DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 22-005

RE: Guidance on Nursing Facility State Plan Payment and Upper Payment Limit Approaches in Medicaid Relying on the Medicare Patient-Driven Payment Model

September 21, 2022

Dear State Medicaid Director:

This letter provides guidance to states as they consider transitioning from the Resource Utilization Groups (RUGs) to the Patient-Driven Payment Model (PDPM) to pay Medicaid nursing facilities, as well as incorporating PDPM payments as the basis for nursing facility upper payment limit (UPL) demonstrations. The guidance herein is important for states, since CMS will no longer support the Medicare RUGs systems after October 1, 2023, as CMS is ending support for RUG-III and RUG-IV on federally required assessments for patients residing in Nursing Facilities and Skilled Nursing Facilities as of October 1, 2023. The ending of this support was previously communicated in a 2018 Medicaid Informational Bulletin[1] which had signaled that this support would end on October 1, 2020, however, as a result of the COVID-19 Public Health Emergency, the end date was delayed to provide stakeholders additional time to make necessary systems changes.

In an August 2018 Medicare final rule, the Centers for Medicare & Medicaid Services (CMS) announced that the RUG-IV case-mix classification model used under the Medicare skilled

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib120618.pdf

nursing facility (SNF) prospective payment system (PPS) was being replaced with the PDPM case-mix classification model beginning on October 1, 2019.[2] CMS designed implementation of PDPM to be budget neutral relative to total payments that would have been made under RUGs, had it continued.

In accordance with 42 C.F.R. § 447.272, Medicaid payments for nursing facility services are limited in the aggregate by provider ownership category, as specified in 42 C.F.R. 447.272(a), to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles. The Medicaid UPL is calculated on an aggregate basis, and described in an annual demonstration submitted by states for each of the following categories of provider: state government-owned or operated, non-state government-owned or operated, and privately-owned and operated facilities. Within Medicaid UPL demonstrations, most states historically used the RUGs categories and the Minimum Data Set (MDS) data for all SNF residents to categorize Medicaid patients and calculate the Medicare-equivalent payment amount. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare- and Medicaid-certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.[3]

In light of the transition from RUG-IV to PDPM, states will need to consider whether to transition Medicaid payments to nursing facilities to PDPM, and whether to transition the Medicaid UPL calculations to the PDPM methodology.

Background

In establishing the PDPM system in the August 2018 Medicare SNF PPS final rule, CMS clarified that it distinctly recognizes the nursing, therapy, and ancillary care that patients are

[2] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 FR 39162 (August 8, 2018); the final rule is available at: https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports

likely to receive during SNF stays, and that the provision of those services is based upon the specific needs of an individual patient. Under RUGs, the nursing and therapy components were linked together by one RUGs code per resident, resulting in payment rates that did not necessarily recognize the distinction between providing therapy and nursing services in the SNF. In the August 2018 Medicare SNF PPS final rule, CMS characterized the differences between RUGs and PDPM by saying:

> "[while] the RUG-IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG-IV group, the proposed PDPM would separately identify and adjust for the varied needs and characteristics of a resident's care and combine this information together to determine payment. We stated we believe the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care."[4]

The PDPM rate is based on six components that determine the payment rate: nursing, physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), non-therapy ancillary (NTA), and non-case-mix related expenses (e.g., room and board, capital cost, overhead). The non-case-mix-related component is the only rate component that is not dependent upon resident characteristics or services received. Through the MDS clinical assessment, a case-mix value is calculated and assigned for each individual rate component for a patient, which is then added together to determine the overall payment amount Medicare will make to the facility for the patient day. PDPM accounts for payments for a maximum length of stay of 100 days for each Medicare patient based on the length of stay limit of the Medicare SNF benefit. In addition to the case-mix assigned to each of five case-mix payment components based on the resident's MDS clinical assessment form, a variable per diem adjustment is further applied to the PT, OT, and NTA components to account for how long the resident has been in the facility (e.g., for therapy, days 1-20 are paid at a factor of 1.0, while days 21-27 are paid at a factor of 0.98, and later days are paid at a still lower factor). Under the RUGs system, an individual is assigned one case-mix group, which informs the amount of payment for both nursing and therapy services.

