HOUSE BILL REPORT
E2SHB 2935

As Passed Legislature

Title: An act relating to nursing home payment rates.

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).

Brief History:
Committee Activity:
Health Care: 1/16/98 and 1/23/98 (work sessions) 1/27/98 [DPS];
Appropriations: 2/9/98 [DP2S(w/o sub HC)].
Floor Activity:
Passed House: 2/17/98, 96-0.
Passed Legislature.

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).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care. Signed by 27 members: Representatives Huff, Chairman; Alexander, Vice Chairman; Clements, Vice Chairman; Wensman, Vice Chairman; H. Sommers, Ranking Minority Member; Doumit, Assistant Ranking Minority Member; Gombosky, Assistant Ranking Minority Member; Benson; Carlson; Cody; Cooke; Crouse; Grant; Keiser; Kessler;

Lambert; Linville; Lisk; Mastin; McMorris; Parlette; Poulsen; Regala; D. Schmidt; Sehlin; Sheahan and Talcott.

Minority Report: Without recommendation. Signed by 4 members: Representatives Chopp; Dyer; Kenney and Tokuda.

Staff: Jason Hall (786-7145).

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 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 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 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. 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.

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.

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 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, transferring from a chair, and bed mobility.

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.

Payment System Establishes an Allocation Formula:

The statute is 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 payment rates exceed the budgeted rate when the allocation formula is applied, or during the course of the year, due to rate adjustments or changes in patient acuity, all rates 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. Normally, facilities with costs above the ceiling would be brought down to the ceiling; however, the bill adopts a hold harmless approach for facilities with costs above the corridor. 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. 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. 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. 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 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, 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 85 percent. Each facility's operating component payment will be set at the median cost per patient.

- **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. Payment for support services will be set at 110 percent of the median cost for each of the MSA and non-MSA 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 will sunset 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 90 or 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 90 or 85 percent occupancy, as applicable. 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 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.

Occupancy Rate Used for Setting Costs Per Day:

The 90 percent occupancy rate is reduced to 85 percent.

Case-Mix Adjustment Payment:

Adjustments to the case-mix payment must be made on a quarterly basis.

Bailey-Boushay:

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 is subject to the same provisions of the proportional rate decreases if the statewide average daily rate exceeds the statewide average daily rate.

Tax Liabilities Not Incurred:

No facility is allowed to receive payment for a tax liability which was never actually incurred by the facility.

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.

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 home.

Current Revisions Repealed:

Repealers are included to eliminate current law which is no longer relevant to the method of paying for nursing facility services.

Settlement:

Settlement is retained for several components, but allows for an incentive payment to facilities. The direct care, therapy care and support services rate components will be settled; however, facilities which are in substantial compliance with federal survey regulations are allowed to keep 1 percent of any amount of payment which exceeds the facility's actual allowable costs.

An effective date and severability clause are included in the bill.

Appropriation: None.

Fiscal Note: Requested.

Effective Date: The bill takes effect on July 1, 1998.

Testimony For: (Health Care) None (see below).

(Appropriations) (On first substitute) There will be no system in place to pay nursing homes as of July 1, 1998, making passage of some new system imperative. This bill is good because it breaks the link between a facility's spending and state payment. Settlement should be reduced or done away with because it gives incentives to spend all the money and offers no incentives for efficiency. The current payment system does not recognize increasing patient acuity; the proposed one will.

Testimony Against: (Health Care) None (see below).

(Appropriations) (On first substitute) This proposal offers no guarantee for good health care and means poor stewardship of public funds. This bill is a step backwards. The impact to the Caroline Kline Galland Home will be a $300,000 loss, which may cause the home to close. The case-mix system is used in other states to add money to the system, not take it away. This will cause an automatic and immediate drop in payments to nursing homes. The bill should focus only on direct care. State occupancy at nursing homes has fallen from 98 percent to 85 percent on average and this has a cost impact. Staff and wage ratios vary according to facility. The goal for the state may be to remain revenue neutral, but our nursing home won't be left revenue neutral. Hospital-based nursing facilities pay hospital staff nurse wages to their nursing facility nurses. Unique needs like these exist in places throughout the state. In some places, there are few or no other care alternatives. This bill should hold rates harmless, affect only direct care, delay implementation of the new system until January 1, 1999, and phase-in the corridor for direct care payments over four years. Members should ask themselves if this bill will improve care and if it will allow for livable wages to nursing staff to be maintained. The process is flawed because it will eventually set just one price for rural facilities and one price for urban facilities, without recognizing wage and benefit differences among facilities in these categories. If there is no settlement, the state will pay facilities amounts in excess of their costs. The bill shows savings in the first year, but will cost the state more than the current system in future years. The number-one concern among nursing facility residents is staff. They want staff that stay for long periods of time and know resident care needs. That requires paying a good wage. The Legislature set aside food as a separate component in the old system. It's important to keep food as a separate component because it is an area of great importance to the residents.

Testified: (Health Care) 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.

(Appropriations) Jerry Reilly, Washington Health Care (pro); Rick Guthrie, Port Orchard Care Center (pro); Bruce Reeves, Senior Citizens' Lobby (con); Paul Opgrande, Tacoma Lutheran Home (con); Gary Peck, St. Joseph Hospital (con); Karen Tynes, Washington Association of Homes for the Aging (con); Chuck Hawley, Sisters of Providence (con); Denise Gaither, DSHS (con); Kary Hyre, Long Term Care Ombudsman (con); Randi Abrams, Jewish Federation (concerns); Joshua Gortler, Caroline Kline Galland Home (concerns); and Ann Simons, UFCW District Council #17 (concerns).