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Missouri Medicaid Update

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Meet the Presenter

Sherri Robbins, RN, BSN, CLNC®, RAC-CTA®, LNHA

Senior Managing Consultant, FORVIS

Sherri.Robbins@Forvis.com

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Components of Medicaid Per Diem Prospective Rate

- Basic Cost Components
  - **Patient Care** (Ceiling of 120% of Median)
  - **Ancillary** (Ceiling of 120% of Median)
  - **Administration** (Ceiling of 110% of Median)
  - **Capital** (Fair Rental Value (FRV))
- Working Capital Allowance
- Incentives
  - Patient Care Incentive
  - Ancillary
  - Multiple Component
- NFRA Add-On

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Clinical Considerations

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RUG IV – 48 Grouper

- 48 RUG categories each with a specific case mix index
- Based on capture of information on each completed MDS assessment
- ADL Score impacts every one of the 48 categories and the categories with low ADL scores (0-1) have a significantly lower case-mix index

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Index Maximizing Model

- This will result in the MDS calculating the RUG Category with the highest case mix index.
- Example: Patient receiving 5 days of therapy (PT, OT, or SLP) with 150 minutes of treatment in the look-back period with an ADL score of 10 would qualify for the RAC RUG category with a 1.36 case mix index. The patient is also a diabetic with daily insulin injections and 2 or more days of insulin order changes in the look-back period with an ADL score of 10 and a PHQ-9 score of 11 and this would qualify for the HC2 RUG category with a 1.57 case mix index.
- This MDS would ultimately calculate HC2 due to the higher case mix index under the index maximizing model.

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Snapshots to determine CMI

- July 1, 2022: used snapshots of January 1, 2022 and April 1, 2022 – The CMI will be an average of the two quarters
- January 1, 2023: used snapshots of July 1, 2022 and October 1, 2022 – The CMI will be an average of the two quarters

Providers will receive a new case mix index on July 1 and January 1 moving forward

CMI reports will be available quarterly through a secure site but the final logistics have not yet been determined. Myers & Stauffer portal sign up instructions were provided late in 2022

CMI report correction period will be 30 days from issue of the CMI reports (resident listings).

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Clinical Considerations

- MDS assessments will provide a case mix index for Medicaid reimbursement based on information coded on each assessment:
  - Admission Assessments
  - Quarterly Assessments
  - Significant Change in Condition Assessments
  - Annual Assessments
  - Combined assessments (OBRA & PPS) will be included if they are the most current non-discharge assessment in the reporting period.
  - All MDS assessments completed will be used to determine the facility overall case mix used to establish the patient care limit. Assessments for Medicaid residents will determine the Medicaid Case Mix.

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Seven Major Classifications

- Extensive Services = E
- Rehabilitation = R
- Special Care High = H
- Special Care Low = L
- Clinically Complex = C
- Behavioral Symptoms and Cognitive Performance = B
- Reduced Physical Function = P

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Activity of Daily Living (ADL) score

- The ADL score is a component of the calculation for the placement in **all** RUG-IV groups. The ADL score is calculated from Section G of the MDS
- Based on the 4 late loss ADLs:
  - Bed mobility
  - Transfers
  - Eating
  - Toileting
- Indicates the level of functional assistance and support required by the resident and is a vital component of the classification process

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ADL Score and RUG Category:

- The second character of the RUG category for Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Reduced Physical Function are determined by the patients ADL score:

  “E” = 15-16

  “D” = 11-14

  “C” = 6-10

  “B” = 2-5

  “A” = 0-1

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Additional ADL Score Information

- To calculate into extensive services the ADL score must be at least 2
- The third character of the Rehabilitation categories indicates the ADL score range:
- “E” = 15-16
- “D” = 11-14
- “C” = 6-10
- “B” = 2-5
- “A” = 0-1

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Extensive Services

ADL Score	Qualifying Criteria for Extensive Services		Services Count	RUG Category	CM1
2-16	• Tracheostomy • Ventilator or Respirator • Infectious Isolation	Extensive Services	Tracheostomy **and** Ventilator/Respirator	ES3	3.00
			Tracheostomy **or** Ventilator/Respirator	ES2	2.23
			Infectious Isolation only	ES1	2.22

