HOUSE BILL REPORT
HB 2935

As Reported By House Committee On:
Health Care

Title: An act relating to nursing home payment rates.

Brief Description: Implementing the nursing facility medicaid payment system.

Sponsors: Representatives Dyer, Cody, Huff and Backlund.

Brief History:
Committee Activity:
Health Care: 1/16/98 and 1/23/98 (work sessions) 1/27/98 [DPS].

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: The substitute bill be substituted therefore and the substitute bill do pass. Signed by 9 members: Representatives Dyer, Chairman; Backlund, Vice Chairman; Skinner, Vice Chairman; Cody, Ranking Minority Member; Murray, Assistant Ranking Minority Member; Anderson; Parlette; Sherstad and Zellinsky.

Minority Report: Without recommendation. Signed by 2 members: Representatives Conway and Wood.

Staff: Antonio Sanchez (786-7383).

Background:

Nursing Homes: Nursing homes care for approximately 23,000 people daily, generate over $1 billion in revenues per year, and employ over 25,000 full-time people. There are 296 facilities in 37 counties. The state plays two major roles with regard to nursing homes: as the regulator, and service purchaser. The state purchases, through Medicaid, about two-thirds of all nursing home care delivered in the state. The fiscal year 1998 projected yearly costs per person for nursing home care is $41,504.

Nursing Home Rate Setting - The Current Reimbursement System: The Washington state nursing home rate refers to the Medicaid payment made to a nursing facility operator to care for one person for one day. The Department of Social and Health Services (DSHS) estimates that the nursing home rate will average $114.31 during fiscal year 1998 and $121.62 during fiscal year 1999 if the current system is maintained.

The Washington nursing home payment system may be characterized as prospective, cost-based, and facility-specific. This means that each facility receives its own rate of payment, which is unique to that facility, and based upon that facility's costs **(facility specific)**. Payments are based on an individual facility's expenditures up to a ceiling and then often indexed for inflation **(cost based)** The amount paid to each facility is determined in advance of when the actual costs are known **(prospective)**. Limits (referred to as ceilings) are placed on costs and vary based on whether a facility is located in a rural or metropolitan area.

Multiple Components to the Rate: The rates paid to nursing facilities are based on six different cost components. These cost components are: nursing services, operations, administration, food, property, and the return on investment (return on investment consists of two parts - financing and variable return costs). Each individual facility is paid the lower of: (1) their actual cost of providing a component of care; or (2) the ceiling for that component. The following is a description of the components rate setting system:

- **Nursing Services Cost Component**: This cost component is the largest of the five cost components and comprises 55% of the total daily rate in a nursing home. It includes expenses related to the direct provision of nursing and related care including, fringe benefits and payroll taxes for the nursing and related care personnel, therapy, and the cost of nursing supplies. These costs are capped at 125 percent of the median for urban and rural areas.

- **Operational Cost Component:** The operational cost component accounts for 18% of the medicaid daily rate. The operational cost includes such things as utilities, minor maintenance, and housekeeping. These costs are capped at 125 percent of the median for urban and rural areas.

- **Administrative Cost Component**: The administrative costs are those related to administration, management and oversight of the facility. These costs are capped at 110 percent of the median for urban and rural areas respectively.

- **Food Cost Component**: The food cost component is 4 percent of the total reimbursement rate. The food cost component includes bulk and raw food and beverages purchased for the dietary needs of the residents. Savings in the food can be moved to the nursing services component to increase resources for residents care. These costs are capped at 125 percent of the median for urban and rural areas respectively.

- **Property Cost Component** : The property cost component makes up 4 percent of the total medicaid reimbursement rate. The amount of payment is calculated by dividing allowable depreciation from the prior year by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on 90

percent occupancy. Allowable depreciation is based on the estimated economic life of the building according to the American Hospital Depreciation Schedule. For example a building with a 30 year life will be depreciated at one thirtieth of its value each year. There is no cost cap for this component.

- **Return on investment Cost component which consists of two sub components:**

  - **Variable Return Component**: This component does not reimburse for a specific nursing facility cost. Instead, the variable return cost component is intended to provide an incentive for facilities to operate efficiently, and to allow for a profit. Each facility is eligible to receive an additional 1 to 4 percent on the remainder of the rate (excluding property and financing). Facilities in the lowest cost quartile receive 4 percent variable return. Facilities in the next quartile receive 3 percent variable return Facilities in the next quartile receive 2 percent variable return. Facilities in the highest cost quartile receive 1 percent variable return. Efficiency is defined as lowest cost per resident day. Currently, variable return makes up 2 percent of the total medicaid reimbursement rate.

