SENATE BILL REPORT
SB 5715

As of February 22, 2017

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: Senators Rivers, Keiser, Cleveland, Becker, Hunt, Billig, Bailey and Kuderer.

Brief History:
Committee Activity: Ways & Means: 2/21/17.

Brief Summary of Bill

- Exempts certain residents in nursing facilities from a rate penalty.
- Provides an exception from a rate penalty if community placements are not available.
- Authorizes a rate adjustment for nursing facility residents with behavioral or cognitive needs.
- Updates references to the classification grouping system for nursing facility residents.

SENATE COMMITTEE ON WAYS & MEANS

Staff: James Kettel (786-7459)

Background: There are approximately 210 skilled nursing facilities licensed in Washington to serve about 10,000 Medicaid-eligible clients. Skilled nursing facilities 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

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unique to each facility and are generally based on the facility's allowable costs, occupancy rate, and client acuity, sometimes called the case mix.

The nursing home rate methodology, including formula variables, allowable costs, and accounting/auditing procedures, is specified in statute (RCW 74.46). The rates are primarily based on calculations for three different components: direct care, indirect care, and a capital component. Noncapital components are calculated based on facility cost reports and are typically updated biennially in a process known as rebasing. The capital component is also calculated by using facility cost reports but is rebased annually. Facilities may also qualify for a rate add-on if they meet established quality criteria.

Resource Utilization Groups. The nursing home rate methodology utilizes a classification system to align Medicaid payments with the resource needs of nursing home residents. Resource Utilization Groups (RUGs) are derived from data within specific sections of the federal Minimum Data Set (MDS). The MDS assesses a resident's therapy needs, Activities of Daily Living (ADL) impairments, cognitive status, behavioral problems, and medical diagnosis. Ultimately, each client receives a weighted score that approximates the nursing needs, and the ADL needs, for the client. Typical ADL needs include bed mobility, transfer, and toilet use.

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

The RUG codes that begin with a "B" indicate that the resident's resource use is driven primarily by behavioral symptoms and cognitive performance.

Legislative Actions. In the 2011-13 biennial budget—ESSB 5581 (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 rate modification is sometimes called the 13 percent penalty, or low-acuity penalty. The rate modification was assumed to generate ongoing savings of $22.6 million total funds—$11.3 million General Fund-State—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 that mitigated the impact of the reduced reimbursement. This rate add-on was called the comparative add-on.

In SHB 1274 (2015) and SHB 2678 (2016), the Legislature modified the nursing home rate methodology, effective July 2017. These modifications reduced the number of rate components, including removal of the comparative add-on.

In 2ESHB 2376 (2016), the 2016 supplemental budget included proviso language that temporarily exempted five of the 10 RUG categories, PC2 through PE2, impacted by the 13 percent penalty. This proviso was cost neutral for fiscal year 2017. To maintain cost-neutrality, DSHS was given the authority to cap the direct care component of the nursing home rate at 118 percent over 2014 direct care costs, move less acute residents to community

placements, utilize available funding from case mix adjustments, and increase the penalty on non-exempt RUG categories, if needed. The proviso language will only be in effect for fiscal year 2017.

Summary of Bill: The low-acuity penalty is modified. Residents in RUG codes PC2 through PE2 are exempt. Residents in the RUG codes PA1 through PB2 are still subject to the penalty, unless a resident also presents with behavioral RUG codes. Exceptions to the penalty are permitted 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.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill cleans up the last vestiges of the nursing facility payment system that imposed a 13 percent acuity penalty on ten resident groups. Without passage of this bill, 46 percent of residents will be subjected to an acuity penalty in their clinically assessed acuity scores. These scores are used to establish payment rates. The bill eliminates the acuity penalty on six of the ten groups. Residents in these six groups have significant physical care needs, including residents who are totally dependent on nursing home staff for mobility, transfer, eating, and toileting. Generally, these residents are not appropriate for community based care. Therefore, the penalty does not act as an incentive to discharge these residents, and instead simply acts as a penalty. The bill maintains the penalty on four of the original groups, but excludes residents with behaviors or residents without community placement options. The bill allows DSHS to increase acuity scores for residents with behavioral or mental health needs. The goal is to further incentivize placement option for clients with behavioral health needs, including residents currently living at Western State Hospital or Eastern State Hospital. The low-acuity penalty represents a serious threat to residents and also nursing home providers. If allowed to fully go into effect, then the penalty will impact nearly one-half of the entire nursing home population. Almost 78 percent of facilities will see their rates drop in Fiscal Year 2018, and about 97 percent of facilities will see their rates drop in Fiscal Year 2020. This bill attempts to right the ship by narrowing the focus of the penalty to only those clients who are lower acuity and in a position to be placed in a community based setting. The remainder of clients were inaccurately placed into the penalty from the beginning, and need to remain in a skilled nursing facility. A new payment system will soon be in effect, and we do not want to move into the new system already broken. The ten RUG groups included for the low-acuity penalty are not the ten lowest acuity client groups. Some of the clients in these RUG groups require pretty heavy care. The RUG scores may just look like groups. However, as a nurse,

it is clear that residents in these RUG groups cannot be placed into community settings. Residents have a right to remain in a facility under federal regulations and also state regulations.

Persons Testifying: PRO: Robin Dale, Washington Health Care Association; Jeff Gombosky, Washington Health Care Association; Laura Hofmann, Leading Age Washington; Scott Sigmon, Leading Age Washington.

Persons Signed In To Testify But Not Testifying: No one.