

# Nursing Home Reimbursement

## Long-Term Care Overview

The state, through the Aging and Disability Services Administration in DSHS, funds services to eligible persons in nursing homes, community residential settings, and in the home. State funding is provided as reimbursement to long-term care providers for allowable costs of care of persons eligible for Medicaid, the state-federal program of health coverage for needy and disabled people.

Nursing homes make up a diminishing portion of the state-funded infrastructure of long-term care services. Over the last couple of decades the number of persons served through community care (including home care) has risen rapidly, while the number served in nursing homes has declined. From fiscal year 1996 through FY 2008, the number of clients served in community care has increased by 18,556, or 89 percent. Over the same time the number served in nursing homes has declined by 4,665, or 29 percent. Nursing Homes made up 43 percent of the DSHS-Long-Term Care caseload in FY 1996, compared to a forecast 21 percent in FY 2007.

Of the principal long-term care settings, nursing facilities typically offer the most support for a client, but at the highest average cost. For FY 2008, monthly per capita costs by setting are an estimated \$4,095 for nursing homes, \$1,331 for community residential facilities, and \$1,430 for in-home care. (See Issues Brief, Long-Term Care.)

## Background: Nursing Home Payment System

The system for determining payments to nursing homes is highly complicated. Reimbursement of facilities for Medicaid patients is made through a daily, per patient rate made up of several component rates, each calculated differently. More than half of the rate is for *direct care*, which pays for wages and benefits for nursing staff and for medical supplies. Other rate components include *support services*, such as food and laundry; *operations*, which covers such costs as utilities and administration; *property* (or capital), a depreciation allowance for buildings and equipment, and a *variable rate of return*, which does not reimburse for a specific cost but instead provides an efficiency incentive for facilities that serve residents at the lowest cost per resident day.

The method for determining nursing home payment rates has gone through major changes since the mid-1990s. The current reimbursement system originates in changes initiated by the 1994 Legislature. Members were concerned about the rapid increase in state expenditures for long-term care, with three-fourths of that growth stemming from higher costs per person served rather than from larger caseloads. The Legislature found that nursing home payment rates were growing much faster rate than medical inflation, and also much faster than the overall budget growth allowed by the I-601 spending limit enacted the year before.

The nursing home payment system in place at that time was *prospective, cost-based, and facility-specific*. This means that each facility received a rate payment unique to that facility and linked to its specific costs. Payments were based on an individual facility's expenditures up to a limit (or "ceiling"), and then often indexed for inflation. The amount paid to each facility was

determined in advance of when its actual costs were known. This system of payment, protected by a federal law known as the Boren Act, had incentives for higher expenditures by nursing facilities, penalized efficient use of resources, and did not link payment for services to the actual care needs of patients.

Legislation passed in 1993 directed the Legislative Budget Committee (now JLARC) to assess the financial stability of the nursing home industry, evaluate the adequacy of the reimbursement system for promoting cost-effective care, and recommend improvements to promote quality care.

In *Nursing Home Reimbursement* (Report 94-4), LBC found:

- The state's system of nursing home reimbursement was not cost-effective;
- The system created an incentive for nursing homes to increase spending;
- Reimbursement rates were higher than the national average and the national median rates;
- Reimbursement rates were not correlated with client acuity (that is, with care needs), or with the geographic location of the facility;
- Frequent "rebasings" of rates, or setting payment rates equal to a facility's allowable costs, tended to increase costs;
- The nursing home industry was financially stable.

The Legislature directed DSHS to develop a plan to control growth in long-term care expenditures, including a reduction in the rate of increase in nursing home payments.

In **ESHB 1908** (C 18 L 95), the Legislature sunset the state's cost-based system of nursing home reimbursement and required that any payments made to nursing facilities from FY 1999 forward be based on a new system. The new system "shall include case-mix reimbursement methods for paying for nursing services and shall design and develop alternative methods for matching nursing facility payments to patient care needs, while providing incentives for cost controls and efficiencies."

The new payment system was developed over the next three years and implemented in the 1998 Session by **E2SHB 2935** (C 322 L 98). E2SHB 2935:

- Established, effective 10/98, a "case mix" system in which payments to facilities are matched to specific measures of patient care needs.
- Established six rate components with limits, or "ceilings," on each. Each facility would be paid the lower of their actual cost of providing a component of care, or the ceiling for that component.
- Held facilities harmless for any reduction in the direct care rate through 6/02.
- Provided for a maximum average daily rate to be set by the Legislature in the budget act. If that rate were exceeded, all rates would be reduced proportionately to stay within the maximum. (This became known as "the budget dial.")
- Reduced the minimum occupancy rate used for setting costs per day from 90 percent to 85 percent, so as not to overpay facilities for empty beds.
- Sunset the methodology for the capital payment rate.

There have been significant adjustments since then to the system established by HB 2935. For example, **SHB 2242**, passed in 2001 (C 8 L 01 E1), made the capital payment system permanent, returned the minimum occupancy requirement to 90 percent for the purpose of calculating the

operations and capital rate components, and established a case mix “corridor” at 90 to 110 of peer group median rates. Payment rates to individual facilities could not fall below the “floor” or above the “ceiling” of this “corridor.”

