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CENTERS FOR MEDICARE & MEDICAID SERVICES
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# *CMCS Informational Bulletin*

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**SUBJECT**: Medicaid nursing facility payment approaches to advance health equity and improve health outcomes.

## Introduction

Millions of Americans, including children, non-elderly adults, and older adults, need long-term services and supports (LTSS) because of disabling conditions, chronic illness, and other factors. Medicaid, which is the primary payer across the nation for these services, allows for the coverage of LTSS through several authorities and programs and over a continuum of settings—ranging from institutional care, such as in nursing facilities, to home and community-based services (HCBS). The Biden-Harris Administration, including CMS, is committed to ensuring that all older adults and people with disabilities have access to high quality services in the setting of their choice.

Over the last decade, CMS and states have worked and continue to work closely together to reduce the reliance on institutional services and expand access to high-quality HCBS. Today, most Medicaid LTSS spending is on HCBS, accounting for $125 billion, while institutional services accounted for $75 billion in Medicaid expenditures in 2020.[1]

In February 2022, the White House and CMS announced a comprehensive set of reforms to improve safety and quality of care in our nation's nursing homes through the action plan "Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes" (Biden-Harris Administration's Nursing Home Reform Action Plan).[2] Improving health equity in nursing facilities is a priority for CMS to not only improve the quality of care, but also quality of life for nursing home residents.[3] As of 2019, two million Medicaid beneficiaries received

[1] Medicaid LTSS expenditures totaled approximately $200 billion in FY 2020, with HCBS accounting for $125 billion (62.5 percent) and institutional services accounting for $75 billion (37.5 percent). Source: Murray, Caitlin, Michelle Eckstein, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020." Chicago, IL: Mathematica. Forthcoming.
[2] https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.
[3] Ibid.

institutional services.[4] Medicaid is a key lever for accomplishing the goals of strengthening quality of care, accountability, and transparency.

This Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) describes actions that states can implement using existing Medicaid authority. CMS encourages states to assess their approach to payments to long-term care providers and utilize flexibilities provided by section 1902(a)(30)(A) of the Social Security Act (the Act) in establishing Medicaid base and supplemental payments, as appropriate, to provide adequate, performance-driven nursing facility rates to ultimately achieve better health care outcomes and address longstanding inequities for Medicaid beneficiaries residing in nursing facilities. States can implement a number of initiatives immediately through the Medicaid state plan, waiver, or demonstration process, which are highlighted below. Through initiatives like these, we expect that Medicaid beneficiaries residing in nursing facilities will receive better care through the collaboration of CMS and states to realize the goals outlined in the White House Biden-Harris Administration's Nursing Home Reform Action Plan.

In addition to the actions below, CMCS continues to encourage states to "rebalance" their LTSS systems to achieve a more equitable and person-centered balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care.[5] A key priority of the Biden-Harris Administration is strengthening the availability of Medicaid-funded HCBS, as an alternative to institutional care. Funding made available to expand, enhance and strengthen HCBS under section 9817 of the American Rescue Plan Act (ARP) has resulted in approved state actions to include expanding the scope of HCBS available to targeted populations and increasing payments to the direct service workforce.[6] In addition, implementation of the 2014 home and community-based settings regulation continues to ensure the reimbursement of HCBS is happening in settings that facilitate person-centeredness and individual decision-making.

In addition, on behalf of those Medicaid beneficiaries who receive and will continue to require care through nursing facilities and other institutional long-term care settings, states are encouraged to use the tools available through Medicaid to improve safety, accountability, quality, and overall resident experience in alignment with the measures established by CMS, such as the Nursing Home Five-Star Quality Rating System.

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[4] In 2019, nearly 9 million Medicaid beneficiaries received LTSS. Of these, 7.4 million (84 percent) received HCBS, 1.7 million beneficiaries (19 percent) received institutional services, and 0.3 million (3 percent) received both. Source: Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki. "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019." Chicago, IL: Mathematica, Forthcoming.

[5] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.

[6] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html

***Using Provider Payment Structures to Encourage Quality of Care***

CMS is launching new initiatives in both Medicare and Medicaid to ensure that nursing facility residents get the quality care they need. These initiatives are intended to help ensure adequate staffing, dignity, and safety in resident accommodations, as well as high-quality care, including: establishing a minimum nursing home staffing requirement; undertaking efforts to reduce resident room crowding; strengthening the Medicare Skilled Nursing Facility (SNF) Value-Based Purchasing ("VBP") program; and reinforcing safeguards against unnecessary medications and treatments.

