

Idaho Payment System

APRIL 26, 2024 BILL ULRICH




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Discussion Topics


- State of the State
- Review Idaho quality metrics and expected changes
- Review changes in Direct Care payment based on PDPM
- Review changes in the Medicare Upper Payment Limit [UPL] calculation
- Budget Adjustment Factor



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State of the State - Idaho

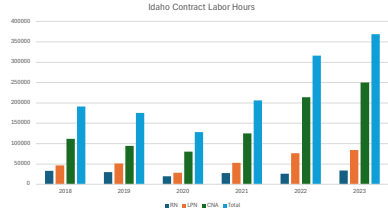


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Contract Nursing Staff Hours

Nursing homes forced to use contract labor due to labor shortage
Contract nursing staff hours are projected to be over 368,867 in 2023. An 79% increase over 2021



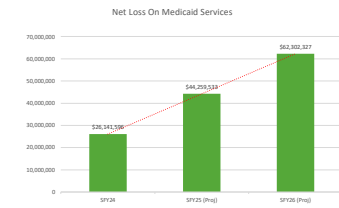
Source: CMS PBI



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Nursing Homes Lose Money on Medicaid Service

Medicaid losses are projected to increase to \$62.3 million in state fiscal year 2026 (July 1, 2025 to June 30, 2026)



Source: State of Idaho Rate Files



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Idaho Medicaid Rate System



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History of Idaho Medicaid Payment Systems

- July 1, 2000 – New prospective payment system implemented
- Acuity adjusted [RUG-III 34 Grouper]
- 3 cost centers [Direct, Indirect, FRV]
- Certain items passed through and paid at cost [Exempt]
- Inflation recognized
- Medicare carve-out for ancillary services only
- Separate ceilings for rural hospitals
- Special rates for certain services
- Quality metrics designed for UPL Payment Effective SFY 2017
- New Margin Cap System Implemented July 1, 2021
- Incorporates quality into payment system
- Rewards "efficiency"



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Margin Cap System

- The indirect and direct care components of the rate use the modified price system.
- Each of these components will allow for a maximum margin incentive, if operating costs are maintained below the set price.
- The direct care component margin incentive will vary, based upon the quality level of care provided
- The overall calculated rate is subject to a budget adjustment factor.



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Goals of the Margin Cap System

- Implementation date of July 1, 2021
- Account for resident needs
- Promote quality care
- Consider reasonable cost principles
- Maintain a system within state budget limitations
- The budget will be established on an annual basis and is subject to prospective legislative approval.
- Unfortunately, budget has not increased in 3 years despite massive increases in provider costs




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What is a Margin Cap

- A price is set for the desired cost component
- A margin cap is set as a percentage of the established price
 - The margin cap is used as the maximum amount of margin payment available
- The difference between the provider's actual cost and the price is determined.
- A provider is paid the lower of:
 - The price
 - Cost inflated to the rate year plus the maximum margin.

Example

- Direct Care Price is \$165
- Direct Care Cost is \$150
- Quality Tier = 1 [3%]
- Margin = \$15
- Margin Cap = \$4.95
- Provider Rate = \$154.95 [150+4.95]
- Rate is then adjusted for Medicaid acuity




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Margin Caps

- Established Indirect Margin Cap: 5%
 - This is the same for all provider types
- Established Direct Margin Cap is based on Quality Scores:
 - Tier1: 3%
 - Tier2: 2%
 - Tier3: 1%
- The quality tiers will be based upon the quality tiers calculated for the Quality Payment Program
- Margin caps will be the same for all provider types
- For the 7/1/24 rate period, quality will be based upon the tiers calculated using the calendar year 2022 data (used in the SFY 2023 Quality Payment)
 - Quality scores are updated annually




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Cost Basis

- Cost reports ended in fiscal year 2022 will be used to set rates effective on 7/1/24
- This will allow for all rates to be calculated as finalized rates
- Interim rates are no longer calculated
 - The July 1, 2023, is your final rate
- Cost Components
 - Indirect Care Costs
 - Direct Care Costs
 - Costs Exempt from Limitations
 - Property Costs
- These cost components have not changed




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Inflation

- Since older cost reports will be used to calculate finalized rates, inflation will be applied to the allowable costs
- This applies to Direct and Indirect care costs only
- Inflation will be calculated using the IHS Market Basket Nursing Facility without Capital table.
- Inflation will calculate from the mid-point of the cost report period to the mid-point of the rate year




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How are Price Levels Established?

