SENATE BILL REPORT

E2SHB 2935

As Reported By Senate Committee On:
Health & Long-Term Care, February 27, 1998
Ways & Means, March 10, 1998

Title: An act relating to nursing home payment rates.

Brief Description: Adopting a new system for establishing nursing home payment rates.

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

Brief History:
Committee Activity: Health & Long-Term Care: 2/26/98, 2/27/98 [DPA-WM].
Ways & Means: 3/2/98, 3/10/98 [DPA].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Deccio, Chair; Wood, Vice Chair; Benton, Franklin, Strannigan and Wojahn.

Staff: Jonathan Seib (786-7427)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators West, Chair; Deccio, Vice Chair; Strannigan, Vice Chair; Hochstatter, Long, McDonald, Roach, Rossi, Schow, Swecker, Winsley and Zarelli.

Staff: Tim Yowell (786-7435)

Background: Nursing Homes: The state's 296 nursing homes care for approximately 23,000 people daily, and employ over 25,000 full-time people. 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 FY 1998.

The Washington nursing home payment system is prospective, cost-based, and facility-specific. Each facility receives its own unique rate of payment, based on the facility's expenditures. The amount paid to each facility is determined in advance of when the actual

costs are known. Limits are placed on costs, and vary based on whether a facility is located in a rural or urban area.

Multiple Components to the Rate: The rates paid to nursing facilities are based on six cost components: nursing services, operations, administration, food, property, and the return on investment. Each facility is paid the lower of: (1) its 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 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. 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 total 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.

- *Food Cost Component*: The food cost component is 4 percent of the total reimbursement rate. These costs are capped at 125 percent of the median for urban and rural areas respectively.

- *Property Cost Component*: The property cost component is 4 percent of the total Medicaid reimbursement rate. 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. 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, each facility receives an additional 1 to 4 percent on the remainder of the rate (excluding property and financing, based on a facility's relative efficiency. 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.

Rates are recalculated ("rebased") every three years based on the costs incurred in the previous calender year. In other years, rates are increased using the Health Care Finance

Administration (HCFA) nursing home input price index. Additional payment may be provided for increased costs in patient acuity, new capital needs, or changes in service required by DSHS. Nursing homes may also receive additional payments for exceptional care residents.

Settlement of Payment: Settlement is the process by which the rates which have been paid to a facility during the year are reconciled with actual expenditures. The current system generally requires a nursing home to pay back the difference if its costs during the period are less than it has been paid through the rate. 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 is passed, directing the Legislative Budget Committee (LBC) to evaluate the adequacy of the existing nursing home payment system.

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

- The existing payment system creates an incentive for nursing homes to increase spending.
- This incentive leads to differences in payment rates not related to resident care needs, the quality of services provided, or the location of the facilities.
- This incentive is important in explaining relatively higher payment growth rates in Washington.

LBC recommended complete overhaul of the existing payment system.

1995 « E2SHB 1908 is passed. It requires any payments to nursing facilities made beginning in FY 1999 be based on a case-mix system. DSHS is directed to work with stakeholders to develop alternative systems for matching payments to patient needs.

1997 - The Legislature directs DSHS to provide example case mix payment system rates « called "shadow rates" « to nursing homes beginning July, 1997, and directs DSHS to propose a system under which rates increase by no more than 175 percent of the HCFA market basket index during the first year of the new system.

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

Summary of Amended Bill: Beginning October 1, 1998, the current nursing home payment system that bases reimbursement primarily on costs per patient is replaced with a new system that incorporates reimbursement based on costs per case-mix unit. The bill addresses reporting requirements, auditing requirements, allowable costs of operation, payment determination, billing requirements, and administration of the facility.

Resident Assessments: Residents must be assessed using the Minimum Data Set at specified intervals. 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.

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.

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, as discussed below, the bill adopts a hold harmless approach for facilities which would otherwise receive a lower direct care payment rate under the new system than they currently receive.

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. The corridor will narrow to a ceiling of 110 percent and a floor of 90 percent in 2001 and 2002. The corridor will narrow again in 2003 and 2004 to a ceiling of 105 percent and a floor of 95 percent. Beginning July 1, 2004, all facilities will be paid the peer group median cost per case mix unit.

Hold Harmless: During fiscal years 1999 and 2000, facilities will be paid the higher of their June 30, 1998 direct care rate, adjusted for any authorized inflation increases, or the direct care rate as calculated under the new system described above. During fiscal years 2001 and 2002, facilities will be paid the higher of their June 30, 2000 direct care rate, with no further inflation adjustments, or the direct care rate which they would receive under the new system.

Inflationary Adjustments: Rates are to be adjusted annually by a factor or factors identified in the biennial appropriations act. Different adjustment factors may be identified for different components of the rate, and for "hold harmless" as opposed to other facilities.

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, and other activities and services. Each facility’s operating component payment will be no more than the median rate.

- *Support Services Cost Component*: The support services component rate includes food, food preparation, dietary, housekeeping, and laundry services. Payment for support services will be no more than 110 percent of the median peer group rate.

Capital Component Payment: The capital component rate is generally maintained as it is calculated in the current system. The variable return payment is retained in its current statutory form. The financing allowance is retained at its current level of 10 percent. Statutes governing the capitol component rate will expire on June 30, 1999.

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.

Rates Not To Exceed Budgeted Levels: If actual average payment rates begin to exceed the average payment rate identified in the biennial appropriations act, DSHS is required to reduce all component rates for all facilities by the percentage by which actual rates would otherwise exceed the budgeted level.

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.

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: 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: 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. DSHS will consider averaging costs for several years in its study.

