November 6, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-3442-P: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) on establishing mandatory federal minimum staffing standards and Medicaid payment reporting requirements for long-term care facilities published on September 6, 2023 (CMS 2023). MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

In MACPAC's March 2023 *Report to Congress on Medicaid and CHIP,* the Commission outlined principles for policymakers to consider when setting nursing facility payment policies and made a number of recommendations for improving transparency (MACPAC 2023a). As discussed below, the Commission supports efforts in this proposed rule to improve payment transparency, but is concerned that the proposed data reporting will be difficult to interpret without additional information on facility costs and payments. We suggest that the Centers for Medicare & Medicaid Services (CMS) use this opportunity to collect additional data that would allow a more complete and useful assessment of whether Medicaid payments are consistent with the statutory goals of efficiency, economy, quality, and access.

The Commission has not made recommendations on nursing facility staffing standards, but this letter concludes with technical comments on the provisions of the proposed rule based on our prior work in this area. Although staffing is just one of many measures of quality, staffing rates have been a key area of focus for the Commission since facilities that serve a higher share of Medicaid-covered residents generally have lower staffing rates compared to other facilities. As these facilities also serve more racial and ethnic minorities, these disparities also raise health equity concerns. Although the Commission supports the proposed rule's goal of increasing staffing rates, we advise CMS to consider potential unintended consequences of the proposed staffing standards.

Medicaid institutional payment transparency

The proposed rule would require states to report annually on the share of Medicaid payments to long-term care facilities that are spent on compensation for direct care workers and support staff. States would be required to report this ratio at the facility-level and report separately for payments in fee for service (FFS) and managed care.

In the Commission's view, it would be more helpful if states reported complete, facility-level data on Medicaid payments and costs, not just the ratio of Medicaid payments spent on staffing. Complete data could be used to calculate the staffing compensation ratio that CMS is proposing. Additional data could also be used to inform analyses of whether Medicaid payments are sufficient to cover the costs of care for efficient and economically operated facilities and how Medicaid payment policies relate to quality outcomes and health disparities.

Below we outline additional information that CMS should collect that would be most useful for future analyses of Medicaid payment policies. Because of the complexities of Medicaid payment policy and nursing facility finances, the Commission recommends that CMS clearly define its reporting requirements so that data can be compared across states and facilities. CMS should also provide analytic support and technical assistance to states to help complete these analyses and make data publicly available in a standard format to enable further analyses by other researchers.

CMS's proposed rule would apply to both nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). Although MACPAC has not formally reviewed Medicaid payment policies for ICF/IIDs, we provide technical comments below on the unique considerations for tracking Medicaid payments and costs for these facilities.

Medicaid payment rates

In the Commission's view, assessments of Medicaid nursing facility payments should consider all types of Medicaid payments that providers receive. These include base payments for services in FFS and managed care, supplemental payments, managed care directed payments, value-based payments, and resident contributions to the cost of their care.

The proposed rule includes many of these payment types, but does not clearly specify how resident contributions to the costs of their care will be accounted for. The preamble to the proposed rule acknowledges that states should include FFS base payments paid by the state plus any deductible or coinsurance required to be paid by the individual, but this distinction is not described in the proposed regulation text. Moreover, this definition does not appear to include resident contributions to the cost of their care as a result of Medicaid rules for post-eligibility treatment of income (PETI). According to MACPAC's analyses of allowed payment amounts reported in the Transformed Medicaid Statistical Information System (T-MSIS), PETI-related resident contributions to the cost of their care accounted for about 10 percent of Medicaid payments to nursing facilities in 2019 (MACPAC 2023b).

CMS proposes to include managed care payments when calculating the staffing ratio but raises questions in the proposed rule about whether CMS has the authority to collect information about managed care payment rates because they are contractually negotiated. However, CMS already requires states to collect information on managed care payment rates (42 CFR 438.42) and CMS has clarified in prior regulations that these data are needed for proper monitoring and administration of the Medicaid program (CMS 2020). Given that managed care accounted for 29 percent of Medicaid payments to nursing facilities in 2019, these data are needed to fully understand Medicaid payments to nursing facilities (MACPAC 2023b).

