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Principles for Assessing Medicaid Nursing Facility Payments Relative to Costs

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Overview

- Nursing facility payment work plan
- Background on nursing facility payment policies
- Technical expert panel feedback
  - Measuring costs
  - Measuring payments
- Preliminary findings
  - Base payments
  - Supplemental payments
  - Relationship between payment and staffing
- Potential payment principles
- Next steps

Nursing Facility Payment Work Plan

- The Commission has been examining Medicaid nursing facility payment policies since 2019
  - Compendium of state fee for service (FFS) payment methods
  - Interviews with state officials and other stakeholders
  - Review of payment methods to promote adequate staffing
  - Analyses of Medicaid payments relative to costs
- In this report cycle, we plan to synthesize our findings into a report chapter that outlines policy principles for states to consider
  - Findings suggest promising practices but not recommendations on requiring particular payment methods or amounts
  - Commission may want to consider recommendations regarding transparency and support for state data collection and rate-setting activities

Nursing Facility Payment Background

- Medicaid primarily covers long-stay nursing facility residents
  - Most Medicaid-covered residents are dually eligible for Medicare
  - Medicare Part A covers up to 100 days of skilled nursing facility care and Medicare Part B covers most therapy services for long-stay residents
  - The cost of care for Medicaid-covered residents is generally much lower than the cost of care for Medicare-covered residents
- States make a variety of different payments to nursing facilities
  - Base payments
  - Supplemental payments, up to the upper payment limit (UPL)
- Medicaid-covered nursing facility residents also contribute toward the cost of their care

Comparing Medicaid Payments to Costs

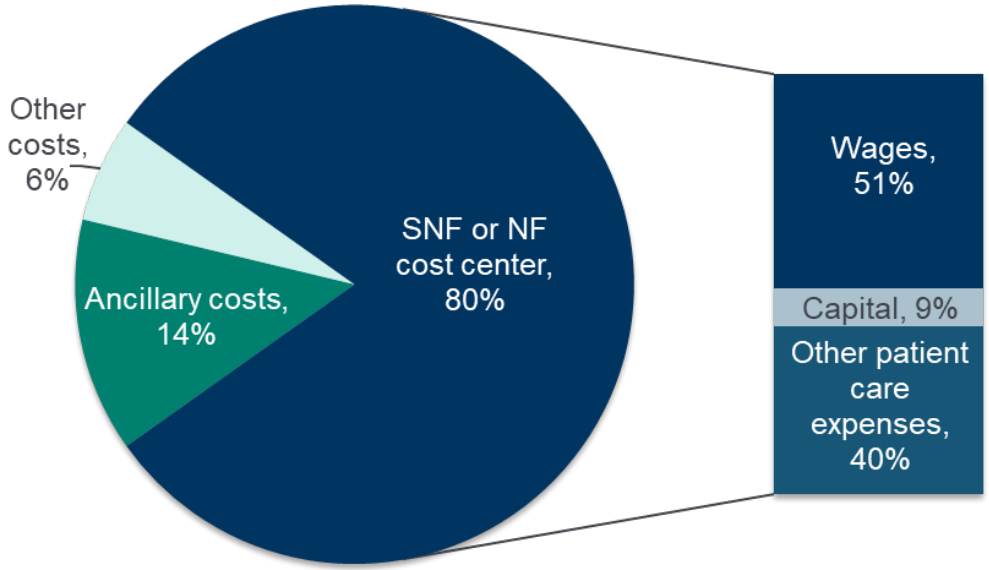
- Historically, Medicaid nursing facility payments were required to be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities (Boren amendment)
  - Boren amendment was repealed in 1996
  - Medicaid payments are still required to be consistent with efficiency, economy, quality, and access (Section 1902(a)(30)(A) of the Social Security Act)
- Costs are an imperfect measure of payment adequacy
  - Costs may be too low to meet resident care needs, such as adequate staff
  - Costs may be too high if the facility is not operated efficiently or if costs are inflated by related-party transactions
- Most states currently set nursing facility payments based on costs, with ceilings and limitations on which costs are allowable

