Working with Medicare
Medicare and Medicaid Nursing Facility Benefits: The Basics and Opportunities for Integrated Care

April 30, 2015
1:00-2:00 PM Eastern Time
Welcome and Introductions

- Julie Stone
  - Senior Researcher, Mathematica Policy Research

- Jim Verdier
  - Senior Fellow, Mathematica Policy Research
Purpose and Goals of This Call

- Draw attention to the significant role nursing facilities (NFs) play in the continuum of services currently used by dually eligible beneficiaries
- Compare and contrast the Medicare and Medicaid NF benefits under fee-for-service (FFS)
- Describe the typical demographic profile of NF residents and highlight their often changing service needs and financial status during the time they engage with NFs
- Summarize Medicare’s and Medicaid’s NF reimbursement methodologies, elements of which are often used by health plans to determine contracted NF rates under capitation
- Identify opportunities for states to:
  - Engage their health plans in addressing NF quality
  - Leverage capitation to achieve more effective reimbursement incentives
  - Use policy levers and care models to reduce avoidable hospitalizations
Medicare and Medicaid Spending on Dually Eligible Beneficiaries
Dually Eligible Beneficiaries as a Share of Medicare and Medicaid Enrollment and Spending, CY 2010

**Medicaid**
- Total enrollment: 67.2 million
- Total spending: $340.5 billion

**Medicare**
- Total enrollment: 48.9 million
- Total spending: $498.9 billion

Note: Spending totals include full benefit and partial benefit dually eligible beneficiaries. Spending exclude spending on program administration. For Medicaid, spending also excludes payments by state Medicaid programs for Medicare premiums.

Source: MEDPAC –MACPAC Dual Eligible Data Book, January 2015, Exhibit 4
FFS Spending on Full Benefit Dually Eligible Individuals by Type of Service, CY 2010

**MEDICAID**
$112.6 billion

- Institutional LTSS, 50%
- HCBS Waiver, 23%
- HCBS State Plan, 9%
- Drugs, 1%
- Outpatient, 12%
- Inpatient, 2%
- Managed Care Capitation, 4%

**MEDICARE**
$134.7 billion

- Inpatient Hospital, 28%
- Other Outpatient, 30%
- Part D Drugs, 24%
- Skilled Nursing Facility, 10%
- Home Health, 5%
- Other Spending, 3%

Annual Average
- **MEDICARE** $17,343 Per User
- **MEDICAID** $41,414 Per User

Source: MEDPAC –MACPAC Dual Eligible Data Book, January 2015, Exhibits 14 and 15
Nursing Facility Benefits Under Both Programs
Medicare and Medicaid Coverage of Nursing Facility (NF) Care

Medicare Coverage: Skilled Nursing Facilities (SNFs)
• Short-term skilled nursing care and rehabilitation services
• Up to 100 days of SNF care per spell of illness
• Ordered by a physician
• Skilled nursing, rehabilitation, medical social services, drugs/biologicals, durable medical equipment, and bed and board

Medicaid Coverage: Nursing Facilities (NFs)
• Long-term custodial care
• Safety net for persons who cannot afford the cost of NF care
• Mandatory service for ages 21+/optional for under age 21
• Room and board, skilled nursing care and related services, rehabilitation, and health-related care
• Optional state coverage of therapies, such as physical therapy, occupational therapy, and speech pathology and audiology services
# Medicare and Medicaid NF Eligibility in FFS

<table>
<thead>
<tr>
<th>Medicare SNFs</th>
<th>Medicaid NFs</th>
</tr>
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<tbody>
<tr>
<td><strong>Program Eligibility</strong></td>
<td><strong>Benefit Eligibility</strong></td>
</tr>
<tr>
<td>• 65+ and paid Medicare payroll taxes ≥ 10 yrs</td>
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<tr>
<td>• &lt; 65 who receive SSDI for at least 24 months (wait period waved for ALS)</td>
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<td>• ESRD receiving dialysis regularly or a kidney transplant</td>
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<tr>
<td><strong>Benefit Eligibility</strong></td>
<td>• Financial eligibility (income and assets)</td>
</tr>
<tr>
<td>• Must be preceded by a 3+ day consecutive hospital stay</td>
<td>• Categorical or medically needy eligibility</td>
</tr>
<tr>
<td>• Require skilled nursing or skilled rehab daily (e.g., physical therapy following stroke, wound treatment following surgery)</td>
<td>• Variation across groups and states</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td><strong>Benefit Eligibility</strong></td>
</tr>
<tr>
<td>• Level of care criteria:</td>
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</tr>
<tr>
<td>• Functional limitations in (ADLs/IADLs)</td>
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</tr>
<tr>
<td>• Cognitive capacity</td>
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</tr>
<tr>
<td>• Need for supervision</td>
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</table>
## Beneficiary Responsibility for NF Costs

