MN HOUSE RESEARCH

Nursing Facility Reimbursement

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Medical Assistance (MA) reimburses nursing facilities for services provided to low-income elderly and disabled persons who meet income and asset limits and other eligibility requirements. The Minnesota Department of Human Services (DHS) administers the MA reimbursement system for nursing facilities and establishes the reimbursement rates for each facility.

What are the components of a nursing facility's reimbursement rate?

MA reimburses nursing facilities for operating costs, external fixed costs, and property costs.

Operating costs include: (1) *direct care costs*, which are salaries, wages, and associated fringe benefits and payroll taxes of nurses, certified nursing assistants, and other health care staff; services from a supplemental nursing services agency; supplies such as dressings, bandages, water pitchers, soap, and syringes; technology related to the provision of nursing care; costs of materials used for resident care training; and costs for nurse consultants, pharmacy consultants, and medical directors; (2) *other care-related costs*, which are activities costs, raw food costs, therapy costs, social services costs, and the salaries, wages, and associated fringe benefits and payroll taxes of mental health workers, religious personnel, and other direct care employees not specified under direct care costs; and (3) *other operating costs*, which are administrative costs (including property insurance), dietary costs, housekeeping costs, laundry costs, and maintenance and plant operation costs.

External fixed costs include surcharges and fees; scholarships; planned closure rate adjustments; consolidation rate adjustments; single-bed room incentives; property taxes, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentives; performance-based incentives; special dietary needs; border city rate adjustments; and Public Employee Retirement Act costs.

Property costs include interest expense and return on equity.

How are nursing facility payment rates determined?

On January 1, 2016, DHS implemented a new reimbursement system, called the value-based reimbursement system. Under the value-based reimbursement system, nursing facility operating payment rates are determined based on each facility's reported costs. A facility's operating rate reflects the costs it reported in its most recent cost report. Due to the timing of the cost reporting cycle, this means that there is at least a 15-month lag between when a facility accrues costs and when those costs are reflected in the facility's rate.

How does DHS control the costs of nursing facility reimbursement?

The value-based reimbursement system assigns each facility a limit on its *total care-related costs.* This limit is tied to the facility's quality score; facilities with higher quality scores are assigned higher limits. DHS assigns each facility in the state a quality score of 0 to 100 based on resident surveys, resident screenings, and facility inspection scores. DHS does not reimburse facilities for *direct care* or *other care-related* costs above the facility's limit.

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Additionally, each facility in the state receives the same *other operating* payment rate. This rate is set at 105 percent of the other operating costs per resident day for the median facility in the seven-county metropolitan area.

Are nursing facility rates adjusted for inflation?

The current value-based reimbursement system does not include an inflationary adjustment, but facilities' rates increase over time as their costs increase. Under previous reimbursement systems, inflation adjustments for nursing facility rates were sporadic. From July 1, 1999, through September 30, 2011, the automatic inflation adjustment was applied only to the property-related rate.

Do nursing facility rates vary by facility?

Reimbursement rates are facility- and resident-specific. Rates vary with the facility's historical costs, with the amount of care needed by a resident (as measured by a case-mix classification), and reflect any statutory facility-specific rate adjustments authorized by the legislature.

What are case-mix classifications?

Nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUG) case-mix system to reflect the varying care needs of residents.

All applicants to nursing facilities are assessed by the Department of Health upon admission and at least every 90 days thereafter. Residents are assigned to a case-mix classification based on the level of their dependence in activities of daily living, the severity of their cognitive and/or behavior management needs, and the complexity of their nursing needs. Each case-mix classification is assigned a case-mix weight, with the lowest level of care receiving the lowest weight and the highest level of care receiving the highest weight.

The direct care costs component of a facility's rate is adjusted based upon a resident's case-mix weight. All other components of a facility's rate are the same for all residents in the facility.

What methods have been used to determine payment rates in the past?

Prior to October 1, 2006, nursing facilities were reimbursed under a cost-based system sometimes referred to as "rule 50," where reimbursement to facilities was based on their reported costs, subject to various limits. From October 1, 2006, through September 30, 2008, all nursing facilities participating in MA were reimbursed under the Alternative Payment System (APS), a contract-based system where facilities were exempt from certain statutory requirements of the cost-based system and reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner. From October 1, 2008, through December 31, 2015, facilities were reimbursed under a blend of APS and a "rebased" reimbursement rate.

What other payments do nursing facilities receive?

Nursing facilities may receive several other payments or rate adjustments including rate adjustments for the first 30 days and rate adjustments for ventilator-dependent persons.