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Rehabilitation

Qualifying Criteria for Rehabilitation		ADL Score	RUG Category	CM1
PT/OT/SLP 150+ minutes, 5 distinct calendar days **OR** PT/OT/SLP 45+ minutes, 3 distinct calendar days **AND** 6 days of restorative nursing, 2 programs for at least 15 minutes each per day		15-16	RAE	1.65
		11-14	RAD	1.58
		6-10	RAC	1.36
		2-5	RAB	1.10
		0-1	RAA	0.82

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Special Care High

Qualifying Criteria for Special Care High		ADL Score	Depression Severity >10	RUG Category	CM1
Received one of the following with an ADL score of at least 2; • Comatose and completely ADL dependent or ADL did not occur • Septicemia • Diabetes with **both** insulin injections all 7 days and 2 or more insulin order changes • Quadriplegia with ADL score>5 • COPD and SOB when lying flat • Parenteral /IV feedings • Respiratory therapy for all 7 days • Fever and one of the following: Pneumonia, Vomiting, Weight loss, or Feeding Tube*	Special Care High	15-16	Yes	HE2	1.88
		15-16	No	HE1	1.47
		11-14	Yes	HD2	1.69
		11-14	No	HD1	1.33
		6-10	Yes	HC2	1.57
		6-10	No	HC1	1.23
		2-5	Yes	HB2	1.55
		2-5	No	HB1	1.22

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Special Care Low

Qualifying Criteria for Special Care Low		ADL Score	Depression Severity >10	RUG Category	CM1
Received one of the following with an ADL score of at least 2; • Cerebral palsy with ADL score >5 • Multiple Sclerosis with ADL score >5 • Parkinson's with ADL score >5 • Respiratory failure **and** oxygen therapy while a resident • Feeding Tube* • Two or more stage 2 pressure ulcers with 2 or more selected skin tx • Any stage 3 or 4 pressure ulcers with 2 or more selected skin tx • Two or more venous/arterial ulcers with 2 or more selected skin tx • 1 stage 2 and 1 venous/arterial ulcer with 2 or more selected skin tx • Foot infection, diabetic foot ulcer or other open lesion of the foot • Radiation treatment while a resident • Dialysis treatment while a resident	Special Care Low	15-16	Yes	LE2	1.61
		15-16	No	LE1	1.26
		11-14	Yes	LD2	1.54
		11-14	No	LD1	1.21
		6-10	Yes	LC2	1.30
		6-10	No	LC1	1.02
		2-5	Yes	LB2	1.21
		2-5	No	LB1	0.95

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Clinically Complex

Qualifying Criteria for Clinically Complex		ADL Score	Depression Severity >10	RUG Category	CM1
Received one of the following:	Clinically Complex	15-16	Yes	CE2	1.39
• Pneumonia		15-16	No	CE1	1.25
• Hemiplegia/hemiparesis with ADL score >5		11-14	Yes	CD2	1.29
• Surgical Wounds or open lesions with any selected skin tx;		11-14	No	CD1	1.15
Surgical wound care		6-10	Yes	CC2	1.08
Application of dressing or ointment (not to feet)		6-10	No	CC1	0.96
• Burns		2-5	Yes	CB2	0.95
• Chemotherapy while a resident		2-5	No	CB1	0.85
• Oxygen therapy while a resident		0-1	Yes	CA2	0.73
• IV medications while a resident		0-1	No	CA1	0.65
• Transfusions while a resident					
NOTE: Resident with ADL score of 0-1 and meeting criteria for Extensive Services, Special Care High and Low will qualifying in Clinically Complex RUG group.					

