FINAL BILL REPORT
E2SHB 2935

C 322 L 98
Synopsis as Enacted

Brief Description: Implementing the nursing facility medicaid payment system.

Sponsors: By House Committee on Health Care (originally sponsored by Representatives Dyer, Cody, Huff and Backlund).

House Committee on Health Care
House Committee on Appropriations
Senate Committee on Health & Long-Term Care
Senate Committee on Ways & Means

Background:

Nursing Homes. Nursing homes in Washington 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 as a 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 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 were 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 used in the rate setting system:

- Nursing Services Cost Component. This cost component is the largest of the five cost components and comprises 55 percent 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 percent of the 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 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 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 Consisting of Two Subcomponents.

    - 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. Variable return makes up 2 percent of the rate.

- Financing Allowance Cost Component. The financing allowance makes up 5 percent of the 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: 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 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 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 - Legislation directed 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 reimbursement system was not cost effective;
- the reimbursement system created 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) contributed 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; and
- 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 - Legislation made changes to the reimbursement system. Any payments to nursing facilities made in FY 1999 and after had to 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.

1997 - 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.

The federal government also recently required that nursing homes adopt case-mix for the Medicare payment system. Twenty-seven states are currently using a case-mix payment system of some form:

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; and
- 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 (RUG III)," is established.

Summary: Implementation of Case-Mix Reimbursement System. The 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 October 1, 1998. Under the new case-mix payment system, over half the rate paid to nursing homes is 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 the following activities of daily living: eating, toileting, transferring from a chair, and bed mobility.

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.

The direct care component of the rate fluctuates according to changes in the facility's average resident assessment.

Resident Assessments. A resident must be assessed, upon admission, quarterly, annually, and whenever a significant change in a resident's 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). 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 RUG III resident case-mix system, 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 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 will then be used.

Payment System Establishes an Allocation Formula. The statute provides an allocation formula and not a promise of the exact payment each facility will receive. The amount by which each rate component is inflated each fiscal year is not stated in statute, but will instead be determined in the biennial appropriations act. The statewide average daily rate per person to be paid to nursing facilities will also be stated in the biennial appropriations act. If the DSHS determines that payment rates will exceed the average daily rates identified in the budget, then all rate components for all facilities will be adjusted proportionally to bring them back within the budgeted level. However, rates will not be adjusted to meet the budgeted rate if the nursing home census is higher than the budgeted census.

Direct Care Component (Nursing Services) Payment. The new payment system will pay facilities a direct care amount which is tied to relative patient resource use, and will be limited by a minimum payment amount or floor, a maximum payment amount or ceiling, and by a measure of inflation for those facilities whose current payment exceeds the new ceiling. This approach for setting direct care payments may generally be described as a corridor. Using a corridor payment method, facilities receive as a minimum payment the amount at the floor, if their costs fall below the floor. Facilities with costs above the floor but below the ceiling receive their actual costs, adjusted for relative patient resource use. Normally, facilities with costs above the ceiling would be brought down to the ceiling; however, the act adopts a hold

harmless approach for facilities with costs above the ceiling. Facilities whose costs exceed the ceiling will continue to receive the payment for direct care in effect on June 30, 1998, plus an adjustment, which will be defined in the biennial appropriations act. An adjustment will be applied to the direct care rate for facilities above the ceiling in only fiscal years 1999 and 2000, while all other facilities are eligible for annual adjustments to reflect economic trends and conditions. That inflation adjustment will be applied at the start of each future fiscal year to the payment made in the prior fiscal year.

The corridor will narrow over time, but the ceiling and floor that define the corridor will increase as rates are rebased. Beginning in FY 1999, direct care payments to providers will be based on the corridor approach, with the ceiling and floor based on an array of nursing facility costs from the calendar year 1996 cost report. This process of moving to the 1996 cost report as the basis for calculating payments is known as "rebasing" the rate. Rebasing rates to reflect a prior period's actual costs will occur in FY 1999 and 2002. This will have the affect of increasing the median cost of urban and rural nursing facilities, and will thus raise the corridor for nursing facility payment. During fiscal years 1999 and 2000, the ceiling will be set at 115 percent of the median cost of all facilities in a peer group and the floor will be set at 85 percent of the median cost of all facilities within a peer group. During fiscal years 2001 and 2002, the ceiling will be set at 110 percent of the median and the floor will be set at 90 percent of the median. During fiscal years 2003 and 2004, the ceiling will be set at 105 percent of the median and the floor will be set at 95 percent of the median. During fiscal year 2005, the direct care component rate will be set at the median cost of rural or urban facilities, according to the facility's location.

Therapy Payment. Therapy care will be paid separately from direct care at the actual Medicaid cost up to a ceiling of 110 percent of the median cost. No limit is set on the number of units of therapy the agency may provide.

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, bookkeeping, 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 is to be adjusted using the greater of actual resident days or a minimum occupancy of 85 percent. Each facility's operating component payment will be set at the median cost per patient.

· Support Services Component - The support services component rate includes food, food preparation, housekeeping, and laundry and dietary 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. Payment for support services will be set at 110 percent of the median cost for each of the urban and rural peer groups. The facility is required to repay to the department the amounts not spent for services and items within this cost component. Per patient day costs will be based on the greater of actual patient days or days at 85 percent occupancy.

Capital Component Payment. The capital component rate is maintained as it is calculated in the current system. Provisions that were to expire July 1, 1998, are restored. 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 85 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 85 percent occupancy. The variable return payment is retained in its current statutory form, as is the financing allowance.

Initial Year Base Rate Setting/System Rebasing. The medians used to calculate base rates in FY 1999 use calender year 1996 costs, adjusted for inflation. The medians used to set payments in FY 2002 and beyond will be based on calendar year 1999 costs, adjusted for inflation. Rates may be adjusted for inflation during those years when rebasing does not occur.

Occupancy Rate Used for Setting Costs Per Day. The 90 percent occupancy rate is reduced to 85 percent. This is the minimum occupancy rate the department will use for calculating a daily rate.

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

Bailey-Boushay House. The pilot facility especially designed to meet the needs of persons with AIDS located in King County (Bailey-Boushay House) is excluded from the new direct care payment system, and will be reimbursed for direct care at cost, to be rebased every three years. However, Bailey-Boushay House is subject to the same provisions of the proportional rate decreases if the statewide average daily rate exceeds the statewide average daily rate.

Provisions for Exceptional Care Rates and DSHS Study. The DSHS is required to do further studies to adjust the RUG III classifications to reflect the resources required to care for HIV, traumatically brain injured (TBI), ventilator dependent, or behaviorally complex residents.

Rebase Study. The DSHS is required to report to the Legislature on the cost impact of rebasing payments to prior period allowable costs for different intervals of time. The DSHS will consider averaging costs for several years in its study.

Property Payment Study. The DSHS is required to study and report to the Legislature on different methods of paying facilities for capitol and property expenses.

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 homes.

Provisions Repealed. Repealers are included to eliminate provisions that are no longer relevant to the method of paying for nursing facility services.

Settlement Settlement is retained for several components, but an incentive payment to facilities is allowed. The direct care, therapy care and support services rate components will be settled; however, facilities that are not out of substantial compliance with federal survey regulations for more than 90 days and that are not found to provide substandard quality of care, are allowed to keep 1 percent of any amount of payment which exceeds the facility's actual allowable costs.

Votes on Final Passage:

House 96 0
Senate 47 0 (Senate amended)

House 98 0 (House concurred)

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July 1, 1998 (Sections 1 through 37, 40 through 49, and 51 through 54)
October 1, 1998 (Sections 38 and 39)