Nursing Facility Fee-for-Service Payment Policy

Nursing facility services are mandatory benefits that all state Medicaid programs must cover. Nursing facilities are institutions certified by a state to offer 24-hour medical and skilled nursing care, rehabilitation, or health-related services to individuals who do not require hospital care. In 2016, there were about 15,600 nursing homes in the United States and about 95 percent of these were certified by state Medicaid programs (NHCS 2019).

Medicaid nursing facility residents account for a disproportionate share of Medicaid spending. In FY 2013, Medicaid fee-for-service (FFS) spending for beneficiaries residing in nursing facilities, who made up about 2 percent of all Medicaid beneficiaries, accounted for approximately 20.4 percent of total Medicaid spending (MACPAC 2018).[1]

Nursing facility residents are a diverse group, spanning a range of ages with different types of physical and cognitive disabilities that affect their ability to conduct activities of daily living. Beneficiaries receive services and supports for years or even decades, and the types and intensity of services they require can vary significantly among each other and over time.

In 2017, Medicaid was the primary payer of nursing facility services for about 62 percent of nursing facility residents nationally (KFF 2019). In fiscal year (FY) 2016, Medicaid spent approximately $56.7 billion on nursing facility services, which was 34 percent of total long-term services and supports (LTSS) spending and 10 percent of Medicaid spending overall (Eiken et al. 2018). Although states now spend more on home and community-based services than on institutional LTSS, nursing facility services remain the second-largest portion of Medicaid spending, after hospital services.

State Medicaid programs have broad flexibility to design their own payment methods; federal rules do not prescribe how or how much nursing facilities should be paid. Section 1902 (a) of the Social Security Act simply requires Medicaid payment policies to promote efficiency, economy, quality, access and safeguard against unnecessary utilization. It requires states to develop rates through a public process and publish them.

MACPAC has documented each state's FFS nursing facility payment policies in *States' Medicaid Fee-for-Service Nursing Facility Payment Policies* (MACPAC 2019). This brief summarizes trends in state policies and discusses recent policy developments.

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Payment Policies

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

Basis of payment

The per diem rate is generally developed from facilities' reported costs or by states establishing a price prospectively. In a few cases, states use a combination of the two or a unique state-based method.

- **Cost-based.** Each facility's costs are submitted on a cost report form and are divided by the number of days a patient is in the facility to determine a daily amount. Facilities are paid their actual costs per day up to a predetermined ceiling, described below. As of July 2019, 31 states have established base rates using nursing facility reported costs.

- **Price-based.** Prices are developed prospectively by the state and are established for each facility or resident. Facilities still submit cost reports, but this information is used to establish set prices for future rate years. As of July 2019, 15 states used this methodology.

States make other policy determinations in establishing base per diem rates for nursing facilities. For example:

- **Rebasing.** States periodically update cost reports they use to calculate base rates, a practice known as rebasing. Twenty-two states rebase costs annually; 12 states rebase costs every two to four years. The remaining state Medicaid programs either do not specify a rebasing frequency or rebase less often. States that rebase less frequently risk paying facilities outdated amounts that may not account for inflation and other changes in costs.

- **Bed hold.** Nursing facility residents may take a short leave of absence from the facility either for an inpatient hospital stay or for therapeutic leave (e.g., family visits). States may choose to continue to pay the per diem rate for these patients during these periods to reserve their beds, or discontinue payment temporarily. If states allow payment for these reserved beds, they specify a maximum number of days allowed and may pay only a percentage of the per diem rate. Forty-three states allow payment for held beds.

Cost centers

Cost centers are the detailed cost and rate information used to calculate payments to nursing facilities. Related costs are grouped into cost centers, and the daily rates for each cost center are added together when determining the total per diem rate for that facility. States generally limit payments within each cost center by establishing payment ceilings between 105 and 125 percent of the median or the average costs of the facility, peer group, or state. States that establish per diem rates for price may set a specific dollar amount as the price ceiling.

States determine components of each cost category (category titles may vary), the most common cost centers are described below:

- **Direct care**. Direct care includes medical supplies and salaries and benefits for those providing services directly to facility residents. Since MACPAC originally collected information on state policies in 2014, three states have raised the direct care ceiling while nine states either lowered the ceiling or introduced a limit where none was previously found.

- **Indirect care.** The indirect care cost center incorporates ancillary costs such as social services, patient activities, medical directorship, and clinical consultants. Generally, the ceiling is set at either the same, or 5 to 10 percentage points less than the ceiling for direct care costs.

- **Administration.** Administration generally includes administrative services, meals and special dietary provisions, housekeeping, maintenance, laundry, and utilities. Payment ceilings for administration are typically set at a few percentage points less than the indirect care ceiling.

- **Capital.** Capital costs are those incurred for the physical building and typically include costs such as depreciation, mortgage interest, lease expense, and property taxes. While some states use similar methodologies to pay for capital as they do for other cost centers, the most common method of paying for capital expenses (21 states) is by calculating the fair rental value of the facility in lieu of actual property costs. The fair rental value system accounts for property-related expenses to provide an estimate of rental value, and is intended to lower providers' incentive to perform unnecessary services, as is often associated with paying based on costs incurred (Buchanan et al. 1991).

States also frequently place parameters around payment in terms of the occupancy rate within a facility. Twenty-seven states had occupancy rate minimums between 80 and 96 percent, meaning that they will generally calculate payment as though 80 to 96 percent of beds are being utilized. In some cases, the occupancy rate minimum only applies to certain cost centers. For example, Arkansas determines capital costs by assuming an occupancy rate of at least 80 percent.