Technical Expert Panel

Technical Expert Panel

- To inform our analyses of Medicaid payments and costs, we convened a technical expert panel in February 2022
  - State and federal officials
  - Nursing facility representatives
  - Accounting firms
  - Researchers
- Experts discussed the reliability of different federal data sources available to measure Medicaid payments relative to costs
  - Medicare cost reports
  - Transformed Medicaid Statistical Information System (T-MSIS)
  - Upper Payment Limit (UPL) demonstrations
- Examined available 2019 data (pre-pandemic)

Components of Nursing Facility Costs, 2019



Notes: SNF is skilled nursing facility. NF is nursing facility. Cost components are a weighted average of costs per day, based on the total number of nursing facility resident days for each facility.
Source: Abt Associates, 2022, analysis for MACPAC of Medicare cost reports.

Average Nursing Facility Costs per Day Under Different Methods, 2019

Cost measure	All facilities	Share of residents whose primary support was Medicaid			
		Lowest quartile (<51%)	Second quartile (51 – 65%)	Third quartile (65 – 76%)	Highest quartile (>76%)
Total facility costs per day	$293	$360	$303	$279	$266
Medicaid-covered costs per day	$244	$270	$250	$239	$230
Acuity-adjusted Medicaid costs per day	$239	$265	$245	$235	$226

Notes: Medicaid-covered costs per day are estimated based on costs for the nursing facility cost center and exclude ancillary costs. Average costs per day are based on a weighted average based on the total number of Medicaid nursing facility resident days for each facility.
Source: Abt Associates, 2022, analysis for MACPAC of Medicare cost reports.

Measuring Nursing Facility Payment Rates

- T-MSIS is the only federal data source with managed care payment data
  - 24 states currently have managed long-term services and supports (MLTSS)
  - FFS and managed care payments rates are similar in many states
- Base payment rates (the allowed amount) are higher than the payments providers receive from the state because of post-eligibility treatment of income
  - Resident contributions to their share of costs accounted for about 10 percent of total payments for Medicaid-covered nursing facility residents
  - Allowed payment amounts are needed for payment analyses
- UPL demonstrations include incomplete information on supplemental payments
  - Total spending does not match CMS-64 expenditure reports
  - Discrepancies between data sources about which states make supplemental payments
- We do not have information on provider contributions to the non-federal share of nursing facility payments (e.g., provider taxes)