[4] 83 FR 39162 at 39194 (August 8, 2018); available at: https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.

Under PDPM, the patient is assigned to a PDPM group for each of the five case-mix components, each of which affect the payment rate for therapy and nursing services separately.

CMS indicated in the August 2018 Medicare SNF PPS final rule that PDPM would be budget neutral relative to payments that would have been made under the SNF PPS were it not for the implementation of PDPM. Moreover, given that payments under RUG-IV were weighted heavily toward therapy services, CMS indicated that, when developing the PDPM case-mix weights, this would cause a shift in payments from the therapy component to the nursing component. In other words, given that the shift to PDPM was not intended to raise or lower total SNF PPS payments, shifting payments from therapy to nursing meant higher nursing CMIs, relative to those under RUG-IV, and lower therapy CMIs, relative to those under RUG-IV.

Conversely, the Medicaid nursing facility services benefit is nursing services-focused, with patients often living in the facility well after any rehabilitation or other therapy interventions show improvement for the patient. As a result, a large portion of the Medicaid patient population would fall into that non-rehabilitation case-mix distribution. By virtue of the differences in the patient populations and covered benefits between the two programs, the Medicaid population often would not be expected to receive the same scope of services as the Medicare population and would be expected to have much longer lengths of stay than the Medicare benefit allows. To arrive at a reasonable estimate of what Medicare would pay for the same services, the PDPM rates may need to be adjusted to account for different utilization of the five case-mix components by Medicaid beneficiaries.[5]

Differences in Medicare Skilled Nursing and Medicaid Nursing Facility Benefits

The scope of services in the Medicare program under the SNF benefit defined in section 1819(a) of the Social Security Act (the Act) is typically different from a state's Medicaid nursing facility benefit under section 1905(a)(4)(A) of the Act. Under the Medicare program, the SNF benefit includes both nursing care and rehabilitation services provided in the facility and pays for those services as one comprehensive benefit, with these benefits being limited to a 100-day length of stay for a given benefit period. As such, the Medicare SNF payment methodology includes most

[5] See Appendix

of the services provided to an individual residing in the SNF, with only a limited set of services excluded from SNF consolidated billing.

Conversely, the Medicaid nursing facility services benefit specifically describes the nursing care component provided in the nursing facility. Physical therapy and related services and rehabilitation services, are defined separately from nursing facility services as Medicaid benefits under section 1905(a)(11) and 1905(a)(13) of the Act, respectively. There is no defined limit to the nursing facility services benefit in Medicaid. While this distinction does not preclude a state from defining the nursing facility benefit similarly to Medicare (i.e., as a comprehensive state plan benefit that covers and pays for nursing, therapy and rehabilitation services), it provides states with the option to pay for each component benefit separately. Nothing in this guidance precludes states from continuing their preferred practice under their state plans. However, based on this flexibility, this guidance acknowledges that states' payment methodologies for the care provided within nursing facilities may vary significantly depending on how the state has defined the scope of the nursing facility benefit.

PDPM as a Payment System in the Medicaid State Plan

While states have broad flexibility to establish Medicaid payment rates and methodologies, the state plan must comply with section 1902(a)(30)(A) of the Act, including that payments must be consistent with efficiency, economy, and quality of care, as well as sufficient to enlist enough providers to meet the statutory access standard for Medicaid beneficiaries. It follows that payment rates for services must be consistent with how the state has defined the relevant benefit under the Medicaid state plan. As discussed above, states have the flexibility to define their nursing facility benefit to either include or exclude therapy services and rehabilitation services provided in the nursing facility, and the state's nursing facility payment methodology must be reflective of the services the state has chosen to include under the benefit category. For example, it would not be economic and efficient for a state to provide for Medicaid payments to nursing facilities that are calculated based on payment amounts that include payment for physical therapy services, if physical therapy services are not included in the nursing facility benefit (and instead are paid separately).