### Medicare Cost-Sharing for SNF
- Days 1-20: $0
- Days 21-100: $157.50 per day (2015)

### Medicaid Beneficiary Responsibility for NF
- All income (minus personal needs allowance) applied to the cost of care
- Special rules apply to community spouses

### Who Pays These Costs for Dually Eligible Beneficiaries?
- Medicaid pays Medicare cost-sharing for most dually eligible beneficiaries
- Other payers might include retiree insurance or out-of-pocket

- Beneficiaries’ income may come from a variety of sources such as Supplemental Security Income (SSI), Social Security, pensions, Social Security Disability Insurance (SSDI)
Characteristics of NF Residents and Facilities
Characteristics of All Residents in Medicare & Medicaid Certified Facilities (2012)

Demographics
- 85% ≥ age 65, 15% < age 65
- Almost 70% are women
- Almost 80% are white

Impairments
- 20% - no limitation in ADLs
- 62% - 4-5 ADLs

Cognitive impairment
- 38% severe
- 26% moderate
- 36% mild

Note: Data describe all residents, regardless of payer or program participation.
# Common Scenarios for Entry into Medicare SNF and Medicaid NF

<table>
<thead>
<tr>
<th>Doorways into Medicare SNF Stay</th>
<th>Doorways into Medicaid NF Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience an acute episode that results in an ED visit, followed by a hospital stay of ≥ 3 days.</td>
<td>• Prior to NF stay, individual may be receiving home and community-based services at home or in assisted living. Becomes increasingly frail and in need of higher level of care. Admitted to NF.</td>
</tr>
<tr>
<td>• Experience ≥ 3 day hospital stay, transferred to community or other post-acute setting, transferred to SNF within 30 days.</td>
<td>• Transferred from Medicare SNF stay to extended stay as private pay. Deplete income and assets on care until qualify for Medicaid.</td>
</tr>
<tr>
<td></td>
<td>• Already dually enrolled and residing in NF. NF sends resident to hospital. Return for skilled care as Medicare SNF. Then back to NF.</td>
</tr>
</tbody>
</table>

**Notes:**

Approximately 25% of NF residents return to the hospital within 30 days of admission. Medicare acute care costs often spike prior to SNF entry.

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2. Newcomer, Robert, et.al. “Service Use and Expenditures Before and After Entry into California’s LTSS Programs,” CAMRI, University of California, April 2014.
Medicare & Medicaid Certified Nursing Facilities’ Statistics

• 14,330 nursing facilities (or 95%) participated in both Medicare and Medicaid (2012)
• Vast majority (81%) had between 50-199 beds (2012)
  • Combination of SNF and NF beds
• Profit Status (2012)
  • For profit: 69% of nursing facilities and 71% of beds
  • Non-profit: 25%; Government: 5%
• Of All Medicare-Certified Facilities (2013)
  • 95% - Free-standing facilities
    • Medicare SNF services plus custodial Medicaid NF services
    • Generally, SNF patients make up just a small portion of all residents
  • 5% - Hospital-based facilities
    • Dedicated SNF beds
    • Swing beds in some rural hospitals

Medicaid and Medicare Payment Basics
Medicaid’s NF Payment Approach

• Federal requirements regarding state payment to NFs must meet the following standards:
  ...assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area.” (§1902(a)(30)(A) of the Social Security Act)

• Required to implement public process for determining rates (states publish all proposed and final rates for comment)