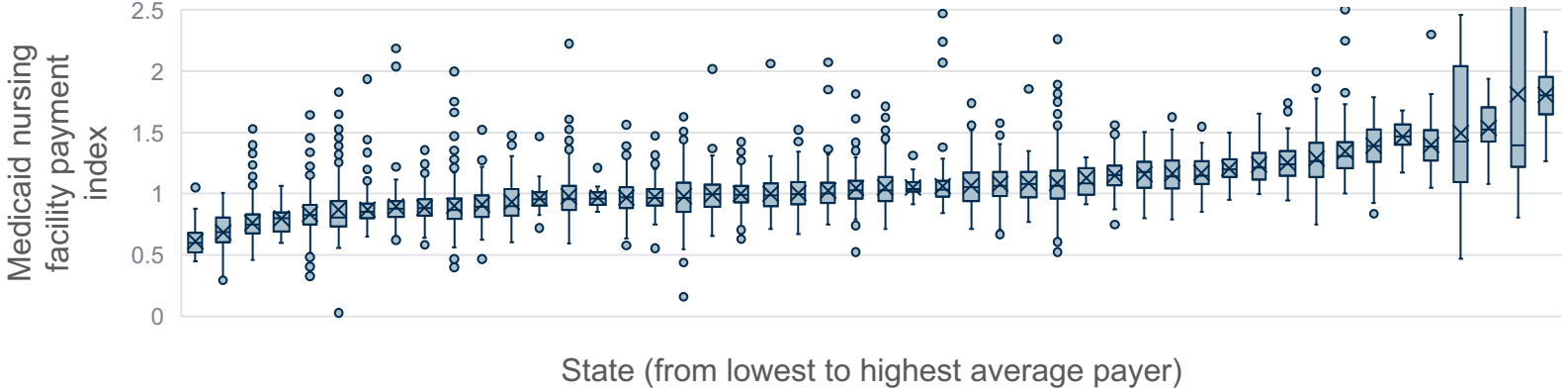
Preliminary Results

Methods and Key Findings

- Examined base payment and cost information for 12,785 facilities in 47 states and the District of Columbia (91 percent of all free-standing, dually certified facilities)
- We estimated the effects of supplemental payments for states with available UPL demonstration data
- Overall:
  - Base payments varied widely across states and within states, even after adjusting for differences in area wages and resident acuity
  - Supplemental payments can substantially affect measures of Medicaid payments relative to costs
  - The relationship between staffing rates and payments rates is unclear

Base Payment Amounts Vary Widely

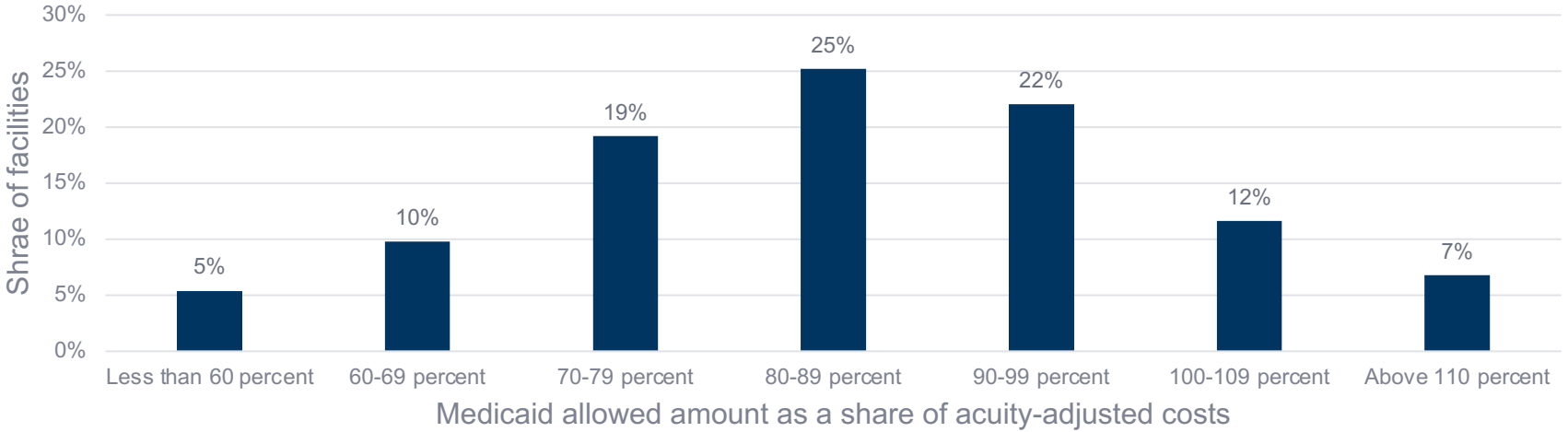
Distribution of Medicaid Allowed Base Payment Amounts, by State and Facility, 2019