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Behavioral Symptoms & Cognitive Performance

Qualifying Criteria For Behavioral Symptoms and Cognitive Performance		ADL Score	Restorative Nursing Services	RUG Category	CM1
• BIMS summary score of 9 or less • One of the following exists; Coma and completely ADL dependent or ADL did not occur Severely impaired cognitive skills (C1000 = 3) Two or more or the following are present: Problem being understood (B0700 > 0) Short-term memory problem (C0700 = 1) Cognitive skills problem (C1000 > 0) **AND** one or more of the following are present: Severe problem being understood (B0700 >=2) Severe cognitive skills problem (C1000>=2) • Hallucinations • Delusions • Physical/verbal behaviors directed toward others (2 or 3) • Other behaviors not directed toward others (2 or 3) • Rejection of care (2 or 3) • Wandering (2 or 3)	Behavioral Symptoms and Cognitive Performance	2-5	2 or more	BB2	0.81
		2-5	0 or 1	BB1	0.75
		0-1	2 or more	BA2	0.58
		0-1	0 or 1	BA1	0.53
NOTE: Resident with ADL score greater than 5 and meeting Behavioral Symptom and Cognitive Performance criteria will qualify in Reduced Physical Function group					

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Reduced Physical Function

Qualifying Criteria for Reduced Physical Function		ADL Score	Restorative Nursing Services	RUG Category	CM1
Residents who do not meet any previous RUG groups OR meet criteria for		15-16	2 or more	PE2	1.25
Behavioral Symptoms and Cognitive Performance but have an ADL score		15-16	0 or 1	PE1	1.17
greater than 5.		11-14	2 or more	PD2	1.15
Restorative Nursing Services;		11-14	0 or 1	PD1	1.06
o Urinary and/or Bowel toileting program		6-10	2 or more	PC2	0.91
o Passive and/or active ROM		6-10	0 or 1	PC1	0.85
o Splint or brace assitance		2-5	2 or more	PB2	0.70
o Bed mobility and/or walking training		2-5	0 or 1	PB1	0.65
o Dressing and/or grooming training					
o Transfer training		0-1	2 or more	PA2	0.49
o Eating and/or swallowing training					
o Amputation/prostheses care		0-1	0 or 1	PA1	0.45
o Communication training					

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Common Errors and Opportunities

- Shortness of breath lying flat (COPD)
- Respiratory Therapy
- Parenteral/IV Feeding
- Pressure Ulcer/Injuries and Skin Conditions
- Restorative Nursing Programs
- Depression
- Diagnosis information
- Fever
- Therapy

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Processes to Implement or Refine:

- ADL Scoring: Section G of late loss ADLs
- Baseline temperatures
- Skin and wound monitoring
- Restorative Nursing program
- Capturing appropriate diagnosis information
- Respiratory therapy services

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Other Thoughts

- ARD Management
- Supportive documentation in medical record for all information captured on each MDS with the exception of patient interviews
- Clinical services provided
- Clinical changes among other qualifiers
  - Is an extra Significant Change warranted? Does an additional quarterly assessment need to be completed?
- Documentation
  - At least daily documentation prior to the ARD for admission, quarterly, significant change and annual MDS assessments

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Value Based Purchasing Incentive

Missouri Medicaid Case Mix Payment Model

Value Based Purchasing Incentive

A facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets, up to a maximum per diem adjustment of seven dollars ($7.00). The threshold for each QM is based on national cut-points used by CMS in the Five Star Rating System. Each threshold is the minimum value needed in order to earn the maximum points for that QM. These thresholds are listed in table A3 of the Five-Star Quality Rating System: Technical User's Guide dated January 2017.

We have included the Quality Measure, the threshold and per diem adjustments on the next slide.

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Missouri Medicaid VBP Incentive

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	10.0%	$1.00
Decline in Mobility on Unit	8.0%	$1.00
High-Risk Residents w/ Pressure Ulcers	2.7%	$1.00
Anti-psychotic Medications	6.8%	$1.00
Falls w/ Major Injury	1.3%	$1.00
In-dwelling Catheter	1.1%	$1.00
Urinary Tract Infection	1.9%	$1.00

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Missouri VBP Incentive

- A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for the VBP incentive. The VBP percentage will be determined by the total QM score calculated from the Five Star Rating System scores for each of the long-stay QMs. This scoring is also listed in Table A3 of the Five Star Quality Rating System: Technical User's Guide dated January 2017.