### **2003 -- The “Bed Tax”**

To avoid reductions and support rate increases in the cash-strapped 2003-05 biennium, the 2003 Legislature passed E2SSB 5341 (C 16 L03 E1), which assessed an industry-proposed quality maintenance fee, or “bed tax,” on skilled nursing facilities at \$6.50 per patient day. It directed DSHS to request a waiver of federal Medicaid rules to exempt state-operated facilities, public hospital districts, and facilities with low numbers of Medicaid clients from the fee. The fee was expected to generate \$78.2 million in the biennium, and enabled the Legislature to increase nursing home payment rates by a total \$91.7 million, rather than reducing funding as proposed by Gov. Locke. A portion of the revenue raised would reimburse Medicaid facilities for the \$6.50 per patient day fee, and the rest would fund a 3 percent increase in the non-capital portions of the rates. The federal government initially balked at the waiver request, but eventually approved a modified waiver in which 17 more facilities were exempted than in the original request.

There were strong complaints by the industry subsequently that the full amounts of revenue raised by the bed tax had been not plowed back into rate increases. At the same time, the use of such mechanisms by the states to secure increased Medicaid funds was coming under increased scrutiny by the federal government. The omnibus revenue bill of 2005, ESHB 2314, provided for a phased repeal of the nursing home bed tax adopted in 2003. Under HB 2314, the fee would be phased down over three biennia and eliminated on July 1, 2111. That reduced revenue by \$2.7 million in the biennium, with a corresponding reduction in the portion of the nursing home payment rate that covered the fee for state-funded patients. The 2006 Legislature opted not to wait for the phase-out and in SB 6368 repealed the bed tax entirely, effective July 1, 2007.

### **2006 -- EHB 2716**

During the 2005 interim, nursing home providers voiced strong concerns about inadequate state payments to facilities as reimbursement for Medicaid patients. In testimony to the Joint Executive and Legislative Task Force on Long-Term Care, the Washington Health Care Association (WHCA) stated that “The greatest threat to a viable long term care system in Washington is the chronic, ongoing and persistent underfunding of Medicaid care . . . Inadequate payment and cost-shifting to private payers is a formula for disaster.” (*Member Alert*, Nov. 3, 2005.)

The industry pointed to what it said was a large and growing gap between costs of care and Medicaid reimbursement. Inadequate payments, it said, was causing increasing numbers of nursing homes to close down around the state, leaving some areas short of access to services. The problem would become worse, WHCA said, as the senior population grows and the need to care for the frail and sick in congregate settings increased. The industry expressed particular concern that there had been no full “rebasings” of payment rates to reflect actual costs since July 1999.

In a December 2005 fact sheet, DSHS disputed the industry contention that nursing home closures reflected a “crisis in nursing home care” and were due primarily to low Medicaid payment rates. The Department said that while many factors may contribute to the closures, the primary cause was a low rate of occupancy – too many facilities with too many empty beds.

“The inability to attract sufficient residents to maintain efficiencies and economies of scale is far more detrimental than any perceived lack of Medicaid payment,” the Department said. It noted that Washington’s payment rates had consistently been in the top third nationally.

**HB 2716** was enacted in response to industry concerns that Medicaid rates were inadequate and the payment system needed to be changed. The bill moved the payment system away from some of the features of the case mix system put in place in 1998:

- Rebased the direct care and operations component rate allocations to facilities based on calendar year 2003 cost reports.
- Removed the minimum occupancy standard used for determining costs per day in calculating the direct care component of the rate. The rate would now be based on actual facility occupancy.
- Expanded the case mix corridor by eliminating the corridor floor and increasing the corridor ceiling.
- Established a new category of facility called “vital local providers,” defined as nursing facilities with a home office in the state that have a large number of Medicaid patient days. The vital local providers would receive the greater of their (a) their June 30, 2006 direct care and operations component rate allocations, or (b) the direct care and operations component allocations for which they would qualify under the standard payment system.

### **2007 – Joint Task Force on Long-Term Care Payment Systems**

The 2007-09 operating budget act, HB 1128, established a Joint Legislative Task Force on Long-Term Care Residential Facility Payments. The duties set out for the Task Force in the budget proviso were the following.

- Review the current payment methodology for nursing homes, boarding homes and adult family homes, giving strong consideration to a set of principles that included (1) consumer choice among a continuum of residential care settings; (2) payment methodologies that are based on resident acuity, that recognize the impact of state and federal regulatory impacts, that support retention of qualified direct care staff, and that are linked to performance measures.
- Review and consider recommendations submitted by an independent contractor for revisions to the current Medicaid payment methodology for nursing homes.
- Consider input from long-term care “stakeholders.”
- Make recommendations for revisions to, restructuring of, or replacement of existing payment methodologies to the Legislature by December 31, 2007, consistent for FY 2009 with amounts appropriated in the budget for payment increases.