As discussed above, the Medicare PDPM rate is based on six components that determine the payment: nursing, PT, OT, SLP, NTA, and non-case-mix-related expenses. This means that PDPM as a potential Medicaid state plan payment methodology presents options to states for rate setting that aligns with how the state defines its Medicaid nursing facility benefit. For states that define the Medicaid nursing facility benefit to include only a portion of the benefits paid under the Medicare PDPM rate (e.g., the state defines its Medicaid nursing facility benefit only to include nursing services, and the state plan separately covers and pays for therapy services and other services included within the Medicare PDPM rate), the state would not adopt the unadjusted Medicare PDPM rate, and would instead need to adjust the Medicare PDPM payment to account for the differences between state plan nursing facility benefit and Medicare SNF benefit definitions. Such an adjustment is necessary because it would not be economic and efficient as required by section 1902(a)(30)(A) of the Act for the state to use the full Medicare PDPM rate when the state plan only covers the nursing care component and separately covers and pays for therapy services and other services included within the Medicare PDPM rate. Paying the full Medicare PDPM rate in addition to making separate payments for therapy services and other services included within the Medicare PDPM rate (but not within the state's Medicaid nursing facility benefit) would duplicate payments for Medicaid-covered services. Simply put: state Medicaid payment rates for nursing facility services should reflect the services that the facility is expected to provide under the approved Medicaid state plan benefit categories.

As states consider changing their nursing facility payment methodologies to be based on the Medicare PDPM, states should be mindful that all of the relevant state plan submission rules apply under 42 C.F.R. part 430, subpart B. The state plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, its implementing regulations in 42 C.F.R. chapter IV, and other applicable official issuances of the Department of Health and Human Services. The state plan must contain all information necessary for CMS to determine whether the plan can be approved to serve as a basis for federal financial participation in the state program. States must determine the Medicaid services that are included in the state plan nursing facility benefit package, and establish payment rates accordingly. States have broad discretion in establishing their state plan payment methodologies and are not required to use a methodology based on Medicare PDPM as their payment

methodology for Medicaid services. However, the absence of CMS support for RUGs-based payment systems going forward will mean that any states that continue using RUGs-based payment methodologies in their Medicaid programs will have to maintain appropriate data systems and claim pricing processes separately, apart from that which has been previously supported by the Centers for Clinical Standards and Quality within CMS. States may already have the appropriate systems in place to do so, in which case those states may continue to use their current Medicaid payment methodologies for nursing facility services.

Using PDPM as the UPL Demonstration Methodology in Medicaid

Similar to the section above related to state plan payment methodologies for Medicaid nursing facility services, a state's UPL demonstration methodology must align with the services provided under the Medicaid state plan nursing facility benefit definition. As noted above and described in regulations at 42 C.F.R. 447.272, the UPL is "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in [42 C.F.R. chapter IV, subchapter B]." The term "services furnished by the group of facilities" is limited to those services that the facilities provide under the Medicaid state plan benefit definition, not the Medicare package of services available under section 1819(a) of the Act. As such, states, in their Medicaid nursing facility UPL demonstrations, account for (1) the amount that would be paid "under Medicare payment principles in [42 C.F.R. chapter IV, subchapter B]" to reflect only the Medicaid services defined under the state's Medicaid nursing facility benefit, and (2) the amounts Medicaid pays for those services under the associated payment rates and methods under the approved state plan.