Notes: Medicaid allowed payment amounts are case-mix adjusted based on the resource utilization group (RUG-IV) nursing index and wage adjusted using the Medicare wage index. Medicaid nursing facility payment index values are normalized around the national average, which has a value of 1. For example, a facility with an index value of 1.1 would have Medicaid allowed payments 10 percent higher than the national average, after adjusting for wages and case mix. The box in the figure indicates the first and third quartile range for each state. X indicates the state average payment amount. Dots indicate outlier values greater than 1.5 times the interquartile range from the first or third quartile. Lines indicate minimum or maximum values that are within 1.5 times the interquartile range. Payment values truncated at 2.5 times the national average. Alaska, Idaho, and New Hampshire are excluded because of missing or outlier data. Managed care allowed amounts in California, Massachusetts, New Jersey, Rhode Island, and Virginia were not available, and so only fee for service spending is included for these states.
Source: Abt Associates, 2022, analysis for MACPAC of the transformed Medicaid statistical information system (T-MSIS), the Minimum Data Set (MDS), and the Medicare wage index.

Median Payment was 86 Percent of Costs

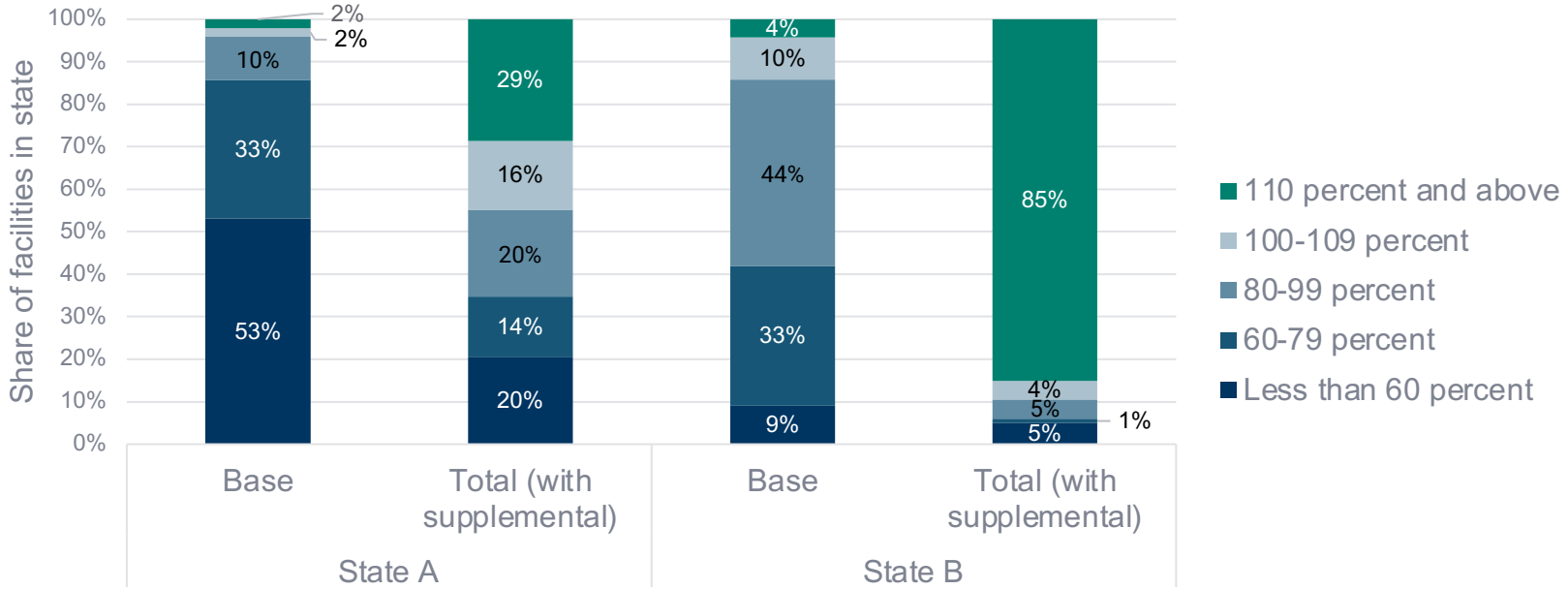
Distribution of Medicaid Allowed Base Payment Amounts as a Share of Acuity-Adjusted Costs, 2019



Notes: Analysis excludes Alaska, New Hampshire, and Idaho because of unreliable or missing data. Managed care allowed amounts in California, Massachusetts, New Jersey, Rhode Island, and Virginia were not available, and so only fee for service spending is included for these states.
Source: Abt Associates, 2022, analysis for MACPAC of transformed Medicaid statistical information system (T-MSIS), the Minimum Data Set (MDS), and Medicare cost reports.

