

Chapter 2:

Principles for Assessing Medicaid Nursing Facility Payment Policies

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Recommendations

- 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.
- 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 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.

Key Points

- Medicaid is the largest payer for nursing facility care and has an important role to play in reducing health disparities that have been exacerbated by the COVID-19 pandemic.
- Medicaid payment rates and methods vary widely by state, and there are limited data available about how rates compare to costs and how Medicaid payment policies affect quality outcomes.
- Most Medicaid-covered nursing facility residents are dually eligible for Medicare, but payment incentives for Medicare and Medicaid are not well aligned.
- To advance Medicaid statutory goals of efficiency, economy, quality, and access, states should do the following:
 - ensure that nursing facility payment rates are sufficient to cover the costs of efficient and economically operated facilities;
 - design payment methods to incentivize better quality outcomes and reduce health disparities; and,
 - aim to get the maximum value for the amount that they are spending.

CHAPTER 2: Principles for Assessing Medicaid Nursing Facility Payment Policies

Medicaid is the largest payer for nursing facility care and has an important role to play in improving the care that nursing facility residents receive. However, facilities that serve a high share of Medicaid-covered residents have long had worse quality outcomes on average than other facilities. The COVID-19 pandemic has exposed and exacerbated many of these disparities. In response, policymakers are considering a variety of reforms to how they regulate and pay for nursing facility care.

The Commission has identified several principles for states to consider when setting Medicaid nursing facility payment rates and payment methods. These principles are intended to advance the statutory goals of Medicaid payment policy: economy, efficiency, quality, and access (§1902(a)(30)(A) of the Social Security Act (the Act)).

First, in the Commission’s view, Medicaid payments should be sufficient to cover the costs of efficient and economically operated nursing facilities. When assessing payment adequacy, states should consider all types of Medicaid payments that providers receive and review reported costs carefully. For example, states should consider the costs of staffing facilities at appropriate levels to meet residents’ care needs and the potential for transactions with related parties in the same nursing facility chain to inflate costs reported on state cost reports.

Second, states should design nursing facility payment methods to incentivize better quality outcomes and reductions in health disparities. Although many of the factors that affect quality care are outside of Medicaid’s authority, the persistent disparities between Medicaid-covered residents and those covered by other payers are an issue that Medicaid payment policy can help address. Doing so would also help reduce racial and ethnic disparities.

Finally, nursing facility payment policies should be evaluated based on whether they are efficient—that

is, whether states are getting the maximum value for the amount they are spending. Comparing payment rates and quality outcomes across states can help identify potential opportunities to improve efficiency, particularly in states with relatively high payment rates and poor outcomes. In addition, policymakers should continue to explore opportunities to improve efficiency across payers by better aligning payment incentives for patients dually eligible for Medicare and Medicaid. More detailed state-level analyses are needed to identify the best approaches for each state, which would require increased state capacity to examine these issues.

The Commission recommends that the Secretary of the U.S. Department of Health and Human Services (HHS) direct the Centers for Medicare & Medicaid Services (CMS) to take the following actions to improve the availability of data to assess whether state payment policies are consistent with these principles:

- To improve transparency of Medicaid spending, the Secretary of HHS should direct CMS 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.
- To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals of efficiency, economy, quality, and access, the Secretary of 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.

The Commission reviewed data on Medicaid payment methods, payment amounts, and quality outcomes to better understand the factors that affect the development of nursing facility payment policies and whether they are achieving their intended goals. This chapter summarizes the Commission's analyses, which informed the development of the Commission's payment principles and recommendations. The chapter begins with background information on nursing facility industry trends and Medicaid's role relative to other payers. Then it discusses current Medicaid payment policies, how they can be used to improve quality, and how they align with other payers. The chapter concludes by discussing the payment principles, recommendations, and supporting rationale in more detail.

As more information on Medicaid nursing facility payments becomes available, the Commission will continue to monitor state payment policies. In particular, the Commission will closely follow how any future changes in federal regulatory requirements (e.g., minimum staffing standards) affect states, providers, and beneficiaries.

Background

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.¹ Medicaid is the primary payer for most nursing facility residents, but it generally pays less than other payers. The nursing facility industry faces a number of challenges, which are generally worse for facilities that serve a high share of Medicaid-covered residents and have been exacerbated by the COVID-19 pandemic.

Role of nursing facilities in the continuum of care

Nursing facilities provide both short-term care for patients recovering from a hospital stay and long-

term care for residents who need ongoing assistance with activities of daily living. Of the approximately 1.1 million patients and residents receiving care in nursing facilities on September 30, 2019, about half had short stays of less than 100 days, and half had long stays of more than 100 days (Abt Associates 2020).²

The short-term care that nursing facilities provide (referred to as "skilled nursing facility (SNF) services") is part of the continuum of post-acute care after a hospital stay. Nursing facilities generally provide more intensive care than home health providers and less intensive care than rehabilitation or long-term care hospitals. In 2019, nursing facilities accounted for about half of all Medicare hospital discharges to post-acute care providers (MedPAC 2022a).

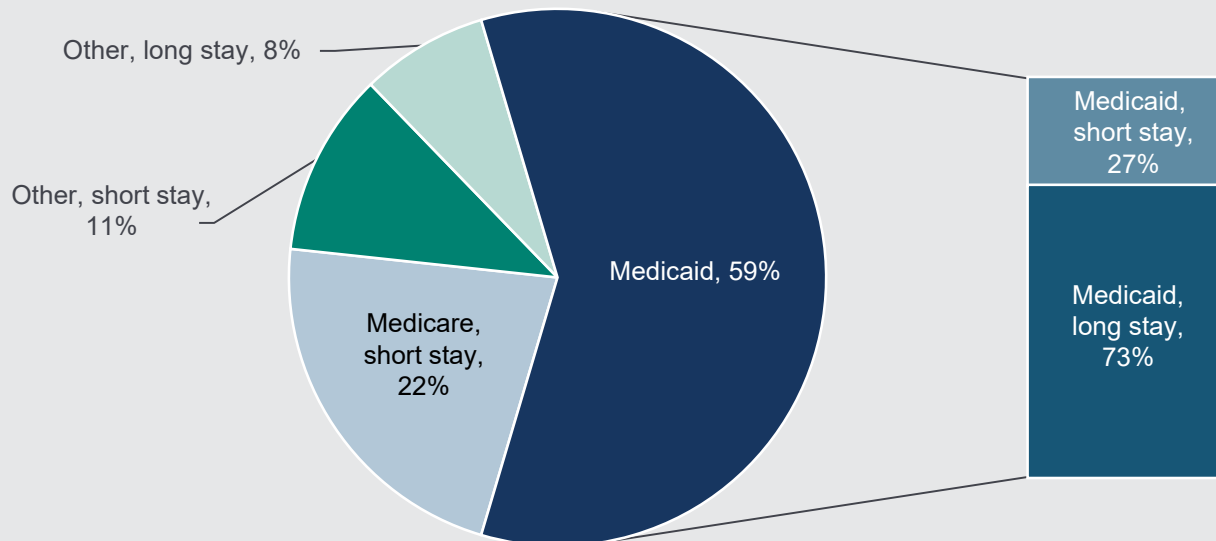
The long-term care that nursing facilities provide is also part of the continuum of long-term services and supports (LTSS). Nursing facility services remain an important site of care for beneficiaries who are not able to receive care in the community. In fiscal year 2019, nursing facility services accounted for about 80 percent of Medicaid spending on institutional LTSS, 33 percent of total Medicaid LTSS expenditures, and 11 percent of total Medicaid spending (Murray et al. 2021).³

Medicaid coverage of nursing facility care

In 2019, Medicaid was the primary payer for 59 percent of nursing facility residents (Figure 2-1). Most Medicaid-covered nursing facility residents had long stays, but about one-quarter of Medicaid-covered residents had short stays of less than 100 days. Medicare is the largest payer of short-stay nursing facility residents. About 19 percent of nursing facility residents were not covered by either Medicare or Medicaid. Long-stay residents not covered by Medicare or Medicaid likely paid for their care out of pocket because private insurance coverage for long-term care is rare.⁴

About 90 percent of Medicaid-covered nursing facility residents are older than age 65 (Abt Associates 2020). Non-elderly Medicaid beneficiaries with a need for institutional LTSS are often served in other settings, such as intermediate care facilities for individuals with intellectual or developmental disabilities, which are outside the scope of this chapter (ASPE 2013).

FIGURE 2-1. Characteristics of Nursing Facility Patients and Residents by Primary Payer and Length of Stay, 2019



Notes: Short-stay patients are defined as individuals residing in the facility for less than 100 days. Long-stay residents are defined as residing for more than 100 days. Analysis is based on nursing facility residents who were active on September 30, 2019. Length of stay is based on the number of days between the entry date and the target date of the latest Minimum Data Set assessment used in the analysis, not the discharge date of the stay.

Source: Abt Associates 2020.

Medicaid eligibility requirements. To qualify for Medicaid coverage, nursing facility residents must have low income and assets. Many Medicaid-covered nursing facility residents are eligible through mandatory eligibility pathways that are tied to the receipt of supplemental security income (SSI), which in 2022 had an income limit of \$841 a month and an asset limit of \$2,000 for individuals. As of 2018, 42 states also provided Medicaid coverage to nursing facility residents with incomes up to 300 percent of the SSI limit (an option referred to as the “special income rule”), 25 states used the medically needy option to allow higher-income individuals to qualify for Medicaid coverage by subtracting the amount that they paid for their care from their income (a process referred to as “spenddown”), and 21 states provided coverage to seniors and persons with disabilities up to 100 percent of the federal poverty level regardless of whether they had a nursing facility level of care (referred to as the “poverty-level pathway”) (Musumeci et al. 2019).⁵ According to an analysis by the HHS Assistant Secretary for Planning and Evaluation using 2006–2007 data, 22 percent of Medicaid-covered

nursing facility residents qualified through SSI-related pathways, 50 percent qualified through the special income rule, 21 percent qualified through a medically needy pathway, and about 7 percent qualified through the poverty-level pathway (ASPE 2013).

Because the out-of-pocket costs for nursing facility care are substantial and few individuals have private long-term care insurance, many private-pay nursing facility residents with long stays eventually become eligible for Medicaid after spending most of their income and assets toward the cost of their care.⁶ In 2001, more than half of Medicaid-covered nursing facility residents began their Medicaid coverage after residing in the nursing facility, and 21 percent of Medicaid-covered residents began coverage after residing in the facility for more than six months (Wenzlow et al. 2008).