CMS requests comments on whether it would be helpful for states to report a single average per diem rate for all facilities in their state. In the Commission's view, facility-level payment rate information would be more useful because of the wide variation in provider payment rates within each state. According to MACPAC's analyses of 2019 base payment rates relative to acuity-adjusted costs, one-fifth of facilities had allowed payment amounts greater than 100 percent of costs and 15 percent of facilities had allowed payment amounts less than 70 percent of costs (MACPAC 2023b). If states report facility-level payment rates, these data could be used to calculate statewide average per diem payment rates, as well as other measures of central tendency that may be more useful, such as the median payment rate.

Facility costs

The Commission recommends that CMS collect and report data on all costs of care for Medicaid-covered residents, not just staffing costs. This information is needed to assess whether Medicaid payments are sufficient to cover the costs of care for efficiently and economically operated facilities, an assessment that is already required under federal regulations (42 CFR 447.253). CMS could require reporting on staffing and non-staffing costs separately so that it could still use this information to calculate the staffing compensation ratio proposed.

To ensure that costs are measured in a standard way, CMS should provide states with additional technical assistance on how costs for direct care workers and support staff should be measured. Medicare cost reports currently include facility-level information on spending on direct care staff, but it is difficult to determine how staff allocate their time between residents with different care needs. In MACPAC's recent analyses of Medicaid nursing facility-payments relative to acuity adjusted costs, we used data on resident acuity from the Minimum Data Set (MDS) to estimate the costs of care for Medicaid-covered residents. In our analysis, we also excluded spending on ancillary and therapy services, since many of these costs are paid for by Medicare Part B for residents who are dually eligible for Medicare and Medicaid (MACPAC 2023b). Medicare cost reports also distinguish multiple types of staffing costs, including direct care staff, ancillary staff who support patient care, and administrative staff who are not directly involved in patient care, which could be a useful distinction to maintain in any new reporting of facility costs.

The Commission also recommends that CMS collect more data on related-party transactions, which may inflate reported staffing and non-staffing costs above what they would be if a facility were operated more efficiently and economically. Although CMS does not currently collect complete information on related-party transactions through Medicare cost reports, some states have recently developed state-specific, consolidated cost reports to collect these data. Requiring more standardization of cost information collected would not limit a state's flexibility to define allowable costs for their Medicaid program; instead it would provide a useful baseline for comparing costs and payments across states.

Provider contributions to the non-federal share of Medicaid payments

CMS should collect data on provider contributions to the non-federal share of Medicaid payments in order to calculate net payments at the provider level. 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). In addition, many states finance Medicaid payments to publicly owned nursing facilities using intergovernmental transfers and certified public expenditures.

Although these financing methods are permissible, provider contributions to the non-federal share reduce net payments to providers. For example, in two states that did provide information on provider taxes in their Medicaid upper payment limit demonstration submitted to CMS, we found that these taxes reduced net payments by 2–3 percent (MACPAC 2023b).

CMS does not currently have any processes in place to collect provider level data on provider contributions to the non-federal share. However, the costs of provider taxes appear to be included on Medicare cost reports, so it may be possible to revise cost reporting standards to collect this information at the facility level.

Comparing payments to costs

MACPAC's recent analyses of Medicaid nursing facility payments relative to costs may help inform additional technical decisions CMS should consider when comparing Medicaid payments to costs. MACPAC's methodology was developed based on feedback from a technical expert panel that included states, nursing facilities, accounting firms, and academic researchers (MACPAC 2023b).

MACPAC's analyses excluded claims for which Medicaid is not the primary payer, which CMS also proposes to do in the NPRM. Because the vast majority of Medicaid-covered nursing facility residents are dually eligible for Medicare and Medicaid, Medicare is the primary payer for skilled nursing care during the initial portion of a resident's stay, and Medicaid is the primary payer for subsequent days of long-term care.

Our analysis also excluded swing-bed hospitals, which the NPRM also proposes to exclude. As noted in the NPRM, the facilities account for a small share of Medicaid-covered nursing facility stays and have different cost structures than stand-alone nursing facilities.

Finally, our analysis excluded bed hold days, which are payments made when a resident is not in the facility. The NPRM requests comments about whether these days should be included in the analysis. The Commission has collected information on Medicaid bed hold policies as part of our review of state FFS payment methods (MACPAC 2019). However, we excluded bed hold days from our analysis because our technical expert panel (TEP) could not identify an appropriate cost benchmark to use for days when a resident is not in the facility.

