HOUSE BILL REPORT
HB 1968

As Reported by House Committee On:
Appropriations

Title: An act relating to limiting nursing home direct care payment adjustments to the lowest case mix weights in the reduced physical function groups and authorizing upward adjustments to case mix weights in the cognitive and behavior groups.

Brief Description: Limiting nursing home direct care payment adjustments to the lowest case mix weights in the reduced physical function groups and authorizing upward adjustments to case mix weights in the cognitive and behavior groups.

Sponsors: Representatives Jinkins, Schmick, Tharinger, Harris, Bergquist, Vick, Pettigrew and Holy.

Brief History:
Committee Activity:
Appropriations: 2/16/17, 2/24/17 [DPS].

Brief Summary of Substitute Bill

- Exempts nursing homes from paying a 13 percent direct care rate penalty on residents in certain Resource Utilization Group (RUG) codes that represent residents with reduced physical functions.
- Allows exceptions to the rate penalty for nursing home residents with limited placement options in the community.
- Authorizes the Department of Social and Health Services to adjust upward the weighted scores of acuity for nursing home residents in certain RUG codes that represent residents with behavioral and cognitive performance issues.
- Updates rate statutes to reflect the current data system and RUG classification in use for Medicaid nursing home rates in Washington.
- Caps the direct care component of the nursing home rate at 118 percent of the nursing home's direct care allowable costs.

HOUSE COMMITTEE ON APPROPRIATIONS

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 30 members: Representatives Ormsby, Chair; Robinson, Vice Chair; MacEwen, Assistant Ranking Minority Member; Stokesbary, Assistant Ranking Minority Member; Bergquist, Buys, Caldier, Cody, Fitzgibbon, Haler, Hansen, Harris, Hudgins, Jinkins, Kagi, Lytton, Manweller, Nealey, Pettigrew, Pollet, Sawyer, Schmick, Senn, Springer, Stanford, Sullivan, Tharinger, Vick, Volz and Wilcox.

Minority Report: Do not pass. Signed by 2 members: Representatives Chandler, Ranking Minority Member; Taylor.

Staff: Mary Mulholland (786-7391).

Background:

The Washington Medicaid program includes long-term care assistance and services provided to low-income individuals. It is administered by the state in compliance with federal laws and regulations and is jointly financed by the federal and state government. Clients may be served in their own homes, in community residential settings, or in skilled nursing facilities (nursing homes).

There are approximately 210 nursing homes licensed in Washington to serve about 9,600 Medicaid clients. Nursing homes are licensed by the Department of Social and Health Services (DSHS) and provide 24-hour supervised nursing care, personal care, therapies, nutrition management, organized activities, social services, laundry services, and room and board to three or more residents. The Medicaid nursing home payment system is administered by the DSHS. The Medicaid rates in Washington are unique to each facility and reflect the client acuity (sometimes called the case mix) of each facility's residents.

Resource Utilization Groups.
Washington uses Resource Utilization Groups (RUGs) as a scoring or classification system to align direct care Medicaid payments with the resource needs of nursing home residents. The RUGs derive data from specific portions of the federal Minimum Data Set (MDS) Resident Assessment and Care Screening that assess a resident's therapy needs, Activities of Daily Living (ADL) impairments, cognitive status, behavioral problems, and medical diagnosis. The RUGs consist of 57 classifications that are not direct hierarchical expressions of resident acuity. Acuity is identified by a weighted score, which represents actual nursing resources utilized by the resident, and ADL scores, which represent resident self-performance and support provided for ADLs that are often lost later in life (bed mobility, transfer, toilet use, and eating).

The RUG codes that begin with a "P" indicate that the resident's resource use is driven by reduced physical functions rather than wound care, therapies, or special needs (known as the reduced physical functions group).

The RUG codes that being with a "B" indicate that the resident's resource use is driven by behavioral symptoms and cognitive performance (known as the behavioral and cognitive performance group). The behavioral and cognitive performance group codes have low RUG

weights as an expression of acuity. Any resident that is in the behavioral group but has a score greater than five for ADLs is moved to the "P" group for reduced physical functions.

Legislative Actions.
In the 2011-13 Omnibus Operating Appropriations Act and through legislation enacted in 2011, the Legislature directed that Medicaid nursing home residents in the 10 RUG codes from PA1 through PE2 be reimbursed at 87 percent of the average direct care daily rate. This is sometimes referred to as the 13 percent penalty or "low-acuity penalty." The action was assumed to generate ongoing savings of $22.6 million total funds ($11.3 million in the State General Fund) per biennium.