Post-eligibility treatment of income. Unlike many other Medicaid beneficiaries who have little or no cost-sharing obligations, recipients of LTSS are required to contribute most of their income toward the cost of their care through a process known as “post-eligibility

treatment of income.” The amount of income that a beneficiary can retain is set by the state’s personal needs allowance and other exceptions.⁷ In 2018, the median state personal needs allowance for institutional care was \$50 per month, meaning that in most states, all but a small amount of a Medicaid-covered resident’s income went toward the cost of their care (Musumeci et al. 2019).

Residents’ contributions to the cost of their care reduce the amount of state and federal Medicaid payments that a facility receives. In 2019, these contributions accounted for about 10 percent of Medicaid payments to nursing facilities (MACPAC 2023a).

Patients dually eligible for Medicare and Medicaid.

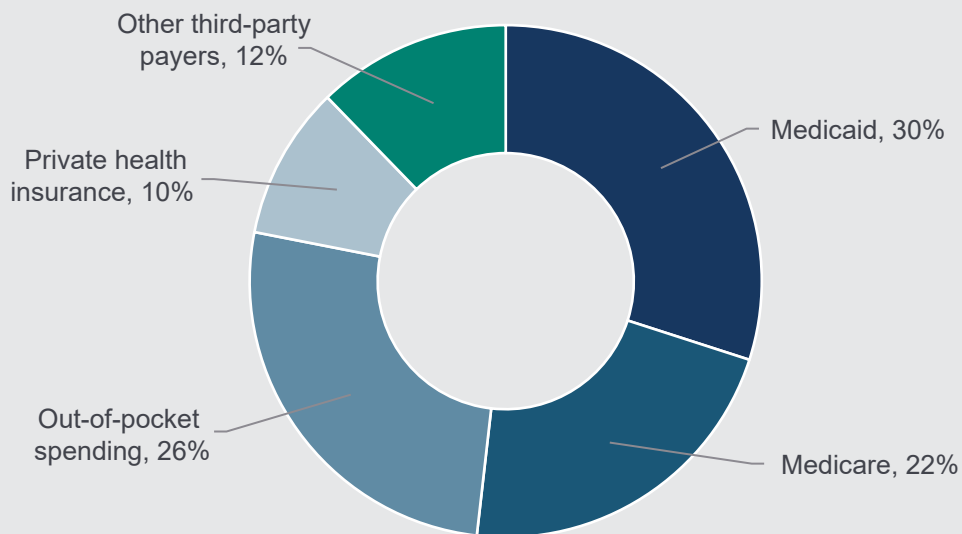
The vast majority (84 percent) of Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid (Abt Associates 2020). For these beneficiaries, Medicare pays for SNF care during the initial portion of their stay, and Medicaid pays for subsequent days of care. Medicare Part B also continues to cover physician and therapy services for long-stay nursing facility residents after

the Medicare Part A SNF benefit is exhausted. State Medicaid programs have the option to pay for Medicare cost sharing during the initial portion of the stay, but most do not, which results in lower payments to the facility (MACPAC 2013).

Medicaid payments compared with other payers

According to the National Health Expenditure Accounts, Medicaid accounted for 30 percent of total revenue for all nursing facilities, including those that were part of continuing care retirement communities, in 2019 (Figure 2-2). Although Medicaid is the largest payer for nursing facility services, Medicaid payments as a share of total revenue are much lower than the share of nursing facility residents covered by Medicaid (59 percent) (Abt Associates 2020). Medicaid payments are generally lower than other payers because of differences in the services that Medicaid covers and because Medicare typically pays facilities much more than the costs of care for Medicare-covered patients.

FIGURE 2-2. Sources of Revenue for Nursing Facilities and Continuing Care Retirement Communities, 2019



Note: Analysis includes all certified nursing facilities, including those part of continuing care retirement communities.

Source: OACT 2022.

Differences in resident acuity and covered services.

Medicaid payment rates are not comparable to those in Medicare because of differences in resident acuity and the services that Medicaid covers. First, long-stay residents, who are predominately covered by Medicaid, generally have less intensive nursing and therapy care needs than short-stay patients covered by Medicare, so the costs of their care are lower (MACPAC 2023a, Abt Associates 2020). Second, for patients dually eligible for Medicare and Medicaid, Medicare Part B continues to pay for some physician and therapy services for long-stay residents, and so these services are not included in the Medicaid rate. Third, because of Medicaid spenddown and post-eligibility treatment of income rules, many Medicaid-covered residents pay for a substantial portion of their care out of pocket, which reduces the amount that Medicaid pays the facility.

Medicare payment rates often exceed facility costs.

According to the Medicare Payment Advisory Commission (MedPAC), Medicare has long paid SNF payments much more than their costs of care for Medicare-covered patients. For example, freestanding nursing facilities reported a 20 percent aggregate Medicare profit margin in fiscal year 2019, compared with an aggregate non-Medicare margin of -2 percent (MedPAC 2021). Although some stakeholders contend that high Medicare payment rates are justified because they can offset low Medicaid payment rates, MedPAC has long argued that this policy is inefficient, since the policy benefits facilities that serve more Medicare-covered residents instead of facilities that serve a high share of Medicaid-covered residents (MedPAC 2022b). In addition, because Medicare payment rates are set nationally, they do not account for differences in Medicaid payment rates across states. As discussed in the following sections, state payment rates vary widely, and in some states, facilities report positive Medicaid margins.

Industry trends

In 2019, there were 15,462 certified nursing facilities nationwide. Most nursing facilities (93 percent) are certified by both Medicare and Medicaid, and most of these facilities (97 percent) are freestanding, meaning that they are not based within a hospital. Roughly 9 percent of facilities are part of a continuing care retirement community, which includes assisted living options in addition to certified nursing facility beds (Abt Associates 2022).

Ownership. In 2022, most nursing facilities (72 percent) were for profit, and about two-thirds of facilities (66 percent) were also part of a larger chain.⁸ Nursing facility chains vary widely in size: in 2022, about 15 percent of nursing facilities were part of chains with 10 facilities or fewer, and about 11 percent of nursing facilities were part of chains with more than 100 facilities (ASPE 2022a).

Between 2016 and 2021, a total of 3,254 nursing facilities were sold, and the pace of transactions has generally increased since 2016 (ASPE 2022b). About one-third of these transactions involved multiple owners (ASPE 2022b). For example, multiple related parties can own a nursing facility when a private equity firm purchases a nursing facility, sells the real estate to another entity, and then leases the building to a third entity that manages the care provided.

Declining occupancy rates. Even before the COVID-19 pandemic, nursing facility occupancy rates were declining, which creates financial challenges for facilities that must continue to pay fixed overhead and capital costs with declining revenue. Between 2010 and 2019, occupancy rates declined from 88 to 85 percent, in part because of efforts to shift care to home- and community-based services, and since the start of the COVID-19 pandemic, occupancy rates have declined even further (MedPAC 2022b). In January 2021, median occupancy rates reached a low of 69 percent, and by November 2022, median occupancy rates were 78 percent (CLA 2023).

Nursing facility closures. Between 2015 and 2019, more than 500 nursing facilities closed (Flinn 2020). Although some closures are expected as care shifts from nursing facilities to other settings, closures can be particularly problematic in rural areas where residents may not have access to other facilities nearby where their loved ones can easily visit. In 2018, 7.7 percent of U.S. counties had no nursing facility, an increase of 44 counties since 2008; these closures were more common in facilities that served a higher share of Medicaid-covered residents (Sharma et al. 2021).

New care models. Despite the challenges that the nursing facility industry faces, some providers are testing new models of care that reflect resident preferences for less institutional, more homelike settings. One example is the Green House initiative launched in 2003 with funding from the Robert Wood Johnson Foundation. In contrast to the average

nursing facility, which has about 100 beds with many shared rooms, facilities participating in the Green House initiative have about 10 to 12 beds and single-occupancy rooms. The model has shown promising quality outcomes, but these facilities represent less than 2 percent of nursing facilities and serve less than 1 percent of all nursing facility residents. Moreover, these facilities report that it has been challenging to expand access to more Medicaid-covered nursing facility residents because of Medicaid payment rates and state limitations on Medicaid covering private rooms if they are not medically necessary (Waters 2021).

Facilities that serve a high share of Medicaid-covered residents

The payer mix of Medicaid, Medicare, and private-pay residents varies widely and is associated with a number of facility characteristics (Table 2-1). Although some of these differences may reflect facility decisions on whether to accept more short-stay patients versus

long-stay residents, they also reflect facility decisions about whether to accept Medicaid-covered residents. Federal law prohibits facilities from discharging a resident once they become Medicaid eligible, but in many states, facilities can choose to not admit residents who are likely to become Medicaid eligible.⁹ As a result, there is evidence that Medicaid-covered residents may have more difficulty accessing high-quality facilities (Sharma et al. 2020).

Quality ratings. On average, facilities that serve a high share of Medicaid-covered residents have lower quality ratings than other facilities on all of the domains measured by the Medicare.gov Care Compare five-star rating system (Box 2-1). However, there is wide variation in the quality of care provided to Medicaid-covered residents, and in 2019, 12 percent of facilities that served the highest quartile of Medicaid-covered residents had five-star ratings overall (the highest on Care Compare) compared with 21 percent of all facilities in our analysis.

TABLE 2-1. Facility Characteristics by Payer Mix, 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%)
Average Medicare.gov Care Compare five-star quality ratings					
Overall rating	3.1	3.7	3.1	2.8	2.7
Inspection component	2.7	3.2	2.8	2.6	2.4
Staffing component	2.9	3.4	2.9	2.7	2.6
Quality measure component	3.6	3.9	3.6	3.5	3.4
Race and ethnicity of nursing facility residents					
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
Ownership					
Private, for profit	74%	56%	73%	82%	84%
Private, non-profit	21	38	22	13	11
Public	5	6	5	5	5

Note: Analysis excludes hospital-based nursing facilities and those that are not dually certified by Medicaid and Medicare.

Sources: MACPAC, 2022, analysis of Medicare.gov Care Compare, Medicare cost reports, and the Minimum Data Set.

Racial and ethnic disparities. Facilities serving a high share of Medicaid-covered residents also serve more racial and ethnic minorities, so poor quality ratings in these facilities contribute to health disparities. In general, Black Medicaid beneficiaries are more likely than white Medicaid beneficiaries to receive care in nursing facilities, and when they do, they are less likely to be admitted to high-quality facilities (Zuckerman et al. 2018). The racial and ethnic disparities in nursing facility care are long standing and have persisted even as other health care settings, such as hospitals, have been desegregated (Nolen et al. 2020).