- Prices for the indirect and direct care services will be established using the bed-weighted median rate
- Once the price is calculated, it will be adjusted as a percent of the median for each provider type.
- These percentages were set to result in a distribution of spending that matches the system before July 1, 2021.



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Medians July 1, 2023

- Indirect Price as a % of Median:
 - Free-Standing SNF BCUs: 103.865%
 - Rural Hospital-Based & Rural Hospital-Based BCUs: 124.101%
- Direct Price as a % of Median:
 - Free-Standing SNF: 108.15%
 - Free-Standing BCU: 136.59%
 - Rural Hospital-Based: 130.96%

Indirect Price	SFY 2024	SFY 2023	Change	% Change
Free-Standing NFs, Including BCUs	\$ 110.56	\$ 104.46	\$ 6.11	5.85%
Hospital Based NFs, Including BCUs	\$ 132.11	\$ 124.81	\$ 7.30	5.85%

Direct Price	SFY 2024	SFY 2023	Change	% Change
Free-Standing NFs	\$ 175.77	\$ 163.70	\$ 12.07	7.37%
Hospital Based NFs	\$ 212.84	\$ 198.23	\$ 14.61	7.37%
Free-Standing BCUs	\$ 221.99	\$ 206.75	\$ 15.24	7.37%



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RUG III – 34 Groups
Seven Major Categories

- Extensive Services
- Rehabilitation
 - ADL split
- Special Care
 - ADL split
- Clinically Complex
 - ADL and Depression splits
- Impaired Cognition
 - ADL and Restorative Nursing splits
- Behavior Problems
 - ADL and Restorative Nursing splits
- Reduced Physical Function
 - ADL and Restorative Nursing splits

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PDPM

- PDPM uses data elements that show clinical need and relies more on patient diagnosis and functional measures.
- Under PDPM there are five case mix adjusted categories where each category has a base payment rate along with a range case mix score.

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PDPM Component Summary					
Component	Nursing	NTA	PT	OT	ST
Patient Characteristics	1) Clinical Information from SNF Stay 2) Functional Status Section GG 3) Extensive Services Received 4) Presence of Depression 5) Restorative Nursing	1) Comorbidities 2) Extensive Services Received	1) Primary reason for SNF Care 2) Functional Status from section GG	1) Primary reason for SNF Care 2) Functional Status from section GG	1) Primary reason for SNF Care 2) Cognitive status based on BIMS 3) Presence of swallowing disorder or mechanically altered diet 4) Other Comorbidities
Case-Mix Adjustment	.66 to 4.06	.72 to 3.24	1.08 to 1.92	1.09 to 1.69	.68 to 4.21
Time Based Payment Change	No reduction based on LOS	Payment decreases after 3 days	Payment tapers beginning on day 21	Payment tapers beginning on day 21	No reduction based on LOS
Case-Mix Groups	25	6	16	16	12
Base Rate Urban	\$106.64	\$80.45	\$61.16	\$56.93	\$22.83
Base Rate Rural	\$101.88	\$76.86	\$69.72	\$64.03	\$28.76

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PDPM Intent

- Prior to CMS implementing the Patient Drive Payment Model [PDPM] it did extensive research and convened several Technical Expert Panels [TEP]. CMS wanted to strengthen the relationship between payment and clinical characteristics which promotes payment accuracy by providing SNFs the resources necessary to meet the care needs of a diverse range of patient types. Researchers have recommended two key reforms to improve payment accuracy and strengthen incentives to provide an appropriate level and quality of care:
- Remove therapy minutes as a determinant of payment and create a new therapy payment model in which payment is linked to differences in clinical characteristics.
- Create a separate payment component for non-therapy ancillaries [NTA] services, using resident characteristics to predict utilization of these services.



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CMS Issues Fiscal Year 2019 Payment & Policy Changes for Skilled Nursing Facilities

- The new model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives.
- CMS also significantly reduced the overall complexity of the PDPM, as compared to RUG-IV.
- The new case-mix classification system (the PDPM) will be effective October 1, 2019, to allow time for education and training of SNFs to prepare for this new model.
- The improved SNF PPS case-mix classification system moves Medicare towards a more value-based, unified post-acute care payment system that puts unique care needs of patients first while also significantly reducing administrative burden associated with the SNF PPS.