Under the Medicaid nursing home rate methodology in use until July 2017, many nursing homes that received the penalty for PA1 through PE2 residents also received a rate add-on known as the "comparative add-on" that mitigated the impact of the reduced reimbursement.

In 2015 and 2016, the Legislature modified the nursing home rate methodology effective July 2016. These modifications reduced the number of rate components, including removal of the comparative add-on.

The 2016 supplemental budget included proviso language that temporarily exempted five of the 10 RUG categories (PC2 through PE2) affected by the 13 percent penalty in a way designed to be cost-neutral for fiscal year (FY) 2017. Mechanisms to maintain cost-neutrality included capping the direct care component of the nursing home rate at 118 percent over 2014 direct care costs, targeting efforts to move less acute residents to community placements, and authorizing the DSHS to increase the penalty on the non-exempt RUG categories if needed. The proviso language will no longer be in effect when FY 2017 closes on June 30, 2017.

Summary of Substitute Bill:

Nursing home rates are modified to exempt nursing homes from paying the 13 percent direct care penalty on behalf of certain residents, specifically:

- residents in the RUG codes PC1 through PE2; and
- residents in the RUG codes PA1 through PB2 with behavioral RUG codes.
- In addition, the DSHS is authorized to allow exceptions to the penalty for residents with limited placement options in the community.

The DSHS is authorized to adjust upward the weighted RUG scores for the BA1 through BB2 codes in the behavioral and cognitive performance group.

Updates are made to reflect the current MDS system and RUG classification in use for Medicaid nursing home rates in Washington.

The direct care component of the nursing home rate is capped at 118 percent of the direct care allowable costs in the base rate year. Nursing homes that are below the statutory minimum staffing standard of 3.4 hours per resident day are not subject to the direct care cap.

The act is null and void unless funded in the operating budget by July 1, 2017.

Substitute Bill Compared to Original Bill:

The direct care component of the nursing home rate is capped at 118 percent of direct care allowable costs in the base rate year, except for nursing homes that are below the statutory minimum staffing standard.

A null and void clause is added, making the bill null and void unless specific funding is appropriated in the operating budget by July 1, 2017.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) Last year, major reforms were adopted to the Medicaid nursing home rate methodology. The low-acuity penalty (penalty) was not part of that reform and is one of the last pieces that needs to be put into effect. When the hold-harmless provisions of the old methodology were removed, the impact of the penalty was realized. The penalty would affect 46 percent of Medicaid nursing home residents, and is anticipated to impact 78 percent of nursing homes in the 2017-19 biennium and 97 percent in the biennium beyond that. When the penalty was adopted in 2011, no one knew the scope and financial impact it would have. Retaining the penalty would risk breaking the new rate methodology that connects price and acuity.

Under federal law, nursing homes cannot discharge residents who wish to stay and would have to pay the penalty on behalf of the residents who cannot be discharged. Although some residents who would be subject to the penalty can successfully live in a community placement, others cannot. Residents in the RUGs that would be exempt from the penalty have significant physical disabilities, including residents who are totally dependent on nursing home staff for bed mobility, transfer, and toileting. In addition, there is a 90–100 day wait period for a nursing home to find an adult family home or assisted living placement for a resident, and it must pay the penalty on behalf of the resident during the waiting period.

Residents with mental and behavioral health issues would also be exempt from the penalty, which would remove the disincentive for placing these residents in nursing homes. Increasing the weighting for residents with mental and behavioral health issues will incentivize nursing homes to serve these residents, such as those who may be discharged from state psychiatric hospitals.

(Opposed) None.

(Other) The removal of the penalty should be looked at in the bigger context of the state's mental health needs and how nursing homes and other providers can be incentivized to serve clients with mental health needs. It is also important for funding to support the need for quality staff in nursing homes, particularly to support clients with mental health needs.

Persons Testifying: (In support) Jeff Gombosky and Robin Dale, Washington Health Care Association; Scott Sigmon, Leading Age Washington; Colleen Marlatt, Cornerstone Consulting; Nikole Jay, Judson Park; and Vineeta Chand, Panorama.

(Other) Nick Federici, Service Employees International Union 775.

Persons Signed In To Testify But Not Testifying: None.