The report to the Task Force by contracted consultants from Brown University recommended several major changes to the current payment methodology:

- 1) Simplify the system by collapsing the several components of the current payment rate into a relative few.
- 2) Modify the capital component of the rate by replacing the current method, which makes payments for depreciation and interest on real property, with a “fair rental” approach that pays a simulated rent on the appraised value of a facility’s assets.
- 3) Add a new component to the payment rate that rewards nursing homes for good performance along a series of performance indicators.
- 4) Make additional, facility-specific Medicaid reimbursements on an annual basis to achieve certain policy objectives, outside the formula-driven calculation of the payment rate.
- 5) Rebase rates to audited costs at least once every three years, making the actual date of rebasing uncertain so as not to give providers an incentive to inflate costs in the rebasing year.
- 6) Improve the quality of case-mix acuity data.
- 7) Phase in these changes over several years, while examining their impacts.

The Task Force got off to a slow start, and failed to give much attention to some of the topics mandated for its study, particularly as regards community residential facilities. The final report made the following recommendations with regard to nursing home payment.

- Continue the task force through 2009 to do more analysis of the impacts of the Brown recommendations and provide a forum for comments on final recommendations.
- Sunset the current statute on nursing home reimbursement, replacing it with new law setting an overall framework for reimbursement and authorizing DSHS to develop and administer a new payment system within that framework.
- Direct DSHS to develop a proposal for a simplified nursing facility payment system, to include an assessment of impacts on the budget and client services. The task force specified certain elements that should be in the new system, including continuation of rebasing and pay for performance outcomes.
- Direct DSHS to review and report to the Legislature on the costs and benefits of moving to a fair rental system for the capital component of the rate.

Republican members objected to the proposal to sunset the present nursing home reimbursement statute, as well as what they believed to be insufficient opportunity for provider consultation in the development of a new payment system, and did not join in the final report.

**HB 2692**, Creating a new nursing facility payment system, was introduced in the 2008 Session to implement the recommendations of the Joint Legislative Task Force. The legislation would:

- Repeal the nursing facility payment statutes that are related to non-capital payments, effective July 1, 2009, and the statutes related to capital payments effective July 1, 2010.
- Require DSHS to develop a new nursing facility payment system.

- Give DSHS authority to adopt rules for a new payment system if the 2009 Legislature does not enact the department's proposal or another payment system.
- Re-establish the Task Force through January 1, 2010.

HB 2692 was abandoned when the Appropriations Committee failed to reach bipartisan agreement on an approach to development of a new payment system. An effort to incorporate HB 2692 in the supplemental operating budget bill was dropped as well.

In the absence of a legislative directive, DSHS's Aging and Disability Services Administration is working on its own during the 2008 interim to create a simplified framework for the nursing home payment system with the objectives of improving accountability for outcomes and making the system easier to understand. The department is working on the premise that any proposal it may develop for a new payment system will be budget neutral. Organizations representing for-profit and nonprofit nursing home providers and employee groups are participating in the discussions.

### **Summary: Recent Rate Increases for Nursing Homes**

In addition to the payment rates that nursing facilities receive for Medicaid clients through the case mix system that is set in statute, the Legislature often also provides across-the-board vendor rate increases, as it does for private providers of other kinds of state services. Recent nursing home rate increases from legislation or budget actions include:

**1999** – The 1999-01 biennial budget provided \$12.6 million General Fund-State, \$26.2 million Total Funds to increase most nursing home payment rates an average 2.1 percent per year.

**2000.** The 2000 supplemental budget included \$3.4 million state funds, \$6.9 million total funds for an additional 1 percent increase in the direct care rate for those facilities not paid in accordance with case mix.

**2001.** The 2001-03 biennial budget provided \$19.3 million state funds, \$38.9 million total funds to increase nursing home payments an average 4.4 percent per year.

**2003.** The 2003-05 biennial budget included \$91.7 million for a 3 percent increase in non-capital rates, supported by a quality maintenance fee. (See discussion.)

**2005.** The 2005-07 biennial budget provided \$10.1 million state funds, \$21.9 million total funds to increase all but the capital component of the nursing home rate by 1.3 percent in July 2005 and 1.3 percent in July 2006.

**2006.** The 2006 supplemental budget added \$10.1 million state funds, \$20.1 million total funds for EHB 2716.

**2007.** The 2007-09 biennial budget provided \$29.1 million NGF-S, \$60.7 million total funds to rebase rates under ESSB 6158 (C 508 L 07), hold facilities harmless for any decreases resulting from re-basing, increase non-capital rates by 3.2 percent, and provide an additional \$8.8 million state funds, \$18 million total funds for unspecified rate increases in FY 2009 to come from recommendations of the newly established Joint Legislative Task Force.

**2008.** The 2008 supplemental budget adds \$3.0 million NGF-S, \$6.1 million total funds as an add-on payment rate to nursing homes with Medicaid clients to increase compensation for low-wage workers. It also directed the expenditure of the \$18 million set aside for rate increases in the original biennial budget, with about half the total going for 1.99 percent rate increases for direct care, therapy care, support services and operations.