  - **Financing Allowance Cost Component**: The Financing allowance makes up 5 percent of the total reimbursement rate and pays for facility improvements and for equipment purchases. The financing allowance is calculated by multiplying fixed assets minus depreciation by 10 percent and dividing by total resident days at the greater of actual resident days or 90 percent occupancy. There are no cost lids for this component.

Payments to nursing homes change in one of three ways, depending on the year and specific circumstances of the facility: Currently, rates are rebased every three years to reflect actual review of each individual allowable facility. During years when rates are not rebased, Washington has increased rates by using the Health Care Finance Administration (HCFA) nursing home input price index. Nursing homes may also require additional payment to provide for increased costs in patient acuity new capital needs, or changes in service required by the DSHS. Nursing homes may also apply to receive exceptional payments for residents who require two times the average nursing hours provided in the facility.

Settlement of Payment:

Settlement is the process by which the nursing home rates that have been paid to a facility over the course of a year are later reconciled against the facility's actual expenditures. Under Washington's current nursing home payment system, a nursing facility is generally required to pay back to the state the difference between its actual allowable costs during the period less the amount that it has been paid.

The following rate components are currently settled: Nursing Services, food, property, administration, and operations.

If the facility's allowable costs are less than the reimbursement rate it has been paid throughout the year, then the facility must return the difference between its payment rate and its allowable costs, to the state. If the facility's allowable costs meet or exceed the facility's reimbursement rate, no further adjustment is made.

Legislative History Regarding the Case Mix Reimbursement System:

1993/1994 - ESSB 5724 was passed by the Legislature and mandated that a study be conducted by the Legislative Budget Committee (LBC) to assess the financial stability of the nursing home industry, evaluate the adequacy of the reimbursement system for promoting cost-effective quality care, and recommend improvements in the system's capacity to promote sufficient availability of quality care.

In its study, completed in 1994, the LBC found that:

- The current reimbursement system was found not to be cost effective.
- The study indicated that the current reimbursement system creates an incentive for nursing homes to increase spending. A combination of rates being set on the basis of individual facility costs and the incentive to spend the entire rate (use it or lose it) contribute to costs increasing faster than the general health care inflation.
- Payments were higher than the national average and higher than a majority of states.
- Spending increases lead to higher reimbursement rates.
- Reimbursement rates are not correlated to acuity or the geographic location of the facility. Some facilities showed high costs and low acuity (extent of resident's need for care) and vice versa. There was, however, correlation found between the amount of private pay revenue and the Medicaid rates.
- Frequent rebasing, or setting payment rates equal to a facility's allowable costs, increased costs.
- The study also found that the nursing home industry is financially stable.

The LBC study recommended that the state consider implementing a case-mix reimbursement system and other cost savings measures.

1995 - The Legislature passed E2SHB 1908 mandating changes to the reimbursement system The Legislature required that any payments to nursing facilities made in FY 1999 and after must be based on a case-mix system. The DSHS was required to design and develop alternatives for the nursing facility payment system, consult with stakeholders in development of the alternatives, and report to the Legislature on the projected costs and benefits of the alternatives.

1996 - The Legislature required the DSHS (by budget proviso) to develop a shadow case-mix payment system to educate facilities about payment system alternatives and to test the new system prior to implementation. The shadow case-mix system is a method of continuing to use the current reimbursement system while at the same time running the new system on a test basis in each facility. Shadow rates were started July 1, 1997. Through the budget, the Legislature has stated its intent that payment rates should not increase by more than 6.4 percent during the first year of implementing a new payment system.

In addition to the 1994 LBC recommendations and the provisions of ESHB 1908, the federal government recently required that nursing homes adopt case-mix for the Medicare payment system. In addition to the federal government moving to a case-mix system for Medicare, 27 states are currently using a case-mix payment system of some form. However, beyond these two factors, the greatest motivators towards moving the state to consider a case-mix payment system for nursing homes are:

Case-Mix Payment System:

Case-Mix is a method of paying nursing homes by matching payments to the characteristics of the homes' residents. A case-mix reimbursement system is based upon the following assumptions:

- As the care needs of residents of a facility increase, so should the payments to the facility to care for the resident.
- Similarly, a facility with patients who on average require less care would receive a lower payment.
- Ideally, this method of payment removes disincentives to treat residents with heavy care needs, because a facility's payment will increase as it admits these highly-dependent patients.
- If these incentives work correctly under a case-mix system, the outcome will be increased access to necessary nursing facility care for those who require it and cost maintenance for patients who need less care.