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CMS Issues Fiscal Year 2019 Payment & Policy Changes for Skilled Nursing Facilities

- The new case-mix model, PDPM, focuses on clinically relevant factors, rather than volume-based service for determining Medicare payment, by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification.
- Further, PDPM adjusts Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs), which are items and services not related to the provision of therapy such as drugs and medical supplies, thereby more accurately addressing costs associated with medically complex patients.
- Finally, PDPM adjusts the SNF per diem payments to reflect varying costs throughout the stay and incorporates safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals.



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Rate Setting
RUG / PDPM

Rate Eff Date	Acuity Date	Type
7/1/2023	4/1/2023	RUG
10/1/2023	7/1/2023	RUG
1/1/2024	10/1/2023	RUG
4/1/2024	1/1/2024	RUG - OSA
7/1/2024	4/1/2024	PDPM

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- Focus for Today
- April 1 picture date will use most recent MDS assessment and PDPM category
 - This is generally a quarterly assessment
 - Your MDS today are setting the state direct care rate for your July 1, 2024, AND
 - The UPL for SFY25
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- ### PDPM CMI Nuances
- Q1: Which of the five case mix categories will be used?
 - A1: We assume nursing only because that is Myers and Stauffer's thing
 - Q2: How will change in Depression scoring impact Nursing CMI?
 - A2: We assume it will reduce CMI based on end splits in categories
 - Q3: How will change in ADL to Function scoring change nursing CMI?
 - A3: Not quantified
 - Q4: Will there be a hold harmless to prevent large swings in payment rates?
 - A4: Has not been discussed
 - Q5: Will the state issue shadow rates so the provider knows the impact
 - A5: Seems like no!
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Mood Evaluation [D-1]

- CMS Changed MDS effective October 1, 2023
- New PHQ2-9
- Interview should be attempted with ALL residents
- If a resident cannot communicate, then Staff Mood Interview (D0500 A-J) should be conducted
- A. Little interest or pleasure in doing things
- B. Feeling down, depressed or hopeless
- If both are coded = No response or,
- If both are coded less than 7 out of 14 days
- End the interview



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Impact of Depression on Case Mix

Description	Group	Function	Depressed	Not	Diff	Rate
Special Care High	HDE	0-5	2.27	1.88	-0.39	\$ (63.57)
Special Care High	HBC	6-14	2.12	1.76	-0.36	\$ (58.68)
Special Care Low	LDE	0-5	1.97	1.64	-0.33	\$ (53.79)
Special Care Low	LBC	6-14	1.63	1.35	-0.28	\$ (45.64)
Clinically Complex	CDE	0-5	1.77	1.53	-0.24	\$ (39.12)
Clinically Complex	CBC	6/14	1.47	1.27	-0.2	\$ (32.60)
Clinically Complex	CA	15-16	1.03	0.89	-0.14	\$ (22.82)



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Tale of Two Providers

Depression End Splits [All Days]					Depression End Splits [All Days]				
Yes	Days	NO	Days	CMI Loss	Yes	Days	NO	Days	CMI Loss
HDE2	1,644	HDE1	187	-0.39	HDE2	-	HDE1	548	-0.39
HBC2	1,881	HBC1	656	-0.36	HBC2	98	HBC1	2,517	-0.36
LDE2	600	LDE1	521	-0.33	LDE2	41	LDE1	1,176	-0.33
LBC2	227	LBC1	318	-0.28	LBC2	1	LBC1	1,621	-0.28
CDE2	1,004	CDE1	288	-0.24	CDE2	-	CDE1	981	-0.24
CBC2	585	CBC1	60	-0.2	CBC2	42	CBC1	1,411	-0.2
CA2	84	CA1	92	-0.14	CA2	-	CA1	582	-0.14
Total	6,025		2,122		Total	182		8,836	




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Two Fallacies of Medicaid Case Mix

RUG is a better case mix system than PDPM

PDPM is a better case mix system than RUG




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Upper Payment Limit



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Something to Think About

What is your average Medicaid Rate?

How much would Medicare have paid for those same patients?