A state that provides a nursing facility services benefit and payment rate for the nursing facility that fully aligns with the Medicare scope of benefits included in PDPM would not need to adjust the Medicare PDPM rate in performing its Medicaid nursing facility UPL demonstration. This is because the coextensive set of services under the Medicaid and Medicare benefit definitions already would result in an "apples-to-apples" comparison. To align with the Medicare benefit and PDPM methodology, the Medicaid nursing facility services payment methodology in Attachment 4.19D of the Medicaid state plan must comprehensively describe a payment rate

methodology that includes nursing services, PT, OT, SLP, NTA, and non-case-mix-adjusted overhead, to be paid to the facility under the nursing facility benefit of the state plan.

Conversely, a state that provides less than the full scope of Medicare's SNF benefit as its Medicaid nursing facility benefit as specified in Attachment 4.19D of the Medicaid state plan would only use the matching components of the Medicare PDPM payment system in its Medicaid nursing facility UPL methodology to create a reasonable comparison to the amount that Medicare would have paid for the applicable Medicaid services provided under the state plan benefit definition. UPL methodologies that are not designed to produce an "apples-to-apples" comparison of Medicaid and Medicare payment for the same set of services would distort the UPL demonstration, potentially resulting in a significant overstatement of the Medicare payment estimate and artificially inflating the Medicaid UPL. For example, if a state only provides and pays for Medicaid nursing services and non-case-mix overhead in the approved Medicaid payment rates for the nursing facility services benefit of the state plan, it would not be reasonable to include the full scope of the benefits for which Medicare PDPM pays (including nursing services, PT, OT, SLP, NTA, and non-case-mix-adjusted overhead) as a reasonable estimate of what Medicare would have paid for the same services. In that case, the estimate of what Medicare would have paid would be for a significantly expanded suite of services beyond what the state includes in its Medicaid nursing facility services benefit definition.

To provide an illustration, see the table below. In this scenario, a facility provides Medicaid nursing facility services in a state in which the nursing facility benefit is limited to nursing services, NTA services, and non-case-mix related expenses. Other types of therapy services (i.e., PT, OT, and SLP services) included in the Medicare SNF services definition and PDPM rate are covered, paid, and claimed on the Form CMS-64 under other, non-NF benefit categories under the Medicaid state plan.

Example A

PDPM Rate Components	**State Medicaid Rates** **Nursing, NTA, and Non-Case-Mix Only**	**Medicare** **Nursing, NTA, and Non-Case-Mix Only**
Nursing	$ 135.00	$ 149.27
PT (Not covered as NF service in State Plan)	*N/A*	*N/A*
OT (Not covered as NF service in State Plan)	-	-
SLP (Not covered as NF service in State Plan)	-	-
NTA (Covered as NF service in State Plan)	$ 50.00	$ 88.28
Non-Case-Mix	$ 85.00	$ 96.85
Total	**$ 270.00**	**$ 334.40**

Example B

PDPM Rate Components	**State Medicaid Rates** **NF-only w/ *Non-State Plan* Services Added**	**Medicare** **Full PDPM**
Nursing	$135.00	$ 149.27
PT (Not covered as NF service in State Plan)	*$ 45.00*	*$ 62.25*
OT (Not covered as NF service in State Plan)	*$ 45.00*	*$ 58.69*
SLP (Not covered as NF service in State Plan)	*$ 35.00*	*$ 41.33*
NTA (Covered as NF service in State Plan)	$ 50.00	$ 88.28
Non-Case-Mix	$ 85.00	$ 96.85
Total	**$ 395.00**	**$ 496.67**

Examples A and B illustrate two processes for demonstrating that the Medicaid NF payment does not exceed the UPL.

In example A, when the benefits actually covered under the Medicaid nursing facility benefit and the corresponding elements of the Medicare SNF benefit are accurately aligned, the result is a UPL gap of $64.40 ($334.40 minus $270.00). The state has appropriately calculated the UPL and demonstrated that the NF payment is within the UPL.

