Reimbursement Update and Review of Upcoming Changes

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Quick Recap of Some Outstanding Issues

- Several years ago, certain Medicaid claims were reprocessed due to a retroactive case-mix freeze. When reprocessed, many of these were paid using an incorrect patient monthly liability amount. The state is still working on a solution for this.
- The above situation also applies to certain claims involving co-payments made for Qualified Medicaid Beneficiaries (QMBs).
- If a DSS office tells you that Medicaid does not automatically pay for the first month of nursing home services, they are wrong. Please let me know if you have experienced this recently and have not been able to get it resolved.
- Delays in getting some Medicaid applications processed.

April Adjustment to Fair Rental Value (FRV)

- Each April, FRV variable are adjusted
  - Cost per square foot
  - Location factors
  - Items submitted on the FRV Capital Data Survey
  - Additional year of depreciation (maximum age of 32.5 years)
- It is possible to have a rate adjustment outside of the April timeframe
  - Replacement facility – new rate when certificate of occupancy is obtained
  - Beds and additional square footage added

FRV Threshold

- For items to be considered for FRV purposes, the total capitalized items must meet or exceed $500 per bed for the October – September reporting period. (100 bed facility must have at least $50,000)
- Anything less than this will not be counted!
- Not based solely on what the provider has spent. But there is an exception for grants from the state.

Depreciation Recapture

Question: I got rid of an asset, what do I have to do for FRV?

Answer: Nothing, unless you sold it to another Medicaid participating provider. If this is the case, you remove an amount equal to whatever you received from the other provider.

If you receive a check from insurance for damage, do not reduce the amount claimed on the Capital Data Survey!

PDPM

PDPM will create some large operational challenges for providers already taxed with an aging population, the growing staff shortage and burdensome regulations that can create an onerous system for delivering quality patient care. The biggest change is that providers can no longer rely on predictable Medicare reimbursement for therapy minutes provided, as they do currently. Instead, payment will be contingent on a predetermined amount based on a single patient assessment of patient progress and successful outcomes. This creates the need for a thoughtful, results-oriented, approach to providing patient focused care.

PDPM

- Patient Driven Panic Mode
- Panic Driven Payment Model
- Pretty Darn Preposterous Model
- Partly Desirable, Partly Menacing
- Please Do Pay Me
- Philosophically Darn Poor Move
- Pretty Dumb Payment Model

PDPM

- Patient Driven Payment Model (PDPM) will replace the current RUG-IV Medicare Part A SNF FFS system on October 1, 2019.
- PDPM Training
  - March 26, AHCA PDPM Academy training in Greensboro
    - Pre-requisite PDPM webinars
    - Full day of training
    - Propriety PDPM tools
    - Monthly 90 minute PDPM webinars
  - Upcoming AHCA On-Line PDPM Academy
  - NCHCFA Summer Symposium, August 7-9, 2019
- AHCA ICD-10 Training for PDPM
  - For coders
  - For non-coders

PDPM

- Shifts away from therapy minutes as primary driver of rates. PDPM is based on resident characteristics.
- Still uses a per diem payment
- PDPM rate is the sum of 6 rate components
  - Case mix adjusted
    - PT (with rate adjustment starting day 21, 2% drop every 7 days)
    - OT (with rate adjustment starting day 21, 2% drop every 7 days)
    - SLP
    - Nursing
    - Non-therapy ancillaries (with rate adjustment starting day 4, 2/3 reduction)
  - Non-case mix adjusted

PDPM

- Current Rehab RUGs determined by 20 MDS items
- PDPM component rates set using 5 day assessment using 188 MDS items
  - PT (37)
  - OT (37)
  - SLP (66)
  - Nursing (132)
  - NTAS (34)

PDPM Assessments

- RUG-IV
  - Day 5
  - Day 14
  - Day 30
  - Day 60
  - Day 90
  - PPS Discharge MDS
- PDPM
  - Day 5
  - Interim Payment Assessment (IPA) (optional)
  - Discharge MDS

PDPM Interrupted Stay Policy

- Resident discharged from a SNF and readmitted 4 or more days later, or is immediately transferred to another SNF
  - This is considered a new stay requiring a new 5 day assessment.
- Resident discharged from a SNF and readmitted to the same SNF 3 or fewer days later
  - This is considered a continuation of the previous stay.
  - Payment schedule continues on original admission assessment.
  - Per diem payments continue from the point prior to discharge. (last day was day 14, first day back is day 15)
  - An optional IPA assessment could be completed, but this does not reset payments to day 1.

