


# Nursing home upper payment limit calculation and supplemental payment model

Engrossed Substitute Senate Bill 6168; Section 211(13)(b); Chapter 353; Laws  
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# Table of contents

Executive summary .....	2
Nursing home proportionate share .....	2
Payment determination .....	2
Current nursing home UPL calculation .....	3
Impacts of changing the UPL calculation .....	6
Technical challenges and limitations .....	7



# Executive summary

This report examines alternatives to the current upper payment limit calculation and supplemental payment model for nursing homes operated by a public hospital district. We have submitted this report as required by Engrossed Substitute Senate Bill 6168 (2020), Section 211(13)(b):

*The health care authority in consultation with Department of Social and Health Services (DSHS) and nursing homes operated by public hospitals, must develop a plan with recommendations for an upper payment limit calculation and the supplemental payment model for nursing homes operated by a public hospital district. The group must consider how to restructure payments taking into consideration alternate upper payment limit calculation. If upon completion of the plan, the authority determines it can implement the recommendations of the group within the amounts provided in (a) of this subsection, the authority must submit a state plan amendment, if necessary and submit a report to the fiscal committees of the legislature no later than September 30, 2020.*

## Nursing home proportionate share

Nursing home proportionate share (Proshare) payments are calculated using a formula to determine the maximum payment public hospital district (PHD) nursing facilities (NF) may receive.

The process includes:

- Estimating payments for the current state fiscal year
- Calculating and comparing weighted Medicare and Medicaid rates
- Allocating payments among facilities based on their proportionate share of the total costs and days
- Interim and final cost settlement

The Proshare payments are a supplemental payment. Facilities receive the lesser of the Medicare Upper Payment Limit (UPL) or their provider-specific costs.

The program is a certified public expenditure (CPE) program where the PHD is responsible for certifying it has provided the required nonfederal match for the supplemental payments. PHD nursing facilities are paid the federal portion of the supplemental payment. PHD facilities have tax authority to generate funds that are certified as the state share of the supplemental payment.

## Payment determination

### Prospective Proshare supplemental payments

Because this is a prospective payment system (PPS), the Health Care Authority (HCA) estimates the UPL difference for the current state fiscal year (SFY). The process becomes more complex when



considering the different fiscal years used. Nursing homes operate on a calendar year (January – December). Medicaid operates on the state fiscal year (July – June). Medicare operates on the federal fiscal year (October – September). Estimated prospective Proshare supplemental payments are made to PHD nursing homes during the service year based on historical data and trended forward to the current year. For example, the prospective Proshare supplemental payments for SFY 2021 were based on SFY 2019 hospital cost reports. The supplemental payments are subject to retrospective interim and final cost settlements based on the nursing homes’ as-filed and final Medicare cost reports.

## Interim adjustment

HCA completes an interim analysis approximately one year after the end of the state fiscal year when nursing homes submit their as-filed Medicare cost reports. For example, HCA completed the SFY 2017 interim analysis in September 2019 using the “as-filed” 2019 Cost Report). HCA compared the results of this analysis to the total grant payments made to nursing homes for the state fiscal year.

## Final adjustment

The final adjustment is made approximately two years after the end of the state fiscal year when nursing homes submit their final Medicare cost reports. With both the interim and final settlement, HCA would recoup any amount that exceed the Medicaid cost limit and/or the Medicare UPL.

# Current nursing home UPL calculation

## Definitions

### Upper payment limit

Upper payment limit (UPL) for nursing facilities is defined in 42 CFR § 447.272(b). This section states:

(b) *General rules.* (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter. (2) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

In other words, the Medicare UPL is the amount that would have been paid had Medicaid paid at the Medicare rate: (UPL Medicare Rate times Medicaid Days) minus ((Medicaid Rate plus Medicaid Ancillary Rate) times Medicaid Days).



