Integrated Care Resource Center

August 14, 2018

Spotlight: State Implications of Medicare Skilled Nursing Facility Payment System Changes and New Floor for Medicaid Hospice Rates

Skilled Nursing Facility Payment System Changes

Overview. On July 31, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that makes significant changes to the Medicare prospective payment system (PPS) for skilled nursing facilities (SNFs). These changes, which take effect on October 1, 2019, may have implications for states that base Medicaid nursing facility (NF) payment, at least in part, on the SNF PPS case mix adjustment methodology used in the current Medicare SNF payment system. In addition, a new SNF financial incentive aimed at reducing hospital readmissions for SNF residents is scheduled to take effect on October 1, 2018 as part of the SNF Value-Based Purchasing (VBP) program. States and health plans that serve dually eligible beneficiaries and are developing VBP approaches for Medicaid NFs may want to take this new Medicare SNF VBP initiative into account. A CMS fact sheet has more information on the new SNF payment system and the SNF VBP program.

New Medicare SNF "Patient-Driven Payment Model"(PDPM) case mix payment system. The new CMS payment system, which will replace the current Resource Utilization Group, Version IV (RUG IV) system, will base Medicare SNF payments primarily on patient characteristics, care needs, and goals rather than on the amount of physical, occupational, and speech therapy provided to patients, as the current system does. (See pp. 39183-39185 of the final rule for a summary of the reasons for moving to the new PDPM system.) The PDPM is also designed to reduce administrative burden by substantially reducing the number of required patient assessments.

As CMS notes, the current system provides incentives for SNFs to deliver therapy to beneficiaries based on financial considerations rather than the most effective course of treatment. While most of the upcoming changes to the Medicare SNF payment system involve therapies, prescription drugs, and other post-acute services that SNFs provide during a covered Medicare Part A SNF stay, and not the longer-term nursing care services provided as part of Medicaid NF benefits, there are some changes being proposed that may have relevance for Medicaid NF payment systems that are based on the current Medicare RUG-IV case mix system.

Potential state implications. States that use Minimum Data Set (MDS) assessments and/or RUGs classifications for Medicaid nursing facility payment purposes should consider any potential impacts that may result from the new Medicare PDPM system. For example:

- **Potential impact of changes in RUGs-based case mix categories and frequency of MDS assessments on state Medicaid payment and claims processing systems.** If state NF payment systems are tied very closely to the RUGs categories used for payment purposes in SNFs and/or to the Medicare SNF MDS assessments, modifications to those elements of the SNF payment system could require changes in Medicaid payment and claims processing systems. MDS assessments for SNF residents are currently quite frequent (on or around days 5, 14, 30, 60, and 90), reflecting to some extent the variations in therapy use that may occur during a SNF stay. Since payment in the new PDPM model will be based primarily on patient characteristics and care needs, which are less subject to change over short periods, there will be fewer and less frequent MDS assessments (an initial assessment, with reassessments if there are significant changes in status, and at discharge) for the new PDPM system (see pp. 39229-39231). CMS notes that it plans to work with states on these and other issues related to the transition from the RUG-IV to the PDPM payment system.

- **Potential impact on Medicaid upper payment limit (UPL) calculations.** In 2015, the Medicaid and CHIP Payment and Access commission reported that 22 states were making UPL supplemental payments to Medicaid NFs. Some states make higher UPL-based payments to government-owned NFs, which states are allowed to put in a separate UPL category. While CMS plans to implement the new PDPM system in a budget neutral way so that aggregate SNF payments will be unchanged, there will be increases and decreases for specific types of residents and types of facilities. CMS estimates that implementation of the new PDPM system in a budget neutral manner will result in an increase in SNF payments of about 4.2 percent to government-owned facilities, which make up about 5 percent of all SNFs (see Table 38 on p. 39260). This could allow higher UPL-based payments for these facilities. CMS briefly discusses this issue on p. 39187.
- **Potential impact on payments to SNFs by managed care plans serving dually eligible beneficiaries.** Medicare-Medicaid Plans (MMPs) in the Financial Alignment Initiative demonstrations, Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), and other plans that cover Medicare SNF benefits are likely to change the way they pay SNFs to correspond more closely to the new PDPM system. The increased focus on patient characteristics, care needs, and goals in the new SNF payment system could make it easier for health plans to coordinate the SNF benefit with Medicaid long-term nursing facility benefits and home-and community-based services, especially in states that have a similar focus on assessing patient needs when determining eligibility and payment for these Medicaid services. CMS briefly discusses this issue on p. 39188.

SNF Value-Based Incentive Payments. Beginning on October 1, 2018, the SNF VBP program will make either positive or negative incentive payments to SNFs based on the program's hospital readmissions measure. This claims-based, all-cause 30-day hospital readmissions measure will be used to determine how much each facility's rate for the upcoming fiscal year should be adjusted up or down (see pp. 39272-39282). This new SNF VBP program and the availability of facility-specific hospital readmissions data will provide opportunities for states to enhance their Medicaid NF VBP programs. To date, state Medicaid NF VBP systems have generally focused on measures other than hospitalizations, which Medicare covers for dually eligible Medicaid NF residents, although managed care organizations in some states have begun moving toward VBP arrangements that consider both Medicare and Medicaid nursing facility benefits together. (For details, see ICRC's November 2017 TA tool *Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans*) and the July 24, 2018 Study Hall Call on *Using Value Based Purchasing (VBP) Arrangements to Improve Coordination and Quality of Medicare and Medicaid Nursing Facility Benefits*.) Now that this VBP measure of hospital readmissions is being used in SNFs, states and health plans have the opportunity to make it a part of any VBP payment they establish for dually eligible beneficiaries in Medicaid NFs or Medicare SNFs.

Medicare Hospice Payment Increase Will Result in Medicaid Payment Increases

As of October 1, 2018, Medicare payments for hospice services will increase by 1.8 percent. CMS detailed this change in an August 1 fact sheet.

State Medicaid payments for hospice care are required to be "in amounts no lower than the amounts, using the same methodology" as in Medicare (Section 1902(a)(13)(B) of the Social Security Act). As a result, minimum Medicaid payments for hospice will increase by the same amount as Medicare on October 1, 2018. CMS will send a memo with details on the Medicaid hospice rates for FY 2019 to CMS Regional Offices in early September, and will post the memo on Hospice Benefits page of Medicaid.gov.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for individuals dually eligible for Medicare and Medicaid. The state technical assistance activities are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit http://www.integratedcareresourcecenter.com.