

Medicaid Nursing Facility Payment Policy

Overview

State Medicaid programs are required to cover nursing facility services, which are services provided by a Medicaid certified institution that offers 24-hour medical and skilled nursing care, rehabilitation, or health-related services to individuals who do not require hospital care.

In fiscal year (FY) 2014, Medicaid spending on nursing facility services was about \$66 billion, or about 14 percent of total program benefit spending. Medicaid is the primary payer of nursing facility services for about 63 percent of nursing facility residents nationally.

States have broad flexibility to determine payments to nursing facilities. MACPAC has documented each state's fee-for-service (FFS) nursing facility payment policy, including how individual states set their payment rates and various adjustments and supplemental payments, in [States' Medicaid Fee-for-Service Nursing Facility Payment Policies](#).

Basis of payment

State Medicaid programs typically pay nursing facilities a daily rate. States often apply a variety of adjustments and incentives to the base payment rates, as described below.

Base payment rates

State Medicaid programs generally establish nursing facility payment rates through a cost-based or price-

based methodology. In a few cases, states use a combination of the two.

- **Cost-based:** Rates are established based on each nursing facility's reported costs. Typically each facility's costs are divided by the number of days a patient is in the facility to determine a per diem (daily) amount. Facilities are then paid their actual costs per day up to a predetermined ceiling.
- **Price-based:** Rates are established based on the costs of a group of facilities. All facilities in a group are paid the same base rate or price per day.

As of October 2014, 30 states used cost-based methods and 12 established prices for nursing facilities. Nine states used a combination of these approaches.

Cost centers

In most cases, nursing facility rates are determined based on providers' reported costs. Related costs are grouped into cost centers and the total per diem rate is a sum of the daily rates determined for each cost center. The most common cost centers are direct care, indirect or ancillary care, administration, and capital.

- **Direct care** generally consists of nursing salaries, fringe benefits, and medical supplies. Direct care costs are often adjusted for acuity as described later in this brief.



- **Indirect care** generally includes social services, patient activities, medical directorship, clinical consultants, and associated fringe benefits.
- **Administration** includes all other nursing facility operating expenses such as facility administration, dietary, housekeeping, maintenance, laundry, utilities.
- **Capital** includes depreciation, mortgage interest, lease expense, and property taxes. In some cases, capital expenses are paid based on the fair rental value of the facility in lieu of actual property costs.

Some states also include some pass-through payments in their rates. These include costs allocated to the Medicaid program that are fully reimbursed without limitation, such as the Medicaid share of health care related taxes. Some states also include the Medicaid share of property taxes.

Payment adjustments

States typically adjust base nursing facility rates according to a variety of factors. The most common adjustments include:

- **Acuity or case-mix:** Most states adjust rates to account for the acuity (level of need) of nursing facility residents, and the most common source of information on resident acuity is known as the Minimum Data Set (MDS), which is also used to determine Medicare nursing facility payment. As of October 2014, 40 states adjusted rates based on acuity.
- **Peer groups:** Some states determine rates based on peer groups of facilities of similar size and in the same geographic area. As of October 2014, 29 states based rates, at least in part, on number of beds or geography.

- **High-need patients:** Rates are often adjusted to account for residents with particularly high needs such as ventilator dependence or traumatic brain injury. As of October 2014, 39 states adjusted rates, at least in part, based on specific high-need conditions.

Other less common adjustments to nursing facility rates include those for public facilities and those with particularly high Medicaid patient volumes.

Additional payments

States may also make supplemental payments or incentive-based payments to nursing facilities:

- **Supplemental payments:** These are typically lump-sum payments that are not directly associated with an individual nursing facility service. Such payments are often made to public facilities. As of October 2014, 20 states reported making supplemental payments to nursing facilities.
- **Incentive payments:** As of October 2014, 23 states made incentive payments based on measures of quality of care. Also, 23 states made payments based on efficiency, typically to reward providers for keeping costs below a specified amount.

Nursing facility payment process

In most cases, nursing facility payment is triggered when a nursing facility submits a claim indicating that a service has been provided. There are many state and federal requirements that providers must comply with in order to receive payment for services, including the federal rules contained in Title 42 of the Code of Federal Regulations (CFR), Parts 440



through 456; state statutes and regulations; and billing instructions in state-specific provider manuals.

Nursing facilities typically submit claims to the state Medicaid agency (or its fiscal agent) for payment. Most claims are submitted electronically in a standardized format consistent with the requirements of the Health Insurance Portability and Accountability Act (HIPAA, P.L.104-191) and federal regulations, including the use of a provider's national provider identifier. Because nursing facilities provide long-term care, their claims typically cover multiple days. For ongoing stays, claims may be submitted monthly.

Many nursing facility residents are responsible for a portion of the payment for their stay. In such cases, nursing facilities typically collect these amounts from residents and the balance is paid by Medicaid.

More information can be found in a separate brief on the [Medicaid fee-for-service payment process](#).

Payment policy issues

Federal rules do not prescribe how nursing facilities should be paid or how much they should be paid, but require that Medicaid payment policies should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization. Rates are required to be developed through a public process and published. While per diem rates are the predominant method of Medicaid nursing facility payment, the basis for individual rates varies and there is considerable variation in rates both within and across states.

As noted above, many states also make supplemental payments, which comprise the difference between Medicaid payments for services and what Medicare would have paid for the same

services (in the aggregate), also referred to as the upper payment limit (UPL). In FY 2014, states reported making about \$3 billion in supplemental payments to nursing facilities. Because UPLs are tied to the services rendered by entire classes of providers rather than individual providers, states have discretion in allocating these supplemental payments among individual institutions within a class. For more information on MACPAC's framework for evaluating provider [payment policy](#), see [Chapter 7 in MACPAC's March 2015 report](#).

Providers often question the adequacy of Medicaid payments, particularly when states reduce rates. In some cases, providers have contested payment reductions in federal court. However, on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided, in *Armstrong v. Exceptional Child Center, Inc.*, that that Medicaid providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under 1902(a)(30)(A) of the Social Security Act.

On January 4, 2016, the Centers for Medicare & Medicaid Services implemented new regulations at 42 CFR Part 447 that create a standardized, transparent process for states to follow prior to implementing Medicaid provider payment rate reductions or changes in the provider payment structure for services provided on a fee-for-service basis. States are now required to consider input from providers, beneficiaries, and other stakeholders when evaluating the potential impacts of rate changes. In addition, states need to analyze the effect that rate changes may have on beneficiary access to care and then monitor the effects for at least three years after the changes are effective.