PDPM Therapy Minutes

- Payment determination moves away from therapy minutes, but the therapy minutes need to be tracked and reported on the discharge MDS.
- The following items will be reported by discipline:
  - Start and end dates
  - Total treatment days during entire stay
  - Total individual therapy minutes
  - Total concurrent therapy minutes
  - Total group therapy minutes
- There is a 25% limit on the total amount of concurrent and group therapy permitted per stay, within each discipline.
  - If this limit is exceeded, CMS will issue a warning on the validation report. If abused, providers may be flagged for audit.

PDPM Rate Component Drivers

- PT and OT – Primary reason or SNF care
  - ICD-10-CM Code
  - Type of Inpatient Surgery
  - Function (4 functional score ranges)
    - 11 MDS Section GG items
    - Must be assessed days 1-3 (before treatment started)
- SLP – Primary reason for SNF care
  - Presence of acute neurological condition ICD-10 code
  - SLP comorbidities
    - MDS checklist
    - ICD-10 codes
  - Cognitive Impairment
  - Mechanically altered diet
  - Swallowing Disorder

PDPM Rate Component Drivers

- Nursing
  - Extensive Services
  - Clinical Conditions
  - Adjustors
    - Depression
    - Restorative nursing (minimum of 6 days in 7 day lookback)
    - Function
      - 7 MDS Section GG items
      - Must be assessed days 1-3 (before treatment started)

PDPM Rate Component Drivers

- NTAS
  - High NTAS cost conditions
  - High NTAS cost extensive services

Preparing for PDPM

- This is a big change.
- Way too complicated to be completely addressed in this webinar.
- No such thing as too much information, as long it is from a reliable source.
- Challenges:
  - Transforming the way care is delivered: a different focus
  - Coding: ICD-10 and getting it right
  - New roles for staff: Will workflow and responsibilities change with PDPM?
- Transitional issue: Admissions prior to the end of September will be handled as they currently are, but will need a PDPM admission assessment the first week of October.

PDPM – the ripple effect

Other changes may take place, outside of Medicare, due to the implementation of PDPM.

- Medicare Advantage Plans that pay based on RUGs may need to find another way to pay. CMS does not specify how these plans must determine payments.
- NC Medicaid uses a case-mix system based on the MDS that is changing. As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all unscheduled PPS assessments will be retired. To fill this gap in assessments, CMS will introduce the Optional State Assessment (OSA), which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules. There is currently no definitive timeline for retiring the OSA. Once states are able to collect the data necessary to consider a transition to PDPM, CMS will evaluate the continued need for the OSA, in consultation with the states.

AHCA PDPM Resources

- https://www.ahcancal.org/facility_operations/medicare/Pages/PDPM-Resource-Center.aspx
- PDPM Academy
- https://educate.ahcancal.org/pdpm
  - CMS PDPM Reference Resources and Crosswalk Tables
  - **PDPM Frequently Asked Questions (FAQs) (revised 4-11-19)**
  - PDPM MDS Accuracy Toolkit – Resident Classification
  - PDPM Hospital Discharge Toolkit
  - PDPM Compliance Guide and Best Practice Model Policies Toolkit
  - PDPM Readiness Toolkit
  - PDPM ICD-10 Toolkit

Medicaid Managed Care

Pre-Paid Health Plan (PHP) Core Medicaid Operations

1. Managing Medicaid Managed Care beneficiary lives (including Member services and the administration of clinical benefits and services);
2. Provider network management;
3. Performing care management functions;
4. Processing and paying claims; and
5. Assuming risk through capitated contract.