## Case mix

Case mix, also case mix and patient mix, is a term used within health care as a synonym for cohort. Essentially, a case mix groups statistically related patients. An example case mix might be male patients under the age of 50, who present with a myocardial infarction and also undergo emergency coronary artery bypass surgery.

## Case mix resource utilization groups (RUG-IV) (this method is currently being used)

RUG-IV is a patient classification system for skilled nursing facility (SNF) patients used by the federal government to determine reimbursement levels. This method is stemming from the SNF PPS FY 2012 Final Rule and was previously RUG-III.

Payment is determined by categorizing patients into groups based on their care and resource needs. This system primarily determines payment by the number of therapy minutes, which doesn't fully consider the wide range of clinical characteristics that influence the relative resource use of residents.

## Case mix patient driven payment model (PDPM) (future method)

PDPM is a case-mix group (CMG) reimbursement method that focuses on clinically relevant factors rather than volume-based services or RUG-IV codes. It improves payment accuracy and appropriateness by focusing on the patient rather than the volume of services provided. PDPM focuses on the unique, individualized, and characteristic needs and goals of each patient, and significantly reduces administrative burden on providers to improve targeting resources to beneficiaries with diverse care needs. Payments are calculated through patient CMG scores, meaning, with PDPM therapy, minutes are no longer the driving force for payments.

Currently, the Medicare rate UPL is RUG-IV-based, and is based on an average per county (or one rate for all rural areas). As noted, a facility receives the lesser of the Medicare rate UPL or its costs. The UPL gap dollars are defined as the difference between what Medicare would have paid—which is currently RUG-IV-based and is the same rate among all rural nursing homes—and the average Medicaid payments.

HCA's nursing home Proshare funding has historically been set at the state level at an appropriation of \$6 million. This appropriation was increased to \$7 million in SFY 2021 (July 1, 2020 – June 30, 2021).

Since calculating the nursing home Proshare calculation, HCA's appropriation has been sufficient to cover all costs for all nursing homes under this program. With the reduction in nursing homes that participate in this program, the gap between UPL and costs has been reduced to the point where future costs would not be paid in full.

As an example, the original proposed fiscal year prospective payment UPL gap for 2021 for the five rural nursing homes was only \$2.8 million compared to the \$7 million UPL gap in the prior two fiscal years. As a result, HCA, the Department of Social and Health Services Aging and Long-term

Services Administration (AL TSA), and nursing home stakeholders met to analyze the original Fiscal Year 2021 UPL prospective payment calculation and calculation methodology.

The main goals of this group were to analyze the current UPL calculation model, ensure the model creates predictable results, is able to distribute funds in a sustainable fashion over time, and does not limit the calculation to provider cost of care.

This analysis led to a revision of the Fiscal Year 2021 UPL gap calculation and as a result, an increased UPL gap. This revised prospective UPL gap increased from its original amount of \$2.8 million to a little over \$5 million. While this amount is less than the \$7 million UPL gaps from the two prior years, it must be noted that a nursing home participating in the Proshare program closed in 2019, so the pool of candidates for UPL funds decreased from six to five. The closure of Newport Nursing Home accounted for approximately \$2 million in lost UPL gap for Fiscal Year 2021.

Other revisions that impacted the SFY 2021 prospective UPL gap:

