Provider Fee Public Workshop

Date: April 19, 2018 **Time:** 2:00 pm – 3:00 pm

Location: Public Utilities Commission Carson City and Las Vegas

Conference #: 775-687-0999 **Access Code:** 43639

Attendees

Name		Name	
Sarah Lamb	X	Kelly Frantz	X
Drew Banford	X	Brady Flygare	X
Lisa Chappelon	X	Kirsten Coulombe	X
Chris Johnson	X	Blayne Osborn	X

Agenda

Item	Topic	Discussion/Decision
*	Introduction and Agenda Overview/Attendees	Recording Time: 1:06 Sarah: Well, again I apologize for the delay and the technical difficulties. I think we will go ahead and get started? Good afternoon, my name is Sarah Lamb and I work with the Supplemental Reimbursement Unit at the Division of Health Care Financing and Policy. This public workshop is being held today to solicit comment on the reporting guidelines in the free-standing nursing facility provider fee and supplemental payment program. Before we begin our workshop, I just want to go over just a couple formalities. In a moment we will go through the attendees here in Carson City and Las Vegas, as well as those calling in. This workshop is being recorded so if you would like the minutes you can request those afterwards. If you have called into the workshop, please do not put us on hold, if you need to, put us on mute. If you put us on hold then we all get to hear your hold music and it makes it difficult to hear anything else. (Introductions in Carson office.) Sarah: Thank you all. I don't see anyone in the Las Vegas office. Would the people on the phone please introduce yourselves? If you guys are on mute, could you please take yourself off mute to introduce yourselves? (No one identifies themselves on the teleconference line.)
1.	Presentation and Public Comment with Free-Standing Nursing Facilities to Discuss Current Reporting Guidelines in the Provider Tax Program a. Public Comment Regarding Subject Matter	Recording Time: 2:51 Sarah: Alright, let's go ahead and begin the workshop. The purpose of this workshop today is to solicit public comment on the current reporting guidelines in the free-standing nursing facility provider fee and supplemental payment program. I'm going to go ahead and give a brief overview of the process and then open this up for

		public comment. In this program, the monthly provider fee forms are due, as well as the payments are due, from all the facilities thirty days after the end of the reporting month. These reports include all the bed days provided by each nursing facility in the reporting month separated by payor such as Medicaid, pending Medicaid, Medicare, and other bed days. As part of the quarterly nursing facility provider fee and supplemental payment program, the Division of Health Care Financing and Policy compiles the base quarter data which is six-month lag data used in the calculation of the upcoming quarterly provider fee rates and supplemental payments. A summary of all the bed days reported in the base quarter, by payor, is sent out to all nursing facilities for review. The purpose of sending out this base quarter review is to give the nursing facilities an opportunity to make revisions to the bed days as they need to. One of the most important parts of this revision process is for the nursing facilities to move any days reported as pending Medicaid into the Medicaid day total if the recipients Medicaid application has been approved in the time since the bed day was initially reported. These Medicaid days count in the facility's Medicaid occupancy percentage as well as into their supplemental payment. These are very important days to have in the correct bucket. The base quarter review is usually sent out to providers in the second month of the quarter. When it's sent out for review, the Division of Health Care Financing and Policy includes a due date by which all revisions must be returned to us by. This due date is generally three weeks after the base quarter review is sent out. This due date is really important because it is one of the steps we need to finalize the whole quarterly process. And in order to keep the payments in the provider fee program on schedule. We must also submit a quarterly waiver request which includes the finalized calculations to the Center of Medicare and Medicaid Services for approval. If we accept revisions after the due date, excuse me, revisions that we receive after the due date, will not be accepted and included in the upcoming quarterly calculations. If we accept revisions after the deadline, what that requires potentially a recalculation of the entire quarterly program including the supplemental payments to all facilities as well as the provider fee rates and it could also require us to submit another waiver request and demonstration to CMS to operate the program. So, the purpose of being here today is to discuss the reporting guidelines we've just reviewed so with that I would like to move on to agenda item 1. A and open the workshop to public comment. Recording Time: 5:56 Public comments: Brady Flygare: I'd like to comment, this is Brady Flygare, again from Desert Care Facilities. With the recalculation of the entire, pertaining to the recalculation the entire quarterly program that you said we are not able to do if it's not done by the due date. What I would ask is that if there is any changes that need to be made after that due date, that that is calculated into the next quarter. Or that be calculated and credited into the next quarter. Sarah: So, if the days were not reported…

