January 26, 2023

Nursing Facility Provider Payment Principles

Review of Recommendations and Draft Chapter for March Report

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Overview

- Review of draft chapter for March report
  - Background
  - Medicaid payment policies
  - Using Medicaid payments to improve quality
  - Interaction between Medicare and Medicaid
  - Payment principles
- Proposed recommendations

Background

- Medicaid is the primary payer for most nursing facility residents
- Medicaid payments are generally lower than other payers because:
  - Medicaid-covered residents have lower acuity and fewer services paid for by Medicaid
  - Medicare payment rates typically exceed facility costs
- The nursing facility sector faces many challenges and opportunities
  - Large share of for-profit facilities that are part of chains, including complex ownership models
  - Concern about the effects of closures in rural areas
  - New models of smaller, homelike settings have shown promise
- Facilities that serve a high share of Medicaid-covered nursing facility residents generally have worse quality ratings than other types of facilities
  - Contributes to racial and ethnic health disparities
  - Problems have been exposed and exacerbated by the COVID pandemic
  - However, some facilities that serve a high share of Medicaid residents have five-star ratings

Medicaid Payment Policies

- Since Congress repealed the Boren amendment, states have had considerable flexibility to set nursing facility payment rates
- Most payments are base payment rates made in a fee-for-service (FFS) delivery system but there has been a growing use of supplemental payments and managed care
- States often finance nursing facility payments with provider taxes or intergovernmental transfers (IGTs) and certified public expenditures (CPEs) from publicly owned facilities
- Base payments vary widely by state and for facilities within states
  - Missing complete data on supplemental payments, resident contributions to their share of costs, and provider contributions to the non-federal share

Using Medicaid Payments to Improve Quality

- Medicaid payment policy has the potential to improve staffing rates
  - Staffing is just one measure of quality but has been associated with many positive outcomes and has been a key area of focus for states
  - There is considerable variation in staffing rates by state and also variations in disparities by Medicaid payer mix, suggesting state policy has an important role
- Although prior research suggests that higher Medicaid payment rates can increase staffing, we did not find a clear relationship
- Other state policies may affect the extent to which nursing facilities spend the revenue they receive on direct care staff
  - Medicaid payment methods (e.g., wage pass-through requirements)
  - State minimum staffing standards
- During interviews, states noted several barriers to changing Medicaid payment policies to promote more value

Interaction Between Medicare and Medicaid

- Recent changes to Medicare's acuity adjustment system have been difficult to apply in Medicaid
  - Most states used Medicare's Resource Utilization Group (RUG) model
  - The new Patient Driven Payment Model (PDPM) was not designed for long-stay residents who are primarily covered by Medicaid
- Reducing avoidable hospitalizations for patients dually eligible for Medicare and Medicaid is difficult because payment incentives are not aligned
  - About one quarter of nursing facility residents are hospitalized each year and avoidable hospital use is estimated to cost Medicare and Medicaid $1.9 billion a year
  - After long-stay Medicaid-covered residents are hospitalized, they return to the facility to begin a new Medicare-covered stay at a higher rate
  - Mixed results from prior CMS demonstrations to address these misaligned incentives
  - During the COVID-19 public health emergency, CMS waived the hospitalization requirement to begin a new Medicare skilled nursing stay

Nursing Facility Payment Principles

- Payment rates should cover the costs of economic and efficient providers
  - Important to consider costs needed to meet staffing requirements
  - Concern about related-party transactions that may inflate reported costs
  - Analyses should consider all Medicaid payments that providers receive
- Payment methods should incentivize better quality and reductions in health disparities
  - Medicaid policy is particularly important for addressing disparities by payer mix
  - More evaluation is needed to help policymakers identify the most effective strategies
- States should aim to get the maximum value for the amount they are spending
  - Cross-state comparisons of payment rates and quality outcomes can help identify opportunities to improve efficiency
  - Better alignment of Medicare and Medicaid payment can also help promote efficiency

Proposed Recommendations

Recommendation 1

- To improve transparency of Medicaid spending, the Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report in a standard format that enables analysis:
  - facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care;
  - data on the sources of non-federal share necessary to determine net Medicaid payment at the facility level; and
  - comprehensive data on nursing facility finances necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and examine the effects of real estate ownership models and related-party transactions.

Rationale

- Transparency of Medicaid payments is a long-standing Commission goal and will enable further analyses
- Our review of available federal data found several gaps on base payments, supplemental payments, and provider contributions to the non-federal share
- Comprehensive data on facility finances is also needed to evaluate Medicaid payment rates
  - Similar to the recent National Academies report, the recommendation calls for data on both related-party transactions and real estate ownership models
  - These data are not available on current Medicare cost reports

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
- Health plans
  - May need to provide additional information if not already collected
- Enrollees
  - No direct effect, but over time transparency may lead to changes in payment policies that benefit enrollees

Recommendation 2

- To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 residents' care needs. States and CMS should make facility-level findings publicly available in a format that enables analysis.

Rationale

- 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
- Federal 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 public engagement in the rate setting process
- CMS can make needed changes when updating existing rules
  - Add requirements related to quality and health disparities
  - Could consider whether to include managed care rates
  - CMS can provide more guidance and technical assistance to states

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
- Health plans
  - May need to provide additional information depending on how recommendation is implemented and whether information is already collected
- Enrollees
  - No direct effect, but over time more oversight may lead to changes in payment policies that benefit enrollees

Next Steps

- Chapter will be included in the Commission's March 2023 report
- Vote on recommendations on Friday
- MACPAC will continue monitoring state nursing facility payment policies, including the effects of future changes to federal regulatory requirements, such as minimum staffing standards

Summary of Recommendations

1. **Transparency:** To improve transparency of Medicaid spending, HHS should direct CMS to collect and report in a standard format that enables analysis:
   - facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care;
   - data on the sources of non-federal share necessary to determine net Medicaid payment at the facility level; and
   - comprehensive data on nursing facility finances necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and examine the effects of real estate ownership models and related-party transactions.
2. **Rate studies:** To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, HHS should direct CMS to:
   - update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents
   - This analysis should also include an assessment of how payments relate to quality outcomes and health disparities
   - CMS 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 residents' care needs
   - States and CMS should make facility-level findings publicly available in a format that enables analysis

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Vote on Recommendations for March Report

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Recommendation 2.1

- To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis:
  - facility-level data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care;
  - data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and
  - comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions.

Recommendation 2.2

- To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS 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 residents' care needs. States and CMS should make facility-level findings publicly available in a format that enables analysis.