In the Medicaid program, states have broad flexibility to design their provider payment structures to incentivize providers for implementing or performing highly on the types of initiatives listed above. Medicaid payments based on improvements to performance on quality measures have already been approved in numerous Medicaid State Plan Amendments (SPAs), such as:

- California's long-standing quality and accountability supplemental payment initiative provides increased payments to facilities that improve quality of care to their residents, using quality indicators defined by CMS to reward facilities whose performance is at or above statewide average.[7]
- Illinois's new nursing facility payment initiative includes robust facility staffing incentives.[8] In 2022, Illinois implemented a data-driven staffing ratio target program and a wage incentive initiative which supports nursing facilities in increasing and maintaining the wages of Certified Nursing Assistant (CNAs) through the "CNA Tenure and Promotion Payments" to increase retention of direct care staff in the facility, which, studies suggest, leads to better outcomes for residents of the facilities.[9]

Similarly, to help reduce resident room crowding, states can implement Medicaid payment initiatives that adjust provider payment rates based on resident room occupancy, or set a higher payment rate for Medicaid residents in a single occupancy room. Whether integrated into the base rate or established as a separate value-based payment program, these efforts link payment to improved health care quality and shift from a focus on volume to value.

***Accountability in Nursing Facilities***

It is in the state's and federal government's best interest, and in the best interests of our beneficiaries, to direct taxpayer dollars to nursing homes that support patient safety. In an effort to increase accountability, oversight, and transparency, CMS's planned initiatives include: increasing scrutiny on more of the poorest performing nursing facilities; expanding financial penalties and other enforcement sanctions when warranted; increasing accountability for chain owners of substandard facilities; providing technical assistance to nursing homes to help them

[7] https://www.medicaid.gov/medicaid/spa/downloads/CA-20-0021.pdf.
[8] https://www.medicaid.gov/medicaid/spa/downloads/IL-22-0009.pdf
[9] https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.

improve; improving transparency of facility ownership and finances; and enhancing Medicare's Nursing Home Care Compare website.

To support these accountability initiatives, CMS recently implemented a number of efforts that aim to increase accountability, oversight, and transparency. In 2021, CMS implemented new Medicaid supplemental reporting requirements for states as required under the newly added section 1903(bb) of the Act.[10] Likewise, CMS recently made a large volume of Medicare provider data available, including nursing home quality data and a database showing changes in ownership of facilities.[11] States are encouraged to use any federal or state data at their disposal to improve and better target oversight of the facilities located in their own states. For example, a number of states use the CMS Nursing Home Five-Star Quality Rating System as part of their calculation of bonus payments to nursing facilities. States may also develop incentives to encourage provider participation in Medicaid-specific quality improvement activities based on state-developed program goals.

***Supporting High Quality Staffing***

Low nursing home wages contribute to frequent turnover and staffing shortages.[12] Research has long demonstrated a clear association between nurse staffing ratios and nursing home quality of care, with evidence showing higher staff turnover associated poorer quality of care.[13] Leveraging payment approaches to strengthen staffing further aligns with and complements the new minimum staffing requirements for nursing homes which, per the Action Plan, CMS plans to propose within a year of announcing the Biden-Harris Administration's Nursing Home Reform Action Plan.

Consistent with these efforts to establish minimum staffing requirements, CMS advises states to continue developing long-range solutions for training and improving staffing and workforce sustainability issues in nursing facilities. Individual states should look to state-specific data sources for measurable metrics by which improvements can be monitored and incentivized. CMS has already approved a number of different staffing improvement incentives in state Medicaid programs. For example, Connecticut[14] designed a 2% rate increase for nursing facilities to be used for increases to employee wages or salaries, increases to the health or dental benefit or retirement plans or for a combination of these. Additionally, Rhode Island recently increased nursing facility rates to support new minimum staffing and wage requirements, whereby 80% of any base rate increase paid to a nursing facility must be dedicated to increase base salary or hourly wage increases, benefits, and other compensation for all eligible direct-care workers.[15]

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[10] https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf. This effort was mandated by Division CC, Title II, Section 202 of the Consolidated Appropriations Act, 2021 (CAA).
[11] https://data.cms.gov/provider-data/dataset/y2hd-n93e.
[12] https://www.macpac.gov/wp-content/uploads/2021/12/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf.
[13] https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.
[14] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CT/CT-19-0022.pdf.
[15] https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0015.pdf

States are encouraged to work with facilities and CMS to determine if there are any costs, such as continuing education training for CNAs, that can be included in the payment rate for Medicaid services. We also encourage states to seek out other solutions to training and testing capacity issues within the nursing facilities through collaboration with the states' Departments of Public Health that certify Nurse Aide Training and Competency Programs (NATCEPs) to promote funded training opportunities for nursing facility staff.