• Significant variation among states
  • Prospective per diem rates
  • Adoption of case-mix acuity-based adjustment
  • Retrospective payments based on reported costs
  • Sometimes specified by state statute

# Medicare SNF Prospective Payment System

<table>
<thead>
<tr>
<th>Component</th>
<th>Medicare SNF Payments</th>
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<tbody>
<tr>
<td>SNF Payment Approach</td>
<td>Daily “per diem” urban and rural base amounts • Covers all services for a day, including room/board, nursing, therapy, and prescription drugs (excludes physician visits, dialysis and certain prosthetics and orthotics)</td>
</tr>
<tr>
<td>Payment Adjustments to Base Per Diem</td>
<td>Case-mix varies by treatment and care needs • 66 Resource Utilization Groups (RUGs) • Minimum Data Set (MDS) • Area wage variation (i.e., hospital wage index)</td>
</tr>
<tr>
<td>Annual Updates to Per Diem</td>
<td>SNF Market Basket • National average costs of good and services purchased by SNFs • Offset by productivity adjustment (started 2012)</td>
</tr>
<tr>
<td>AIDS</td>
<td>Per diem payment increased by 128% for a SNF resident with AIDS</td>
</tr>
</tbody>
</table>

Example of Medicare SNF Prospective Payment System

Urban Base Rate \times \text{Adjusted by RUG for Nursing & Therapy} = \text{Case Mix Adjusted Rate} \times \text{Labor Portion Adjusted by Area Wages} = \text{Global Per Diem Rate}

FY 2015 Sample Rates for New York

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>One day for resident with high ADLs in a high RUG group</td>
<td>$710.07</td>
</tr>
<tr>
<td>Rural</td>
<td>One day for resident with low ADLs in a medium RUG group</td>
<td>$266.75</td>
</tr>
</tbody>
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Medicare SNF Payments: Recent Trends

• High and sustained Medicare margins
  • >10% for 14 consecutive years
  • In 2013, 500 facilities with relatively low-cost and high-quality care had margins of 20%

• Costs varied widely among facilities
  • Variation in costs based on ownership & upcoding
  • Variation not attributed to case mix

• Medicare Advantage pays considerably less than FFS (in some cases, 22% less)
  • May be due to lower payment rates and/or stricter rules than FFS for SNF admissions, lengths of stay, therapies, etc.

State and Health Plan Options to Address SNF and NF Coordination, Payment, and Quality Issues
Care Coordination and Quality

Health plans can:

• Improve transitions between hospitals and nursing facilities
  • May include waiving the SNF three-day hospital stay requirement
  • Should include providing information on hospital Rx drug use, diagnoses, and care needs to nursing facilities and primary care physicians

• Reduce the need for inpatient hospitalization for NF residents by:
  • Paying nursing facilities extra for “in place” treatment when appropriate instead of hospitalization
  • Funding nurse practitioners and pharmacists to assist with appropriate treatment in nursing facilities

• Increase use of Medicaid community-based LTSS
  • States can build incentives for use of community-based LTSS into health plan capitated rates
    • See January 2013 ICRC webinar for details: http://www.chcs.org/media/Study_Hall_Call_-_MLTSS_Ratesetting2.pdf
Payment

• Health plans are not limited by Medicare and Medicaid FFS reimbursement rules, although they usually build on them in negotiating rates with nursing facilities. Health plans can:
  • Waive SNF three-day hospital stay requirement to increase access to SNF services
  • Determine need for skilled care reimbursement without being constrained by SNF 100-day limit
  • Pay NFs more for high-need residents and less for lower-need residents
    • Can include extra short-term payment for services needed to avoid unnecessary hospitalizations
    • Can reduce payment “cliffs” when residents shift between Medicare and Medicaid benefits
  • Make performance-based incentive payments to nursing facilities
  • Limit payment to NFs for “bed-hold days” if hospitalization is not needed
  • Pay nursing facilities directly for Medicare beneficiary cost sharing for dually eligible beneficiaries in SNFs, without the need for “crossover claim” submissions
    • Can reduce SNF “bad debt” for unpaid beneficiary cost sharing
NF Quality and Performance Measurement