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Upper Payment Limit [UPL]


- Medicaid payments cannot exceed a **reasonable estimate** of the amount that would be paid for the same services under Medicare payment principles
- The Medicare Upper Payment Limit [UPL] is calculated in every state as a requirement for receiving federal matching funds
- States have flexibility to use either Medicare principles of cost reimbursement or prospective payment systems as the foundation of their estimate
 - Idaho uses the prospective payment system [RUGS]

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Idaho Uses the UPL to Fund the GAP


- The UPL is simply the rate Medicare “would have paid” had the Medicaid resident been on Medicare Part A
- The difference between the Medicare equivalent rate and the Medicaid rate is known as the UPL Gap
- Idaho is unique in that it uses the UPL to fund the federal share of the GAP
- Assessment is limited to 6% of Net Patient Revenue
- Idaho calculates and FUNDS the “UPL Gap”
 - Idaho funds the GAP back to providers
 - Providers pay the State share based on the FMAP rate [29%]
 - The State is revenue neutral from the UPL funding

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UPL Change from RUG to PDPM

-  Beginning in SFY 2024; intention is to use PDPM for Medicare equivalent rate
-  Advantage of using PDPM over RUG for Medicare equivalent rate is that PDPM rate is much higher creating a bigger UPL GAP
-  Tax in paid on all non-Medicare Days
-  Picture date for SFY 24 is April 1 of each year [April 1, 2023]
-  Initial UPL was RUG based – paid in Sept/Oct 2023
-  PDPM supplemental funding is expected in the spring of 2024
-  Funding will be the difference between what was funded under RUGS versus what would be funded under PDPM

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CMS Crashed the Party

- Idaho has been out of compliance with Directed Payments
- Per CMS; Idaho should not be distributing \$ through the MCOs
- CMS Limited additional PDPM based UPL to Traditional Medicaid Days only
- SFY24 UPL Uses 2021 Days
- Total Medicaid Days 889,147
- Traditional Mcd = 263,731
- BC MMCP = 105,038
- BC IMPlus = 270,998
- Molina MMCP = 26,537
- Molina IMPlus = 222,843
- Traditional Mcd Days = 29.66%



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State Fiscal Year 2024

Should have Received

	SFY24 - RUGS	SFY24 - PDPM	Change
Net Taxable Days	978,341	978,341	-
Assessment Limit @ 6% of NPR	\$ 29.70	\$ 29.70	-
Assessment to Fund UPL	\$ 12.89	\$ 26.99	\$ 14.10
Amount Under 6% of Net Revenue	\$ 16.81	\$ 2.71	\$ (14.10)
Amount Under 6% of Net Revenue	\$ 16,445,912	\$ 2,651,304	\$ (13,794,608)
Total Assessment	\$ 12,610,803	\$ 26,405,397	\$ 13,794,594
			-
Avg Private Payout PPD	\$ 55.11	\$ 114.52	\$ 59.41
Avg Govn Payout PPD	\$ 179.96	\$ 179.96	\$ 0.00
Total Medicaid Days	845,946	845,946	-
Total UPL GAP [Paid to Providers]	\$ 51,493,664	\$ 99,434,636	\$ 47,940,972
NSGO Match	\$ 2,022,790	\$ 2,022,790	\$ (0)
Paid to Providers Net of Tax	\$ 36,860,071	\$ 71,006,449	\$ 34,146,378



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State Fiscal Year 2024

FFS PDPM UPL

Idaho State Fiscal Year 2024				
	SFY24 - RUGS	PDPM FFS	SFY24 - PDPM	Change
Net Taxable Days	978,341		978,341	-
Assessment Limit @ 6% of NPR	\$ 29.70	\$ 29.70	\$ 29.70	-
Assessment to Fund UPL	\$ 12.89	\$ 4.73	\$ 17.62	\$ 4.73
Amount Under 6% of Net Revenue	\$ 16.81		\$ 12.08	\$ (4.73)
Total Assessment	\$ 12,610,803	\$ 4,627,548	\$ 17,238,351	\$ 4,627,548
				-
Avg Private Payout PPD	\$ 55.11	\$ 66.41	\$ 121.52	\$ 66.41
Total Medicaid Days	845,946	263,731	845,946	-
Total UPL GAP [Paid to Providers]	\$ 51,493,664	\$ 15,297,574	\$ 66,791,238	\$ 15,297,574
NSGO Match	\$ 2,022,790		\$ 2,022,790	\$ -
Paid to Providers Net of Tax	\$ 36,860,071	\$ 10,670,026	\$ 47,530,097	\$ 10,670,026



