Analysis of the Washington Nursing Facility Medicaid Payment Methodology

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**Introduction**

Navigant Consulting, Inc. was engaged by the Washington State Department of Social and Health Services (DSHS), also referred to as “the Department”, to conduct an analysis of the current Medicaid payment methodology and rates paid for nursing facility services relative to the efficiency, accessibility and the quality of care standards established under Federal requirements. The Federal requirements that apply to the methods states employ to pay for Medicaid services, which are described in U.S.C. § 1396a (a)(30)(A), specify that a state plan for Medical Assistance (referred to herein as Medicaid) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

As such, our analysis focused on an evaluation of the current Washington Medicaid payment methodology and related rates for nursing facilities relative to consistency with efficiency and economy, and access to care and quality of care in Washington State. The rates analyzed in this report are for State Fiscal Years (SFYs) 2018 and 2019.

# Section I: Overview of Current Medicaid Payment Methodology

This section describes the current Medicaid payment methodology for nursing facilities in Washington. This description is intended to provide a high level overview of how payment rates are set for Medicaid residents in nursing facilities. Medicaid rates are facility-specific in Washington and are related to the Medicaid costs of providing services, occupancy levels and the resource needs of individual residents.

**Current Methodology**

In 2015, the Department proposed a significantly simplified reimbursement rate structure for nursing facilities for rates effective SFY 2017, and the simplified reimbursement rate structure was approved by Legislature through House Bill 2678. This new reimbursement methodology, effective July 1, 2016, is a price and measured payment structure with four components: direct care, indirect care, capital, and quality-enhancement measures.

The direct care component reflects costs associated with direct nursing care, therapy care, food, laundry, and dietary services. This component is set at the statewide median costs based on calendar year 2014 cost report data and will be adjusted every six months to reflect case-mix, and will subsequently be rebased every two years. The direct care component is also adjusted regionally based on county wage index data published by the Bureau of Labor Statistics (BLS).

Under the new reimbursement methodology, the direct care component of the rate will be subject to a settlement process. However, it should be noted that the Legislature will review the value of the settlement under the new payment methodology and may discontinue this process after the 2017 to 2019 fiscal biennium.

The indirect component of the rate reflects costs associated with administrative, maintenance, and housekeeping services. The indirect rate component is set at 90 percent of the statewide median costs based on calendar year 2014 cost report data and a minimum occupancy assumption of 90 percent is applied. As with the direct care rate component, the indirect component will be rebased every two years.

The capital component is based on a fair market rental system. Under this system, a fair market price per bed is established that is adjusted for the age of the facility, and providers are then paid an amount that represents the rental value of the property. In this case, the rental rate is 7.5%. The capital component is also adjusted for occupancy and assumes a minimum occupancy of 90 percent.

In addition to the rate components described above, a quality rate enhancement will be added for facilities that meet or exceed performance standards beginning on July 1, 2016. More specifically, a quality standard, tied to performance based on the Federal 5-Star Quality Rating System, will be established. Facilities will qualify for a rate enhancement based on how the facility scores based on a set of specific quality measures. Facilities will then be assigned to tiers based on how many points they score in the identified quality measures. The quality incentive payment received by a facility will be determined based on the tier the facility assigned to. The quality enhancement must be no less than one percent and no larger than five percent of the statewide average daily rate reimbursed to facilities that meet or exceed the standard for receiving a quality incentive. This quality incentive will be adjusted semiannually on July 1 and January 1 of each year.

For more information on how the estimated SFY 2018 and SFY 2019 rates were calculated by DSHS for the purposes of this report, please refer to Appendix A and B.

Budget Dial

Over and above all the rate setting methodologies provided in both the statutes and regulations, there is the budget dial imposed by RCW 74.46.421. In the biennial appropriations act, the Legislature sets a statewide weighted average maximum nursing facility payment rate for each state fiscal year. By statute, DSHS is required to adjust rates for all Medicaid participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate approaches these limits. The budget dial ensures that total Medicaid nursing facility spending does not exceed the amount appropriated by the Legislature. The state’s operating budget set the budget dial rate for SFY 2018 at $197.08 and at $204.94 for SFY 2019.

# Section II: Access to Care

In this section, we analyze the availability of nursing facility beds in Washington as a way to determine if barriers to access exist for Medicaid eligibles requiring nursing facility care. We analyze access to care primarily using two measures: nursing facility occupancy rates and the number of per capita nursing facility beds for the aged population. We analyze these metrics looking at trends over time, and in comparison to other states.