Supplemental Payments Can Be Substantial

Medicaid Payments as a Share of Costs Before and After Supplemental Payments, 2019



Notes: Medicaid payments reported include Medicaid resident contributions to the share of costs. Medicaid costs are adjusted for resident acuity.
Source: Abt Associates, 2022, analysis for MACPAC of upper payment limit (UPL) demonstration data, Medicare cost reports, and the Minimum Data Set (MDS).

Relationship between Payment Rates and Staffing is Unclear

- Facilities with higher staffing ratings paid higher wages
- Facilities with lower staffing ratings had higher Medicaid margins
  - Difference largely explained by lower staffing costs, which increase margins
  - Facilities that serve a high share of Medicaid-covered residents also had higher Medicaid margins than other facilities, explained in part by lower staffing rates
- At the state level, differences in payment rates were not clearly correlated with differences in staffing rates
  - Some states with high payment rates and low staffing may not have payment methods that incentivize facilities to spend revenue on staff
  - States with higher minimum staffing standards had higher staffing rates regardless of their payment rates

Potential Payment Principles

Developing Payment Principles

- Despite the data limitations that we encountered, the findings from our work can help inform the development of payment principles that can guide future analyses and payment reforms
- The Commission could also make recommendations to support the adoption of these principles, such as:
  - More data at the federal level to enable future analyses
  - Support for states to conduct their own analyses and test promising practices
- We have organized potential principles and recommendations according to MACPAC's provider payment framework
  - **Economy** is a measure of what is spent on provider payments
  - **Quality and access** are measures of what is obtained as a result of payment
  - **Efficiency** is a measure of what is spent to what is obtained

Economy

- Assessments of Medicaid nursing facility payments require complete data all Medicaid payments and provider contributions to the non-federal share necessary to calculate net payments to providers
  - **Policy option:** CMS should collect payment rate information and data on sources of non-federal share necessary to calculate net payments to providers
- Measures of the costs of care for Medicaid-covered residents should adjusted for differences in resident acuity
  - **Policy option:** Update federal staffing studies that are used to estimate staff time for residents with different care needs

Quality and Access

- Medicaid residents should have equal access to adequately staffed facilities
  - Medicaid payment rates and payment methods can both play a role, but more research is needed to evaluate promising models
  - CMS is expected to revise federal minimum staffing standards in the coming year
- Medicaid payment policy can also help address other quality and access issues, such as:
  - Reducing hospital readmissions and improving other long-stay quality measures
  - Increasing the availability of private rooms
  - Managing nursing facility closures

Efficiency

- More detailed, state-level analyses are needed to assess payment rates relative to quality and access outcomes
  - During prior interviews, the states we spoke with had limited capacity to conduct nursing facility rate studies and we learned that CMS does not require them
  - **Policy option:** Require states to regularly assess payment rates and outcomes, make the results of these analyses publicly available, and provide federal support to help states conduct these analyses
- The Commission may want to comment on other ways to encourage states to test new payment models
  - The Centers for Medicare and Medicaid Innovation (CMMI) has been testing new models for integrating payments for patients dually eligible for Medicare and Medicaid

Next Steps

- Staff would appreciate feedback on payment principles and any recommendations we should include in our forthcoming chapter
  - What issues are most important to highlight?
  - What additional information and analyses would you need to help support your decision making?
- We plan to publish a report with more technical details on our payment and cost findings after it is reviewed by the TEP

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