MACPAC

Payment Methods and Recent Developments in Nursing Facility Payment Policy

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Payment methods
  - Base payments
  - Supplemental payments
- Recent policy developments
- Policy questions and next steps

Background

- Nursing facility services are the second-largest category of Medicaid spending, after hospital services
  - $56.7 billion in fiscal year (FY) 2016
  - 10 percent of Medicaid spending and 34 percent of spending on long-term services and supports (LTSS)
- In 2017, Medicaid was the primary payer for 62 percent of nursing facility residents nationally
- Most Medicaid enrollees who use nursing facilities are also eligible for Medicare

Medicare and Medicaid Nursing Facility Benefits

Medicare

- Only covers skilled nursing care following a hospital stay of at least 3 days
- Limited to 100 days per spell of illness
- Paid under a prospective payment system that will be changing in October 2019

Medicaid

- Covers skilled nursing and long-term care, regardless of whether the individual was hospitalized first
- No duration limit
- Payment methodologies vary by state

Provider Payment Framework

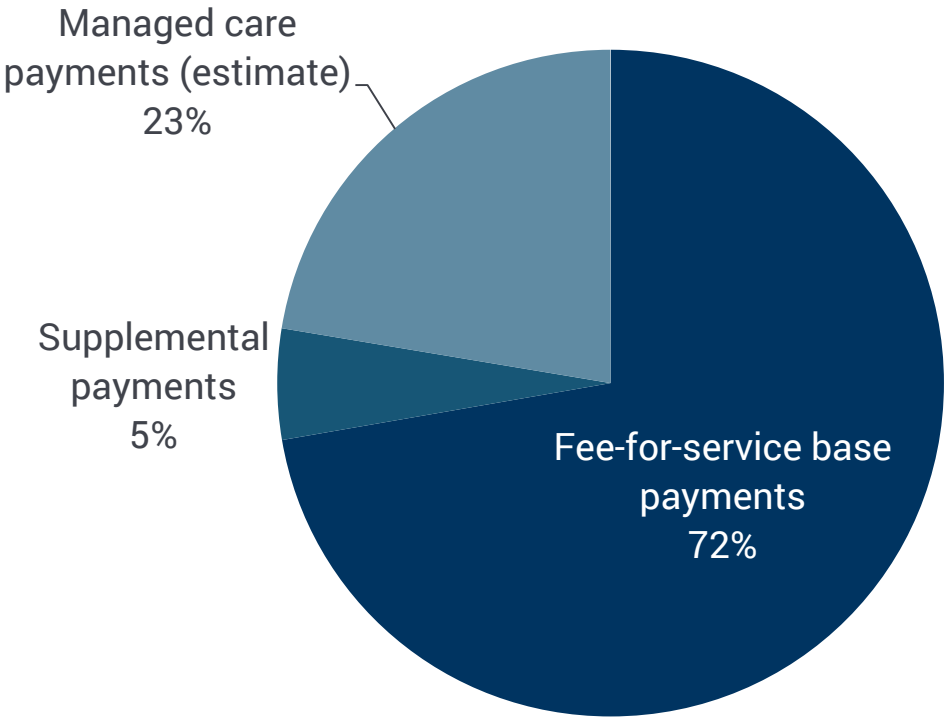
- MACPAC's framework is based on the statutory principles of Medicaid payment policy
  - Economy: What is spent on provider payments
  - Access and quality: What is obtained as a result of the payment
  - Efficiency: A measure that compares what is spent to what is obtained
- To evaluate whether policies are consistent with statutory principles, we need information on:
  - Payment methods
  - Payment amounts
  - Outcomes related to the payment

Payment Methods

Payment Policy Review

- MACPAC reviewed Medicaid fee-for-service (FFS) payment policies for nursing facilities as of July 2019
  - Update to MACPAC's prior compendium of nursing facility payment policies as of October 2014
  - Does not include information on managed care payments to nursing facilities
- Overall, there has been little change in nursing facility payment methods

Base and Supplemental Payments to Nursing Facilities, FY 2016



Total spending: $56.7 billion

Notes: FY is fiscal year. Estimated managed care payments are based on state-reported spending for all states except California, Michigan, and South Carolina.
Source: MACPAC, 2019, analysis of CMS-64 Financial Management Report net expenditure data as of July 20, 2018 and Eiken et al. 2018, Medicaid expenditures for long-term services and supports in FY 2016, available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.

FFS Base Payments

- States typically pay nursing facilities a daily rate
  - 31 states establish per diem rates based on costs
  - 14 develop payment rates using a pre-determined price
  - 4 states use a combination of approaches
- Common adjustments to nursing facility base payment rates include:
  - Acuity or case-mix (42 states)
  - High-need conditions (43 states)
  - Peer groups, e.g., geography or bed size (37 states)

FFS Supplemental Payments

- As of July 2019, 24 states made FFS supplemental payments to nursing facilities
- 18 states target nursing facility supplemental payments to government-owned facilities
  - These payments are often financed by intergovernmental transfers (IGTs)
  - Some public hospitals buy or lease privately-owned nursing facilities to receive supplemental payments

Upper Payment Limit (UPL)

- Base and supplemental FFS payments cannot exceed the UPL in the aggregate for a class of providers
  - The UPL is based on a reasonable estimate of what Medicare would have paid for the same service
  - States demonstrate UPL compliance annually
- We compared state fiscal year 2016 nursing facility UPL demonstrations to actual spending
  - Large discrepancies between actual and reported data
  - Few concerns about total spending exceeding the UPL

Managed Care Payments

- 24 states use managed long-term services and supports to cover some or all nursing facility services in their state
- We do not know much about how managed care plans pay nursing facilities
  - Payments are likely similar to FFS since managed care capitation rates are often based on FFS rates
  - Some states require plans to pay no less than the Medicaid FFS rate

Recent Policy Developments

Medicare Payment Changes

- Beginning October 2019, Medicare is adopting a new payment method for nursing facility care, the patient driven payment model (PDPM)
- By October 2020, Medicare will stop supporting its previous methodology for classifying patient acuity: resource utilization groups (RUGs)
  - 34 states currently use RUGs to make Medicaid payments to nursing facilities
  - 33 states use RUGs to calculate the UPL

Other Policy Issues

- Nursing facility quality and safety
  - Nursing facilities that serve a higher share of Medicaid patients generally have lower quality ratings than other facilities
- Nursing facility closures
  - Concerns about the effects of closure on access, especially in rural areas
  - Some closures may be related to low Medicaid payment rates

Policy Questions

- How do Medicaid payments to nursing facilities compare to Medicare?
- How will the upcoming changes to Medicare payment policies affect Medicaid?
- How does the use of IGTs and provider taxes to finance nursing facility payments affect Medicaid payment policies?
- What is the role of Medicaid payment policy in nursing facility closure?

Next Steps

- Plan to publish updated nursing facility payment compendium and issue brief this fall
- Potential proposed rule on FFS supplemental payments expected this fall
- Seek Commissioner feedback on areas for future work
  - What policy questions should we prioritize?
  - What types of analyses would be most helpful?

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