A case-mix payment system involves classifying patients into distinct care related groups (resource utilization groups or RUGs) for payment. In order to classify residents into groups with similar care needs and resource use, the nursing facilities must collect uniform data about resident care needs. The tool used by the facilities to collect this data, is called the Minimum Data Set (MDS). The MDS is part of a federally-mandated resident assessment and care planning tool. National time studies were conducted in 1990 and 1995 to determine how much time was spent by caregivers to assist residents with a given set of characteristics. Once residents are separated into these divisions the case-mix classification system, referred to as Resource Utilization Groups - version III (RUGs III),– is established.

Summary of Substitute Bill:

Implementation of Case-Mix Reimbursement System:

The current nursing facility cost specific payment system that bases costs solely on nursing home expenditures is removed and is replaced with an individual resident based case-mix payment system. The new system addresses reporting requirements, auditing requirements, allowable costs of operation, payment determination, billing requirements, and administration of the facility. The DSHS is directed to begin implementation of the case-mix payment system on July 1, 1998. Under the new system, case-mix payment rates are set for nursing homes based on individual client needs. The system requires that a higher rate is paid for a resident who requires more nursing care than for a resident requiring less assistance with care such as eating, toileting, etc..

The payments made for direct nursing care are changed from a facility average payment to payment tied directly to the amount of care needed for each individual resident. Facilities are required to collect data on each resident (such as diagnosis, treatments, and activities of daily living dependencies) to determine the resident's resource requirements and placement in an appropriate RUG classification category. This individual resident information is the key ingredient for setting the reimbursement rate under the new case-mix reimbursement system.

Resident Assessments: Residents must be assessed, upon admission, quarterly, annually, and whenever a significant change in the residents' condition occurs. If a required resident assessment is submitted late, the department is directed to place the resident into a case-mix category having a score of 1.000, which is the score assigned to the lowest case-mix category (i.e., category requiring lowest level of care and receiving lowest reimbursement). Once the assessment data is submitted, the department will adjust the case-mix weight according to the resident's correct case-mix category and retroactively adjust the payment for days of care within that category. The department is allowed to question the accuracy of assessment data for any resident. The nursing home is given the opportunity to contest any determination made by the department as to the accuracy of the data submitted.

State quality assurance nurses must validate completion and accuracy of resident assessments. Facilities will be penalized through the survey process if assessments are late and/or inaccurate.

Case-Mix Classification System to be Used: A resident case-mix system called RUG III based on the most recently completed nursing facility staff time study must be used to determine case-mix indices (categories)under the new system. The department is authorized to revise or update the RUG III case-mix classification. The process by which the case-mix classification is established is specified. Classification groups are weighted

by days of stay within a particular case-mix group, by average minutes of nursing time, by skill level needed to provide the required care for residents care for resident's within each case-mix group, and by weighting the minutes of time by the ratio of the nursing wages, by skill level. The case-mix weights may be revised if the Federal HCFA revises its time study, in which case, the most recent wage data shall then be used.

Direct Care Component (Nursing Services) Payment: Under the new payment system the base price for the cost incurred by the nursing facility for the hands-on care of an individual residents is set at 110 percent of median and transition corridors are set over three years. During year one, the corridor floor is set at 85 percent of the base price and the ceiling is set at 110 percent of the base price. Beginning in year two, the corridor floor is set at 92.5 percent of the base price and the ceiling is set at 105 percent of the base price. In year three, the corridor is eliminated and payment is set at the base price of 110 percent of the median. Whether a facility is paid the ceiling, floor, or its own cost per case-mix unit will depend on where in the array it appears. For example, for July 1, 1998, payment for facilities above the base price plus 10 percent will be paid at the ceiling and facilities below the base price minus 15 percent will be paid at the floor price. Facilities falling between the ceiling and floor will have their price set at their average cost per case-mix unit. For July 1, 2000, and beyond, the base price will be used to determine payment for each resident. The facility average cost per case-mix unit (or medium), used to establish the base price, is to be set once per year and is to be adjusted forward by use of the HCFA index since prior year's costs are used. There is no minimum occupancy requirement. The facilities base price will be multiplied by each facilities medicaid case-mix index of its residents to determine its direct care payment rate. Cost will be rebased annually. Under this new system the department would receive 50% of all overpayment in the direct care component.