Example B, however, illustrates that counterfactual Medicaid services have been added in to match the services included in the Medicare SNF benefit definition, with corresponding amounts paid under Medicare PDPM, even though these services (identified in italics) are not included in the state's Medicaid nursing facility benefit definition and are not paid under the Medicaid nursing facility rate. Here, we see a UPL gap of $226.67 ($496.67 minus $270.00), if the state's UPL demonstration methodology were to compare the full Medicare PDPM payment estimate to the amount actually paid by Medicaid. Alternatively, if the state's UPL demonstration methodology attempted to create an "apples-to-apples" comparison by adding to the Medicaid payment the amounts Medicaid would have paid for Medicaid services covered under other benefit categories (which, as non-NF services, should not be included in the NF UPL demonstration), we would see a UPL gap of $101.67 ($496.67 minus $395.00). In both examples A and B, the same services are provided to a Medicaid beneficiary by the nursing facility, which received Medicaid payment of $270.00 under the state plan. Yet, the resulting UPL gap for example B could be approximately $101 or even $226.67, depending on the state's UPL demonstration methodology, in comparison to the $64.40 gap that results from a true "apples-to-apples" comparison. The effect occurs when therapy and other rehabilitation services are covered and paid outside of the state plan nursing facility benefit, but the UPL demonstration assumes that all of the Medicare PDPM component services are covered and paid under the Medicaid program as a comprehensive nursing facility service payment.

In summary, the state's UPL may include all services and rate components in the Medicare PDPM rate so long as the state covers and pays for all of those same services under Medicaid nursing facility benefit and so specifies in Attachment 4.19D of the Medicaid state plan. To the extent that the state provides a nursing facility services benefit that is different in scope from Medicare SNF benefit, the state must make necessary adjustments to the Medicare PDPM rate to ensure that the adjusted amount used in the Medicaid UPL demonstration reflects a Medicare payment estimate corresponding only to the suite of services covered and paid under the Medicaid nursing facility services benefit.

Other Adjustments to PDPM in Medicaid Payments and UPL Demonstration Methodology

Acuity Adjustments

Consistent with other state plan payment methodology and UPL demonstration guidance, states should make acuity adjustments to account for the characteristics of the state's Medicaid population to reflect differences in the services provided to Medicaid beneficiaries and Medicare beneficiaries.[6] Our historical policy related to the Medicaid NF UPL allows states to calculate a case-mix index differential to account for the differences in acuity reflected in the RUGs score between the Medicare population and the Medicaid population. These case-mix indices are indicative of the level of services provided to patients in the facilities. The resulting adjustments amount to a percentage increase or decrease to the Medicare payment side of the Medicaid NF UPL calculation, depending upon whether the Medicaid population had a higher or lower average patient acuity than the Medicare population.

Length-of-Stay Adjustments

As noted in the *Background* section, PDPM includes a number of variable rates that decrease over the course of a patient's length of stay in a facility. The variable per diem adjustments are only applied to the PT, OT, and NTA components of the PDPM rate. To the extent any of the components of PDPM used by the state are adjusted by patient length of stay, CMS requires that the state use the PDPM rate at day 100 as the state's starting point within the Medicaid UPL calculation. The reason for this adjustment is two-fold. The first is due to the fact that the Medicare SNF benefit does not cover or pay for services after the 100th day of a patient's stay in the SNF, with most Medicare stays ranging from 27 to 31 days.[7] Medicaid patients often reside in nursing facilities well beyond the 100-day limit, and this approach would reflect a reasonable proxy for the amount that Medicare would pay for those patient days, which eventually would outweigh the first 100 days for the many Medicaid beneficiaries with extended nursing facility stays.[8] The second is that Medicare PDPM assumes that the initial intake of the patient and the initial volume of PT, OT, and NTA services the patient receives will be quite high and will decrease over the course of a Medicare patient's stay due to the rehabilitation-intensive nature of

