Nursing Facility Payment Rate Calculation

Minn. Stat. ch. 256R

HOUSE RESEARCH

The value-based reimbursement system, authorized by the 2015 Legislature, sets nursing facility reimbursement rates under Medical Assistance based on nursing facilities' historical cost reports.

Calculation of the Total Payment Rate

A facility's rate has five "components," each of which reflects a different portion of a facility's costs. The total payment rate is the sum of all of the facility's rate components.

$$\textbf{\textit{Total Payment Rate}} = \textit{Direct Care Rate} + \textit{Other Care-Related Rate} + \textit{Other Operating Rate} + \textit{External Fixed Rate} + \textit{Property Rate}$$

Payment rates are adjusted for resident acuity

Different nursing facility residents require different levels of care, which affect a nursing facility's costs. To account for these cost differences, the Department of Human Services (DHS) adjusts payment rates based on differences in the "acuity" of each resident. This means that, in practice, facilities receive a different rate for each resident. The payment rate after adjusting for resident acuity is called the case-mix adjusted total payment rate.

$$\textbf{\textit{Case-Mixed Adjusted Total Payment Rate}} = \textit{Direct Care Rate} * \textit{RUG Weight of Resident} + \textit{Other Care-Related Rate} + \textit{Other Operating Rate} + \textit{External Fixed Rate} + \textit{Property Rate}$$

Each resident is assigned a "resource utilization group" (RUG) classification and weight—the weights vary from .45 for less resource-intensive residents to 3.0 for more resource-intensive residents. The rate is adjusted for acuity by multiplying a facility's direct care rate by the resident weight. Only a facility's direct care rate is adjusted for acuity; other components of a facility's rate are the same for all residents.

Rates reflect a facility's historical cost results, but with a significant lag

At a minimum, there is a 15-month lag between when a facility accrues a cost and when the cost is reflected in the facility's rate. This is due both to the differences between the rate year and the reporting period, and the time allowed for DHS to calculate facilities' rates. The table below shows an example of this timeline.

Month	Steps in the Process
October 2014 - September 2015	Facility cares for residents and accrues costs by employing nurses, paying rent, purchasing food, etc.
February 2016	Facility files a cost report with DHS detailing its costs during the 2014-2015 reporting period.
November 2016	DHS sends facilities "notice of rates" for the 2017 rate year. Facilities' rates are calculated using the cost report filed on February 1, 2016, which reflect the costs accrued during the 2014-2015 reporting period.
January 2017	The 2017 rate year begins and new rate takes effect. When a facility cares for MA residents during the 2017 rate year, it is reimbursed for these services at the new rate.

Prepared by Sean Williams and Danyell Punelli, House Research Department, Minnesota House of Representatives
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Calculation of a facility's rate components

The facility's **Direct Care Rate** equals its direct care costs divided by its standardized days. Standardized days are weighted to reflect how resource-intensive it is to care for the specific resident.

$$\boldsymbol{Direct\ Care\ Rate = \frac{Facility's\ Direct\ Care\ Costs}{Facility's\ Standardized\ Days}}$$

A facility's **Other Care-related** costs are not expected to vary significantly from resident to resident. As a result, a facility's other care-related costs are divided by resident days, which are not weighted by the acuity of the resident.

$$\boldsymbol{Other\ Care\text{-}Related\ Rate = \frac{Facility's\ \ Other\ Care\text{-}Related\ Costs}{Facility's\ Resident\ Days}}$$

DHS reimburses all facilities at 105 percent of the median other operating cost for facilities located in the seven-county metro area; every facility is reimbursed at the same rate. Facilities with higher "other operating" costs will not see such costs fully reflected in their other operating rate.

$$Other\ Operating\ Costs = 105\% * (Median\ Other\ Operating\ Costs\ per\ Resident\ Day\ in\ the\ 7\text{-}county\ Metro)$$

The **External Fixed Costs** rate component is a group of miscellaneous add-ons to a facility's rate, such as reimbursement for nursing facility surcharges and licensure fees, single-bed room incentives, employee scholarships, and incentives for quality.

$$External\ Fixed\ Costs\ Rate = Sum\ of\ External\ Fixed\ Rate\ Components$$

A nursing facility's **property rate** is set according to the previous reimbursement system, the "contract-based" or "alternative payment system." Under that system, a facility's rate is set in a contract signed by the facility and DHS. The rate established in the contract was based on the facility's historical costs at the time the contract was signed. Over time, the property rate in the contract may have increased due to a construction project, inflationary adjustments, or legislative action (see Minn. Stat. § 256B.431 and 256B.434).

DHS controls costs by assigning each facility a care-related limit, which is tied to the facility's quality score

To control the costs of providing care under the value-based system, the legislature enacted the following formula to assign each facility a "care-related limit." If a facility's total care-related rate exceeds the limit, the rate is reduced to the limit.

$$Care\text{-}Related\ Limit = \frac{89.375 + .5625 * (Facility's\ Quality\ Score)}{100} * (7\text{-}County\ Metro\ Median\ Care\text{-}Related\ Rate)$$

DHS assigns each facility in the state a quality score of 0 to 100 based on resident surveys, resident screenings, and facility inspection scores. To incentivize facilities to improve their quality of care, a facility's limit is tied to its quality score. A facility with a quality score of 90 has a limit equal to 140 percent of the seven-county metro median care-related rate; a facility with a quality score of 10 has a limit equal to 90 percent of the metro median.

For more information: See the House Research publication *Nursing Facility Reimbursement and Regulation*.