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Potential Nursing Facility Payment Principles and Recommendations

Robert Nelb and Drew Gerber

MACPAC

Medicaid and CHIP Payment and Access Commission

@macpacgov

www.macpac.gov

Overview

- Outline of nursing facility payment chapter
- Payment principles
  - Economy
  - Quality and access
  - Efficiency
- Potential recommendations
  - Transparency
  - Rate reviews
  - Other policies considered
- Next steps

Background

- Over the past three years, the Commission has conducted a number of analyses of nursing facility payment
  - Compendium of state fee-for-service (FFS) payment methods
  - Interviews with state officials and other stakeholders
  - Analyses of staffing challenges that disproportionately affect Medicaid-covered residents and a review of state policies to help reduce these disparities
  - Analyses of Medicaid payment rates relative to costs
- In this report cycle, we plan to synthesize these findings into a report chapter that outlines policy principles for states to consider when setting nursing facility rates and payment methods

Draft Outline of Chapter

- Context for understanding Medicaid nursing facility payment
  - Characteristics of nursing facilities and nursing facility residents
  - Medicaid's role compared to other payers
  - Nursing facility industry trends, including the effects of the COVID-19 pandemic
- Discussion of payment principles, organized by statutory goals
  - Economy
  - Quality and access
  - Efficiency
- Recommendations

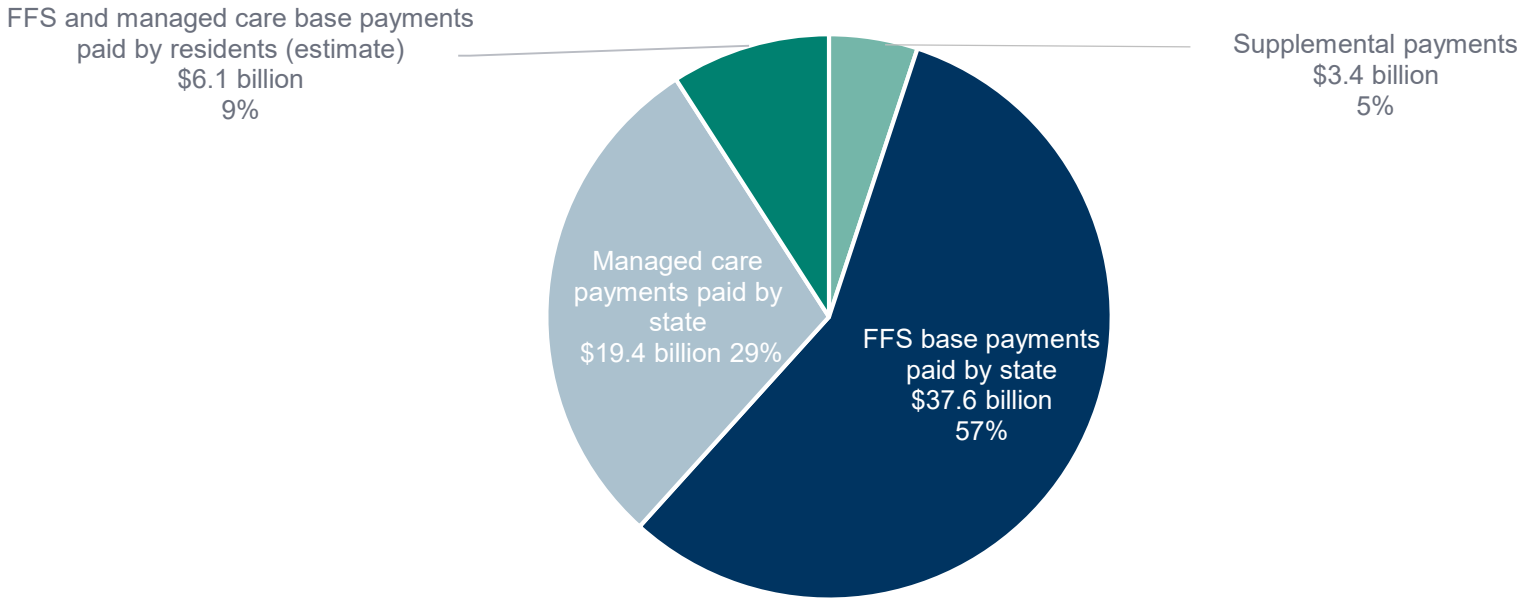
Economy

A measure of what providers are paid

Types of Payments to Nursing Facilities

- Analyses of Medicaid nursing facility payment policy require data on all types of payments to nursing facilities
  - Base payments in FFS and managed care
  - Supplemental payments
  - Resident contributions to their share of cost
- Data on provider contributions to the non-federal share are important to understand the net payments that providers receive
  - Provider taxes
  - Intergovernmental transfers
  - Certified public expenditures