		Brady: Correctly… Sarah: You could move them into the next quarter's calculations. Brady: The other thing that I would also ask as it pertains to our rural buildings and even Mesquite, even though Mesquite is considered in Clark County, it's not considered a rural building, we're not able to count the pending Medicaid days that are still pending during that quarter we are only allowed to count the approved Medicaid days, I'd like to ask the department if we can begin to include those pending Medicaid days to be able to reach that 65% threshold because it is so hard in our rural buildings. I'd like to either do that or consider, have the department consider to put in a waiver for our rural buildings because we are turning away members of our community specifically, I think I have the number 67 people, between Elko and Fallon, within the last year that we've turned away because it would take us under that 65% threshold at a cost of right around three quarters of a million dollars. That's something that we absolutely hate to do, but in order to be financially viable, we have to do that. Sarah: How do you find the pending application process working for you, are you finding that there's a delay, is that working smoothly, what is the experience you guys have in getting someone from pending to actual Medicaid? Brady: I think we can each talk about our own experiences. Drew Banford: So, of course, this is Drew Banford. It all depends on the scenario of the actual case. So, we are seeing a lot of complicated cases with QITs, a division of assets, which when we talk to Medicaid about timeframes, they talk about the unusual circumstances to the case where typically if I knew someone was a QIT, we are looking at twelve months for approval. Same thing for division of assets. So of the ten pending cases we have right now, five are either QIT or division of assets. Brady: That's in Elko, in Mesquite, currently we have four. They're in the same boat with QIT. And then, in Fallon, I think we have three. Lisa Chappelon: We have three. Recording Time: 8:48 Sarah: Could you explain QIT? Drew: So if someone is over the income limit, the income limit is $2,099 if I remember right, if someone's over that then Medicaid will still consider getting them approved but they have to get a Qualified Income Trust, they have to get a trust set up by an attorney has to go through the court to allow that overage of the income requirement.

		Brady: I think the overall process of getting people approved for Medicaid is a lot better than it was three years ago. A lot better. However, I think it is more better on the community side than it is on the long-term care side, on the institutional side. And for us, that's what affects us the most because that's all we deal with, the institutional applications. With us being a rural buildings, we don't take straight Medicaid, we don't get straight Medicaid referrals unless they're behavioral referrals that people from, are the facilities from Reno and Las Vegas and (motioning to Drew) you're probably seeing some from Salt Lake that they say no to. Those are the Medicaid referrals that we get, the Medicaid people who we actually take are in the community who come in without Medicaid that have to go through the application process for. So that's really how that, why that affects us in the rural areas more than the facilities on the street, city, city areas. Sarah: Could you give us a guesstimate of how many individuals that are reported as pending that are eventually moved to Medicaid? Is it 50/50, is it closer to all of them? Brady: I would guess closer to all of them eventually because we just have to be diligent in our application process, so we walk them through the process, usually we get an attorney involved that works with our company to help get them through that process if it's not going to be a clean application. So, if there is anyone on the fence, we won't take them because it is too much of a risk for us to hold on to that patient for a year without any income then not have them qualify at the end of that year then have a $70,000 or $75,000 bill. Drew: Part of what we see in Elko a lot, is we have a lot of farmers out there. And for our rural community, we have a lot of people who have land attached to their name so a lot of times we go through an attorney process to get them approved and again those cases take up to ten to sixteen months to get approved and we see those a lot in Elko. I would say the majority of the cases we over the last two years have been actual court cases. Sarah: Really? Drew: Yes. Sarah: Because they have that asset..? Drew: That income, all those things. Sarah: Ok. Drew: All those factors. Brady: So really, as it relates to this reporting, I mean all those pending Medicaid is just another hard thing for us at our buildings to manage appropriately. That's why I ask for changes to be made, if there are mistakes made, if we could, a lot of times we end up waiting until that last day to report to really calculate where we are at because of the strange issues that we get.

		Recording Time: 11:50 Sarah: So, some of the suggestions so far are to allow them to be included in the Medicaid total, if they were then found to be not eligible they'd have to be taken out of that calculation, you'd almost have the reverse of what we are doing now. Brady: I wouldn't say so, I would say keep them in the calculation, cause if they don't qualify, then you still have that bill, a $30,000, $60,000 bill we're ending up having to write off or eat anyway. Sarah: You're thinking the treatment of them as pending anyway, ok… Brady: Because we are taking them on the trust that they will be approved for Medicaid cause they don't have any other pay sources, or income sources. Drew: The only other option, I mean, and that's been the big struggle, it's a huge gamble for facilities to take someone pending on Medicaid. Because there is no payor set up, there's absolutely no payor, it's a risk, and again, like Brady said, I think Medicaid has come a long way over the last few years but still every single person we take is a pending is a huge risk, are we going to get paid or not. This person has no more assets, we're going down this road with them. And sometimes it does, it turns out to be faulty and it doesn't work, you know Medicaid denies, it's a difficult process, really difficult. A lot of facilities don't take pending. But in Elko we don't have that opportunity, we have people that need us. You know, we have to be the best we can at what we do. But sometimes it doesn't work out. Brady: Now, and again, as it pertains to the 65% also, if Drew has a Medicaid census that allows him to be 66% of his building on the 90th day of that third quarter, he gets a Medicare referral, a good Medicare referral from the community that has that need and is going to put him three days over that 65% threshold, he's going to have to say no them because that's going to cost him $160,000. Does that make sense? Drew: And the alternative is for them to go 250 miles to another facility. Outside of our community. Brady: Or in Fallon's case they have to go 60. Lisa: They have to go to Reno. But in Fallon's case, we will get more Medicare referrals. There just isn't the Medicaid coming in to Fallon at all and you're stuck with Drew's same thing still, you have to save the 65% and we are turning down Medicares that need rehab to home so they either have to go to Reno, most of them go to Reno, or Carson. Brady: One thing that our company does, if you've been to any our campuses or buildings, we're not dumpy old buildings, we've invested a lot of money into these rural areas. So that's one of the