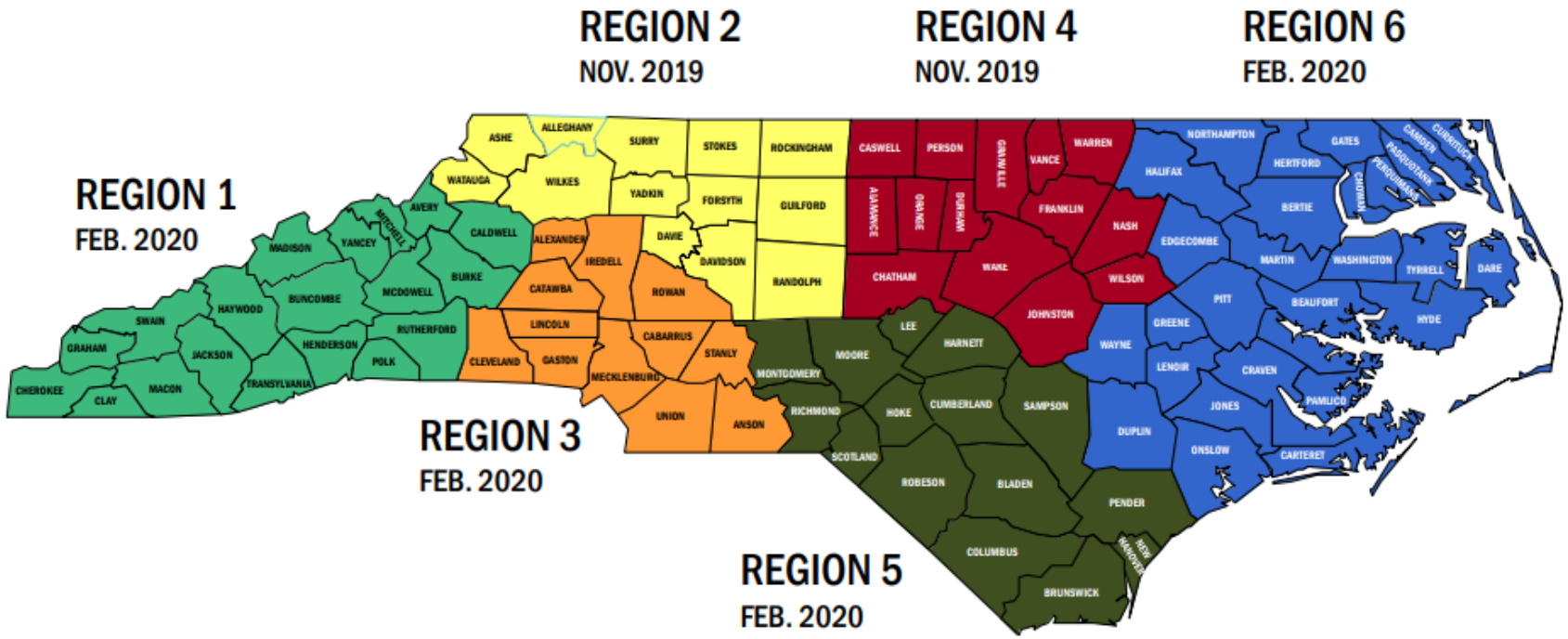
PHP Contracts

- Under the contracts, each PHP will receive a monthly payment for each enrolled beneficiary to assume the financial risk for the individual's care.
- Contracts are for standard plans; behavioral health tailored pans will be procured later.
- PHPs will be subject to rigorous oversight to ensure:
  - Strong networks
  - Full range of benefits
  - Accountability for quality and outcomes
  - Positive beneficiary experience
  - Timely payments to providers
  - Many other aspects of successful managed care program

PHPs Awarded Contracts

- Four state-wide PHP contracts
  - AmeriHealth Caritas North Carolina, Inc.
  - Blue Cross and Blue Shield of North Carolina, Inc.
  - UnitedHealthcare of North Carolina, Inc.
  - WellCare of North Carolina, Inc.
- One Regional Provider Led Entity (PLE)
  - Carolina Complete Health, Inc.
  - Will cover regions 3 and 5

Regions and Implementation Dates



Rollout Phase 1: Nov. 2019 – Regions 2 and 4
Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6

Medicaid Managed Care

Important points nursing home providers should keep in mind:

- For a period not the exceed 5 years
  - Dual eligibles are excluded
  - Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA.
- Until someone is approved for Medicaid and selects a prepaid health plan (PHP), they are covered under Medicaid fee for service
- Any willing provider provision
- Letters of intent and provider contracts
- The Division of Health Benefit (DHB) will be setting a rate floor for nursing facility Medicaid managed care rates, for a limited time.
  - Quarterly case-mix adjustments
  - Fair Rental Value
  - Alternative payment arrangements can apply if mutually agreed upon by the PHP and the provider.