Facility ownership. For-profit facilities are more likely to serve a high share of Medicaid patients than non-profit facilities. For-profit facilities generally have lower staffing levels than other facilities and have lower average quality ratings than other types of facilities (Paul et al. 2016). As a result, some of the differences in quality by payer mix that we observe may be a result of differences in facility ownership. Recent research has highlighted additional quality challenges in for-profit facilities owned by private equity investors, but we do not have data to distinguish these facilities from other for-profit facilities (Braun et al. 2021, Gupta et al. 2021).

BOX 2-1. Medicare.gov Care Compare Five-Star Ratings for Nursing Facilities

Since 2008, the Centers for Medicare & Medicaid Services (CMS) has been reporting five-star quality ratings for nursing facilities on its Medicare.gov Care Compare website. The composite five-star rating is based on three components that have continued to be refined over time:

- **Inspection star ratings** based on the findings from on-site inspections conducted by state survey agencies to assess practices to ensure the safety of residents.¹⁰ Facilities receive a lower star rating if they have more identified deficiencies and if these problems persist upon follow-up visits. Star ratings are assigned on a curve, and so the 20 percent of facilities in each state with the worst inspection ratings are assigned one star, and the 10 percent of facilities with the best inspection ratings in each state are assigned five stars.
- **Staffing star ratings** based on nursing facilities' reported hours of registered nurse and total nurse staffing, which includes registered nurses, licensed practical nurses, and certified nurse assistants. After adjusting for differences in resident acuity, facilities with higher staffing hours per resident day relative to other facilities receive higher star ratings. Historically, nursing facilities self-reported staffing data to CMS, but since 2016, CMS has required nursing facilities to submit staffing data through an auditable payroll-based journal (PBJ) system that is more accurate. CMS began using PBJ data for star ratings in 2018. In 2022, CMS began using the PBJ data to include additional measures of staff turnover and weekend staffing in Care Compare (CMS 2022a). These additional measures are not included in our analyses of 2019 staffing ratings.
- **Quality star ratings** based on performance on a range of measures used to assess quality of care for short-stay and long-stay nursing facility residents. Many of the measures are calculated using data from the Minimum Data Set, which collects information on all nursing facility residents. In 2019, CMS added several additional measures based on Medicare fee-for-service claims data, which are included in our analysis (CMS 2019). Some of these claims-based measures, such as hospitalization and emergency department visit rates, include patients dually eligible for Medicare and Medicaid because Medicare is the primary payer for hospital care. However, these measures do not include patients who are enrolled in Medicare Advantage plans, including plans intended to integrate care for dually eligible patients.

Effects of COVID-19 pandemic

The COVID-19 pandemic has had a disproportionate effect on nursing facilities and their residents. Although nursing facility residents account for less than 1 percent of the U.S. population, they have accounted for about 15 percent of COVID-19 deaths as of December 2022 (CMS 2022b).

While the level of community spread is the primary contributor to the rate of COVID-19 infections in nursing facilities, the pandemic has also exposed and exacerbated long-standing nursing facility quality issues (GAO 2022). A low number of direct care staff per resident and the use of shared rooms have been associated with rates of COVID-19 transmission and death (Harrington et al. 2020a, Li et al. 2020). Because Medicaid-covered residents are more likely to reside in facilities with these characteristics, studies have found that these residents have been disproportionately affected by the pandemic (Weech-Maldonado et al. 2021).

As discussed previously, the COVID-19 pandemic has also led to declines in nursing facility occupancy rates, which have created financial challenges for facilities because of their fixed overhead and capital costs. Although some of the declining occupancy is due to an acceleration of the shifting patterns for post-acute care and LTSS that began before the pandemic, some changes in the occupancy have been driven by pandemic-specific factors, such as the high death rate of nursing facility residents.

In response to lower occupancy rates, nursing facilities have also decreased staffing levels. For example, between January and September 2020, the number of direct care hours declined 9.8 percent, which was commensurate with the decline in nursing facility residents (Werner and Coe 2021). However, as use of nursing facility care begins to recover from pandemic lows, some facilities have reported challenges rehiring staff because of increased labor costs, and without sufficient staff, facilities cannot use all available beds (CLA 2023).

A variety of state and federal policy changes have supported nursing facilities during the COVID-19 public health emergency. For example, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) created a time-limited provider relief fund to offset immediate losses and also provided grants

to states that some have used to increase Medicaid payment rates (MACPAC 2021a). In addition, CMS has authorized a number of temporary waivers of regulatory requirements for nursing facilities, including allowing nursing facilities to be paid Medicare's higher SNF rate for long-stay residents with acute care needs without requiring a prior hospital stay. These temporary changes have helped most nursing facilities manage the disruption in their finances so far, but many providers are concerned about their financial viability after these policies expire (CLA 2023, 2022a).

Policymakers are also using early lessons from the pandemic to consider a variety of permanent nursing facility regulatory and payment reforms. In 2022, the National Academies of Sciences, Engineering, and Medicine released a report recommending a variety of reforms to CMS's oversight of nursing facilities and changes to Medicare and Medicaid policies. Notably, the report calls for greater transparency and stronger evaluations of Medicaid nursing facility rates, which align with the Commission's recommendations discussed later in this chapter (National Academies 2022).

Medicaid Payment Policies

States have considerable flexibility to set Medicaid nursing facility payment rates and methods. MACPAC's analyses of these policies have found wide variation in the types of payments that states make, how these payments are financed, and how Medicaid payments compare to nursing facility costs.

Federal Medicaid payment requirements

Nursing facility services have been a required Medicaid benefit since the program's enactment in 1965, but Congress has made several changes over time to the rules governing how states pay providers. The original statute had few limitations, but in 1972, Congress required that states pay on a reasonable cost-related basis, similar to Medicare, because of concerns that states were overpaying providers (Committee on Finance 1972).¹¹ In 1980, the Boren amendment to the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) removed this requirement and instead required Medicaid nursing facility payments to be "reasonable

and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.” To help states meet this requirement, the Boren amendment also required nursing facilities to submit uniform Medicaid cost reports.

The Boren amendment was difficult to implement and led to a number of provider lawsuits. CMS never formally defined an “efficient and economically operated” facility, so each state developed its own method to comply with this requirement. In 1990, the U.S. Supreme Court ruled in *Wilder v. Virginia Hospital Association* that the Boren amendment created a privately enforceable right for providers, which led to a growth of lawsuits challenging provider payment rates and the methods that states had used to develop them (Wiener and Stevenson 1998).¹² In 1996, Congress repealed the Boren amendment and gave states additional flexibility to set their own payment rates as long as they developed them using a public process (§1902(a)(13)(A) of the Act).

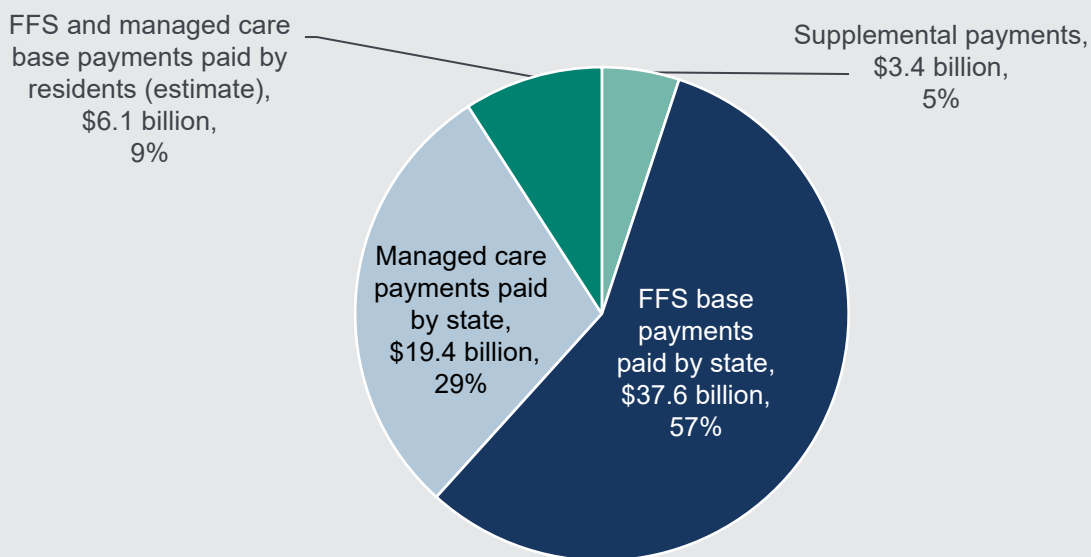
A separate Medicaid statutory provision, Section 1902(a)(30)(A) of the Act, still requires Medicaid payment policies to be consistent with the principles

of efficiency, economy, quality, and access to care.¹³ In 2015, the U.S. Supreme Court ruled in *Armstrong v. Exceptional Child Center, Inc.* that providers no longer have a right to sue in federal court to enforce these Medicaid payment requirements, so now they can only be enforced by CMS.¹⁴

Types of Medicaid payments to nursing facilities

In 2019, nursing facilities were paid approximately \$66.5 billion for care to Medicaid-covered residents (Figure 2-3). The two main categories of payment are base payments, which are typically paid on a per diem basis for a specific resident, and supplemental payments, which are generally paid in a lump sum for a fixed period of time. Most payments are base payments made through the fee-for-service (FFS) delivery system, but a growing share of Medicaid payments to nursing facilities are made through managed care and supplemental payments. In the following sections, we discuss each of these types of payments in more detail as well as the limitations of available data for measuring these payments.

FIGURE 2-3. 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.

Sources: MACPAC, 2022, analysis of CMS-64 net expenditure data and the Transformed Medicaid Statistical Information System (T-MSIS).

FFS base payments. Medicaid programs typically pay nursing facilities a daily rate for Medicaid-covered residents according to a state fee schedule. Currently, most states set Medicaid nursing facility payments based on the costs for various cost centers, such as direct care (i.e., medical supplies and wages of staff providing direct care), indirect care (e.g., the costs of social services and patient activities), administration, and capital. However, Medicaid payments are not intended to cover all costs for all facilities because states set limits on which costs are allowable and set ceilings on the amount of costs that can be reimbursed for particular cost centers (e.g., a fixed percentage of the median or average costs for a particular cost center among similar facilities in the state). Less than a third of states use a price-based method to set payments prospectively based on historic costs adjusted for inflation and other factors (MACPAC 2019a, 2019b).

