MACPAC

Changes in Nursing Facility Acuity Adjustment Methods

Medicaid and CHIP Payment and Access Commission

Robert Nelb

Overview

- Background on nursing facility payment
- Uses of acuity adjustment in Medicaid
- Comparison of resource utilization groups (RUGs) and the patient-driven payment model (PDPM)
- Implications for state Medicaid programs

Background

- Medicaid covers both skilled nursing care and long-term custodial care in nursing facilities
- In 2019, approximately 84 percent of Medicaid nursing facility residents were dually eligible for Medicare and Medicaid
- States have broad flexibility to design their own nursing facility payment methods
  - Base payments
  - Upper payment limit (UPL) supplemental payments

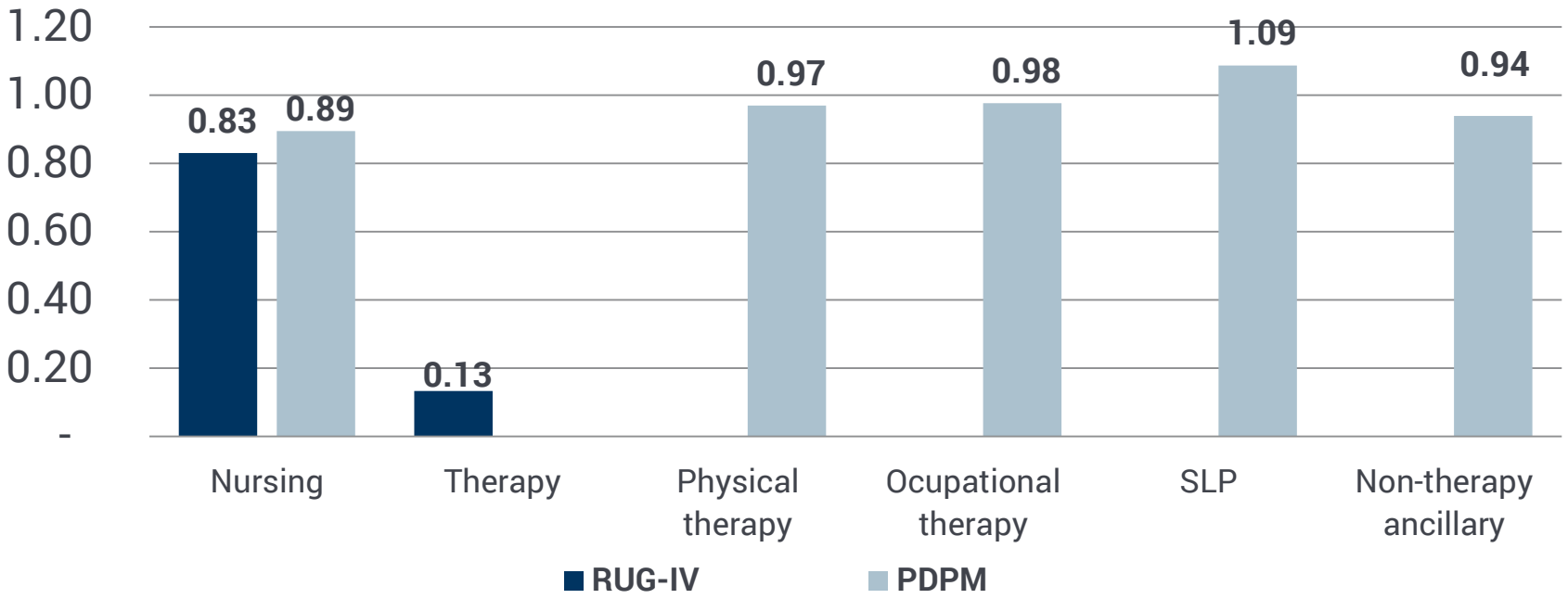
Uses of Acuity Adjustment

- 33 states and the District of Columbia use RUGs to adjust base payment rates for nursing facilities
  - 8 states use a state-developed method
  - 9 states do not use any acuity adjustment method
- 33 states use RUGs to calculate the UPL based on estimates of what Medicare would have paid
  - States can also use a cost-based method
  - Medicare payments to nursing facilities typically exceed costs