[6] Medicaid Nursing Facility UPL guidance document. Available at: https://www.medicaid.gov/medicaid/financial-management/downloads/nursing-facility-upl-guidnce-2022.pdf
[7] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy, March 2021. Chapter 7. Available at: https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch7_sec.pdf
[8] White, A. and Zheng, Q. Comparison of Nursing Facility Acuity Adjustment Methods. November 2020. Page 10. Available at: https://www.macpac.gov/wp-content/uploads/2020/11/Comparison-of-Nursing-Facility-Acuity-Adjustment-Methods.pdf

the Medicare SNF benefit under section 1819(a) of the Act. We do not anticipate that the Medicaid population typically will have the same therapy needs as the Medicare population. Likewise, we do not anticipate that up-front intake activities (involving, e.g., a potentially high volume of PT, OT, and NTA services) necessarily will be paid for by Medicaid, as a large portion of Medicaid beneficiaries residing in nursing facilities are also enrolled in Medicare, which pays for the early part of the nursing facility stay before the Medicare SNF benefit is exhausted and Medicaid becomes the beneficiary's primary payer.

Services for Which Medicaid is not the Primary Payer

Longstanding CMS policy recommends that states exclude cross-over claims, for which Medicare or another third-party payer is the primary payer, from the UPL calculation.[9] The UPL requirements in 42 C.F.R. § 447.272 state that the UPL "refers to a reasonable estimate of the amount that would be paid for the services furnished by a group of facilities under Medicare payment principles in [the Medicare program]." Where a state's payment obligation for those claims is governed by the state's third-party liability policies rather than the state's primary Medicaid nursing facility payment methodology, it is difficult to develop an estimate for those particular claims that would reasonably compare to a Medicare-equivalent payment amount to Medicaid's paid co-insurance and deductible amounts, which we expect would be the Medicaid payment in this circumstance, without overstating the UPL.

Other Adjustments, as Needed

There may be other adjustments that are necessary as CMS reviews states' UPL demonstration methodologies based on PDPM payments, to ensure that the UPL demonstrations reflect a reasonable estimate of the amount that Medicare would pay for the applicable Medicaid services. For example, CMS has considered state-proposed volume adjustments when there have been drastic increases or decreases in expected patient care volume from one year to the next. To the extent that the state has proper documentation or justification, this type of adjustment may be considered in the state's UPL demonstration methodology. Other adjustments could be appropriate based on expansion of service delivery through managed care in the state, changes in

[9] Medicaid Nursing Facility UPL guidance document. Available at: https://www.medicaid.gov/medicaid/financial-management/downloads/nursing-facility-upl-guidnce-2022.pdf

the Medicare SNF PPS, or other factors. CMS is available to provide technical assistance to states with questions about their Medicaid payment and UPL demonstration methodologies through the Medicaid UPL resource mailbox, identified below.

Timeline for Implementation and Alternative Methodologies

CMS has indicated in the recent interim final rule with comment, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to COVID-19 Public Health Emergency" (85 FR 27550, 27596 (May 8, 2020)), that CMS will transition away from supporting the MDS data associated with the RUGs system for SNFs and, shortly after the public health emergency for COVID-19 ends, plans to work with stakeholders to develop a mutually agreeable timeline for releasing the updated MDS that provides sufficient time for SNFs to incorporate the updated version into their operations. Based on this transition, states should consider whether adjustments in their Medicaid payment and UPL demonstration methodologies are necessary.

As noted above, CMS is ending support for RUG-III and RUG-IV on federally required assessments for patients residing in Nursing Facilities and Skilled Nursing Facilities as of October 1, 2023. As noted in the 2018 Medicaid Informational Bulletin, additional resources are available for states to continue to use RUGs for an additional two-years after the October 1, 2023 date. States that wish to continue to use RUG-III or RUG-IV after October 1, 2023, for either state plan payment methodologies or UPL demonstrations, will need to implement a new process called "Optional State Assessments" or OSAs to gather the needed assessment data which will allow the states to calculate a RUGs payment amount for the services provided to the Medicaid beneficiaries. States that are interested in pursing the use of OSAs should direct their questions to the OSA resource mailbox at OSAMedicaidinfo@cms.hhs.gov.