The analysis will suggest whether the current Medicaid payment methodology has resulted in access concerns for Medicaid beneficiaries and for Washington residents in general. The analysis will also suggest whether there are sufficient numbers of nursing facilities willing to provide services at the rates Washington pays to assure that Medicaid beneficiaries have access to care.

**Washington Nursing Facility Capacity and Occupancy from 2006 to 2015**

Nursing facility capacity can be measured by the number of beds days available.[[1]](#footnote-1) Table 2.1 shows the number of nursing facilities in the state, the total number of nursing facility beds and total available bed days for the ten years from 2006 to 2015. This table shows that the number of beds and available bed days in recent years have decreased slightly. The analysis in Table 2.1 excludes closed facilities and facilities that did not serve any Medicaid residents during 2015.

**Table 2.1: Nursing Facility Capacity in Washington 2006 – 2015**

|  |  |  |  |
| --- | --- | --- | --- |
| **Calendar Year** | **Number of Facilities** | **Number of Beds at Year End** | **Number of Bed Days Available** |
| 2006 | 234 | 21,577 | 7,843,865 |
| 2007 | 231 | 21,329 | 7,785,085 |
| 2008 | 227 | 21,574 | 7,896,084 |
| 2009 | 221 | 21,134 | 7,611,452 |
| 2010 | 210 | 20,776 | 7,583,240 |
| 2011 | 211 | 20,869 | 7,617,185 |
| 2012 | 213 | 20,762 | 7,578,130 |
| 2013 | 209 | 20,600 | 7,519,000 |
| 2014 | 207 | 20,297 | 7,408,405 |
| 2015 | 207 | 20,061 | 7,018,794 |

Source:

Number of Facilities, Number of Beds at Year End and Number of Bed Days Available were determined from data provided by the Department.

It is important to note that the number of beds available in Washington is affected by State law, as codified in the Washington Administrative Code (WAC). The WAC describes the State’s Certificate of Need (CON) policy that requires demonstration of a need for new beds before a nursing facility license can be approved. For new licensed beds to be approved, a provider must demonstrate a need for new beds, with the criterion for comparison being 40 nursing facility beds per 1,000 population aged 70 and older. This criterion, which was established effective October 6, 2008 (the previous criterion was 40 beds per 1,000 population aged 65 and older) was modified at the urging of the State’s nursing home industry. The State, working jointly with the industry, determined that this standard would be sufficient to assure access to services in Washington.

Table 2.2 shows nursing facilities’ total resident days, total Medicaid resident days and the average Medicaid utilization rate, that is, Medicaid’s share of total resident days for 2006 through 2015. Total resident days decreased 17.32 percent over this period. The Medicaid utilization rate also decreased slightly between 2006 and 2015 (from 63.1 percent to 60.22 percent), but has for the most part remained fairly constant over the years analyzed. Washington’s continued effort to expand community long-term care options is an important reason for the decrease in nursing facility utilization.

**Table 2.2: Nursing Facility Medicaid Utilization in Washington 2006 – 2015**

|  |  |  |  |
| --- | --- | --- | --- |
| **Calendar Year** | **Number of Total Resident Days** | **Number of Medicaid Resident Days** | **Average Medicaid Utilization Rate** |
| 2006 | 6,866,473 | 4,330,720 | 63.1% |
| 2007 | 6,755,338 | 4,149,481 | 61.4% |
| 2008 | 6,632,100 | 4,028,671 | 60.7% |
| 2009 | 6,369,275 | 3,886,492 | 61.0% |
| 2010 | 6,122,754 | 3,592,405 | 58.7% |
| 2011 | 6,120,296 | 3,685,180 | 60.2% |
| 2012 | 6,085,563 | 3,656,784 | 60.1% |
| 2013 | 5,956,826 | 3,549,713 | 59.6% |
| 2014 | 5,986,227 | 3,515,615 | 58.7% |
| 2015 | 5,676,946 | 3,418,496 | 60.2% |

Source:

Number of Total Resident Days, Number of Medicaid Resident Days and Average Medicaid Utilization Rate were determined from data provided by the Department.