Additional considerations for ICF/IIDs

As CMS considers applying the proposed payment transparency requirements to ICF/IIDs as well as nursing facilities, it is important to recognize the similarities and differences between these types of institutional long-term care. In fiscal year (FY) 2021, ICF/IIDs accounted for 19 percent of Medicaid spending on institutional long-term care (MACPAC 2023c). Although MACPAC has not formally reviewed Medicaid payment policies for ICF/IIDs, we have tracked trends in ICF/IID supplemental payments, financing, cost reporting, and ownership for CMS to consider.

Similar to nursing facilities, states also make supplemental payments to ICF/IIDs, including payments that are financed by provider taxes. However, the use of these payment and financing arrangements in ICF/IIDs is lower than the use of these arrangements in nursing facilities. In FY 2021, supplemental payments accounted for 2 percent of Medicaid FFS spending on ICF/IIDs and in FY 2019, 35 states had provider taxes for ICF/IIDs (MACPAC 2023c, KFF 2019). Accounting for these supplemental payments and provider contributions to the non-federal share is important for understanding overall net payments that providers receive.

Unlike nursing facility services, ICF/IID services are not covered by Medicare and so facilities do not submit Medicare cost reports. However, many states use state-specific cost reports to track costs for these facilities. ICF/IIDs are also not subject to federal staffing requirements that apply to nursing facilities and do not submit resident acuity information through the MDS. As a result, compared to nursing facilities, it would likely be more difficult for ICF/IIDs to submit information on staffing and facility costs to CMS in a standard way.

ICF/IIDs also differ from nursing facilities in many facility characteristics. In FY 2021, 47 percent of Medicaid payments to ICF/IIDs were made to publicly owned facilities (MACPAC 2023c). In contrast, most nursing facilities

(72 percent) were privately owned in 2019 (MACPAC 2023a). Compared to nursing facilities, ICF/IIDs serve more residents under age 65 and generally have smaller bed size (ASPE 2013). These differences in facility ownership and other characteristics may affect the way the facility's cost structure and financial incentives, which could be important context to consider when assessing spending on direct care workers relative to overall facility costs and revenue.

Technical comments on minimum staffing standards

MACPAC's analyses of nursing facilities over the past several years has focused on the need for adequate staffing in nursing facilities. The Commission has documented the link between higher staffing levels and better quality of care, the wide variation in staffing levels by state, and the health equity concerns raised by the fact that facilities that serve a higher share of Medicaid-covered residents generally have lower staffing rates compared to other facilities (MACPAC 2022a). The Commission has also documented state strategies to improve staffing rates, including minimum staffing standards (MACPAC 2022b). Although we have found that minimum staffing standards can help improve staffing rates, there are also several potential unintended consequences that CMS should consider.

Most notably, the proposed rule would likely increase costs for many state Medicaid programs. In the NPRM, CMS estimates the rule will increase costs of care for Medicaid-covered residents by $26.9 billion over 10 years but does not assume that state Medicaid payments will need to increase to cover these costs. However, according to MACPAC's review of state Medicaid FFS payment methods as of July 2019, 31 states used cost-based payment methods (MACPAC 2019). As a result, if states do not change their payment methods, Medicaid nursing facility payments in these states would increase if staffing costs increase. There may also be spillover effects on Medicaid spending on home- and community-based services (HCBS) in states where HCBS spending is tied to the costs of institutional care or if states need to increase HCBS spending in response to the increased demand for direct care staff.

In the proposed rule, CMS requests comments on whether minimum staffing standards should be adjusted for patient acuity. MACPAC's prior analyses of acuity-adjustment methods may help inform CMS's consideration of this issue. Overall, we found that Medicaid-covered residents generally have lower acuity than Medicare-covered residents, but measures of resident acuity were different under the Resource Utilization Group Version IV model that CMS previously used and the new Patient-Driven Payment Model (PDPM) that Medicare began using in October 2019 (Abt Associates 2020). The case-mix weights developed for PDPM used data only for Medicare-covered nursing facility residents, and so some components of PDPM are not a good measure of the care needs for long-stay residents, who are predominately covered by Medicaid. If CMS chooses to adjust staffing standards for patient acuity, it should ensure that the measures used are appropriate for Medicaid-covered residents.

Thank you for the opportunity to comment on this proposed rule. The Commission appreciates CMS efforts to promote transparency and adequate staffing in long-term care. If there is any further information MACPAC can provide you to aid in your consideration of our comments, please let us know.

Sincerely,

Melanie Bella

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Cathy McMorris Rodgers, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone, Jr., Ranking Member, House Energy and Commerce Committee

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