Property Payment Study: DSHS is required to study and report to the Legislature by December 1, 1998 on different methods of paying facilities for capitol and property expenses.

Community Case-Mix Extension Study: 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: 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.

Certificate of Need Exemption: Hospice facilities which began operations in December 1996, and which the Department of Health determined did not need a certificate of need, are exempted from obtaining certificate of need approval to add additional beds.

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 eliminated for the operations rate component. Settlement is retained for the direct care, therapy care and support services rate components, but facilities which are in substantial compliance with federal survey regulations are allowed to retain under-expenditures up to 1 percent of the rate paid in that component.

Ways & Means Amended Bill Compared to Health & Long-Term Care Amended Bill: The Ways & Means amended bill is a striking amendment which makes the following changes to the Health & Long-Term Care amended bill:

- The "hold harmless" provision is modified. From October 1, 1998 through June 30, 2000, all facilities (rather than only those with costs above the ceiling) will be allocated the higher of their June 30, 1998 direct care rate, plus inflation adjustments, or the direct care rate they would be paid under the new system. From July 1, 2000 through June 30, 2002, all facilities will receive the higher of their June 30, 2000 direct care rate, or the rate they would be paid under the new system;
- Annual inflationary adjustments are to be established in the biennial appropriations act, rather than in the payment system statute;
- Statewide weighted average payment rates are not to exceed an amount identified in the biennial appropriations act;
- After June 30, 2004, the direct care cost corridors are eliminated, and all facilities are to be allocated the median cost per case mix unit.
- Certain hospice care facilities are exempted from certificate of need approval for added capacity.
- Facilities are allowed to shift savings in the operations cost component to cover over-expenditures in the direct care and therapy cost components.
- No special rate adjustment provision is made for facilities in King County which began operations in February 1995.

Health & Long-Term Care Amended Bill Compared to Second Substitute Bill: The Health & Long-Term Care amended bill is a striking amendment which makes the following changes to the original bill:

- It changes the implementation date of the new system from July 1, 1998 to October 1, 1998;
- It increases the financing allowance to cover costs of financing from 8.5 percent to 10 percent;
- The property rate component is expired on June 30, 1999, with a study of the property component to be performed and reported to the legislature by December 1, 1998;
- The "hold harmless" provision for facilities with costs per case mis unit above the ceiling is modified. These facilities will receive theri June 30, 1998 rate, adjusted for inflation in 1998 and 1999. Thereafter, there will be no inflation adjustment.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on July 1, 1998 except for sections 38 and 39, which take effect October 1, 1998.

Testimony For (Health & Long-Term Care): With the amount of state dollars at stake, and the vulnerable nature of individuals in nursing homes, it is essential that the Legislature maintain control and oversight over the reimbursement process by passing a reimbursement bill this session. The bill is important to maintain high quality staffing in nursing facilities, which corresponds to high quality of care and a high quality of life for nursing home residents. The bill reflects enormous time and effort put in on a bipartisan basis listening to all the stakeholders.

Testimony Against (Health & Long-Term Care): The amount of expenditures that the bill would drive is inconsistent with the Governor's proposed supplemental budget.

Testified (Health & Long-Term Care): PRO: Rep. Dyer, prime sponsor; Rep. Parlette, Rep. Sommers; Rep. Cody; Rep. Alexander; PRO w/amendments: Karen Tynes, Washington Association of Homes for the Aging; Jerry Reilly; Washington Health Care Association; Chuck Hawley, Sisters of Providence; Chris Hurley, Bailey-Boushay House; Joel Wakefield, Virginia Mason Medical Center; Margaret Casey, WSCC & WSAHCS; Cheryl Hymes; Ann Simons, UFCW; Jeff Crollard, Long-Term Care Ombudsman; CON: Denise Gaither, DSHS.

Testimony For (Ways & Means): Case mix is more effective than the current payment system in recognizing the dynamic, changing needs of nursing home patients. There must be stability and predictability in nursing home payment, rather than leaving payment dependent on each year's budgetary circumstances. Nursing home associations have sought to propose a system under which payments would be based on patient care needs; the transition to a new system would not harm patients and the people who care for them; and growth in nursing home payment rates is brought closer to the growth in the state spending limit. DSHS shouldn't be allowed discretion in how rates are set, because they proposed significant reductions to the growth in nursing home payment rates.

The proposed bill makes significant progress toward the two goals the Legislature set in 1995: paying nursing homes according to the care needs of their residents, and providing incentives for cost-control and efficiency. DSHS was not proposing to cut nursing homes, but rather to reduce the rate of increase. Care in Washington nursing homes is better than in most states; legislative oversight and fiscal support is essential to keep it that way.

Testimony Against (Ways & Means): Nursing home associations would like some modifications to the bill, so that the transition to case-mix would occur more quickly, while limiting the potential harm to patients and the people who care for them. The Senior Lobby opposes any proposal which would allow facilities not in substantial compliance with survey standards to retain up to 5 percent of their direct care rates.

DSHS opposes the bill because it costs more than the Governor's budget proposal. The bill needs to include a different way to adjust transfer payments, and provide more control on settlement.

Testified (Ways & Means): Rep. Dyer (pro); PRO w/concerns: Jerry Reilley, Washington Health Care Association; Karen Tynes, Washington Association of Homes for the Aging; Chuck Hawley, Sisters of Providence Health Care Systems; Bruce Reeves, Washington Senior Citizens Lobby; Margaret Casey, Washington State Association of Home Care Agencies; Denise Gaither, DSHS Aging and Adult Services Administration; Karey Hyre, Washington Long-Term Care Ombudsman.