The base payments that states pay are reduced by resident contributions to their cost of care, which are paid to the facility directly. Based on our analysis of claims data in the Transformed Medicaid Statistical Information System (T-MSIS), resident contributions to their cost of care accounted for about 10 percent of base payments to nursing facilities in 2019 (MACPAC 2023a).

Managed care base payments. In 2019, 24 states paid for some or all nursing facility care through managed care organizations, up from just 8 states in 2004. Most states with managed LTSS (MLTSS) include full coverage for nursing facility services, although some states carve out long-stay nursing facility residents from some programs (Dobson et al. 2021, Lewis et al. 2018).

In April 2016, CMS established a new option for states to direct managed care plans to pay particular types of providers according to specified rates or methods, which is referred to as “directed payments.” Based on MACPAC’s review of directed payment arrangements approved as of December 31, 2020, 14 states established minimum fee schedules for nursing facility services provided in managed care (typically no less than the Medicaid FFS rate), and 6 states required managed care plans to increase payments to nursing facilities by a fixed amount above base payment rates, similar to supplemental payments in FFS (MACPAC 2022a).

Managed care payments to nursing facilities are also subject to post-eligibility treatment of income rules, but information on resident contributions to their cost of care is not available for all states. For example, in our analyses of 2019 T-MSIS data, five states with MLTSS reported managed care base payments paid by the state but did not report the total allowed amount, after accounting for resident contributions to their share of cost, and so we could not include managed care payments in these states in our analyses (MACPAC 2023a).

The limited data available on managed care payments to nursing facilities suggest that they are similar to FFS in many states. In the four states with MLTSS that we interviewed in 2020 (Kansas, New York, Rhode Island, and Wisconsin), managed care plans all paid nursing facilities according to FFS rates and methods. Many states had directed payment arrangements that required plans to pay facilities’ FFS rates, but plans also noted that it was administratively easier to do so. Because many managed care plans relied on state rate setting methods to set their own rates, the stakeholders we interviewed noted the need for states to maintain their FFS rate setting capacity even after moving to MLTSS (MACPAC 2020a).

Supplemental payments. In 2019, 23 states made a total of \$3.4 billion in supplemental payments to nursing facilities, which accounted for approximately 5 percent of total nursing facility payments. The use of supplemental payments varies widely by state: 27 states and the District of Columbia did not make any supplemental payments, and 6 states made payments that were more than 30 percent of total FFS Medicaid payments to nursing facilities (MACPAC 2020b).

Medicaid FFS base payment rates and supplemental payments cannot exceed the upper payment limit (UPL), which is an estimate of what Medicare would have paid for the same service in the aggregate.¹⁵ States are required to submit provider-level information on base and supplemental payments to CMS annually to demonstrate compliance with these UPL requirements (CMS 2022c). When calculating the UPL, states are supposed to account for differences in resident acuity and differences in services that Medicaid and Medicare cover; nevertheless, states and CMS still face challenges accurately calculating the UPL because Medicaid and Medicare payment rates are not directly comparable (CMS 2022c).

MACPAC's review of these UPL demonstration data found several discrepancies between the amount of payments reported on UPL demonstrations and the amount of payments claimed by states on CMS-64 reports in the Medicaid Budget and Expenditure System (MBES), which is the official record of actual Medicaid spending.¹⁶ CMS is currently implementing a new process for states to report provider-level supplemental payment data through MBES, which will hopefully help improve the reliability of these data in future years (CMS 2021).

Financing of Medicaid payments

Similar to other Medicaid payments, states and the federal government jointly finance Medicaid nursing facility payments according to the state's federal matching assistance percentage (FMAP). The non-federal share of Medicaid payments can be financed by state general funds, provider taxes, and intergovernmental transfers (IGTs) or certified public expenditures (CPEs) from local governments, including publicly owned nursing facilities.

State use of nursing facility provider taxes has grown in recent years, from 22 states in 2004 to 45 states in 2019 (Gifford et al. 2019). States are allowed to use provider taxes to finance their Medicaid programs as long as the taxes are imposed on a broad base of providers (i.e., not just providers who serve a high share of Medicaid patients), are uniformly applied based on a common tax basis (e.g., provider revenue or the number of certified nursing facility beds), and do not guarantee that providers are paid back the amount that they contribute in taxes. In practice, many states use the increased federal funding generated by provider taxes to increase Medicaid payments, which is permissible as long as the tax does not exceed 6 percent of net patient revenue for the class of providers. Many states impose taxes up to this maximum allowable amount, and in 2019, 22 states had nursing facility provider taxes between 5.5 and 6 percent of provider revenue (KFF 2020).¹⁷

IGTs and CPEs are commonly used to finance nursing facilities that are publicly owned, which accounted for about 5 percent of all nursing facilities, according to Medicare cost reports in 2019. However, in some states, the number of facilities that are classified as publicly owned for Medicaid purposes is much

higher than the number on Medicare cost reports because of complex ownership arrangements between public hospitals and privately operated nursing facilities. Specifically, in some states, it is common for public hospitals to buy or lease privately operated nursing facilities so that these facilities can receive IGT-financed supplemental payments targeted to government-owned facilities. For example, in Indiana, 90 percent of nursing facilities in the state received supplemental payments targeted to government-owned facilities in 2019, including 181 facilities that were classified as privately owned on Medicare cost reports (MACPAC 2023b). Indiana reported more than \$1 billion in nursing facility supplemental payments in 2019, more than any other state, but it is unclear how much of these payments were retained by nursing facilities and how much of these payments were returned to the public hospitals that financed these payments (Galewitz 2017).

During interviews with stakeholders about the factors that affect their nursing facility payment methods, we learned that state decisions to use supplemental payments are often affected by the methods that states use to finance the non-federal share of Medicaid payments. Although states and nursing facilities generally preferred that rate increases be implemented through increases to base payments rather than supplemental payments, these stakeholders generally viewed supplemental payments as a better way to target funding to providers to ensure that they were paid back the amount that they contributed through provider taxes or IGTs (MACPAC 2020a).

Base payment rates vary widely

According to our analyses of base payment rates reported in T-MSIS in 2019, Medicaid nursing facility payment rates varied widely by state and facility. Even after adjusting for differences in the area wage index and differences in resident case mix, average state payment rates ranged from 62 to 182 percent of the national average. Across facilities within states, we also observed considerable variation (MACPAC 2023a).

Although Medicaid rates are often lower than costs, we found that Medicaid payments appeared to exceed the costs of care in some facilities in 2019 (Figure 2-4). The median facility had payment rates that were 86 percent of costs. However, about one-fifth of facilities

had base payment rates greater than 100 percent of costs, and 15 percent of facilities had base payment rates less than 70 percent of costs.

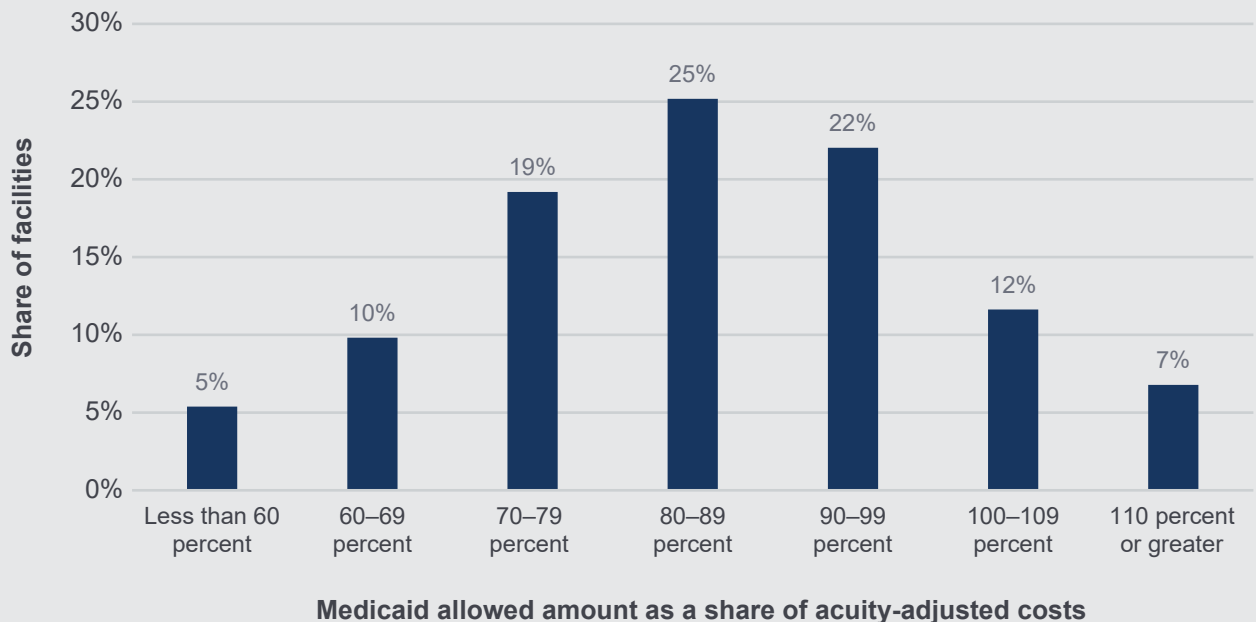
Our estimates of Medicaid payments relative to costs have several limitations. First, we were not able to find reliable data on supplemental payments to providers in all states. In states in which data were available, they suggested that these payments can substantially affect the distribution of Medicaid payments relative to costs (MACPAC 2023a). Second, we were not able to collect information on provider contributions to the non-federal share, which can reduce the net payments that providers receive. Third, the Medicare cost report data we used for this analysis does not account for state-specific differences in allowable costs or the potential effects of related-party transactions, which may inflate costs reported on facility-specific cost reports (Adelberg et al. 2022). Finally, because of the limits of available data, we were not able to examine payments

relative to costs after the start of the COVID-19 pandemic, which has resulted in increased nursing facility costs and also increased Medicaid payment rates in many states.

Using Medicaid Payments to Improve Quality

Medicaid payment policy has the potential to help improve quality outcomes and reduce disparities. To better understand Medicaid's role, the Commission has examined how nursing facility staffing levels vary by state, how they relate to Medicaid payment policies, and which barriers states face in changing payment policies to promote better outcomes.