		reasons we ask the State to look at that, the investment we've made into these communities that honestly nobody in their right mind would do what we've done, but we've done it anyway, with the intention to take care of these underserved communities and we just ask for a little bit of leeway with the State and with the department, anything you guys can do to help us take care of the community members because right now we're just not able to serve all of them because of the financial impact that it's having on our company. Now again, with the reporting, I keep going back to that because this is what this meeting is about, and Elko we missed it, because we mis-reported days, the person at our support services office in Illinois that does that report, we've changed our process so now Drew reviews that, then I review it before it is submitted and so I believe we've changed our process to ensure we are reporting the correct days. At the same time, we still there are things that the State of Nevada can do to help those people in the rural areas. Recording Time: 15:27 Sarah: Ok, and another suggestion was to consider rural areas in a separate pool perhaps with a different… Brady: A waiver, a waiver for the rural areas. I know that Denise has talked with Marta Jensen about that. I don't know what the interest is or the opportunity is for that to happen, but I also think that that would be an option. Kirsten Coulombe: I'm sorry, what is the structure now? I don't know what that waiver would be waiving. There are differences between the urban and the… Sarah: There are two tax rates that are paid. One is nominal that is significantly less and facilities that maintain a Medicaid occupancy of 65% or higher in the base quarter pay the nominal rate. If the occupancy for Medicaid recipients is below 65% the facility will pay the uniform rate which is higher. Kirsten: But it varies by location? If there is a variance for being urban versus… Sarah: There is not currently. Kirsten: Ok. Brady: Not in the supplemental payment. There is in Medicare and also in some of the Medicaid rates that we get, the rural areas are considered different, then different counties like Clark County and Washoe County. They have different rates than what we do in our rural counties, but as it pertains to the supplemental program, no, that's the same. Kirsten: Ok. Your question wasn't for the supplemental program. Brady: The tax difference though, the nominal rate, um the uniform rate, that's almost half of what the uniform rate is so

		really we pay $18, roughly $18 a day for everybody that we have in our building that is non-Medicare. And we pay that tax with the expectation that the federal government matches some of those funds based on our quality and some other measures that are in there. If we don't meet that or don't get that nominal tax rate then the tax rate is $36 per day, per patient. So that's really the difference that we are asking to have a waiver for or some kind of leeway for our buildings because that extra $18 a day per non-Medicare patient really is just hard. We get lower rates than people in the bigger counties, there's just less options for our community members in our areas and it's just a hurdle. And we are sending them and their families to travel to the bigger cities, which is putting them at risk and really their health at risk. I'd also like to say you guys have been great to work with as far as the questions that we've had with the reporting. We are a small provider, I mean as far as beds go we have 350 skilled nursing beds, overall, we are right around 500 with our assisted living and our independent living, but we are a small provider and you guys have been great to answer our questions and help us through this process. Nevada is not the biggest state our company services and so some of these things can fall by the way side as far as our company headquarters go, that's why we are asked to keep such a watchful eye on it with the impact that it has had recently on Elko by missing it, and what we've been able to do there financially. Sarah: We certainly appreciate the services you provide to our recipients and especially in the rural areas, not easy. Brady: Thanks. Recording Time: 18:53 Sarah: Is there any other public comment on the reporting guidelines? We'll move on to agenda item 2. Which is public comment regarding any other matter.
2.	Public Comment Regarding any Other Issue	Brady: I think we've covered it. Sarah: Is there any public comment from the people calling in on the phone? Alright, with that we'll move to the adjournment and adjourn the public workshop for today. I'd really like to thank everyone for participating, it's really, really valuable comment.
3.	Adjournment	

Respectfully submitted,

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