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%0

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VBP Incentive updates

- Semi-annual updates:
- The VBP will be re-calculated effective for dates of service beginning January 1 and July 1 of each year.
- The QM performance data will be updated based on the most current data available as of November 15th for the January 1 rate adjustment as of May 15th for the July 1 rate adjustment

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MDS Assessment and Quality Measures

- Decline in Late Loss ADLs – Section G
- Decline in mobility on the unit – Section G
- High risk residents with pressure ulcers- Sections B, G, I and M
- Antipsychotic medications – Section N
- Falls with major injury- Section J
- In-dwelling catheter – Sections H and I
- Urinary tract infection – Section I

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MDS Assessments and Quality Measures

- It is important to understand what items on the MDS are impacting the quality measures.
  - Increased education and more accurate coding of late loss ADL assistance provided to patients will most likely result in higher percentages for increased assistance with ADLs
  - An early quarterly assessment when a UTI is resolved and it is past the 30-day reporting requirement
  - Understanding that coding G0110E1 (locomotion on the unit, how the resident moves between locations in his/her room and adjacent corridor on the same floor. If in a WC, self-sufficiency once in chair) as an increase of one or more points for self-performance since the prior assessment impacts the decline in mobility on the unit.

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Mental Illness Diagnosis Add-On

- If at least 40% of a facility's Medicaid population have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00)
  - Schizophrenia: MDS item I6000
  - Bi-polar: MDS item I5900

  Each facility's mental illness diagnosis data will be re-evaluated semi-annually using data available as of November 15th for the January 1 rate adjustment and as of May 15th for the July 1 rate adjustment. No information if this is going to come from I5900 and I6000 or if there will be additional documentation requirements.

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Frequently Asked Questions:

- If the Medicaid number populated in A0700 of the MDS is going to drive inclusion in the Medicaid CMI, how does that work for Medicaid pending residents?
  - The following process will be used to determine the payer source from the MDS data. If A0310b (PPS reason for assessment) equals 01 the resident's payer source is considered Medicare. If A0310b equals 99 and A0700 (Medicaid Number) equals a valid number or + for pending the resident's payer source is considered Medicaid. If neither of these conditions are met the resident's payer source is considered Other.
  - Pending Medicaid residents should be captured if the "+" for pending is included in the MDS response. Providers will have the opportunity to review the payer source assigned to each resident and reclassify residents they believe have been classified incorrectly.
  - Residents will be included as Medicaid if Medicaid was a payer source during any point in the quarter.

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Frequently Asked Questions:

- Will Medicaid Hospice residents be included in the Medicaid CMI?
  - Yes, Medicaid Hospice residents are included in the Medicaid CMI.
- Will the overall CMI be recalculated each snapshot date along with the Medicaid CMI?
  - Original answer: Yes, overall averages will be calculated with each snapshot date but will only be used to establish the average acuity for base cost report periods. Only the Medicaid CMI will be used to adjust rates. Based on information received late 2022 it does not appear that the overall CMI is being updated, stay tuned.
- If the snapshot date is April 1st is the actual cut off for including assessments March 31st?
  - The ARD will be used as the cut off date and would need to be March 31st or prior.

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Frequently Asked Questions:

- What are the plans for providing resident roster information to Missouri providers? Will there be a correction period and how long will providers have to correct information.
  - Providers will receive a resident listings to review assessment dates, RUG classifications, CMI values, and payer source assignments. Providers will have a 30-day window to review the listings and submit payer source updates. They will also be able to report other concerns about the listings such as assessments they believe are not current or classifications they feel are incorrect. The state will review these other issues to ensure data was pulled correctly but providers will need to work through the CMS system to correct errors in MDS data.

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Frequently Asked Questions:

- What is the normal turn around time for the newly calculated CMI to impact payment?
  - States that use a semi-annual case mix adjustment process can expect an approximately 6-month offset between when changes in CMI impact the Medicaid rate.

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Frequently Asked Questions:

- Will there be an additional MDS assessment required when a Medicare stay ends other than the End of PPS assessment?
  - No, providers will not be required to complete any other type of OBRA assessment once a Medicare stay ends.

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Questions?

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