added weight that would have been allocated to those groups under PDPM is instead reallocated proportionally to higher acuity residents.

Q8: Is HFs assuming the nursing base rate is still \$85.25?

A: Yes.

Q9: Is it correct HFS is not proposing any changes to support & capital?

A: The form of additional funding for physical improvements associated with infection control and overcrowding is under consideration. Apart from that additional funding, no changes are proposed in support and capital.

Q10: For the % of STRIVE metric on the nursing care incentive are you using the data from 5 star or calculating based on Illinois MDS data and PDPM conversion?

A: Resident-specific MDS results for 3Q2020 were applied to RUG-specific STRIVE targets and compared to actual staffing from the PBJ (Care Compare) to identify the # of Providers in the last column on p. 33.

Q11: Will HFS protect these rates from MCO scrapes?

A: Yes, administratively.

Assessment Tax

Q12: Assuming that the \$155M detailed on page 32 is the total amount projected to be collected, the Department's estimates on how much is available for capture under the federal assessment ceiling appears low.

A: The amount on p. 32 is the additional amount collected v. current total assessment collections.

Q13: Can you provide a walk to your estimate?

A: Please see slide p. 31.

Q14: What is the percent of federal match used in the Department's assumptions?

A: 51.1%

Q15: Does the Department assume that the collection used is the same as used for occupied beds today?

A: Please see p. 31 for new assessment details and comparison to existing assessment collections rates, form, and total amount.

Q16: What are the bed days the Department used to generate the assessment?

A: A separate workbook with this information was sent around after the meeting on 3.25.2021.

Q17: Please provide by region?

A: Please refer to facility-specific days provided in the data workbook sent on 3.25.2021.

Q18: Does the Department's projections assume all federal match is dedicated to increasing the nursing home rate?

A: Use of federal match against the existing level of assessment remains as-is. Use of federal match associated with an increase in assessment revenue follows the allocation of state share on p. 32.

Q19: What period is HFS using for occupied beds data modeling?

A: 1-1-2018 through 12-31-2019. Please refer to the data workbook sent on 3.25.2021.

Q20: Please confirm the definition of "occupied" bed for purposes of taxation.

A: No change from the current statutory definition of what's taxable, or those facilities that are exempt. Data as reported on the Medicaid cost reports, anything that is reported as Medicare Part A is excluded – all others were included.

Q21: HFS stated they wanted to maximize provider tax but modeled at 5.3%, is there a reason?

A: The Department is intentionally conservative when modeling up to 5.3% for a variety of reasons, primarily to increase substantially from where the model is today but not going all the way to 6%. We intent to leave some room in the assessment in case provider assessments are ramped down by the new Biden Administration and to leave room in the model to fluctuate in early years. Finally, we may want to revisit additional increases in the support and capital expenses in coming years.

Disbursement/Impacts

Q22: Is the \$49 million meant to fund SL linked rates or other initiatives?

A: Most other states allocated a proportion of assessment funding to community based alternatives and HFS intends the same for this increase.

Q23: How many losers is HFS modeling across all nursing homes taxed?

A: Our focus is on improving performance and the new rates attach at least \$200M annually to facility performance.

- a. We have kept the base rate the same.
- b. The weights are calibrated to maintain overall spending.
- c. Existing distributional impacts have incorporated quality and staffing at existing levels, but we anticipate and expect improvements that would mitigate the impact on individual facilities
- d. We can't predict volume and performance, e.g., increased staffing in response to these incentives nor DPH enforcement of minimum staffing rules.

Q24: Is the move to modify the support and capital rate into a set base rate similar to Medicare non-case mix rate assumed to be budget neutral, will it result in a savings from the current allocations or will it require additional dollars to be shifted from other components?

A: The proposal does not modify the support and capital rate into a set base rate as envisioned in the original objectives.

Q25: Is the move from RUGS to PDPM designed to be budget neutral?

A: New funding will accompany the switch from RUGS to PDPM in the agency's proposal. The reforms are depicted in two stages enabling an accounting for the use of new funds: a first stage consisting of a budget neutral switch to PDPM and a second and simultaneous stage allocating new funds to that switch.

Q26: Both RUGs and its predecessor paid Medicaid rates based on acuity. What changes are you proposing in the formula that will generate by comparison "higher rates geared toward higher acuity residents" than RUGs and its predecessor?

A: To promote continued rebalancing four low-acuity PDPM groupings are held to the absolute weights they held under RUGs, while the added weight that would have been allocated to those groups under PDPM is instead reallocated proportionally to higher acuity residents.

Q27: What does "uniform incentives" refer to and what does MCO specific incentives mean? Will these be governed by contract or by statutory guidelines?

A: We intend to expand on this at a future meeting.

Q28: Will administrative rules be drafted and made available for public comment?

A: We will follow the appropriate procedures, as always.

Questions about individual slides

Pages 8 and 9

Q29: What are the tables are these pages attempting to convey?

A: The charts convey the facility-level relationship between the percentage of under-65 year-old Medicaid residents coded with a therapy/rehab RUG and the level of staffing v. national RUG-specific STRIVE targets. That relationship is depicted separately for two Chicago-area counties and for the rest of the state.

Q30: Please provide the backup detail for the tables.

A: There will be a separate transmission.

Page 14

Q31: What is the message that the chart on page 14 is attempting to convey?

A: The chart indicates a relatively recent median transfer of ownership for Illinois nursing facilities that is slightly more recent than the nation as a whole.

Q32: What is the source of the chart? Please provide the backup detail.

A: Search for the file entitled "Ownership" at [Search | Provider Data Catalog \(cms.gov\)](#)

Q33: Agenda sheet references "missing ownership records". Where are they missing from?

A: Search for the file entitled "Ownership" at [Search | Provider Data Catalog \(cms.gov\)](#)

Pages 16, 17 & 18

Q34: What is the source for the charts on page 16, 17, and 18? If they were compiled by HFS or a contractor of HFS, please provide the detailed back up, including any assumptions.

A: There will be a separate transmission

Q35: Can you provide the date that the data was collected for each chart?

A: There will be a separate transmission

Q36: Can you provide the source document showing that emergency national research affirms that the number of beds per room contributed "substantially" to COVID outbreaks during Wave 1 and not community spread or the number of individuals the state did not require to be tested?

A: We referred to "emerging" research, which controls for community spread just as our charts did. We can provide a bibliography of relevant citations, as well as to provide copies of the Federal Coronavirus task force final publication and national AHCA/Leading Age recommendations published March 2021.

Q37: Can you add to the staffing chart an overlay of the Medicaid rates corresponding to the date the staffing data was collected?

A: We don't have a list of comparable payment rates for state Medicaid programs.

Page 19

Q38: On page 19 you state that high Medicaid homes and those homes with a high concentration of racial minorities are more likely to receive a lower quality of care. Can you provide the source document?

A: Please see p. 18, 22, and 23, as well as analyses from prior presentations focused on demographics, capacity, staffing and other topics which demonstrate disparities in staffing and room placement. Published research also substantiates disparities in coronavirus impact, infection control, standardized quality metrics, and other dimensions of quality.

Page 21, 22, & 23

Q39: Please provide longitudinal research that support the conclusions.

A: We can provide a number of resources.

Page 26

Q40: What is the measuring tool for assessing sustainable performance? What are the key quality metrics?

A: We will be covering questions about quality in a further discussion.

Q41: What regulations have the Department identified as out of alignment with the funding mechanism? How was this list developed? Will the industry have the opportunity to add outdated and un- or under – funded regulations to the list. Will DPH be involved in these discussions? Please provide legislative language for review.

A: HFS' proposal does not refer to regulations that are out of alignment with the mechanism.

Q42: What other emerging visions do you have for the industry besides the number of beds per room?

A: In this instance, "emerging" refers to research already beginning to be published (see above), research and analysis to come, and to any federal reforms that may emerge in the future.

Q43: Since so much of your proposal is dependent on passage of substantive changes, can you provide a copy, which will allow us to better access what you are suggesting:

- Aligning funding and regulations
- Integrate emerging federal reforms related to COVID
- Integrate lessons learned from COVID experience
- Additional documentation to validate level of care coding and appropriateness
- Data collection

A: This is in progress and will be shared at the common discussion table we have built with all interested stakeholders.

Page 27

Q44: How does cross agency training – DPH, HFS, DoA, Ombudsman – relate to the proposed reimbursement model?

A: Cross agency training is to inform policy direction and ensure coordination across the agencies. The specific nature of cross agency coordination and training will be contingent in part on policies and payment designs that are ultimately adopted.

Q45: Can you describe your vision for HFS's oversight of nursing homes? Are you planning to reinstitute the HFS survey teams of the 80's?

A: Our vision of oversight includes more accountability for both HFS and nursing homes largely using our quality standards already in policy or administrative rule.

Q46: Do the MCOs play a role in HFS's oversight plan? If so, specifically what will their role be?

A: The MCOs play an important role in the Medicaid program, but the oversight envisioned by HFS' proposal for shifting to PDPM, streamlining and increasing the assessment, and implementing quality incentives does not envision any additional MCO oversight.

Page 31

Q47: HFS Model – proposed assessment fees (slide 31) imply current taxes of \$164M and 659 facilities noted on slide 33. The IHCA and HCCI models are based on 728 facilities and a current tax base of \$178M. It is imperative that all have an accurate accounting of the inventory of facilities and starting tax assessments and Medicaid rates.

A: The number of facilities under the assessment as included in our model is reflected in the data workbook shared on 3.25.2021. The number of facilities on slide 33 is a different data set for facilities to project the quality tiers – as not all facilities have submitted their PBJs or other approved forms to include beyond projections.

Page 32

Q48: Under your proposal, where does the match go? For example, does the match on the \$49M for home services stay with home services or does the match against all money collected from nursing homes stay with nursing homes even though they may be expended for other projects?

A: Matching funds follow spending.

Q49: Slide #32 – Currently describes the “use of additional funds” and only accounts for the funds remitted by provider tax assessments. The full pool of funds generated through provider tax assessment and federal match should be totaled with allocations to uses fully documented.

A: We can flesh this out further as we move forward in these discussions.

Q50: It is unclear how allocating 49/155 or 32% of the new money to home and community based services addresses the quality or racial inequity issues that are cited with nursing homes.

A: Our proposal is intended to make resources available for better quality care in more equitable conditions for the 45,000 Medicaid customers residing in nursing homes in Illinois. At the same time, the department has other long term care services and support priorities which are also based in choice, equity, and quality of life. See also the answer to Q48.

Page 33.

Q51: Nursing Care Incentive Structure – as a per diem add on what does 15%, 10%, and 5% translate into.

A: The nursing incentive would serve as a multiplier for the case mix adjusted nursing (direct care) per diem, i.e., the per diem resulting from the new PDPM methodology as applied to the continuing base rate of \$85.25 and adjusted for regional variation. The multiplier would not be applied to direct care add-ons, i.e., for Alzheimer’s, vent care, & TBI.

Q52: What categories of staff are included? Do all carry equal weight?

A: STRIVE targets incorporate nursing staff only, including from RNs, LPNs, and CNAs which are all equally weighted in the calculation of staffing performance. The methodology would match as closely as possible the counting rules used in the establishment of the STRIVE targets themselves.

Q53: FTE? Employed? Contractual? Agency?

A: Hours for all qualified staff regardless of employment status. The methodology would match as closely as possible the counting rules used in the establishment of the STRIVE targets themselves.

Q54: Please provide the formula and the data used to construct the table on page 33.

A: Data used to count nursing hours is publicly available in the “Provider Information” file posted to the Care Compare website in January. The basis of these hours stems from PBJ data collection for Q3 2020 [Search | Provider Data Catalog \(cms.gov\)](#). Confidential resident-specific MDS results for 3Q2020 were applied to RUG-specific STRIVE targets and compared to actual staffing to identify the # of Providers in the last column.