- UPL Medicare rate calculation of RUG-IV Medicaid days per RUG code only used six months of data in the original SFY 2021 UPL calculation whereas 12 months of data should have been used. This change in data resulted in increased UPL gap by \$300 thousand.
- Estimated UPL 2021 Medicaid rates in the original 2021 UPL calculation were overestimated, causing an unusually high UPL Medicaid rate.
  - Original estimated SFY 2021 UPL Medicaid rates included an overestimate of the COVID-19 add-on of \$29 per day. Updated calculation revised this amount to the current estimated average of \$1.88 per day.
    - This revision lowered the Medicaid rate payments in the UPL and increased the UPL gap.
  - Original estimated SFY 2021 UPL Medicaid rates included a Bureau of Labor Statistics (BLS) inflationary rate of 4.4 percent. The revised UPL used a BLS rate of 1.91 percent.
- Since SFY 2019, the UPL Medicare rate is calculated using the Fiscal Year 2019 Federal Registry Final Rule for RUG-IV Case Mix Labor and Non-Labor Wages.
  - The UPL Medicare Rate for FY 2020 and FY 2021 continued to use the same Fiscal Year 2019 Federal Registry Final Rule—even though effective FY 2020, the RUG-IV Case Mix Labor and Non-Labor Wages were replaced with PDPM Case Mix Labor and Non-Labor Wages.
    - RUG-IV still being used due to the DSHS having reports with RUG-IV Medicaid assessment days. The DSHS does not have reports with the PDPM Medicaid assessment days to apply to the PDPM Labor and Non-Labor Wages by PDPM assessment code.
    - To compensate for the lag of Fiscal Year 2019 Federal Register Final Rule RUG-IV Case Mix Labor and Non-Labor Wages, an added two-year Market Basic Index Inflation Midpoint will be applied to a revised FY 2021 UPL Medicare Rate RUG-IV Labor and Non-Labor Wages. This revision will



increase the UPL Medicare rate payments in the UPL and increase the UPL gap.

- Original UPL SFY 2021 Medicare rate for rural calculation used prior-year wage index. The revised SFY 2021 UPL Medicare rate for rural is calculated using an increased wage index percentage, which increased the UPL gap for SFY 2021.

## Impacts of changing the UPL calculation

After reviewing and making changes to the current UPL calculation, the workgroup looked at five possible options—which includes our current UPL calculation process. These options are:

- Using Patient Driven Payment Model (PDPM) when calculating the UPL, instead of the RUG-IV process currently being used.
  - The hypothesis is that using PDPM would reduce the UPL gap shrinkage.
  - PDPM would use the default rate in each category except nursing
    - Nursing would use a very conservative rate (CA1)
    - Rates are derived from most recent Federal Register
    - Distribute all UPL based on Medicaid days
    - Distribute all UPL based on specific provider UPL gap
  - Stakeholder support for this method deteriorated after originally suggested. However, this will be implemented when PDPM Medicaid assessment days per PDPM assessment codes are available to apply to the PDPM Labor and Non-Labor Wages.
- Changing our state plan amendment (SPA) to reflect HCA paying the greater of the two amounts among all Proshare nursing homes.
  - Currently, SPA states we pay the lesser of the Medicare UPL or its costs.
  - Because the provider may be paid more than costs, this scenario would require the providers to pay the local share upfront as an Intergovernmental Transfer (IGT) instead of “certifying” their costs.
    - The Centers for Medicare and Medicaid Services (CMS) may not approve, as they are moving away from IGT programs.
    - This method requires further exploration among the group.
- Changing our SPA to reflect HCA would create an IGT program for all freestanding, state-owned nursing homes, while continuing the UPL Proshare calculation among the non-freestanding, state-owned nursing homes.
  - The SPA would need to be re-written to add the IGT program.
    - CMS may not approve splitting the nursing home calculations into standalone entities and hospital-based nursing homes.
    - Freestanding nursing homes would need to pay their local share upfront instead of “certifying” their costs.
    - This method requires further exploration among the group.
- Changing our SPA to include Worksheet D, Part 1, Apportionment of Ancillary Costs allowable for Medicaid Cost Reporting examples:
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Medical supplies charged to patients





- The reasoning for this change in SPA is the Medicaid preliminary settlement includes these ancillary costs in the development of the Medicaid rate. However, the Medicare costs in the current SPA do not pull these ancillary costs. (Total skilled nursing facility/nursing facility Medicare costs after spenddown are pulled from locations where Worksheet D, Part 1 aren't even addressed).
    - This method requires further exploration among the group.
- Continuing to use the same UPL methodology done currently, which is the Case Mix RUG-IV calculation.
  - Washington nursing facility Medicaid rates calculation has been and is still using Case Mix RUG-IV. As a result, the Medicare UPL rate is developed using the Federal Register Case Mix RUG-IV Labor and Non-Labor Wages.
  - This is currently the preferred method by the department. A full description of all the changes which have been made to the calculation is noted above.