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UPL State Fiscal Year 2025

- Intent to use PDPM
- Picture date for PDPM acuity is April 1, 2024
- Higher the Medicaid equivalent case mix the greater the GAP
- Current estimate is that Idaho will be at the threshold of 6% of Net Patient Revenue [If all Medicaid days are used]
- We were unable to update days from 2021 to 2022
- Estimated growth in Medicare rate
- Used July 1, 2023, Medicaid rate for comparison
- Update net patient revenue



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UPL SFY25 Estimate

	Idaho State Fiscal Year 2025			Change
	SFY24 - RUGS	Final UPL SFY24 - PDPM	FFS Days Only SFY25 - PDPM	
State Share	28.78%	28.78%	32.41%	
Net Taxable Days	978,341	978,341	978,341	-
Net Patient Revenue	\$ 29.70	\$ 29.70	\$ 30.87	\$ 1.17
Assessment Limit @ 6% of NPR	\$ 12.89	\$ 17.62	\$ 9.81	\$ (7.81)
Amount Under 6%	\$ 16.81	\$ 12.08	\$ 21.06	\$ 8.98
Amount Under 6%	\$ 16,445,912	\$ 11,818,359	\$ 20,603,861	\$ 8,785,502
Total Assessment	\$ 12,610,803	\$ 17,238,351	\$ 9,597,515	\$ (7,640,836)
Avg Private Payout PPD	\$ 55.11	\$ 121.52	\$ 131.02	\$ 9.50
Total Medicaid Days	845,946	263,731	263,731	
Actual Total UPL GAP	\$ 51,493,664	\$ 66,791,238	\$ 33,678,704	\$ (33,112,534)
State Funding				\$
Total UPL Paid to Providers	\$ 51,493,664	\$ 66,791,238	\$ 33,678,704	\$ (33,112,534)
NEGO Match	\$ 2,022,790	\$ 2,022,790	\$ 1,134,329	\$ (888,461)
Paid to Providers Net of Tax	\$ 36,860,071	\$ 47,530,097	\$ 22,946,860	\$ (24,583,237)



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Quality Metrics



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Quality Program

- ✓ Used to set tiers for Margin Gap in Direct Care rate
- 📄 Used in UPL to pay based on quality
- ★ Nine metrics; each worth 100 points
- + Max points = 900
- 🔗 Use CMS five star cut points
- 📊 System started with 10 metrics = 1,000 points

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Quality Metrics

- Antipsychotic medication use
- Urinary tract infections
- Indwelling catheter
- Decline in late loss ADLs
- Decline in mobility
- Physical Restraints
- Falls with Major injury
- Percent of high-risk resident with pressure ulcers
- Long stay hospitalization rate
- New Title "percent of residents with pressure ulcer"
- Need to adopt new measure or replace or move to total of 8 metrics
- Decline in mobility & late loss ADL
- Data Frozen
- Move from G to GG
- Measures are frozen beginning with the April 2024 refresh [Q3, 2023 data]
- Measures will unfreeze beginning with the January 2025 refresh [10/1/23 - 9/30/24 data]

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Increased need with Late Loss ADL

- At least one of the following is true:
 - Sit to Lying GG0170B
 - Sit to Stand GG0170D
 - Eating GG0130A
 - Toilet Transfer GG0170F
- Level at target assessment less level at prior assessment <-1
- At least two of the following are true:
 - Sit to Lying GG0170B
 - Sit to Stand GG0170D
 - Eating GG0130A
 - Toilet Transfer GG0170F
- Level at target assessment less level at prior assessment <0

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Impact on UPL / Rates

- July 1, 2024, direct care rate will use 4 quarter average ending December 2022
- Three components will be frozen at 9/30/23 average
- July 1, 2025, direct care rate will use 4 quarter average ending December 2023

Discussion:

- Use frozen data
- For 2023 –change period to use 4 quarter ending 9/30/23
- Comparison data is an issue as tiers are determined based on change in point value