Therapy Payment: Therapy payments are changed from being part of the total direct care component to a separate system based on case managed fee-for-service to be paid outside of the nursing facility rate component system. Therapy care includes speech, occupational, physical, mental health, mental retardation, and respiratory therapy. Payment is based on units of therapy delivered to medicaid residents. Fifteen minutes of one-on-one therapy care is equivalent to one unit. The nursing home is required to submit a bill to the department using the department's billing form. Payment is made based on the fee schedule used by the department for outpatient hospital services for physical, speech and occupational therapy. For other therapies the department must develop appropriate fee schedules in consultation with the providers. The DSHS is given the authority to develop a system to case manage therapy utilization and payment based on either total estimated therapy cost per resident or on the number of units of therapy care estimated.

Administrative, Operational, and Food Service Component Payment: The three rate categories of administrative, operational, and food services used in the current system are combined into two rate components: Operations and support services.

- **Operations Component -** The operations component rate includes management, administration, utilities, office supplies, accounting, book keeping, minor building maintenance, minor equipment repairs and replacements, and other activities and services. The department is required to annually array each facility's costs per patient day for both rural and urban areas and determine the medians. The per patient day cost shall be adjusted using the greater of actual resident days or a minimum occupancy of 80 percent. Each facility's operating component payment will be set at the median cost per patient. The operating component payment rate shall be adjusted by the change in HCFA index multiplied by a factor of 1.5 in the first year, July 1, 1998, rate and by the change in the HCFA index in subsequent years. The additional inflation adjustment of 1.5 is assumed for setting the July 1, 1998 rate because 1996 costs are used in determining the initial median price. In setting the July 1, 1999 rate the 1998 costs shall be used.

- **Support Services Cost Component -** The support services component rate includes food, food preparation, dietary, housekeeping, and laundry services. The department is required to annually array each facility's costs per patient day for rural and urban areas and determine the median cost per patient day. The median rate is what the facility will be paid dependent on their MSA and non MSA location. The facility is required to repay to the department the amounts not spent for services and items within this cost component. There is no minimum occupancy requirement.

Property Component Payment: The property component is maintained as is in the current system. Provisions that will sunset July 1, 1998, are restored. The only change is that the occupancy factor is reduced from 90 percent to 80 percent. The property rate is determined by dividing the allowable prior period depreciation adjusted for capitalized additions or replacements by the greater of a facility's total resident days or days at an 80 percent occupancy. If assets are retired affecting bed capacity, the department is required to use anticipated days. The property component rate is to be rebased annually. The 1996 cost report must be used to set the July 1, 1998, rate and thereafter the preceding year's cost report must be used. If a nursing home banks beds or converts the beds to active services the department is required to use anticipated occupancy but never less than 80 percent occupancy .

Settlement: Under the settlement process (where the state compares audited, allowable costs, to the prospective reimbursement rate paid to a facility), reimbursement is kept at 100 percent for support services (food, food preparation, dietary, housekeeping, and laundry services) and is modified to 50 percent for the direct care (nursing care) component. If the facility's allowable costs for support services are less than the reimbursement rate it has been paid throughout the year, then the facility must return 100 percent of the difference to the state. If the facility's allowable costs for support services meet or exceed the facility's reimbursement rate, no additional payment is made. In the direct care portion of the rate, the department and the facility will share 50 percent in any expenditure less than the rate. For example if the direct care rate is $50 and the

facilities' actual cost is $48, $1 goes to the state and $1 goes to the facility as an efficiency incentive.

Initial Year Base Rate Setting/System Rebasing: - The medians used to calculate base rates use calender year 1996 costs, adjusted for inflation. The time frame for adjusting the system's costs (rebasing) is modified from ever three years to every year. Each year facilities actual allowable costs are arrayed and a new median is set for urban and rural areas respectively.

Occupancy Rate Used for Setting Costs Per Day: - The 90 percent occupancy rate is reduced to 80 percent. All cost centers except direct care and support services will use an occupancy rate of 80 percent. Direct care and support services have no minimum occupancy.

Case-Mix Adjustment Payment: Adjustments to the case-mix payment must be made on a quarterly basis.

Provisions for Exceptional Care Rates and DSHS Study: The DSHS is required to do further studies to adjust the RUGs III to reflect the resources required to care for HIV, traumatically brain injured (TBI), ventilator dependent, or behaviorally complex residents. Until such adjustments can be made in facilities with atypical concentrations of such residents, the facility is paid at its June 30, 1998, rate plus inflation adjustments. It is only the residents with these conditions that are considered for this rate adjustment.

The pilot facility especially designed to meet the needs of persons with AIDS located in King County (Bailey-Boushay House) is excluded from the direct care payment system.