FIGURE 2-4. Distribution of Medicaid Base Payment Rates as a Share of Acuity-Adjusted Costs, 2019



Notes: Base payment rates include resident contributions to their share of costs. Analysis excludes Alaska, Idaho, and New Hampshire because of unreliable or missing data. Data on resident contributions to their share of costs were not available for managed care payments in California, Massachusetts, New Jersey, Rhode Island, and Virginia, and so only fee-for-service spending is included for these states.

Source: Abt Associates, 2022, analysis for MACPAC of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, and the Minimum Data Set.

Background on staffing standards

Although staffing levels are just one of many measures of quality, higher staffing levels are associated with a variety of positive health outcomes and have been a key area of focus for states during the pandemic.¹⁸ Moreover, because staffing levels are primarily affected by how much facilities pay nurses and nurse aides (often referred to as “direct care staff”), payment policy can play an important role in helping to address this issue.

Nursing facilities are staffed by a variety of nurses and nurse aides with different levels of training that provide direct care, including the following:

- registered nurses (RNs), who have at least a two-year degree and are responsible for overseeing residents’ care;
- licensed practical nurses (LPNs), who have a one-year degree and typically provide routine bedside care (such as taking vital signs); and
- certified nurse aides (CNAs), who have at least 75 hours of training and generally assist residents with activities of daily living.¹⁹

Currently, CMS requires facilities have licensed nurse staff (RNs or LPNs) available 24 hours a day, an RN available eight hours a day, and a full-time director of nursing. For a 100-bed facility, this standard equates to 0.3 hours per resident day (HPRD) of licensed nurse staff.

In 2001, a CMS staffing study found that staffing levels of at least 0.75 HPRD of RN staffing and 4.1 HPRD of total staffing of nurses and nurse aides (RNs, LPNs, and CNAs) were associated with optimal quality. The study did not find improvement in quality for facilities that staffed above this level (CMS 2001). Although some stakeholders have argued that 4.1 HPRD is too high a standard for most nursing facilities, this standard continues to be endorsed by a variety of nursing groups (Schnelle et al. 2016, CGNO 2014). Yet, according to CMS’s Care Compare website, approximately 72 percent of nursing facilities had total staffing levels below 4.1 HPRD in 2019. CMS is currently conducting an updated staffing study using more recent data to inform the development of new staffing standards (CMS 2022d).

CMS assigns star ratings to facilities based on how their staffing levels compare to other facilities. In our analysis, we examined the share of facilities with one- or two-star staffing ratings, which included facilities with less than 0.5 HPRD of RN care and 3.6 HPRD of total staffing of nurses and nurse aides in 2019.

State variation in staffing levels

Overall, nursing facility staffing levels vary widely across states. For example, in three states (Alaska, Hawaii, and North Dakota) and the District of Columbia, fewer than 10 percent of freestanding nursing facilities had one- or two-star staffing ratings on Medicare.gov Care Compare in 2019, while in three other states (Georgia, Louisiana, and Texas), more than 70 percent of facilities had these low ratings (MACPAC 2022b).

We also found wide state variation in the disparities between facilities that serve a high share of Medicaid-covered residents and those that do not. For example, in 2019, the difference between the average staffing star rating in the quartile of facilities that served the highest share of Medicaid-covered residents was more than one star lower than the quartile of facilities that served the lowest share of Medicaid-covered residents in seven states (Kansas, Illinois, North Carolina, Ohio, Pennsylvania, Utah, and Virginia). In comparison, the difference between the quartile of facilities that served the highest and lowest share of Medicaid-covered residents was less than 0.1 stars in eight states (Arkansas, Delaware, Mississippi, North Dakota, New Mexico, Oklahoma, Oregon, and Wyoming) (MACPAC 2023c).

The wide state variation that we observe suggests a role for state policy. Although some state variation may be due to factors other than Medicaid, disparities by payer mix are likely affected by Medicaid payment policies. Moreover, the fact that some states have relatively high staffing levels and few disparities by payer mix shows that ensuring adequate staffing to meet the needs of Medicaid-covered residents is an achievable goal.

Relationship between payment rates and staffing

Prior research has suggested that increasing Medicaid payment rates has the potential to improve staffing. For example, studies of rate increases in California, Ohio, and Pennsylvania found that they were associated with improved staffing, particularly for RNs and LPNs (Hackman 2019, Bowblis and Applebaum 2017, Bishop 2014).

However, in our analysis of 2019 data, we did not find a clear relationship between Medicaid payments and staffing levels (Table 2-2). Average base payment rates were higher for facilities with a five-star staffing rating (the highest) compared with facilities with a one-star rating (the lowest). However, after accounting for differences in facility costs, the Medicaid payment-to-cost ratio in facilities with five-star staffing ratings was 7 percentage points lower on average than facilities with a one-star rating.

Average costs are lower in facilities with lower staffing levels in part because these facilities spend less on staff, which is a substantial component of nursing facility

costs.²⁰ After estimating what costs would be if facilities had similar staffing levels, the difference in Medicaid margins between facilities with low staffing levels and high staffing levels narrows, but Medicaid margins are still higher for facilities with lower staffing ratings.²¹

Role of Medicaid payment methods and state staffing requirements

In addition to increasing payment rates, states can also change other policies to encourage facilities to spend more of the revenue that they receive on staff. Two approaches that we studied are (1) changing Medicaid payment methods to incentivize spending on direct care staff and (2) requiring that facilities meet minimum staffing standards that exceed federal requirements. To better understand the potential effects of these policies, we conducted a literature review of relevant studies published since 2008.

Medicaid payment methods. Examples of Medicaid payment methods that may promote higher staffing levels include wage pass-through payments that require facilities to spend a specified portion of the

TABLE 2-2. Average Medicaid Base Payments per Day and Acuity-Adjusted Costs by Five-Star Staffing Rating, 2019

Five-star staffing rating in the CMS Nursing Home Quality Rating System	Number of facilities in analysis	Average Medicaid base payment rate per day	Average cost of care for Medicaid-covered residents	Average Medicaid base payment as a share of costs	Average Medicaid base payment as a share of costs if facilities were staffed with at least 3.6 HPRD
All facilities	12,377	\$199.74	\$237.85	84%	82%
1 star (lowest)	1,701	183.26	209.36	88	83
2 star	3,451	195.71	227.54	86	83
3 star	3,739	201.93	243.94	83	82
4 star	2,572	209.66	257.41	81	81
5 star (highest)	831	230.54	286.93	80	80

Notes: CMS is Centers for Medicare & Medicaid Services. HPRD is hours per resident day. The threshold for a three-star staffing rating in 2019 was 3.6 HPRD. Base payments include resident contributions to their share of costs. Average costs and payments are weighted by the number of Medicaid days in each facility. Alaska, Idaho, and New Hampshire were excluded from analysis due to data quality issues. The analysis also excluded facilities with missing payment data and outlier staffing costs.

Source: Abt Associates, 2023, analysis for MACPAC of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, the Minimum Data Set, and Medicare.gov Care Compare.

Medicaid rate on staff wages, cost-based payment methods that tie payment rates to spending on direct care staff, and pay for performance (P4P) incentive payments that tie payments to meeting staffing goals.

Overall, there is limited research available about the effectiveness of these methods. One multivariate study using 2002 data found that cost-based payment methods were associated with both higher RN staffing and higher total staffing (Harrington et al. 2007). A review of wage pass-through policies implemented between 1996 and 2004 found CNA staffing levels increased in the initial years after implementation but found no statistically significant effect on RN or LPN staffing (Feng et al. 2010). Finally, one review of eight Medicaid P4P programs compared with a nationwide control group found that only one state had a statistically significant effect on staffing measures and that the effects on resident-level outcomes were also limited (Werner et al. 2013).

In response to the COVID-19 pandemic, a number of states made changes to their Medicaid payment policies related to staffing. As of fall 2021, 12 states increased payments to direct care workers, 1 state added a new wage pass-through policy, and 4 states implemented new payment incentives related to staffing since 2020 (MACPAC 2022a).²² In 2022, Illinois implemented a new rate increase for CNAs that was different from other policies that we studied because it targeted higher wages to more experienced staff to help improve staff retention (IL HFS 2021).

During our interviews, we heard mixed perspectives about whether states would be able to continue rate increases in the long term. Some states financed temporary rate increases using grants from the \$150 billion Coronavirus Relief Fund authorized by the CARES Act, which can be used only for expenses incurred during the public health emergency. As a result, to continue these rate increases after the public health emergency using Medicaid authorities, these states would need to provide additional state matching funds.

Minimum staffing standards. States can set their own minimum staffing standards that exceed federal requirements. According to MACPAC's review of state staffing policies in 2021, 38 states and the District of Columbia have state minimum staffing standards that exceed the federal requirements of 0.3 HPRD of licensed nurse staff for a 100-bed facility. However,

state standards vary widely. For example, 9 states have standards that are less than 2.0 HPRD, and 11 states and the District of Columbia have standards that are greater than 3.0 HPRD. In addition, states vary in whether they have specific requirements for licensed nurse staff or whether the HPRD requirements apply to all nurses and nurse aides (including CNAs) (MACPAC 2022b).

Prior research has found that increases in minimum staffing standards are associated with improvements in staffing, particularly for CNAs. For example, an analysis of new minimum staffing requirements in California and Ohio found a 5 percent increase in HPRD overall but a reduction in skill mix (i.e., the ratio of RNs to all direct care staff) (Chen and Grabowski 2014).²³ In another study that examined the effects by payer mix, facilities that served a higher share of Medicaid patients reported larger increases in staffing, including RN staffing, in response to increases in minimum staffing requirements, resulting in larger gains in other measures of quality of care (Bowblis 2011).

Several states recently changed their staffing requirements in response to the COVID-19 pandemic. In our review of policies enacted as of October 2021, we identified 10 states that increased minimum staffing standards since 2020. Two states (Maine and New Jersey) added new minimum wage requirements specifically for direct care staff, a new type of policy that we did not find in states before the pandemic (MACPAC 2022a).

Minimum loss ratio requirements that cap nursing facility profits and require facilities to spend a minimum amount on staffing are a new policy approach to promote staffing that is being developed in Massachusetts, New Jersey, and New York. In 2019, median staffing costs as share of nursing facility revenue were 34 percent but varied widely by state. Facilities in the 90th percentile of Medicaid-covered days have higher median staffing costs as a share of revenue (36 percent), which suggests that policies to increase the share of revenue spent on staff may have less of an effect on facilities that serve a high share of Medicaid-coverage residents (Bowblis et al. 2023).

