

Testimony
Department of Human Services
Long-Term Care Committee
Representative Gary Kreidt, Chairman
March 10, 2010

Chairman Kreidt, members of the Long-Term Care Committee, I am Barbara Fischer, Assistant Director, Budget and Operations of the Medical Services Division for the Department of Human Services. I am here today to provide an overview of the nursing facility payment system, the resident classification process and the implementation of MDS 3.0, and the private pay appeals process.

Legislation was passed in 1987 requiring two aspects of the Medicaid payment system for nursing facility services be implemented on January 1, 1990. The first was that rates for services were to be determined based on resident needs and conditions (case-mix) and the second was that the rates established for the Medicaid population would also be applicable to all residents of a nursing facility regardless of funding source (rate equalization). This payment system is commonly referred to case-mix rate equalization.

When case-mix was implemented in 1990 the source document used to determine a resident's classification was an assessment instrument specific to North Dakota that was designed by a task force. In 1996 the Centers for Medicare and Medicaid (CMS) developed and implemented a Resident Assessment Instrument (RAI) which provided clinical data on all residents of nursing facilities and was mandated for use by all nursing facilities nationwide in the late 90s.

Within the RAI there is a data subset referred to as the Minimum Data Set (MDS) which is used to establish a resident's case-mix classification. The MDS data is used by Medicare to establish a Medicare payment rate when an individual is in a Medicare benefit period and by the Department, since 1/1/2000, to establish a classification used to determine the per day payment rate for all individuals residing in a nursing facility who are not in a Medicare benefit period.

Case-mix Payment System

The North Dakota payment system has 34 classifications that are based on the MDS data. Each nursing facility has facility specific rates associated with the 34 classifications. Desk rates are established annually effective January 1 based on each facility's allowable historical costs subject to limitations. These rates are subject to audit and may change based on the audit. In addition, there are a handful of exceptions that can occur during a rate year that may affect the rates at different times in the rate year. The two most common of these changes is an increase due to construction or renovation and the increase that occurred July 1 for the salary enhancement for facility staff.

There are six categories or components to the rates established for the facility, Direct Care Rate, Other Direct Care Rate, Indirect Care Rate, Property Rate, Operating Margins, and Incentive. Only a facility's Direct Care Rate is case-mix adjusted. The remaining components of the rate are the same for all classifications. Rate limits are established for Direct Care, Other Direct Care, and Indirect Care and the facility receives the lesser of the established rate for the category or the rate limit.

Residents are assessed within 14 days of admission to the facility or upon reentry from a hospital stay and are then assessed every 3 months. A resident's classification can change only during these scheduled assessment periods. The MDS identifies a resident's medical conditions and treatments, need for assistance with Activities of Daily Living (ADLs), behavioral needs, and therapies provided during the assessment period and the data is then used to determine the applicable classification. Use of case-mix classification rates results in residents paying for the care they are receiving rather than having residents with fewer needs and less care requirements subsidize heavy care residents when the rates are the same for all residents.

Rate Equalization

The case-mix classification determined using the MDS is applicable to any resident in the facility, regardless of payment source, for funding of the resident's care. The rate payable for a given classification covers all nursing facility services required to be provided and is based on semiprivate accommodations. Residents may be charged separately for services and items that are not part of this daily rate. These additional charges are not subject to rate equalization and are not payable by the Medicaid program. These services and items may include charges for a private room, cable TV, transportation outside of the facility's medical community, telephones or long distance calls, requested brand name supplies or items, or other nonroutine services that are supplied at the resident's request or for personal comfort.

MDS 3.0

The primary purpose of the RAI and the MDS is to obtain clinical data on nursing facility residents with Medicare payment being secondary. Many states are also using the MDS data for Medicaid payment. CMS is replacing the MDS 2.0 with MDS 3.0 effective October 1, 2010 in response to providers, consumers, policy makers, and researchers concerns that the 2.0 is not clinically up-to-date, valid or relevant; there is a time burden without clear benefit; some items are difficult to respond to or unclear; residents are not directly answering questions; important problems such as pain and depression may be underdetected; and there is a need for improvements in care planning, identification of individuals who may want to transition back to the community, and payment items. The MDS 3.0 addresses these issues and CMS is mandating that the MDS 3.0 replace version 2.0 effective October 1, 2010. The changes to the assessment instrument are based on an extensive process that included feedback from providers, collaborative research between CMS and the Veterans Administration, technical expert review and actual data collection from eight states.