***Safety Issues during Emergencies and Pandemics***

Residents of nursing homes face longstanding care, quality, and safety issues which have been exposed and exacerbated during the pandemic. The federal and state governments must work together to ensure that risks associated with pandemic and emergency preparedness issues are mitigated as much as possible to ensure the safety of vulnerable nursing home residents. To this end, the Biden-Harris Administration's Nursing Home Reform Action Plan includes a list of pandemic and emergency preparedness initiatives that will help ameliorate future risks in these settings, including: the continuation of COVID-19 testing in long-term care facilities; the continuation of COVID-19 vaccinations and boosters in long-term care facilities; strengthening requirements for on-site infection preventionists; enhancing requirements for pandemic and emergency preparedness; and integrating pandemic lessons into nursing home requirements.

CMS advises states to review their emergency preparedness policies and look for areas where state Medicaid agencies can improve their practices. States are encouraged to build incentives in their provider licensure requirements or Medicaid payment structures to gather information and reward providers according to how well the targets set by the state are met by the facilities. Currently, we do not have an example of an incentive payment or methodology for encouraging pandemic or emergency preparedness, but CMS encourages states to submit SPAs aimed at ensuring preparedness in nursing facilities to begin establishing a precedent for this type of proposal.

**Implementation Options**

CMS is committed to working with states to identify existing Medicaid authority to work towards solutions to improve safety and quality of care in nursing facilities. We challenge states to leverage state and federal data and stakeholder insights to inform innovative payment policies that help strengthen safety and quality of care in nursing facilities and provide for adequate staffing over the long term in a way that is specific to the state and geographic areas where care for Medicaid beneficiaries is being provided.

As noted earlier, states have considerable flexibility through the Medicaid program to develop payment methodologies, including base and supplemental payments, to implement incentives to drive positive change. When implementing the proposals described in this CIB through Medicaid payment methodologies, it is important to remember that Medicaid requirements establish parameters for Medicaid provider payments. Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the

plan at least to the extent that such care and services are available to the general population in the geographic area." These requirements are implemented, in part, through the Medicaid Upper Payment Limits (UPLs) with which states must comply.[16] Payment for nursing facility services[17] are subject to the Medicaid UPL requirements. These requirements limit nursing facility payments, in the aggregate, to a reasonable estimate of the amount that would be paid for the same services provided by the facility under the Medicare program. In general, states are allowed to make base and supplemental payments up to that limit. If a state needs a SPA to implement a new incentive payment, states are encouraged to work with CMS, noting that any new or modified payment methodologies generally require a submission of a SPA or proposed amendment to a waiver or demonstration authority.[18]

Additionally, where states need additional data to develop staffing and quality measures in future periods, CMS, as discussed in the Value-Based Care Opportunities in Medicaid SMDL,[19] supports states' approaches to building data collection infrastructure to support these types of payment programs prior to full implementation of the value-based care arrangement. Building transparency and evaluation into these value-based payment arrangements helps build the evidence base to support effective policymaking in the future.

CMS recognizes that state Medicaid agencies may have additional ideas for ways to use nursing facility payments to improve safety and quality of care that work best for their state. CMS welcomes innovative approaches that meet the urgent challenge of improving quality of care and safety for residents of our nation's nursing homes and will continue to provide technical assistance to states interested in developing nursing facility payments to ensure compliance with federal statutes and regulations while maximizing flexibility.

***Conclusion***

CMS is committed to working in partnership with states to develop payment methodologies that address initiatives to improve health care quality and equity in the Medicaid program. CMS encourages states to utilize the flexibilities available to support the provision of high-quality care to residents of nursing facilities.

If states have questions about this informational bulletin or need technical assistance regarding these flexibilities, please contact Andrew Badaracco, Technical Director in the Division of Reimbursement Policy at Andrew.Badaracco@cms.hhs.gov.

[16] 42 Code of Federal Regulations (C.F.R.) § 447 Subpart C
[17] Authorized under section 1905(a)(4)(A) of the Act.
[18] See for example, 42 C.F.R. § 440.200, et seq., sections 1902(a)(13), 1902(a)(73)(A), 1902(a)(30), 1902(a)(2) of the Act, and 42 C.F.R. § 447 Subpart B
[19] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf