Washington State Department of Social & Health Services

Improving the Nursing Home Rate Structure

Aging and Long-Term Support Administration

Background

Per the request of Representative Cody, the Department is submitting a model for a vastly simplified nursing home rate structure which is cost-based, rather than cost reimbursement-based. The current system reimburses nursing homes for their facility-specific expenditures; this is a complex process and drives considerable administrative work for both the Department and the providers. The new system would be primarily based on industry-wide costs with three main components: direct care, indirect care, and capital. The direct care and indirect care components will be centered on median industry-wide costs, which will be rebased every two years. The median costs will result in a flat rate for the direct care and indirect care cost components. The direct care component will be performance-adjusted for acuity (case mix). The capital component will be based on a fair market rental system. In addition, a quality rate enhancement will be added for facilities that meet or exceed performance standards. The current Safety Net Assessment (SNA) will continue. The basis of the new system methodology will be placed in RCW with the specific details written in WAC. The Legislature will control both the overarching principles and the funding for the system.

Details

- The **direct care component** encompasses the old components of direct care and therapy care as well as food, laundry, and dietary services. The component will be at the industry median with no minimum occupancy applied. The direct care component will be case mix adjusted every six months.

- The **indirect care component** includes the old components of administrative, maintenance costs, and housekeeping services. A minimum occupancy of 90% will be applied and the component will be at 90% of the industry median.

- The **capital component** fair market rental system sets a price per bed. The component is adjusted for facility age and minimum occupancy at 90%.

- Direct care and indirect care will be regionally adjusted for non-metropolitan and metropolitan statistical areas.

- There will not be any settlement of costs for any component.

- This model assumes there will be minimum staffing ratios for aides and licensed staff.

- A key piece of this new system will be a quality incentive for facilities that meet or exceed the established standard. The quality incentive will look at “days out of compliance” for each facility. Each facility will receive a rate enhancement unless they are categorized as “out of compliance” by Residential Care Services for more than a specified number of days during the calendar year. Additionally, the overall quality standard will be tied to performance based on the Federal 5-Star Quality Rating System.

Starting SFY17 the legislature modified the Nursing Facilities Payment Methodology with the passage of SHB 2678.

Briefly, these changes include:

- Going forward there are three main rate components: direct care, indirect care, and capital. Additionally there is a quality incentive component and for the next three rate years a hold harmless component. The Safety Net Assessment from prior rate settings will continue unchanged.

- Direct care is the industry median direct care cost per case mix unit adjusted by a county specific wage index and case-mix adjusted with the facility specific Medicaid Case Mix Index. The direct care median includes 2014 Medicaid cost report costs for direct care, therapy, food, laundry, and dietary.

- The Case Mix data used in the direct care rate calculation is Minimum Data Set (MDS) 3.0, Resource Utilization Group (RUG) IV, and Grouper 57.

- Indirect care is 90% of the industry indirect median. The indirect care median includes 2014 Medicaid cost report costs for administrative, maintenance, and housekeeping.

- Capital is a facility specific Fair Market Rental calculation updated yearly and is based on a series of inputs and formulas (for example RS Means data, 2015 square feet, 2015 facility age, 2015 renovations, current licensed beds, regional adjustments, 2015 patient day occupancy at a minimum of 90%, etc.).

- Quality incentive is a quality measure that facilities may earn by doing well on predetermined CMS quality measures of Long-Stay Pressure Ulcers, Urinary Tract Infections, Self-Reported Pain, Falls with Major Injury, and the CMS Quality Five Star Rating. Currently it is an average 1% of the rate; in the future it may be up to 5% of the rate.

- Hold harmless is a component for three years to ensure that any facility will not see a rate reduction of more than 1% in Fiscal Year 2017, 2% in Fiscal Year 2018, and 5% in Fiscal Year 2019 when compared to the rate in effect 6/30/2016 (Fiscal Year 2016 ending rate).

- There is a requirement that facilities have a minimum of 3.4 hours per resident day of direct care staff. The staff that are counted are direct care staff as defined by the CMS Payroll Based Journal. Facilities may also count geriatric behavioral health workers towards their total direct care hours if the workers meet certain criteria.

- Large non-essential community providers (more than 60 beds and not more than forty minutes away from another nursing facility by car) must have an RN on staff 24 hours per day. All other facilities remain at the current standard of 16 hours of RN staff and the remaining 8 with an LPN or RN.

For SFY17 Budget Proviso in 2ESHB 2376 modified the Low RUG score reduction. Additionally further consideration was made to modify the Low RUG score reduction to only the following:

- RUG classifications PA1 through PB2 are reduced by 13% if behaviors are not indicated on assessment form.

- Direct Care is capped at 118% of 2014 Direct Care cost.

- A facility must notify state case managers if a resident is identified as a PA1 through PC1 resident.

- During SFY1 7, facilities shall work collaboratively with the Department to find community alternate settings for 96 residents classified PA 1 through PC 1 who are willing to transition into other community alternatives. Should the Department determine facilities are not making sufficient progress by the end of the first two quarters of FYI 7, the 13% reduction will raise to 20% for the lowest 4 RUG classifications PAI through PB2.