Nursing facility occupancy rates measure the extent to which existing beds are filled with patients. Thus, occupancy rates are one of the metrics that can be used to measure the industry’s efficiency – how well physical plants are utilized. Occupancy rates can also be indicators of whether there is sufficient nursing facility capacity to meet the population’s demand for services. High occupancy rates may suggest potential access problems as people seeking nursing facility services may face difficulty in finding a bed.

Table 2.3 shows the average occupancy rates in Washington nursing facilities in 2006 through 2015, and the number of unfilled nursing facility beds on an annual and daily basis.

**Table 2.3: Nursing Facility Occupancy Rates and Unfilled Beds in Washington 2006 - 2015**

|  |  |  |  |
| --- | --- | --- | --- |
| **Calendar Year** | **Average Occupancy Rate** | **Number of Unfilled Beds Days** | **Average Number of Unfilled Beds per Day[[2]](#footnote-2)** |
| 2006 | 87.5% | 977,392 | 2,678 |
| 2007 | 86.8% | 1,029,747 | 2,821 |
| 2008 | 84.0% | 1,263,984 | 3,454 |
| 2009 | 83.7% | 1,242,177 | 3,403 |
| 2010 | 80.7% | 1,460,486 | 4,001 |
| 2011 | 80.3% | 1,496,889 | 4,101 |
| 2012 | 80.3% | 1,492,567 | 4,089 |
| 2013 | 79.2% | 1,562,174 | 4,280 |
| 2014 | 80.8% | 1,422,178 | 3,896 |
| 2015 | 80.9% | 1,341,848 | 3,676 |

Source:

Average Occupancy Rate, Number of Unfilled Bed Days and Average Number of Unfilled Beds per Day were calculated using data provided by the Department.

The average occupancy rate for nursing facilities in Washington has fluctuated and declined over the period of 2006 to 2015. The 2015 average occupancy rate of 80.9 percent means that on average there were 3,676 empty nursing facility beds per day across the state.

**Washington Nursing Facility Capacity and Occupancy by County, For 2015**

To assess whether Medicaid beneficiaries in all areas of the state have sufficient access to nursing facility services, we analyzed the distribution of nursing facility beds and utilization at the county level.

In 2015, the number of nursing facilities per county ranged from 1 in Asotin, Columbia, Franklin, Island, Jefferson, Kittitas, Pacific, Pend Oreille and San Juan counties to 52 in King County. Exhibit 2.1 shows that the number of beds per county, for counties with at least one nursing facility, ranged from 34 to 5,643 beds. As expected, the most urban and populous counties of King, Pierce and Snohomish have the most nursing facility beds. Of the eight counties with only one facility, the bed count ranges from 34 in Columbia to 125 in Franklin.

Currently, Ferry, Lincoln, Klickitat, Douglas and Skamania counties do not have nursing facilities; however, each county supports Medicaid eligible residents by other means through adult family homes and assisted living. There are nine adult family homes in Klickitat with a total of 46 beds, Lincoln has two homes with 12 beds, Douglas has eight homes with 45 beds, Ferry has one home with 6 beds, and Skamania has one home with 4 beds. There are four assisted living facilities in Douglas County with 262 beds, one in Ferry County with 16 beds, two in Lincoln with 28 beds and one in Skamania with 36 beds.

Garfield and Wahkiakum counties have no nursing facilities, adult family homes or assisted living facilities. These two counties are not very populous counties and between the two have approximately 6,000 people. It should also be noted that a lack of residential facilities in a county does not necessarily mean that there are no services available to individuals requiring care. Personal care services are available in every county in Washington and individuals can arrange for services to be provided to them.

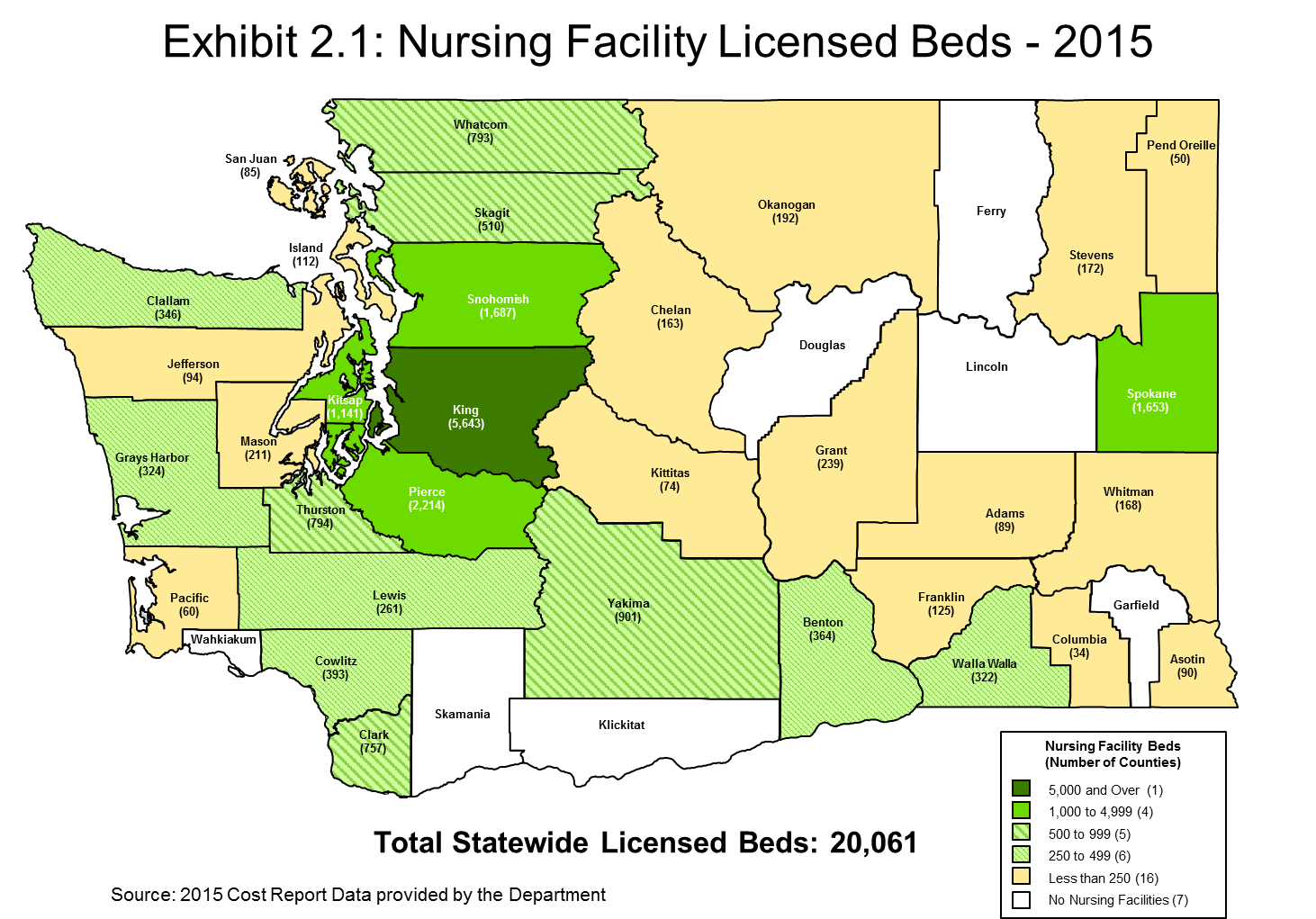


Exhibit 2.2 shows the average nursing facility occupancy rates in each county in 2015. At the county level, average occupancy rates ranged from a low of 49.7 percent to a high of 94.8 percent. Twelve of the state’s 39 counties have an average occupancy rate for nursing facilities in 2015 between 80 percent and 95 percent.

There were six counties with average occupancy rates of 85 percent or greater in 2015 (Kitsap, Pend Oreille, Snohomish, Spokane, Stevens, and Yakima) with the highest being 94.8 percent (Pend Oreille).

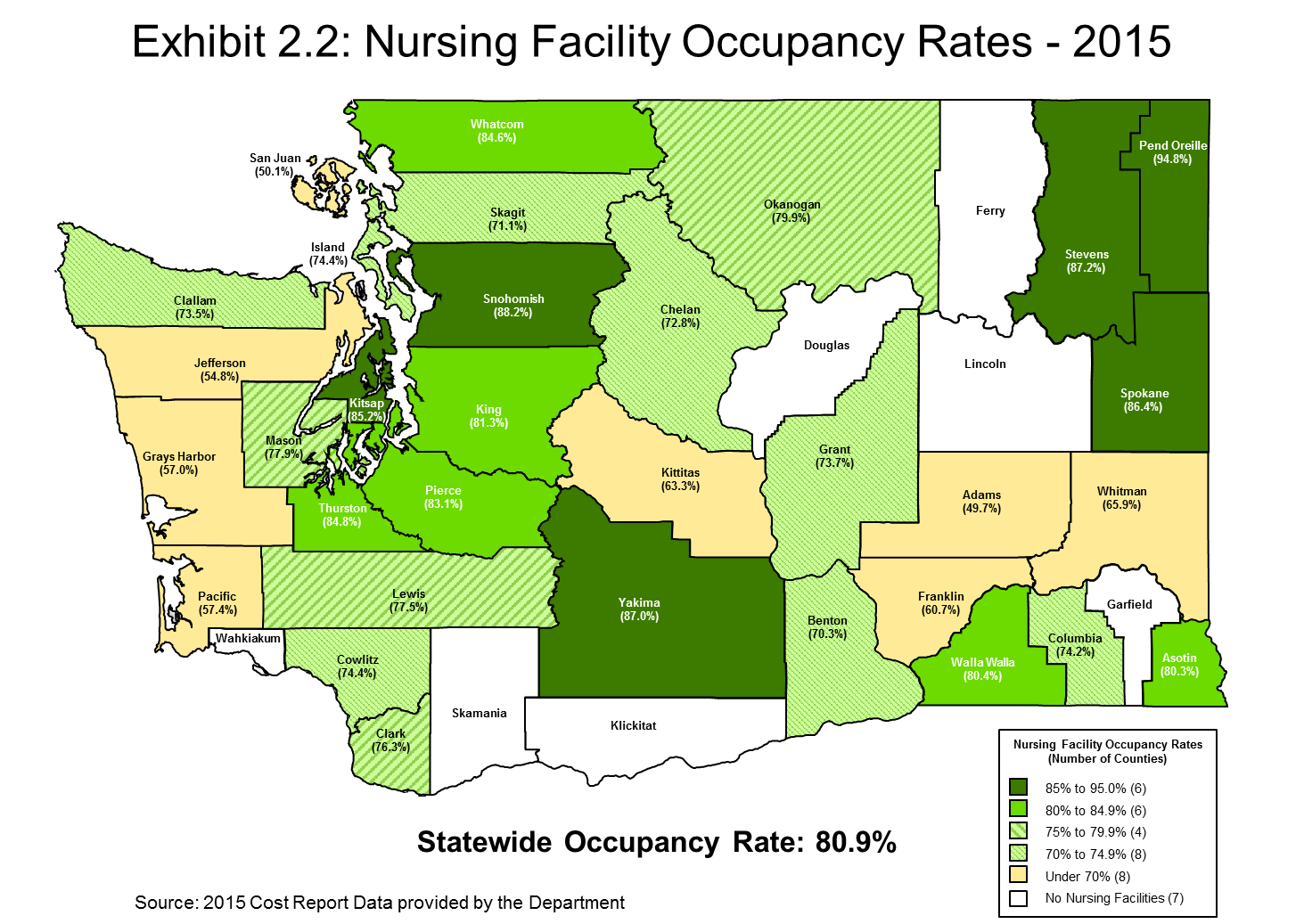
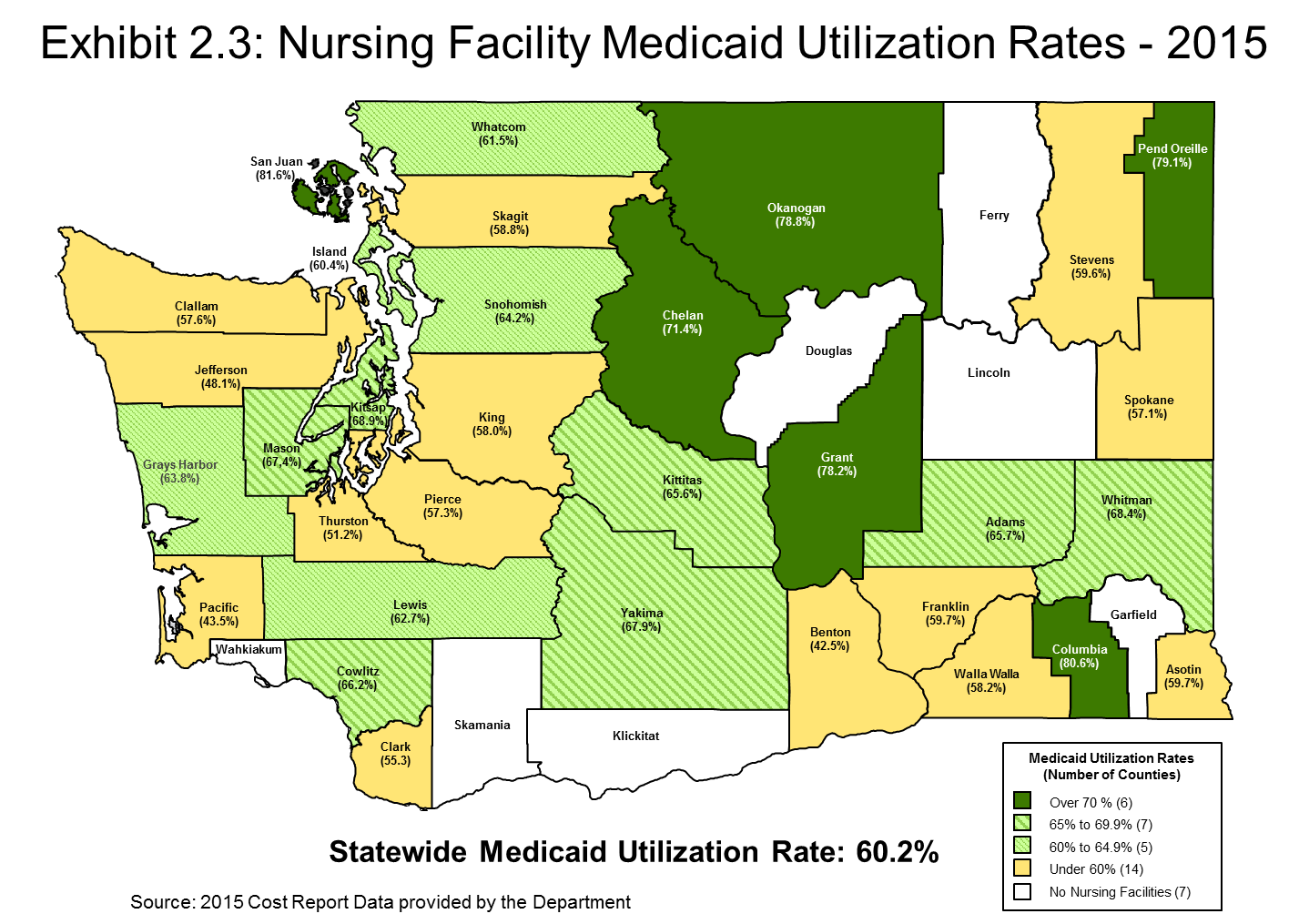


Exhibit 2.3 shows the average Medicaid utilization rates by county for 2015, which ranged from 42.5 percent to 81.6 percent. Medicaid utilization for 12 of the counties was within the 60 percent to 70 percent range. Six of the counties had utilization exceeding 70 percent in 2015.

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**Nursing Facility Capacity in Washington Compared with Other States**

Another way to analyze the adequacy of Washington’s nursing facility capacity is to compare it with the capacity in similar states.

Table 2.4 shows the nursing facility occupancy rates for states in the Centers for Medicare and Medicaid Services (CMS) Region X for the ten years 2006 through 2015. In 2014 and 2015, Washington’s occupancy rates were greater than those in Idaho and Oregon, but less than Alaska, as was the case in 2008 through 2012.

**Table 2.4: Nursing Facility Occupancy Rates for States in CMS Region X: 2006 – 2015**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **State** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** |
| Alaska | 84.1% | 85.2% | 84.7% | 86.7% | 87.3% | 93.8% | 88.2% | 78.4% | 85.8% | 90.0% |
| Washington[[3]](#footnote-3) | 86.3% | 85.5% | 83.4% | 83.2% | 83.0% | 82.6% | 80.3% | 80.1% | 80.5% | 80.9% |
| Idaho | 75.6% | 76.9% | 74.9% | 72.6% | 71.8% | 71.0% | 68.7% | 67.8% | 64.8% | 65.8% |
| Oregon | 65.4% | 66.3% | 68.2% | 63.8% | 62.4% | 61.5% | 60.8% | 60.5% | 60.9% | 60.2% |

Sources:

* States in CMS Region X: CMS website at http://www.cms.hhs.gov/RegionalOffices/downloads/SeattleRegionalOffice.pdf
* Utilization rates for 2006 through 2008: “Nursing Home Data Compendium” by CMS, 2009 Edition.
* Occupancy rates for 2009, 2010, 2011, 2012, 2013, and 2014 are as of June of each year: “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, June 2009, 2010, 2011, 2012, 2013, 2014 and March 2015 Updates.