In April 2022, CMS requested information from stakeholders about raising federal minimum staffing standards, and a new staffing study intended to inform

these efforts is underway (CMS 2022d). Although the relationship between higher staffing levels and higher quality care has been well documented, questions remain about what an appropriate minimum staffing standard should be. Increasing federal standards would help improve quality, but it would also likely result in increased costs for facilities, which may require some state Medicaid programs to make higher payments (CLA 2022b).

Challenges changing state payment methods

Despite the potential for Medicaid payment policies to help improve the quality of nursing facility care, progress in developing new payment models has been relatively slow compared with other provider types. Between 2014, when MACPAC first reviewed FFS nursing facility payment policies, and 2019, when we updated our compendium, few states made any substantial changes to their nursing facility payment methods (MACPAC 2019a). During subsequent interviews with state officials, nursing facilities, and other stakeholders in 2020, we learned that limited state capacity, industry resistance, and a lack of clarity about value-based payment goals were the primary barriers to change (MACPAC 2020a).

Limited state capacity. The state officials we interviewed described several limits in their capacity to make changes to their already complicated financing systems. Some states faced reductions in staffing to analyze Medicaid nursing facility FFS rates due to budget cuts or the expansion of MLTSS. In addition, states reported losing institutional knowledge because of staff turnover, which was hard to replace because Medicaid nursing facility payment policy is so complex. Some states hire external consultants to support their capacity when making new reforms, but these states later reported a similar loss of institutional knowledge when the consultants who initially designed the payment system were no longer available to evaluate future changes to payment policies.

Industry resistance to change. The nursing facility industry associations that we interviewed were generally active in lobbying state policymakers against changes in payment methods that could create winners and losers among nursing facilities in their states. Instead, these associations primarily

advocated for increased payment rates because of a view that state payment rates were too low to cover costs and concerns that states would cut rates further for budgetary reasons. In states that did get provider support for payment changes, state officials noted the need to engage stakeholders early and provide sufficient time to prepare for any change.

Lack of clarity about value-based payment goals.

Twenty-five states had P4P incentive payment programs in nursing facilities in 2019, but the state officials that we interviewed in seven states noted that P4P programs in their states did not appear to be particularly effective (MACPAC 2019a). For example, one state's program was more than two decades old, and due to secular trends and federal policies implemented in recent years, most facilities had already achieved most of the program's initial goals related to reducing survey deficiencies and meeting targets for culture change to promote more person-centered care. States reported challenges selecting new measures that were tied to quality outcomes, such as reductions in rehospitalizations or improvement in long-stay quality measures, because of a lack of consensus among stakeholders about how these quality measures should be defined and how the targets should be set.

In the states we studied, interviewees did not mention any efforts to incorporate nursing facilities into alternative payment models that states were using for their acute care populations, such as accountable care organizations. Although stakeholders acknowledged the high rate of avoidable hospital use among Medicaid-covered nursing facility residents, they noted that it was difficult to develop alternate payment models for residents dually eligible for Medicare and Medicaid because savings from reducing hospital use for these residents accrue to Medicare rather than Medicaid.

We also heard a lack of consensus among stakeholders about whether a value-based measure of cost savings is appropriate in assessing value for nursing facility care because of the risk that facilities may reduce costs by cutting direct care staff needed to meet residents' care needs. One state in our study, New York, switched from a cost-based payment method to a price-based system in 2017 to provide more budget predictability for the state, uniformity across facilities, and administrative efficiency.

Although the state still sets prices based on prior year cost reports, the state has less control than it would in a cost-based system on how facilities spend the Medicaid revenue that they receive. Recently, in response to the COVID-19 pandemic, New York increased state minimum staffing standards and added a new requirement that facilities spend at least 70 percent of their total revenue on direct care, which are other tools that states can use to address staffing issues in the absence of cost-based payment systems (Reiland 2022).

Interaction between Medicare and Medicaid Payment Policy

Because Medicare is the second-largest payer for nursing facility care, many of the payment standards used by Medicare are also used by Medicaid programs. In addition, because most Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid, Medicare payment incentives can affect the care that Medicaid-covered residents receive. To understand these interactions in more detail, the Commission has been monitoring the effects of recent changes to Medicare's acuity adjustment system and the findings of recent evaluations of efforts to reduce avoidable hospital use for dually eligible residents.

Acuity adjustment changes

In October 2019, Medicare changed the method it uses to classify SNF patient acuity from Resource Utilization Group Version IV (RUG-IV) to the Patient-Driven Payment Model (PDPM). Under the RUG-IV model, nursing facilities were incentivized to provide additional therapy services because the measure of a resident's therapy care needs was predominately determined by the number of minutes of therapy the facility provided. PDPM corrects these incentives by setting a case-mix weight based on a resident's primary diagnosis. The case-mix weights for PDPM were developed over several years but used data only for Medicare-covered nursing facility residents, not Medicaid-covered residents (Acumen 2018).

As of July 2019, 34 states used RUG-based payment methodologies for Medicaid-covered residents, and so Medicare's change has prompted many states to reassess their acuity-adjustment methods (MACPAC 2019a). As of October 1, 2023, CMS will no longer collect information needed to determine RUG case-mix groups on the Minimum Data Set, which will make it more difficult for states to continue RUG-based methods. CMS has provided states the option of requiring facilities to report additional information through a state supplement to the Minimum Data Set until September 30, 2025, if needed to help ease the transition (CMS 2022c).

Because PDPM was not developed to measure their acuity or resource use, some components of PDPM are not a good measure of the care needs for long-stay residents. The PDPM includes five components for measuring the acuity of an SNF patient: nursing, physical therapy, occupational therapy, speech-language pathology, and non-therapy ancillary. Although the nursing component is similar to the previous RUG-IV model, the therapy components are different and substantially overstate the needs of long-stay residents (Abt Associates 2020). Because of the challenges adapting the PDPM therapy components to long-stay residents and the fact that most therapy services are not included in the Medicaid nursing facility benefit, CMS issued guidance in 2022 recommending that states exclude the therapy portions of the PDPM from their Medicaid payment methods (CMS 2022c).

Another limitation of PDPM is that the underlying data used to develop the nursing component were based on a 2007 study of nursing staff time, the latest that CMS has completed. Some stakeholders have noted the need for an updated time study that reflects current staffing patterns at high-quality facilities and also considers the unique needs of long-stay Medicaid-covered residents (Harrington et al. 2020b).

Incentives to reduce avoidable hospital use

About one-quarter of nursing facility residents are transferred to hospitals each year, and many of these hospitalizations could be avoided if residents received quick diagnoses and treatments in nursing facilities. Overall, avoidable hospital use for nursing facility

residents is estimated to cost Medicare and Medicaid more than \$1.9 billion a year (RTI 2019).

Unfortunately, misaligned payment incentives between Medicare and Medicaid do not reward states or providers for addressing this issue. Because Medicare is the primary payer for hospital care, the savings from delivery system reforms typically accrue to Medicare rather than Medicaid. Moreover, nursing facilities do not have strong incentives to reduce hospital use for Medicaid-covered residents because Medicare pays for a new SNF stay at a higher rate than a Medicaid-covered stay when a resident is hospitalized and later returns to a nursing facility.

Policymakers have been exploring a number of different approaches to address these misaligned incentives, but the results have been mixed so far.

CMS demonstrations. In 2009, CMS launched the Nursing Home Value-Based Purchasing Demonstration, which provided incentive payments to nursing facilities if they reduced avoidable hospitalizations.²⁴ However, the final evaluation found that there were not major pre- and post-intervention performance differences for participating nursing facilities, and the resulting cost savings were limited (L&M Policy Research 2013).²⁵

The CMS Center for Medicare and Medicaid Innovation (CMMI) has tested two models to reduce avoidable hospitalization among nursing facility residents by helping Medicaid-covered long-stay nursing facility residents access additional skilled care at a nursing facility instead of being transferred to the hospital. Although the CMS evaluation of these initiatives found that the care coordination services helped to reduce hospital use, the payment incentives did not meaningfully affect outcomes, and the overall model did not meet CMMI's cost-effectiveness test (RTI 2019).

Managed care plans. During our interviews in 2020, we spoke to representatives from a variety of Medicaid managed care plans with different degrees of integration with Medicare Advantage plans, but we heard little about efforts to better coordinate the Medicare and Medicaid nursing facility benefits. In 2022, 49 percent of all Medicare beneficiaries were enrolled in a Medicare Advantage plan, including 4.2 million beneficiaries in dual-eligible special needs

plans (D-SNPs) and 98,000 in institutional special needs plans (I-SNPs), which are limited to long-stay nursing facility residents (MedPAC 2022c).

The D-SNPs that we spoke with that were aligned with the Medicaid managed care plans in their states primarily focused their efforts on helping beneficiaries with long-term care needs access services in the community rather than the nursing facility. However, the MLTSS models in these states (Rhode Island and New York) covered only short-term nursing facility stays, and so the views of these plans may not reflect the range of strategies being used by other aligned D-SNPs in states that cover more nursing facility residents through their MLTSS programs.

Two of the states that we studied (Alabama and Wisconsin) had a growing presence of I-SNPs that were exploring new models to avoid hospitalizations by providing additional care to residents in nursing facilities. In Alabama, the I-SNP we spoke with had some facilities that participated in the CMMI model to reduce avoidable hospitalizations by embedding nurse practitioners in the facility and was planning to continue some aspects of the initiative with all participating facilities in the I-SNP after the demonstration expired. In Wisconsin, providers identified a similar opportunity to improve care and believed that they could compete favorably with other Medicare special needs plans, so they reported that they were in the early stages of developing a provider-owned I-SNP.

Payment Principles

Overall, Medicaid can play an important role in helping to address many of today's challenges with assuring access to quality nursing facility care. For Medicaid to achieve its potential, it is important for policymakers to design payment policies that advance the statutory goals of efficiency, economy, quality, and access. In 2014, MACPAC developed an overarching provider payment framework for assessing whether payments are consistent with these goals, which has guided the Commission's development of the following principles for nursing facility payment policy (MACPAC 2014).