As discussed above, while there is no requirement for states to pay nursing facilities based on Medicare PDPM in their Medicaid programs, the data limitations associated with the ending of the data infrastructure supporting the RUGs system may present issues for states in calculating RUGs-based payments. Absent available RUGs MDS data from CMS, states will likely have to consider collecting data independently from providers to support RUGs state plan payment methodologies. States may also consider trending available RUGs data to a current payment

period to establish state plan payment rates. However, this approach should only be used as an interim measure for UPL methodologies, since CMS generally expects UPL demonstrations to use data that are no more than two years old in order to present a reasonable estimate.[10]

Conclusion

As stated at the beginning of this letter, CMS will no longer support the Medicare RUGs systems after October 1, 2023. CMS is available to assist states as Medicare RUGs transition to PDPM. Initial readiness determinations should be made by the states in collaboration with their provider communities. States that decide to transition to PDPM for purposes of Medicaid payment and UPL demonstrations should carefully review their currently approved state plan benefits and payment methodologies, as well as their UPL demonstration methodology for nursing facility services. States that include references to RUGs in the state plan and wish to change their payment methodologies to be based on Medicare PDPM or a different payment system must conduct public process and notices in accordance with statute and regulation and submit a state plan amendment to CMS for approval.

For technical assistance, please contact Andrew Badaracco, Acting Director for the Division of Reimbursement Policy at Andrew.Badaracco@cms.hhs.gov, or the Medicaid UPL resource mailbox at MedicaidUPL@cms.hhs.gov.

Sincerely,

Daniel Tsai

Deputy Administrator and Director

[10] Medicaid Nursing Facility UPL guidance document. Available at: https://www.medicaid.gov/medicaid/financial-management/downloads/nursing-facility-upl-guidnce-2022.pdf

Appendix

Why is PDPM so much different for Medicaid if PDPM was supposed to be budget neutral?

This is one of the central questions we have considered, and the answer can be found in the Medicare final rule for PDPM:

83 FR 39258

Most Common Therapy Levels	**Medicare National Case Distribution Percentage**	**% Change in Payment Rate from RUG to PDPM**	**One State's Medicaid Case Distribution Percentage***
RU *(Highest "Rehab" RUG)*	58.40%	-8.40%	0.34%
RV	22.40%	11.40%	1.97%
RH	6.80%	27.40%	4.84%
RM	3.30%	41.10%	18.63%
RL *(Lowest "Rehab" RUG)*	0.01%	67.50%	0.73%
Non-Rehab	9.10%	50.50%	73.49%

* This state was selected based on the availability of data sufficient to enable the Medicaid case distribution breakout necessary for this example.

The largest portion of Medicare's SNF population falls into the "RU" RUG category, which is the highest therapy RUG in the RUG methodology: 58.4% of the national Medicare population falls into this category. When calculating the PDPM payment rate for a patient previously classified into an RU group Medicare reduced the payment rate by -8.4%. This price reduction only affected 0.34% of the sample state's Medicaid population. Likewise, the largest Medicaid NF population in the sample state falls into the "Non-Rehab" population, which is the population

that largely receives nursing services and little, if any, rehabilitation. When calculating the PDPM payment for a patient previously classified into a non-rehab group under RUG-IV, Medicare increased the payment rate by 50.5%. This was done to maintain the budget neutrality which Medicare set out to achieve by shifting some of the 8.4% reduction in therapy payments to the other components of the PDPM rate.

This illustrates how the budget neutrality design for PDPM was tailored specifically to the Medicare population, for which budget neutrality effectively was achieved, while potential consequences for Medicaid upper payment limit calculations were not considered in the Medicare rulemaking.