Q55: What was the rationale behind the decisions to choose the tiers? How does the Staffing Ratios under the NHCA fit into this scenario?

A: The tiers were a clean and concise policy decision to demonstrate that there would be intentional incentives for facilities to staff toward/at STRIVE, and to complement this incentivized increase we also prioritize staffing through other incentives such as longevity and consistent assignment which have direct impacts on the quality and outcomes of residents.

Q56: At each tier how many providers are non-profit, 80% Medicaid or more, union, HSA?

A: Again, our focus is on improving performance for the benefit of the residents. We believe the new incentives will enable each facility to improve/maintain performance.

Page 34

Q57: Will quality be paid as a per diem or as a fixed payment?

A: Either way we intend to tie to real results.

Q58: What would be frequency of calculating quality? Annually, quarterly, or at another frequency?

A: Quarterly

Q59: Does HFS envision quality as several individual components or all items “score” toward a quality rate/payment?

A: HFS envisions that QI incentive funds would be apportioned to a number of prioritized metrics and/or indices (as indicated on page 34 of the 3.19 presentation), and that qualification, scoring and incentive weighting for each metric/index would then be calculated.

Q60: What does HFS have in mind for infection control? For instance, having at least 1 FTE infection control preventionist is something being discussed nationally.

A: We will be discussing this in future meetings.

Q61: What does “initial uncertainty over the impact of the full package of rate reforms” mean?

A: Using well understood metrics for which recent data is available provides facilities with a better understanding of the impact of financial incentives tied to those metrics.

Q62: Can you walk between \$135M on page and the \$66M on page 32?

A: 48.9% state share v. total computable (minus rounding)

Q63: What does HFS commitment to transparency refer to? Does this refer to transparency for the entire nursing home payment methodology or just the quality improvement incentive program?

A: As we have been openly discussing the payment design metrics and methodology for the last 8 months, we intend to be very transparent on individual homes' performance on equity of care, quality incentives, and overall quality of care for residents.

Page 36 Distributional Analysis of Potential Rate Changes

Q64: Can we get the details for the distribution of "key comparisons" and an explanation of each component?

A: HFS has already provided or addressed these comparisons in this presentation and in previous industry meetings.

Q65: What are the add-on amounts (plus increases and decreases) for Special Conditions, Regional Wage Adjuster?

A: HFS would continue to pay the vent and TBI add-ons per rule and maintain current wage adjusters. Funding for the SMI add-on would be moved to the Alzheimer's add-on. See also the response to Q4.

Q66: In previous conversations, HFS has alleged that double room occupancy can be achieved within the current census, can you provide data to walk this up? What date does the census represent?

A: In previous presentations, HFS has shared region-specific estimates of the number of rooms, beds, and residents, pointing to potential shortfalls in at least one region under a hypothetical 2-bed-per-room limit, but has not intentionally asserted that double-occupancy can be achieved for the current census without some adaptation to capacity, placement and/or facility-level occupancy.

Q67: Does your plan assume that COVID census will be maintained and controls will be put in place to keep census from returning to the pre-COVID level? If so, what controls should be contemplated?

A: No, our plan does not assume COVID-era facility census will remain unchanged.

Q68: Can we assume that nurse staffing levels on page 36 refer to RNs, APNs, and LPNs?

A: No. CNAs are also a high priority for Illinois.

Q69: What does "overall case mix" refer to under Special Conditions? Please see p. 39.

Q70: Is the Alzheimer's increase budget neutral? What is the source of the funds? What is the increase?

A: Funding for the SMI adjuster would be redirected to Alzheimer's, raising it from \$0.63 to \$0.89

Pages 36/37/38/39

Q71: Please provide this information in the following formats:

- a) Rate of return based on new assessment paid
- b) % of change
- c) % of the total increase

A: We provided charted information in tabular fashion and shared with the group.