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Quality Reporting Date	SFY2017 12/31/2016	SFY2018 12/31/2016	SFY2019 12/31/2017	SFY2020 12/31/2018	SFY2021 12/31/2019	SFY2022 12/31/2020	SFY2023 12/31/2021	SFY2024 12/31/2022
Antipsychotic medication use								
Range 100 points	≤ 6.843	≤ 6.843	≤ 6.843	≤ 6.843	≤ 6.843	≤ 6.843	≤ 6.843	≤ 6.843
Range 80 points	≤ 12.705	≤ 12.705	≤ 12.705	≤ 12.705	≤ 12.705	≤ 12.705	≤ 12.705	≤ 12.705
Range 60 points	≤ 17.291	≤ 17.291	≤ 17.291	≤ 17.291	≤ 17.291	≤ 17.291	≤ 17.291	≤ 17.291
Range 40 points	≤ 23.980	≤ 23.980	≤ 23.980	≤ 23.980	≤ 23.980	≤ 23.980	≤ 23.980	≤ 23.980
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	18.971	22.793	26.190	23.298	28.261	31.481	21.897	17.864
Quality Points	40	40	20	40	20	20	40	40
Urinary tract infections								
Range 100 points	≤ 1.852	≤ 1.852	≤ 1.852	≤ 1.852	≤ 1.852	≤ 1.852	≤ 1.852	≤ 1.852
Range 80 points	≤ 3.424	≤ 3.424	≤ 3.424	≤ 3.424	≤ 3.424	≤ 3.424	≤ 3.424	≤ 3.424
Range 60 points	≤ 5.128	≤ 5.128	≤ 5.128	≤ 5.128	≤ 5.128	≤ 5.128	≤ 5.128	≤ 5.128
Range 40 points	≤ 7.599	≤ 7.599	≤ 7.599	≤ 7.599	≤ 7.599	≤ 7.599	≤ 7.599	≤ 7.599
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	8.054	6.899	2.312	6.417	3.000	1.768	1.942	3.865
Quality Points	20	40	80	40	80	100	80	60
Indwelling catheter								
Range 100 points	≤ 1.074	≤ 1.074	≤ 1.074	≤ 1.074	≤ 1.074	≤ 1.074	≤ 1.074	≤ 1.074
Range 80 points	≤ 2.094	≤ 2.094	≤ 2.094	≤ 2.094	≤ 2.094	≤ 2.094	≤ 2.094	≤ 2.094
Range 60 points	≤ 3.178	≤ 3.178	≤ 3.178	≤ 3.178	≤ 3.178	≤ 3.178	≤ 3.178	≤ 3.178
Range 40 points	≤ 4.746	≤ 4.746	≤ 4.746	≤ 4.746	≤ 4.746	≤ 4.746	≤ 4.746	≤ 4.746
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	0.148	0.060	0.060	0.000	4.042	1.698	0.888	0.600
Quality Points	100	100	100	100	40	80	100	100

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Quality Reporting Date	SFY2017 12/31/2016	SFY2018 12/31/2016	SFY2019 12/31/2017	SFY2020 12/31/2018	SFY2021 12/31/2019	SFY2022 12/31/2020	SFY2023 12/31/2021	SFY2024 12/31/2022
Decline in late-loss ADLs								
Range 100 points	≤ 10.049	≤ 10.049	≤ 10.049	≤ 10.049	≤ 10.049	≤ 10.049	≤ 10.049	≤ 10.049
Range 80 points	≤ 13.463	≤ 13.463	≤ 13.463	≤ 13.463	≤ 13.463	≤ 13.463	≤ 13.463	≤ 13.463
Range 60 points	≤ 16.779	≤ 16.779	≤ 16.779	≤ 16.779	≤ 16.779	≤ 16.779	≤ 16.779	≤ 16.779
Range 40 points	≤ 20.794	≤ 20.794	≤ 20.794	≤ 20.794	≤ 20.794	≤ 20.794	≤ 20.794	≤ 20.794
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	11.333	13.265	16.294	14.894	23.684	16.304	21.891	26.154
Quality Points	80	80	60	60	20	60	20	20
Decline in mobility								
Range 100 points	≤ 8.022	≤ 8.022	≤ 8.022	≤ 8.022	≤ 8.022	≤ 8.022	≤ 8.022	≤ 8.022
Range 80 points	≤ 14.455	≤ 14.455	≤ 14.455	≤ 14.455	≤ 14.455	≤ 14.455	≤ 14.455	≤ 14.455
Range 60 points	≤ 19.333	≤ 19.333	≤ 19.333	≤ 19.333	≤ 19.333	≤ 19.333	≤ 19.333	≤ 19.333
Range 40 points	≤ 24.906	≤ 24.906	≤ 24.906	≤ 24.906	≤ 24.906	≤ 24.906	≤ 24.906	≤ 24.906
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	8.487	14.663	16.687	15.997	20.906	26.616	28.648	16.538
Quality Points	80	60	60	60	40	20	20	80
Physical restraints								
Range 100 points	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000
Range 80 points	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000
Range 60 points	≤ 1.425	≤ 1.425	≤ 1.425	≤ 1.425	≤ 1.425	≤ 1.425	≤ 1.425	≤ 1.425
Range 40 points	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000	≤ 0.000
Range 20 points	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000	≤ 100.000
Quality Score	0.000	0.498	0.000	0.000	0.000	0.000	0.000	0.000
Quality Points	100	60	100	100	100	100	100	100