Payment rates should cover the costs of economic and efficient providers

Although costs are an imperfect measure of payment adequacy, the Boren amendment standard that payments be sufficient to cover the costs for efficient and economically operated facilities is a useful benchmark for assessing Medicaid nursing facility payment rates. As discussed earlier in this chapter, Medicare payment rates are not an appropriate benchmark for Medicaid because of the differences in the acuity of short- and long-stay residents and the different services covered by the Medicaid and Medicare nursing facility benefits. Although the Boren amendment led to a number of provider lawsuits and was difficult for CMS to enforce, the underlying payment principle is sound and is consistent with the current requirements of Section 1902(a)(30)(A).

In the Commission's view, it is also important to consider the costs of ensuring adequate staffing and compliance with other quality and safety standards. As illustrated in our analyses of Medicaid payments relative to costs, facilities with lower staffing levels have lower costs on average, but much of these differences are explained by the fact that these facilities spend less on direct care staff overall.

The Commission is also concerned about the potential for related-party transactions to increase costs above what would be expected for an economically operated facility. As a result, states should collect more data on related parties using consolidated cost reports for the larger nursing facility chain to better understand the effects of these transactions.

Finally, when states assess Medicaid payment rates, it is important to consider all types of Medicaid payments that nursing facilities receive, including supplemental payments, which were not available for our analyses. It is also important to consider how provider contributions to the non-federal share reduce the net payments that facilities receive even though these data were also not readily available.

Payment methods should incentivize better quality and reductions in health disparities

The persistent disparities that Medicaid-covered nursing facility residents face are not consistent with the statutory requirement that Medicaid beneficiaries have access to care “at least to the extent that such care and services are available to the general population in the geographic area” (§1902(a)(30)(A) of the Act). Although the nursing facility industry overall may continue to face quality challenges because of factors outside of Medicaid's control, Medicaid payment policy can help ensure that Medicaid-covered residents have access to the same quality of care available to other nursing facility residents.

Our work so far has highlighted a number of ways that states can change payment policies to incentivize higher staffing levels and other quality measures. It is also important for states to consider other state policy levers to promote quality and health equity, such as minimum staffing standards and policies to help Medicaid-covered residents access care in high-quality facilities. Current evaluations of these policies are limited, and so more research would help policymakers identify strategies that are most effective.

States should aim to get the maximum value for the amount they are spending

Efficiency is a measure of whether states are getting the most value (in terms of quality and access) for the amount that they are spending. To identify opportunities to improve efficiency, it is helpful to compare payment rates and quality outcomes across states. States with the highest payment rates and lowest quality outcomes likely have the greatest opportunity to improve efficiency by changing payment methods to get better outcomes for the same level of spending.

Our work on payment rates and staffing has illustrated potential opportunities for states to improve the efficiency of their programs by requiring or incentivizing facilities to spend more of their Medicaid revenue on direct care staff. Although our work has identified some promising practices, more detailed state-level analyses

are needed to identify the best policy approach for each state.

Similarly, for states with large supplemental payments, there may be opportunities to improve efficiency by tying more payments to meaningful quality outcomes or incorporating supplemental payments into base payment rates that have stronger quality incentives. Although it can be politically and budgetarily difficult for states to change supplemental payments because of how they are financed, most of the funding for these payments is provided by the federal government, and so it is important that the payments are consistent with statutory payment goals.

Finally, there are several opportunities to improve the efficiency of Medicare and Medicaid payment for dually eligible patients. The Commission agrees with MedPAC's assessment that it is inefficient to use high Medicare payment rates as a tool for offsetting low Medicaid payment rates and encourages policymakers to set appropriate payment rates for each program as a first step toward aligning payment incentives (MedPAC 2022b). In addition, it will be important for policymakers to grapple with the fact that savings from reducing avoidable hospital use accrue to Medicare rather than Medicaid. Although prior CMMI demonstrations to correct these incentives have had mixed results, it is important to continue testing new models. D-SNPs, I-SNPs, and Medicaid managed care plans can also play a role in testing new approaches to better coordinate care for long-stay nursing facility residents.

Commission Recommendations

The Commission makes two recommendations on actions that HHS and CMS can take to improve the data available to help policymakers evaluate whether Medicaid nursing facility payments are consistent with MACPAC's payment principles and the statutory goals of efficiency, economy, quality, and access.

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.

Rationale

Transparency of Medicaid payments has been a long-standing goal of the Commission since complete data on Medicaid payments to providers are needed to inform assessment of payment policies. This recommendation is similar to MACPAC's prior recommendation calling for greater transparency of Medicaid hospital payments (MACPAC 2016). In 2020, Congress partially implemented this recommendation by requiring reporting of provider-level supplemental payment data, but CMS has not taken any action to date on the other components of the recommendation related to the transparency of managed care payments or data on provider contributions to the non-federal share.

Our review of available federal data on Medicaid nursing facility payments found several gaps in the data on base payments, supplemental payments, and provider contributions to the non-federal share that this recommendation would help address.

First, although base payment information is available for many states in the T-MSIS, the base payment data that are available do not always include information on resident contributions to their cost of care. Because of Medicaid post-eligibility treatment of income rules for long-term care, these contributions are often large and can substantially affect measures of Medicaid payment rates. In states with available data, these contributions accounted for approximately 10 percent of total

Medicaid base payments to nursing facilities in 2019 (MACPAC 2023a).

To improve the availability of data on allowed base payment amounts (which are inclusive of resident contributions to the cost of their care), CMS could provide states with more guidance on how to report them in T-MSIS, particularly for managed care encounters. CMS could also revisit how resident contributions to their cost of care are reported on UPL demonstrations (which include provider-level data on FFS base and supplemental payments). Based on our review of 2019 UPL demonstrations, most states reported allowed payment amounts, but six states reported only amounts paid by the state.

Second, we found that the provider-level supplemental payment data reported on state UPL demonstrations were incomplete and often did not match data that were reported on CMS-64 expenditure reports. Because supplemental payments are such a large share of Medicaid spending for nursing facilities in many states, a lack of complete provider-level data severely limits our ability to assess total Medicaid payment rates.

In response to MACPAC's prior supplemental payment recommendations, Congress required CMS to develop a new system for states to submit supplemental payment data in a standard format beginning October 1, 2021, but these data are not yet available for MACPAC's analysis. CMS is implementing this new reporting requirement through the same financial management system that is used for CMS-64 expenditure reports so that supplemental payment data are reported consistently in these different sources (CMS 2021).

Third, data on provider contributions to the non-federal share of nursing facility payments are important because they reduce the net payments that providers receive. CMS does not currently have a good process in place to collect provider-level data on sources of non-federal share, so implementing this part of the recommendation would likely require more administrative effort for CMS than the effort required to improve the completeness of the payment data that they already collect.

To help stakeholders evaluate Medicaid nursing facility payments, it is also important to collect comprehensive

data on nursing facility finances necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents. Although Medicare cost reports do provide some information on nursing facility finances in a standard format, our review of available cost data found several gaps that could be addressed if CMS required greater transparency. Some states may already collect these data on state-specific Medicaid cost reports, but these data are not collected in a standard format that enables cross-state analysis.

First, at the facility level, we found that the estimated costs of care for Medicaid-covered residents was generally much lower than the costs of care for other nursing facility residents because of differences in resident acuity and differences in the types of costs that are paid for by Medicaid and other payers (MACPAC 2023a).²⁶ To help stakeholders better assess the costs of care for Medicaid-covered residents, CMS could improve the completeness and availability of the resident acuity information by payer that it currently collects through the Minimum Data Set.²⁷ In addition, CMS could work with states to further clarify state definitions of allowable costs and how they relate to Medicare cost reports or other standard reports of nursing facility costs. Requiring more standardization of cost information reported to CMS would not limit a state's flexibility to define allowable costs for their Medicaid program, but it would provide a useful baseline for comparing costs and payments across states.

Second, more transparency of related-party transactions would help shed light on practices that may inflate costs above what they would be if a facility were operated more economically and efficiently (Adelberg et al. 2022). States currently have the flexibility to develop state-specific cost reports that collect these data, and some states, such as California and Virginia, have already developed consolidated cost reports to track these expenditures that could be a potential model for other states.²⁸

Third, more transparency of real estate ownership models is also important for understanding related-party transactions, especially arrangements in which the facility real estate is owned by one entity and then leased to another. Section 6101 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) included new requirements for nursing facilities to report additional ownership information

in the Provider Enrollment, Chain, and Ownership System (PECOS), which was made publicly available by CMS in 2022 (ASPE 2022a). However, these data do not include information on the ultimate owners of some chains, and they do not separately identify specific types of arrangements that stakeholders have raised concerns about, such as real-estate investment trusts and private equity ownership (Braun et al. 2023, GAO 2023, Braun et al. 2021). In addition, these data do not identify public or private ownership, which is important for analyses of Medicaid supplemental payments to publicly owned nursing facilities. To address these limitations, CMS could expand its interpretation of disclosable parties and other information required to be reported in PECOS. On February 15, 2023, CMS proposed additional reporting requirements for nursing facilities owned by private equity entities and real-estate investment trusts, but this proposed rule has not yet been finalized (CMS 2023).

Finally, making the payment and cost data that are collected publicly available in a standard format will help improve transparency and enable further analyses by other researchers. To improve the usability of these data, it would be particularly helpful for CMS to identify facilities by their CMS certification numbers (CCNs), if available. CCNs are used to identify facilities on CMS's Care Compare website, which can be used to help compare Medicaid payments and costs to quality outcomes. CCNs are also used on Medicare cost reports, which have additional information on total nursing facility revenue and margins that may be helpful for understanding Medicaid payments and costs in the context of overall nursing facility finances. States currently have the option to provide the CCN on their state UPL demonstrations, but our review of these data found that this field was often missing.

Implications

Federal spending. This recommendation would result in increased administrative effort for the federal government, but these changes are not expected to result in increased federal spending. Federal administrative burden could be reduced if efforts to collect Medicaid nursing facility payment and cost data are coordinated with existing systems and federal reporting requirements.

States. Depending on how the recommendation is implemented, it could affect state administrative effort. Improving the transparency of base and supplemental payments can be implemented by improving existing reporting structures, but collecting and reporting data on sources of non-federal share would require new reporting by states.

Enrollees. This policy would not have a direct effect on enrollees. However, over time greater transparency of Medicaid payments and costs may lead to changes in state payment rates and methods that affect the extent to which Medicaid payments to nursing facilities are spent on direct care staff and other activities related to patient care.

Plans. Health plans may need to provide additional information about managed care payments to nursing facilities. However, health plans are already required to submit payment information to states and the federal government through T-MSIS, and it is unlikely that this recommendation would substantially increase administrative burden for health plans.