Comparison of RUGs and PDPM

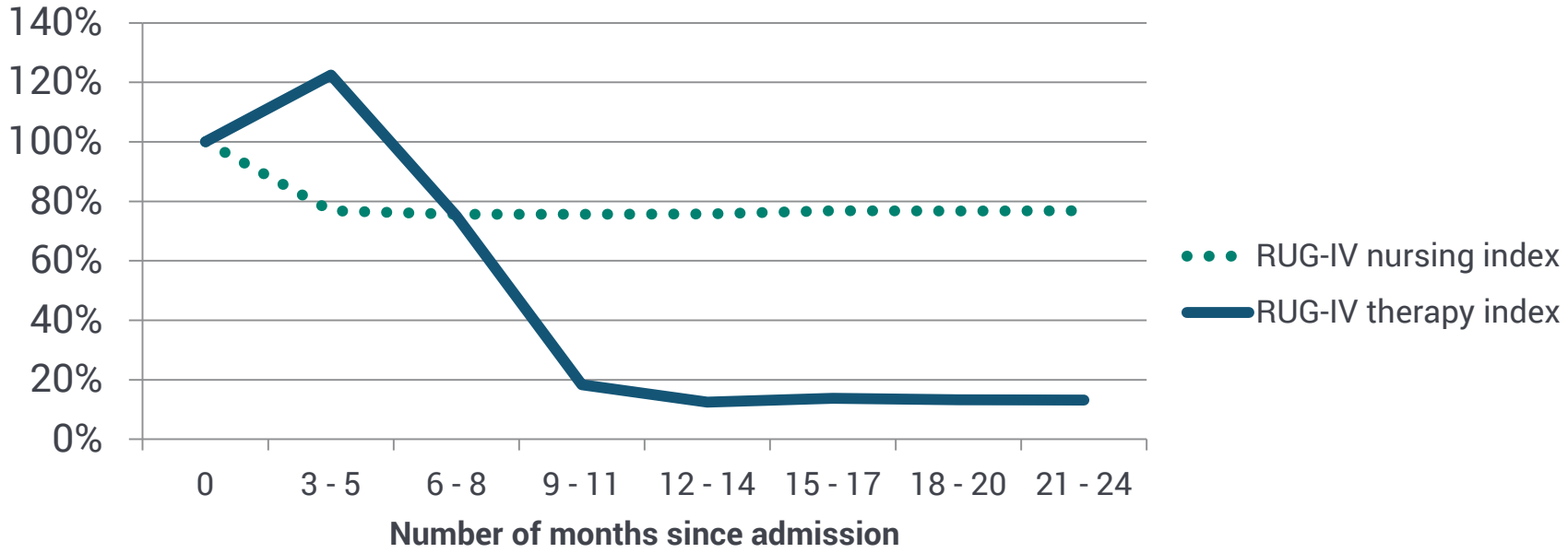
- Beginning October 1, 2019, Medicare changed its acuity-adjustment method from RUGs to PDPM
  - The RUG method varies payment based on the amount of therapy a patient uses
  - PDPM predicts a patient's care needs based on their initial diagnosis
- CMS is planning to remove RUGs-related questions from the standard federal assessment of nursing facility residents, the Minimum Data Set (MDS)

Average RUG-IV and PDPM Medicaid Case-Mix Weights, Standardized as a Ratio to Average Medicare Acuity Levels, 2019



Note: RUG-IV is resource utilization groups, version four. PDPM is patient-driven payment model. SLP is speech-language pathology.
Source: Abt Associates, 2020, analysis for MACPAC of 2019 Minimum Data Set

Average Case-Mix Weight as a Share of Case-Mix Weight at Initial Assessment for Long-Stay Nursing Facility Residents, 2018–2019



Note: RUG-IV is resource utilization groups, version four. Analysis based on a cohort of 6,461 residents admitted between October 1, 2017 and December 31, 2017 who were still in the same facility as of September 30, 2019 with no discharges or readmissions.
Source: Abt Associates, 2020, analysis for MACPAC of 2018 and 2019 Minimum Data Set

Implications for Medicaid

- Base payments
  - CMS has delayed the phase out of RUGs-related questions from the MDS, giving states more time to assess changes to base payment methods
  - Switching from RUGs to PDPM will be more challenging for Medicaid than it was for Medicare
- Supplemental payments
  - States will need to begin using PDPM for UPL demonstrations in FY 2022
  - PDPM may result in a much higher limit than RUGs

Policy Questions

- What resources do states need to support the development of nursing facility payment methods that promote statutory goals?
- What are the implications of using Medicare as an upper limit on Medicaid nursing facility payments?
- What is an appropriate benchmark for Medicaid nursing facility payment adequacy?

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