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Quality Reporting Date	SFY2017 12/31/2016	SFY2018 12/31/2017	SFY2019 12/31/2018	SFY2020 12/31/2019	SFY2021 12/31/2020	SFY2022 12/31/2021	SFY2023 12/31/2022	SFY2024 12/31/2023
Falls with major injury								
Range 100 points	≤ 1,316	≤ 1,316	≤ 1,316	≤ 1,316	≤ 1,316	≤ 1,316	≤ 1,316	≤ 1,316
Range 80 points	≤ 2,404	≤ 2,404	≤ 2,404	≤ 2,404	≤ 2,404	≤ 2,404	≤ 2,404	≤ 2,404
Range 60 points	≤ 3,511	≤ 3,511	≤ 3,511	≤ 3,511	≤ 3,511	≤ 3,511	≤ 3,511	≤ 3,511
Range 40 points	≤ 5,036	≤ 5,036	≤ 5,036	≤ 5,036	≤ 5,036	≤ 5,036	≤ 5,036	≤ 5,036
Range 20 points	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000
Quality Score	1,299	0,000	0,546	2,553	6,863	3,704	0,476	2,281
Quality Points	100	100	100	40	20	40	100	80
Pressure ulcers								
Range 100 points	≤ 2,655	≤ 2,655	≤ 2,655	≤ 2,655	≤ 2,655	≤ 2,655	≤ 2,655	≤ 2,655
Range 80 points	≤ 4,453	≤ 4,453	≤ 4,453	≤ 4,453	≤ 4,453	≤ 4,453	≤ 4,453	≤ 4,453
Range 60 points	≤ 6,162	≤ 6,162	≤ 6,162	≤ 6,162	≤ 6,162	≤ 6,162	≤ 6,162	≤ 6,162
Range 40 points	≤ 8,633	≤ 8,633	≤ 8,633	≤ 8,633	≤ 8,633	≤ 8,633	≤ 8,633	≤ 8,633
Range 20 points	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000
Quality Score	6,882	4,948	6,887	2,609	1,481	2,419	6,040	11,806
Quality Points	60	80	60	100	100	100	60	20
Long stay hospitalization rate								
Range 100 points	≤ 20,000	≤ 20,000	≤ 20,000	≤ 20,000	≤ 20,000	≤ 20,000	≤ 20,000	≤ 20,000
Range 80 points	≤ 40,000	≤ 40,000	≤ 40,000	≤ 40,000	≤ 40,000	≤ 40,000	≤ 40,000	≤ 40,000
Range 60 points	≤ 60,000	≤ 60,000	≤ 60,000	≤ 60,000	≤ 60,000	≤ 60,000	≤ 60,000	≤ 60,000
Range 40 points	≤ 80,000	≤ 80,000	≤ 80,000	≤ 80,000	≤ 80,000	≤ 80,000	≤ 80,000	≤ 80,000
Range 20 points	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000	≤ 100,000
Quality Score	13,000	22,000	80,000	55,200	19,300	49,900	15,200	35,610
Facility Score	8,600	10,100	21,000	15,000	10,000	14,300	8,400	11,800
Quality Points	100	80	20	60	100	60	100	80