Base and Supplemental Payments to Nursing Facilities, 2019



Notes: FFS is fee for service. Resident contributions to their share of cost are estimated based on the difference between allowed payment rates and actual Medicaid payment amounts in states with available data.
Source: MACPAC, 2022, analysis of CMS-64 net expenditure data and the Transformed Medicaid Statistical Information System (T-MSIS).

Assessing Nursing Facility Payment Rates

- Costs are one of the few benchmarks that can be used to assess Medicaid rates because Medicare rates are not comparable
- Costs are an imperfect measure of payment adequacy
  - Costs may be too low if facilities do not have enough staff
  - Costs may be too high because of related-party transactions that inflate costs
- Historically, Medicaid nursing facility payments were required to cover the costs of efficient and economically operated facilities
  - This requirement (known as the Boren amendment) was repealed in 1996 and replaced with a requirement for a public process to determine rates
  - Section 1902(a)(30)(A) of the Social Security Act still requires payments to be consistent with economy, efficiency, quality, and access

Quality and Access

Measures of what is obtained as a result of provider payments

Nursing Facility Staffing

- Higher direct care staffing hours per resident day (HPRD) has long been associated with better outcomes for patients
- The pandemic has exposed and exacerbated staffing challenges
- States have a variety of tools they can use to improve staffing
  - Increasing Medicaid payment rates to help facilities higher more staff and pay higher wages
  - Incentivizing facilities to spend more of their Medicaid revenue on staff
  - Setting state minimum staffing standards that exceed federal requirements
- The Centers for Medicare & Medicaid Services (CMS) is expected to issue a proposed rule increasing federal minimum staffing standards

High Medicaid Facilities Have Worse Staffing Rates, Which Contributes to Health Disparities

Staffing Rates, Race, and Ethnicity by Payer Mix of Facility, 2019

Characteristics	All facilities	Share of residents whose primary support was Medicaid			
		Lowest quartile (<48%)	Second quartile (48 – 61%)	Third quartile (61-71%)	Highest quartile (>71%)
Share of facilities with a 1- or 2- star staffing rating	**38%**	21%	37%	44%	49%
Race and ethnicity					
White, non-Hispanic	**77%**	86%	81%	74%	65%
Black, non-Hispanic	**13%**	7%	10%	15%	21%
Hispanic	**5%**	3%	4%	6%	7%
Other	**5%**	5%	5%	6%	6%

Notes: Analysis excludes hospital-based nursing facilities and those that are not dually certified by Medicaid and Medicare. A 1- or 2-star staffing rating is equivalent to less than 0.5 hours per resident day (HPRD) of registered nurse (RN) care and 3.6 HPRD of total direct care staffing (RN, licensed practical nurses (LPNs) and certified nurse assistants (CNAs)).
Source: MACPAC, 2022, analysis of Nursing Home Compare, Medicare cost reports, and the Minimum Data Set.

Potential Principles for Using Medicaid Payment Policy to Address Staffing Disparities

- Staffing rates in facilities that serve a high share of Medicaid-covered residents should be no worse than staffing rates in other facilities in the same area
  - Section 1902(a)(30)(A) of the Social Security Act requires states to ensure that beneficiaries have access to "enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"
  - Although there are many non-Medicaid factors that affect staffing rates overall, Medicaid policy can help reduce disparities by payer mix
- Medicaid-covered residents should have access to sufficient staff to meet their care needs (§1919(b)(4)(C) of the Social Security Act)
  - CMS is planning to reassess this statutory requirement when it revises federal minimum staffing standards
  - In the chapter, we can discuss the unique needs of Medicaid-covered residents and the potential implications of changes to federal standards