Tax Pass Through: Taxes paid by nursing facilities are treated as a pass through under the new payment system. This has the effect of excluding these tax costs from the total operating costs thereby lowering the median and per day price paid to nursing facilities, while paying facilities their actual amount of taxes paid relative to their medicaid census.

Presumptive Medicaid Eligibility: Facilities will begin receiving payment for care and services provided to the resident if the department fails to make its eligibility determination within 45 days from the date of the request of determination.

Community Case-Mix Extension Study: The DSHS is required to study and provide recommendations to the Legislature on the appropriateness of extending the case-mix principles to home and community service providers in the long-term care system.

Case-Mix Evaluation Study: The DSHS is required to contract with an independent and recognized organization to study and evaluate qualitative impact of case-mix on lives of residents, and access and quality of care. The study is to include an investigation of the

wage and benefit levels of all long-term care employees. The department must submit the report to the Governor and the Legislature by December 1, 2000.

New Definitions: New definitions are established to correspond to a new case-mix payment system.

WWII Veterans: Filipino World War II veterans who swore an oath to American authority and who participated in military engagements with American soldiers are eligible to be admitted to either of the states' two state veterans' nursing home.

Current Revisions Repealed: Repealers are included to eliminate current law governing audit and settlement procedures that are replaced with provision implementing a case-mix payment system and to eliminate the current statue directing the development of a new nursing facility payment system.

Substitute Bill Compared to Original Bill:

Support Services Payment Rate: The payment rate for the support services component, (food, dietary, laundry, and housekeeping), is reduced from 115 percent of the median to 100 percent of the industry median.

Operations Payment Rate: The operations component payment rate is reduced from 110 percent of the industry median to 100 percent of the industry median.

Settlement: The process of the state comparing audited, allowable costs, to the prospective reimbursement rate paid to a facility has been extended to the direct care component. In the direct care portion of the rate, the department and the facility will share 50 percent in any expenditure less than the rate. For example, if the rate is $50 and the facilities actual cost is $48, $1 goes to the state and $1 goes to the facility as an incentive.

Exceptional Care: Until such adjustments can be made in facilities with atypical concentrations of persons with HIV, AIDS, TBI, or are ventilator dependent, or behaviorally complex, residents will be paid at the June 30, 1998 using the current reimbursement system rate plus inflation adjustments. It is only the individual residents with these conditions that are considered for this rate adjustment. An additional provision is established that specifically excludes the pilot facility especially designed to meet the needs of persons with AIDS located in King County (Bailey-Boushay House) from the nursing services cost center reimbursement rate.

DSHS Exceptional Care Rates Study: The DSHS is required to do further studies to adjust the RUGs III to reflect the resources required to care for HIV, TBI ventilator dependent, or behaviorally complex residents. Until such adjustments can be made in facilities with atypical concentrations of such residents, the facility will be paid at its June

30, 1998, rate plus inflation adjustments. It is only the residents with these conditions that will be considered for this rate adjustment.

Tax Pass Through: Taxes paid by nursing facilities are treated as a pass through under the new payment. This has the effect of excluding these tax costs from the total operating costs thereby lowering the median and per day price paid to nursing facilities, while paying facilities their actual amount of taxes paid relative to their medicaid census.

Presumptive Medicaid Eligibility: Facilities are allowed to begin receiving payment for care and services provided to the resident if the department fails to make its eligibility determination within 45 days from the date of the request.

Case-Mix Adjustment Payment: Adjustments to the case-mix payment must be made on a quarterly basis.

Therapy: Music therapy is removed from the list of therapies to be considered for the reimbursement fee schedule.

WWII Veterans: Filipino World War II veterans who swore an oath to American authority and who participated in military engagements with American soldiers are eligible to be admitted to either of the states' two state veterans' nursing home.

Technical Housekeeping Amendments: A number of housekeeping amendments are included that clarify consistent with the intent of the bill.

Appropriation: None.

Fiscal Note: Requested on January 29, 1998.

Effective Date of Substitute Bill: Ninety days after adjournment of session in which bill is passed, except for sections 23 through 26 which take effect July 1, 1998.

Testimony For: None (see below).

Testimony Against: None (see below).

Testified: The following organizations participated in work sessions to discuss case-mix proposal options: Washington Association of Homes for the Aging; Washington Health Care Association; Senior Lobby; State Long-term Care Ombudsman; Providence Hospital; State Government: Aging and Adult Services, and Administration of the Department of Social & Health Services; Bailey-Boushay House; Caroline Klien Galland Home, and rural hospitals.