Medicaid Managed Care

Important points nursing home providers should keep in mind:

- Each PHP will have their own claims processing system.
  - Regions 1, 2, 4 and 6: May need to bill 5 different entities for Medicaid.
  - Regions 3 and 5: May need to bill 6 different entities for Medicaid.
- The PHP will have up to 18 days after claim submission to tell providers whether the claim is clean, or pend the claim and request **all** information needed to timely process the claim.
- The PHP shall pay or deny a Clean Medical Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
- The PHP may require that facility claims be submitted within 180 calendar days after discharge from the facility.

Interest and penalties

- The PHP shall pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.
- In addition to the interest on late payments required by this Section, the PHP shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.
- The PHP shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).

Important Upcoming Dates

- Summer 2019. Each PHP has contracted with many care providers as it builds its network to meet Department standards.
- July 2019. Enrollment Broker must have its call center operational and relevant staff located in North Carolina.
- July-September 2019. Managed care will start in two phases. For regions in Phase 1, this will be the window in which beneficiaries select a PHP.
- September 2019. Beneficiaries who do not select a PHP will have one automatically assigned to them, based on the Department's auto-assignment algorithm.

Important Upcoming Dates

- September-October 2019. Beneficiaries will receive a welcome packet and identification care from their selected or assigned PHP. The PHP will receive transition of care information from the Department to support continuity of care and care management.
- November 2019. NC Medicaid Managed Care Phase 1 will launch. Beneficiaries in Regions 2 and 4 will begin to receive services through their PHPs.
- October-December 2019. For regions in Phase 2, this will be the window in which beneficiaries select a PHP.
- February 2020. NC Medicaid Managed Care Phase 2 will launch. Beneficiaries in the remaining four Regions will begin receiving services through their PHPs.

Provider Enrollment, Credentialing and Contracting

- Enrollment process similar to today
- Centralized credentialing and re-credentialing policies uniformly applied
- Currently enrolled Medicaid providers will not need to re-enroll, but may need to provide additional information/documentation.
- Each PHP must maintain an adequate network of providers.
- PHPs will review provider information and make “objective quality” determinations.
- Department-approved contracts: Mandated clauses and specific provisions
- PHPs must contract with any provider that meets the PHP quality standards and is willing to accept the PHP rate.
- A provider may choose to contract with as many PHPs as necessary.

Reimbursement Scenarios

- The rate floor and mandate rules apply to in-network services only for nursing facilities.
- Where the PHP has made a “good faith” effort to contract with a provider who has refused that contract or where the provider was excluded from the PHP network for failure to meet objective quality standards, PHPs are prohibited from reimbursing at more than 90% of the Medicaid FFS rate.
- Where the PHP has not made a “good faith” effort to contract with a provider who has refused that contract and where the provider was not excluded from the PHP network for failure to meet objective quality standards, in the absence of a negotiated agreement, PHPs are required to reimburse the provider at 100% of the Medicaid FFS amount.

Reimbursement Scenarios

Provider In-Network?	Rate Floor/Directed Payment for Provider Type?	Payment Amount
Yes	Yes	Directed payment or rate floor amount, unless alternative payment agreed to
Yes	No	Negotiated rate
No (Good faith/quality)	Yes	90% Medicaid FFS rate
No (Good faith/quality)	No	90% Medicaid FFS rate
No (Not good faith/quality)	Yes	In absence of a negotiated agreement, 100% Medicaid FFS[12]
No (Not good faith/quality)	No	In absence of a negotiated agreement, 100% Medicaid FFS[12]

NC Medicaid Transformation Website

www.ncdhhs.gov/medicaid-transformation

Thank you for joining us today!