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Quality Reporting Date	SFY2017 12/31/2016	SFY2018 12/31/2017	SFY2019 12/31/2018	SFY2020 12/31/2019	SFY2021 12/31/2020	SFY2022 12/31/2021	SFY2023 12/31/2022	SFY2024 12/31/2023
Points Subtotal	680	620	680	600	600	680	620	560
Temporary Point Add-on	0	0	0	0	0	40	40	40
Total Points	680	620	680	600	600	720	660	600
Max Points Possible	900	900	900	900	900	900	900	900
Difference from previous year	Base	-60	-40	20	-80	100	40	-60**
Payments								
Facility Tier	2	2	3	3	3	2	2	3
Payment Percentage	100%	95%	90%	95%	90%	100%	100%	90%
Points needed to move up to 100%	—	600	600	620	640	—	—	600
Quality								
OAS Five Star Quality Rating	5	4	4	3	2	2	3	4

* - Facility does not have a score, so using the Idaho Base Median Score for this metric.
 ** - Temporary point add-on was dropped and not included in point comparison from previous year.
 * - Facility is a Special Care Unit (w/ ECU) and receive the higher of either their own score or the median score for the metrics "Antipsychotic use for long-stay residents" & "ADL decline"
 † - Scores are estimated based on the latest 6-quarter average of quality data from CMS.
 ‡ - Points added due to the effect of the COVID-19 pandemic.
 § - Each data set is ranked on a national basis with a provider assigned to "Percent Rank" based on how it performs against all Providers nationally. A rank of 0 is good while a rank of 100 is bad.
 ¶ - The payout percentages do not include any successful appeals made by a facility.

My Current & Future Payment Percentages


Your current payment percentage. Your estimated payment percentage for next year.

Payments based on change in score from prior year

Tier	Point Range	Improved by 40 points or more	No change	Declined by 40 points or more
1	720-900	100%	100%	100%
2	620-720	100%	100%	95%
3	100-620	100%	95%	90%

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Budget Adjustment Factor




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Budget Adjustment Factor [BAF]

- To control spending, a budget will be set annually, which will be approved by legislature
- Rates will be calculated for each provider and an estimated total spend will be calculated
- That total estimated spend will be compared to the established budget
- Rates will be adjusted to fit within the budget.
- The amount the provider's rate is adjusted by is referred to as the budget adjustment factor.
- The provider's rate will be paid at the lower of the BAF adjusted rate or customary charge.
- Within a given fiscal year, the Department will take on the risk for changes in utilization and acuity




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Budget Adjustment Factor Nuances

- The BAF \$ reduction is set each July 1
- The ppd BAF amount remains unchanged for subsequent quarters
- As census increases; the allowable payment rate PPD decreases
- As census decreased; the allowable payment rate PPD increases
- As acuity increases; rates got up each quarter during the state fiscal year
- Each July 1, the BAF is reset




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Budget Adjustment Factor Trend

Idaho Budget Adjustment Factor						
Rate	Budget	BAF %	Mcrd Days	PPD	Lost Dollars	
7/1/2019	\$ 224,893,978	-2.70%	876,106	\$ 256.70	(6,241,068)	
7/1/2020	\$ 237,531,591	-2.70%	906,869	\$ 261.92	(6,312,317)	
7/1/2021	\$ 226,709,497	-9.64%	858,618	\$ 264.04	(24,179,466)	
7/1/2022	\$ 226,709,497	-15.20%	833,768	\$ 271.91	(40,644,212)	
7/1/2023	\$ 226,709,497	-23.44%	834,912	\$ 271.54	(69,421,414)	

Note: Figures for 2019 and 2020 are estimates based using Idaho rate files

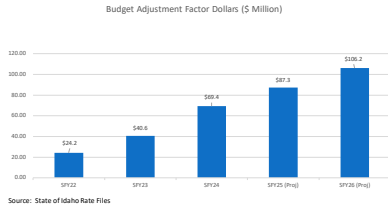


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Budget Adjustment Factor

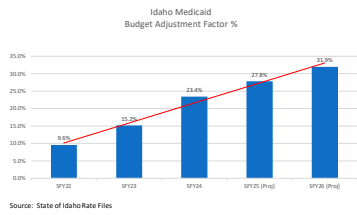
The budget adjustment factor is projected to reduce Medicaid payments by \$106 million in state fiscal year 2026, up from \$69 million in state fiscal year 2024



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Budget Adjustment Factor

The budget adjustment factor is projected to reduce calculated rates by over 31% by state fiscal year 2026



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Thank You!

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