Providers. This policy would not directly affect Medicaid payments to providers. However, over time greater transparency may lead to changes in state payment rates and methods by allowing more stakeholders to participate in the rate development process. This recommendation could also increase administrative burden for providers to the extent to which data on provider finances and related-party transactions are not currently collected by states and the federal government.

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 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

Information on how Medicaid payment rates compare with costs and quality outcomes is important for assessing whether payment policies are consistent with the statutory goals. State-level analyses are needed for an accurate assessment of these issues due to a lack of complete data at the federal level and state-specific differences in definitions of allowable costs.

Federal regulations currently 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 (42 CFR 447.253). However, CMS has not enforced this requirement since the Boren amendment was repealed, and even when the Boren amendment was in place, CMS did not provide states with guidance about how to conduct these studies.

Although the Boren amendment has been repealed, it is still important for states to conduct rate studies to inform the public process for developing nursing facility rates, which is required in Section 1902(a)(13)(A) of the Act. In addition, Section 1902(a)(30)(A) of the Act still requires payments to be consistent with efficiency, economy, quality, and access.

To strengthen this requirement, CMS should update existing regulations to clarify what states should review and the process for making the results of these reviews publicly available. Although the existing regulation describes only assessments of payment rates, it is also important for states to consider payment rates in relation to quality outcomes and health disparities to assess whether states are maximizing efficiency. The measures used in Medicare.gov Care Compare can be a starting point for assessing nursing facility quality, but states should also consider whether to examine additional measures that are specific to the needs of Medicaid-covered residents.

When updating existing regulations, CMS can provide more clarity about what information states should include in their assessments of nursing facility rates. Although current regulations require only rate studies for FFS payments, it would be helpful for states to also include information on all Medicaid payments to nursing facilities, including managed care and supplemental payments. Because most states already provide managed care payment data in T-MSIS, including this additional data may not add much more administrative burden.

CMS can also provide more guidance in regulation or subregulatory guidance about how states should compare payments to the costs of efficiently and economically operated facilities. Such guidance could also include a model approach that states could follow. Because state definitions of allowable costs differ, it would be helpful for states to document how the methods that they use are the same or different from commonly accepted standards, such as those used on Medicare cost reports. Similarly, because Medicaid-covered residents often have different care needs than other nursing facility residents, it is important that states describe their methods for adjusting costs to account for differences in resident acuity.

Ultimately, an assessment of whether Medicaid payments are sufficient requires states to make policy judgments about which facilities are operating efficiently and economically. Although CMS should continue to allow states to make these policy judgments, CMS could provide specific standards that states can use as a starting point. In addition, it would help improve transparency if states made the criteria that they use to assess payment rates available to all interested stakeholders.

Implications

Federal spending. This recommendation could result in increased administrative effort for the federal government, but these changes are not expected to result in increased federal spending.

States. This recommendation is likely to increase administrative effort for states that are not currently conducting regular assessments of nursing facility rates. However, states should be able to use the information that they already collect from state cost reports and state payment systems to conduct these

analyses. Moreover, the administrative effort could be reduced if CMS provided increased technical assistance and analytic support to states.

Enrollees. This policy would not have a direct effect on enrollees. However, over time increased transparency about how payment rates relate to quality and access goals may result in changes in state nursing facility payment policies to better achieve these goals.

Plans. Depending on how this recommendation is implemented, health plans may need to provide additional information about managed care payments to nursing facilities. However, health plans are already required to submit payment information to states and the federal government through T-MSIS, and it is unlikely that this recommendation would substantially increase administrative burden for health plans.

Providers. This policy would not directly affect Medicaid payments to providers. However, over time greater transparency may lead to changes in state payment rates and methods by allowing more stakeholders to participate in the rate development process. Because most nursing facilities already submit cost report information to states, it is unlikely that this recommendation would substantially increase administrative burden for providers.

Endnotes

¹ Although the term “nursing home” is commonly used by stakeholders, we use the term “nursing facility” in this chapter because it is the term used to define these services in the Medicaid statute. Historically, the Medicaid statute used the terms “skilled nursing facility” to refer to short-term, post-acute care and “intermediate care facility” to refer to long-term services and supports provided by nursing facilities. The Nursing Home Reform Act of 1987, which was part of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), changed the statute to refer to both types of care as “nursing facility care” and to require common standards regardless of resident length of stay.

² The number of individuals served by nursing facilities throughout the year is greater than the number of individuals served at a point in time. For example, in 2020, about 1.2 million Medicare fee-for-service beneficiaries had at least

one nursing facility stay during the year, while only 247,500 in Medicare beneficiaries were included in our analyses of individuals receiving care in nursing facilities as of September 30, 2019 (MedPAC 2022b, Abt Associates 2020).

³ Other institutional LTSS providers include intermediate care facilities for individuals with intellectual disabilities and institutions for mental diseases, which are outside the scope of this chapter.

⁴ As of 2017, approximately 7 percent of individuals age 50 and older had long-term care insurance (LIMRA 2017).

⁵ The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provided states with the option to expand Medicaid coverage to non-elderly adults with incomes below 138 percent of the federal poverty level. However, most nursing facility residents (89 percent) are older than age 65 and thus do not qualify for this eligibility group (Abt Associates 2020).

⁶ In 2015, the median annual private-pay charge for a semiprivate nursing facility room was \$80,300 (Genworth Financial, Inc. 2015).

⁷ For example, if a Medicaid-covered resident has a spouse residing in the community, the resident can protect a greater portion of their income from post-eligibility treatment of income rules.

⁸ This analysis was limited to nursing facilities that are certified by Medicare and excluded nursing facilities that are only certified by Medicaid.

⁹ Some states require that nursing facilities admit residents regardless of payer. However, in practice, Medicaid residents in these states often still have difficulty finding a nursing facility bed, as evidenced by secret shopper studies showing that nursing facilities respond more favorably to hypothetical private pay applicants (Kowalczyk and Arsenault 2020).

¹⁰ States must conduct in-person surveys of facilities at least once a year, according to standards set by CMS. These surveys are unannounced and include assessments of a variety of issues that affect patient safety and quality of life, such as infection control, medication management, and protection from physical and mental abuse. Medicaid finances state survey activities at a 75 percent federal medical assistance percentage (FMAP) (§1903(a)(2)(D) of the Act).

¹¹ In 1968, the Social Security Amendments of 1967 (P.L. 90-248) also added the requirement that states “assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.”

¹² *Wilder v. Virginia Hospital Association*, 88-2043, (SCT June 14, 1990).

¹³ The Medicaid payment principles of efficiency, economy, and quality in Section 1902(a)(30)(A) of the Act were added by the Social Security Amendments of 1967, and the standard that payments assure access to care similar to what is available to the general population was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

¹⁴ *Armstrong v. Exceptional Child Center, Inc., et al.*, 14-15, (SCT July 7, 2014).

¹⁵ Because Medicare’s SNF payment covers therapy costs and Medicaid nursing facility payments typically do not, CMS requires states to adjust Medicare payment rates used in UPL calculation to exclude non-covered services (CMS 2022c).

¹⁶ In 14 of the 23 states reporting supplemental payments on CMS-64 expenditure reports, the reported spending on UPL demonstrations was similar, while in 2 states spending reported did not match. In several states, supplemental payments were recorded on CMS-64 expenditure reports but not on UPL demonstrations (three states) or no UPL demonstration was submitted (four states). Nine states reported supplemental payments on UPL demonstrations that are not listed as supplemental payments on CMS-64 expenditure reports.

¹⁷ Provider taxes for which 75 percent or more of taxpayers in a class receive 75 percent or more of their total tax costs back from Medicaid are generally limited to 6 percent of providers’ net patient revenue. More information about provider taxes is available in MACPAC’s issue brief *Health Care-Related Taxes in Medicaid* (MACPAC 2021b).

¹⁸ The relationship between higher staffing levels and better quality care has been well documented. For example, a recent systematic review found that higher registered nurse (RN) staffing levels were associated with fewer pressure ulcers, decreased urinary tract infections, reduced emergency department use, fewer hospitalizations, and decreased mortality (Dellefield 2015). Although RN staffing has the strongest link to quality, higher levels of total direct care staffing (i.e., RNs, licensed practical nurses, and

certified nurse aides) are also associated with improved outcomes (Harrington et al. 2020b).

¹⁹ During the COVID-19 pandemic, CMS has allowed states to waive or reduce training requirements for CNAs. Other non-nursing staff, such as therapists, social workers, and activities staff, also provide direct care, but they are not included in measures of nurse staffing levels.

²⁰ In 2019, wages for staff accounted for 51 percent of costs for nursing care at nursing facilities (MACPAC 2023a).

²¹ In our analysis, we estimated what costs would be if facilities were staffed at 3.6 HPRD, which was the threshold for a three-star staffing rating in 2019.

²² We also identified four states with pending legislation to increase minimum staffing requirements.

²³ Specifically, this study reviewed California’s increase of minimum standards from 3.0 to 3.2 HPRD in 2000 and Ohio’s increase of minimum staffing standards from 1.6 to 2.75 HPRD in 2002 (Chen and Grabowski 2014).

²⁴ In the Nursing Home Value-Based Payment Demonstration, nursing home performance was assessed using measures from four domains: nurse staffing (30 percent of performance weight), quality outcomes (20 percent), survey deficiencies (20 percent), and potentially avoidable hospitalization rates (30 percent).

²⁵ During the three years of the Nursing Home Value-Based Payment Demonstration, savings were realized in Arizona (year one) and Wisconsin (years one and two); no savings were generated in Arizona (years two and three), New York (years one through three), and Wisconsin (year three) (L&M Policy Research 2013).

²⁶ For example, in 2019, the average acuity-adjusted costs per day for Medicaid-covered nursing facility residents were \$239.35, compared with average costs of \$293.36 per day for all nursing facility residents (MACPAC 2023a).

²⁷ The Minimum Data Set does not currently identify payer source explicitly, but it does include information on a resident’s Medicare and Medicaid enrollee identification number that can be used to infer the payer source (Abt Associates 2020).

²⁸ Calif. Health and Safety Code § 128734.1 (2021) and Virginia Code tit. 12, § 30-70-450 (2000).

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on January 27, 2023.

Nursing Facility Provider Payment Principles

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.

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 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.

2.1-2.2 voting results	#	Commissioner
Yes	16	Allen, Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Heaphy, Johnson, Meadows, Scanlon, Weno
Not present	1	Herrera Scott