## Technical challenges and limitations

The Medicaid nursing facility UPL has calculated Medicare rates using the Federal Register Final Rule for the RUG-IV Case Mix Labor and Non-Labor Wages. However, starting Fiscal Year 2020, the Federal Register RUG-IV Case Mix Labor and Non-Labor Wages were replaced with PDPM Case Mix Labor and Non-Labor Wages.

The following issues are due to the Fiscal Year 2020 Federal Register change from RUG-IV to PDPM:

- The Medicaid nursing facility UPL for Fiscal Year 2020 continued to use the same published Federal Register Final Rule for Fiscal Year 2019 RUG-IV Case Mix Labor and Non-Labor Wages for the UPL Medicare rate. This is because the DSHS did not have reports with PDPM Medicaid assessment days per PDPM assessment code to apply to the PDPM Labor and Non-Labor Wages by PDPM assessment code.
- The DSHS will not have complete reports with PDPM Medicaid assessment days per PDPM assessment code to apply to the PDPM Labor and Non-Labor Wages by PDPM code until the middle of 2021. This is because PDPM started October 2019 but will not include Medicaid assessment data until October 2020. The reports have a lookback period for assessments of a quarter and 15 days; therefore, complete reports will not be available until the middle of 2021.
- As a result of not having PDPM reports with Medicaid days by assessment code, the DSHS considered a stakeholder suggestion of a PDPM simplified method to calculate the UPL Medicare rate for SFY 2021. However stakeholder support turned out to be weak. Also the DSHS believes that CMS is willing to give a grace period to continue using RUG-IV UPL calculation until PDPM is fully utilized with Medicaid assessments.
- The DSHS has concluded that the RUG-IV UPL is best for SFY 2021. To compensate for the lag of Fiscal Year 2019 Federal Register Final Rule RUG-IV Case Mix Labor and Non-Labor Wages, an added two-year Market Basic Index Inflation Midpoint will be applied to a revised SFY 2021 UPL. The SFY 2021 UPL will be resubmitted with the SPA in September 2020 with the following updates that will address the shrinking UPL gap and outdated RUG-IV:
  - Actual State Fiscal Year 2021 July 1, 2020 rates instead of prior year rates



- Fiscal Year 2021 ancillary
- Fiscal Year 2021 Final Federal Register Wage Index
- Market Basket Index Inflation will be resubmitted with the SPA in September 2020.
- The RUG-IV UPL calculation will be replaced with PDPM once the DSHS has reports with Medicaid days for PDPM assessments.

## Other issues not related to PDPM

- The remaining five rural hospitals combined show a small average decrease from 2017 to 2019 for total Medicaid days. A decrease in Medicaid days causes less UPL gap.
  - The workgroup reviewed the declining days to determine if nursing homes were now billing days as managed care. The review found only McKay was billing for Medicaid managed care. However, even with this reporting, the days were low compared to the facility's total days. As a result, the workgroup determined that Medicaid managed care was not a factor for the reduced UPL gap.
- The remaining five rural hospitals revised Fiscal Year 2021 UPL weighted average Medicaid rate has increased to \$230.63 compared to Fiscal Year 2020 of \$205.52 . A higher UPL Medicaid rate causes less UPL gap. The causes for this higher UPL Medicaid rate:
  - Fiscal Year 2021 increased Medicaid rates by cost, rebasing the rates from 2016 cost base to 2018 cost base. Fiscal Year 2020 Medicaid rates used 2016 cost base, which had lower costs than 2018 cost base.
- Fiscal Year 2021 increased Medicaid rates by adding a BLS Urban All Inflation of 1.91 percent. Fiscal Year 2020 Medicaid rates did not have any BLS Urban All Inflation.