• Measuring Quality
  • SNF and NF participation requirements/certification (Social Security Act)
  • NF inspections – unannounced and complaint surveys (Online Survey Certification & Reporting System, OSCAR)

• CMS Nursing Home Compare, includes Star Ratings
  • Quality measures
  • Deficiencies from survey results
  • Self-reported staffing levels

• New CMS SNF Value-Based Purchasing and Quality Reporting Programs
  • Developing measures for rehospitalizations, pressure ulcers, major falls, and functional assessments/care plans
    • Details are in April 20, 2015 Federal Register at: https://www.federalregister.gov/articles/2015/04/20/2015-08944/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

• States could consider corresponding measures for Medicaid NFs

Sources: Nursing Home Compare, see http://www.medicare.gov/nursinghomecompare/search.html, Access to data at https://data.medicare.gov/data/nursing-home-compare
ProPublica, ProPublica Nursing Home Inspect
Notices of Medicare Non-Coverage

- CMS requires SNFs to give Medicare-paid residents notice that their Medicare SNF coverage is ending at least two days before termination of services
- Potentially confusing for dually eligible residents who are shifting to Medicaid NF coverage
- States can add language to the end of the notice (under “Optional: Additional information”) clarifying that Medicaid coverage may be available
  - MN language: “Although Medicare-covered skilled nursing facility services are no longer available when your coverage ends, please note that if you have a need, nursing facility services are still covered by [name of health plan] or by the Minnesota Department of Human Services.”
Reducing Avoidable Hospitalizations for Dually Eligible Individuals in Nursing Facilities
New ICRC TA Brief

  - Illustrates what states and health plans, working together, can do to address a long-standing problem for Medicare-Medicaid enrollees
  - ICRC is planning a webinar in June that will focus on this issue
State Options to Reduce Avoidable Hospitalizations: Capitated Managed Care

- Include performance measures in health plan contracts
  - Plan all-cause readmissions within 30 days
  - Percent of plan members using high-risk medications
  - Nursing facility urinary tract infection hospital admission rate
  - Emergency department utilization rate

- Focus health plan performance and quality improvement projects
  - Work with state External Quality Review Organization and Medicare Quality Improvement Organization to coordinate performance and quality improvement projects

- Encourage and facilitate specific health plan efforts
  - Waiving requirement for three-day hospital stay to qualify for SNF-level reimbursement
  - Making greater use of nurse practitioners in nursing facilities
  - Encouraging more appropriate prescription drug use
  - Contracting with selected nursing facilities
State Options to Reduce Avoidable Hospitalizations: Medicaid Fee-for-Service

• Modify bed-hold policies
  • Pays nursing facilities to reserve beds of hospitalized residents
  • In early 2014, 33 states and DC had a bed-hold policy for Medicaid beneficiaries (MACPAC, 2014)
  • Eliminating bed-hold policies or making them less generous is likely to reduce hospitalizations and readmissions (Cai et al., 2010; Grabowski et al., 2010; Intrator et al., 2007; Unruh et al. 2013)

• Use case mix reimbursement system
  • Reimbursement system that pays Medicaid nursing facilities higher amounts per day for residents with higher needs
  • In early 2014, 39 states and DC had some form of acuity-base case mix reimbursement system (MACPAC, 2014)
  • Can make it more financially feasible for facilities to treat higher-acuity residents rather than hospitalizing them
Links to Main Sources Cited


- Nursing Home Compare: http://www.medicare.gov/nursinghomecompare/search.html
Additional Resources

• CMS Medicare-Medicaid Coordination Office
  • http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html

• Integrated Care Resource Center
  • Contains resources, including briefs and practical tools to help address implementation, design, and policy challenges
  • http://www.integratedcareresourcecenter.com
About ICRC

• Established by CMS to advance integrated care models for dually eligible beneficiaries

• ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies

• Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges

• Send additional questions to: integratedcareresourcecenter@chcs.org
Questions and Answers
Next Steps

• MMCO/ICRC goal is to help states improve integration of services for dually eligible beneficiaries

• Tell us what Medicare issues you would like more information on

• Send additional questions to: ICRC@chcs.org