The dependence upon the MDS data for establishment of payment classifications results in the Department following suit to update to version 3.0 in order to continue to pay nursing facilities using the existing case-mix methodologies. Use of an alternative assessment tool to establish case-mix classifications would only result in increased paperwork by the providers.

Shortly after the Department began using MDS 2.0 for classification and payment purposes some modifications were made to the classification grouper logic, commonly known as RUG III, to address differences between services being provided in the nursing facility or in other locations for IV

medications and oxygen. There have been other data elements effecting payment that have raised issues over the years.

With the implementation of MDS 3.0, the Department will be adding two modifications to the RUG III. We are in the process of amending administrative rules to include intravenous feedings only when provided within the nursing facility and to recognize a distinct classification period for therapies when the initiation or discontinuation of therapies results in a change in a resident's classification as a result of consideration of the resident's therapy data within the RUG III process.

A resident's classification period will remain as a 3-month period; however, during that 3-month period, if a resident was classified in a rehab category and therapies are discontinued the resident's classification will be changed as of the date all therapies were discontinued to the classification that would otherwise have been in effect at the beginning of the classification period had there been no therapies. Likewise, if therapies are started during the 3-month classification period, a resident's classification may be changed as of the date of the start of therapies to reflect the provision of therapies.

Along with the MDS 3.0, a RUG IV has been developed by CMS. The Medicaid grouper supported by RUG IV has 48 classifications compared to the existing 34 classifications under RUG III. The RUG IV further refines the assignment of a classification based on a resident's needs and resource use within the facility thus providing a higher specificity of the costs associated with each resident. The Department will not begin using the RUG IV classifications until January 2012. This delay in implementing RUG IV is necessary in order to accumulate sufficient MDS 3.0 data to do a comparison between RUG III and RUG IV to provide a conversion factor for the direct

care rate component to allow for a budget neutral change from 34 to 48 classifications.

Private Pay Appeals

As Carol Olson indicated in her October 29, 2009, testimony, the responsibility for private pay appeals resides within the Department of Human Services; however, we do not believe we are the appropriate location for these appeals. While the Department is responsible for the oversight of the nursing facility rate-setting for both Medicaid clients and private pay individuals (because of rate equalization), we do not believe this should make the Department responsible for managing the private pay appeals.

In 2009 there were 146 classification appeal requests. Of those 146 requests only 1 was for a Medicaid recipient and the other 145 requests were from private pay individuals. Of the 146 requests, 87 classifications were upheld, 26 were modified with no change in their classification, 6 were denied because the appeal was not filed with the Department within 30 days of the classification notice, and 27 (18.4%) were modified with a change in their classification. In the first month of 2010 there were 13 nursing home private pay appeals completed. Of those requests, 9 classifications were upheld, 2 were modified with no change in their classification, and 2 (15.3%) were modified with a change in their classification.

A resident or the resident's representative may request an appeal for the review of any classification issued. Once an appeal request is received by staff, a request is made to the nursing home for supporting documentation related to the classification. Departmental staff reviews the documentation to determine if it supports the coding of the resident's assessment. If it is

determined that the classification is incorrect based on the documentation not supporting the proper coding of a data element, the classification is modified. Correspondence is sent to the resident or resident's representative who made the request indicating the decision on the review of the classification. The guidelines and criteria for coding each data element on the assessment are issued by CMS and the Department of Health is responsible for training on the completion of the RAI and for monitoring the completion as part of the survey and certification process for nursing facilities.

The function of private pay appeals does not "fit" within the administration of programs or services (such as Aging Services, Medical Services or Legal Services) within the Department. The private pay clients (and their families) appeal their classifications because they believe that the nursing facility did not administer the assessment correctly, or at an appropriate time. Also, there is generally an increase in private pay appeals that occurs during a quarter following a change in a facility's rates based on the cost report or as was the case on July 1, 2009, when an increase in the rates occurred because of the salary and benefit enhancements appropriated by the 2009 legislative assembly. The rates as established for a nursing facility are not appealable by an individual but appeals tend to increase when an existing classification's rate is increased.

As suggested by Carol Olson on October 29, 2009, there are two possibilities about how the private pay appeals may be managed: (1) the Office of Administrative Hearings or (2) a Peer Review process. There may be other viable options for the location of private pay appeals; however, the Department does not believe private pay appeals should continue to reside with our agency.

I would be happy to answer any questions you may have.