Efficiency

A measure of what is spent relative to what is obtained

Potential Strategies to Improve Efficiency

- States with relatively high payment rates and low staffing levels may be able to get better outcomes for the same level of spending
  - In particular, payment methods that incentivize facilities to spend more of their revenue on direct care staff may help improve efficiency
  - More detailed state-level analyses are needed to identify the best policy approaches for each state
- In the chapter, we plan to highlight recent reforms in Illinois as an example of data-driven state payment reform
  - The state conducted a two-year review of its payment policies after needing to make changes to its acuity-adjustment system
  - The state identified some Medicare adjustments for therapy services were not appropriate for Medicaid because Medicaid generally does not cover these services
  - The state also targeted new rate increases to facilities that increased staff wages for certified nurse aides with more experience to help improve staff retention

Medicare and Medicaid Alignment

- The vast majority of Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid
- Better alignment between these programs can help improve efficiency
  - Considering the Medicaid implications of changes to Medicare policy, such as recent changes to acuity-adjustment methods
  - Testing new payment models to align payment incentives, learning from recent Centers for Medicare and Medicaid Innovation (CMMI) demonstrations

Potential Recommendations

Draft Recommendation 1

To improve transparency of Medicaid spending, the Secretary of Health and Human Services (HHS) should collect and report facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care, in a standard format that enables analysis. In addition, HHS should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the facility level.

Rationale

- Complete data on Medicaid payments to providers are needed to inform assessments of payment policies
- Recommendation is similar to MACPAC's prior hospital payment recommendation
  - In 2020, Congress partially implemented this recommendation by requiring reporting of supplemental payment data
  - No action yet on transparency of managed care payments or provider contributions to the non-federal share
- Data on resident contributions to their cost of care are particularly important for nursing facility payments because of post-eligibility treatment of income rules
  - These contributions accounted for about 10 percent of nursing facility base payments in 2019
  - Available data on resident contributions is incomplete, especially in managed care
- Provider-level supplemental data that we reviewed for 2019 were incomplete and often did not match CMS-64 expenditure reports
  - Quality of these data may improve as CMS implements new supplemental payment reporting requirements
- Provider contributions to the non-federal share reduce the net payments that providers receive, but CMS does not have a process in place to collect these data

Implications

- Federal government
  - Increased administrative effort, but no expected increase in federal spending
- States
  - Potential for greater administrative effort or new reporting structures
- Providers
  - No anticipated direct effect, although it may enable more stakeholders to participate in the rate development process
- Enrollees
  - No direct effect

Draft Recommendation 2

To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals, the Secretary of Health and Human Services (HHS) should update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents and quality outcomes. HHS should provide analytic support and technical assistance to help states complete these analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet resident's care needs. States and HHS should make facility-level findings publicly available in a format that enables analysis.

Rationale

- Current regulations require states to make annual findings that FFS nursing facility rates are reasonable and adequate to meet the costs of efficiently and economically operated providers
  - Unenforced since the repeal of the Boren amendment
  - Rate studies are still important for informing public engagement in the rate setting process
  - When CMS updates this regulation, it could also consider whether to also require assessments of managed care payment rates
- State-level analyses are needed for an accurate assessment of payment rates because of incomplete federal data and state-specific differences in definitions of allowable costs
- The federal government can help support states by providing more guidance and technical assistance

Implications

- Federal government
  - Increased administrative effort, but no expected increase in federal spending
- States
  - Likely increase in administrative effort, which could be reduced with increased technical assistance and analytic support
- Providers
  - No anticipated direct effect, although it may enable more stakeholders to participate in the rate development process
- Enrollees
  - No direct effect

Other Potential Recommendations Considered

- At the September meeting, staff discussed other potential recommendations, but on further review, we don't have enough information to make specific recommendations
- Updating federal staffing studies
  - A staffing study for CMS is underway
- Encouraging more payment demonstrations
  - Previous CMMI demonstrations had mixed results
  - We do not have a specific model to recommend that CMMI test next

Next Steps

Next Steps

- We plan to incorporate feedback from today's session into a draft chapter
- At a future meeting, commissioners will review the chapter and vote on any recommendations that you would like to pursue

Summary of Recommendations

1. **Transparency:** To improve transparency of Medicaid spending, HHS should:
   - collect and report facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care, in a standard format that enables analysis.
   - collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the facility level.
2. **Rate studies:** To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals, HHS should:
   - update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents and quality outcomes.
   - provide analytic support and technical assistance to help states complete these analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet resident's care needs.
   - States and HHS should make facility-level findings publicly available in a format that enables analysis.

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