Payment adjustments

States typically adjust base rates to nursing facilities using a variety of factors. The most common adjustments are described below.

- **Acuity or case mix.** These adjustments categorize patients in terms of their relative needs and resource use. This adjustment is generally applied only to direct care services. As of July 2019, 42 states adjusted base rates by patient acuity. The majority of these states (34) used the resource utilization group (RUG) case mix system used in Medicare.[2] Each RUG has nursing and therapy weights that are based on patient characteristics and services that are expected to require similar resources.

- **Peer grouping.** Most states also adjust rates based on groups of facilities in the same geographic area, with similar numbers of beds, or that serve a certain percentage of patients with similar acuity levels. As of July 2019, 38 states grouped nursing facilities by one or more of these peer categories.

- **High-need patients.** States also frequently provide rate adjustments to facilities based on the types of services provided. For example, 37 states provide adjustments for facilities that provide ventilator services and 22 states provide adjustments for facilities treating patients with certain mental health or other cognitive impairments. Some states also adjust payment rates to facilities serving patients with AIDS, multiple sclerosis, or other extreme care needs.

Additional payments

States may also make supplemental or incentive payments to nursing facilities.

- **Supplemental payments.** Supplemental payments are intended to make up the difference between base fee-for-service payments and the amount that Medicare would have paid for the same service; they are also called upper payment limit (UPL) payments. They are typically lump-sum payments provided to a targeted group of facilities. As of July 2019, 25 states provided some type of supplemental payment to nursing facilities, an increase from 20 states in 2014. Government-owned facilities continued to be the most common provider type to receive these payments, with 18 states providing supplemental payments to public facilities.

- **Incentive payments.** Incentive payments are generally established to encourage providers to implement certain initiatives or meet specific metrics. As of July 2019, 25 states provided incentives for quality initiatives and 17 states had efficiency incentives. Incentive payments are also provided for other initiatives such as encouraging enhanced nursing facility staffing levels in Texas and support for infectious disease or technology dependent care in Louisiana.

Nursing Facility Payment Process

In most cases, nursing facility payment is triggered when a provider 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 42 CFR 440–456; 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 those governing the use of a provider's national provider identifier. Nursing facility 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 first, and Medicaid pays the balance.

Policy Issues

Although states have flexibility to create and adjust Medicaid payment policies related to nursing facilities, recent Medicare policy developments may affect how states pay nursing facilities payment. Providers have also frequently questioned the adequacy of Medicaid payments, particularly when states reduce rates.

Interaction with Medicare payment policy changes

As discussed previously, 42 states adjust nursing facility payments based on residents' acuity, or level of need. The acuity of Medicare and Medicaid residents is calculated using a federally mandated assessment called the minimum data set (MDS), which contains a standardized set of essential clinical and functional status measures (CMS 2018). Due to an October 1, 2019 change in the way nursing facilities measure the acuity of and receive payment for Medicare residents, the Centers for Medicare & Medicaid Services (CMS) plans to remove certain data elements from the MDS and discontinue use of the RUGs for Medicaid patients on October 1, 2020.

The Medicare methodology has changed from RUG-adjusted payments to the Patient Driven Payment Model (PDPM). The PDPM seeks to connect payment to individual resident acuity as opposed to linking payment levels to the amount of therapy used. This methodology has the potential to reduce incentives for nursing facilities to provide unnecessary care (MedPAC 2019).[3] Although the payment change could reduce Medicare payments to individual providers, it is intended to be budget neutral in the aggregate.

In order to continue using RUGs for Medicaid residents, states would need to require nursing facilities to submit the data that are no longer part of the MDS through an optional state assessment. Alternatively, states could adopt the PDPM for Medicaid nursing facility payments; however, states may need to customize their assessment data collection in order to measure acuity of Medicaid patients in the same way as Medicare patients.

Medicaid patients may experience unintended consequences of Medicare's move to PDPM payment. For example, provider downsizing and restructuring has already been reported in certain nursing facilities, which could affect access to care (Spanko 2019).

The elimination of the RUGs case mix methodology will also affect how states calculate the UPL for nursing facility payments. In state fiscal year 2016, 33 states calculated the UPL based on what Medicare would have paid for specific RUGs, so these states will develop a methodology based on the PDPM or switch to another method for calculating the UPL, such as a cost-based method based on estimates of facility costs of serving Medicaid patients.

Endnotes

[1] Due to the unavailability of current Medicaid Statistical Information System (MSIS) or Transformed MSIS data, 2013 is the most recent data available for this analysis. As of June 2019, 24 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and

supports to certain beneficiaries. Managed care organizations that operate MLTSS plans receive a capitated payment from the state to provide the broad range of LTSS. Most MLTSS programs include nursing facility services, but a few programs carve out all or certain portions of nursing facility stays (Lewis et al. 2018). This issue brief focuses on institutional LTSS provided via fee-for-service arrangements.

[2] As of October 1, 2019, the Centers for Medicare & Medicaid Services (CMS) replaced the Medicare RUG case-mix assessment methodology with the Patient Driven Payment Model (PDPM). This change is described later in this issue brief.

[3] MedPAC has also recommended that payments for all types of post-acute care providers be standardized in order to reduce incentives for patients to be served in the highest paying sites. The PDPM model does not address this recommendation (MedPAC 2019).

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