Table 2.5 compares Washington’s nursing facility occupancy rates over the same ten year period with states that have the largest senior populations in the country. Six of the eight states had nursing facility occupancy rates greater than Washington’s in the most recent eight years.

**Table 2.5: Nursing Facility Occupancy Rates for States with Largest Senior Populations: 2006 – 2015**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **State** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** |
| Pennsylvania | 90.4% | 88.9% | 89.3% | 90.7% | 90.8% | 90.9% | 90.2% | 90.6% | 90.2% | 90.4% |
| New York | 92.7% | 92.6% | 92.7% | 92.7% | 92.4% | 92.2% | 91.8% | 91.9% | 90.9% | 90.1% |
| Florida | 88.2% | 87.8% | 87.5% | 88.0% | 87.8% | 87.8% | 87.7% | 87.5% | 87.7% | 88.5% |
| California | 85.7% | 85.0% | 85.3% | 84.8% | 84.8% | 85.1% | 85.1% | 84.9% | 85.0% | 86.1% |
| Michigan | 88.8% | 86.6% | 86.3% | 86.2% | 85.2% | 84.8% | 84.9% | 84.7% | 84.2% | 85.2% |
| Ohio | 87.9% | 86.8% | 86.5% | 86.7% | 85.8% | 85.3% | 85.2% | 84.5% | 84.2% | 84.3% |
| Washington | 86.3% | 85.5% | 83.4% | 83.2% | 83.0% | 82.6% | 80.3% | 80.1% | 80.5% | 80.9% |
| Illinois | 78.0% | 77.9% | 78.1% | 78.9% | 78.6% | 78.0% | 78.3% | 77.8% | 77.5% | 77.3% |
| Texas | 73.0% | 71.9% | 71.6% | 73.2% | 73.4% | 71.2% | 71.1% | 71.9% | 72.2% | 70.6% |

Sources:

* Population estimates for July 1, 2014 released December 2014 by the U.S. Census Bureau, Population Division.
* Utilization rates for 2006 through 2008: “Nursing Home Data Compendium” by CMS, 2009 Edition.
* Occupancy rates for 2009, 2010, 2011, 2012, 2013, and 2014 are as of June of each year and as of March for 2015: “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, June 2009, 2010, 2011, 2012, 2013, 2014 and March 2015 Updates.

We also analyzed Washington’s nursing facility capacity on a per capita basis compared with similar states. Table 2.6 shows the number of nursing facility beds per 1000 population age 65 and older and age 85[[4]](#footnote-4) and older in 2015 for states in CMS Region X. Of the four states in Region X, Washington had more beds per capita than all but Idaho.

**Table 2.6: Nursing Facility Beds per Capita for Senior Population for States in**

**CMS Region X – 2015**

|  |  |  |
| --- | --- | --- |
| **State** | **Beds per 1000 Population Age 65 and Older** | **Beds per 1000 Population Age 85 and Older** |
| Idaho | 24.4 | 213.0 |
| Washington | 20.4 | 161.6 |
| Oregon | 18.5 | 145.2 |
| Alaska | 9.5 | 112.9 |
| Average for Four States | 18.2 | 158.2 |
| Average for States excluding Washington | 17.5 | 157.0 |

Sources:

* States in CMS Region X: CMS website at http://www.cms.hhs.gov/RegionalOffices/downloads/SeattleRegionalOffice.pdf
* Beds per 1000 Population Age 65 and Older and Beds per 1000 Population Age 85 and Older: Calculated by Navigant using total beds reported in “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, March 20015 Update, and population estimates for July 2015 released June 2016 by the U.S. Census Bureau, Population Division.

Table 2.7 shows Washington’s nursing facilities beds per 1000 population aged 65 and older, and aged 85 and older, to the same metrics for all other Western states for 2015 (excluding Hawaii). This comparison shows that Washington’s metrics generally fall in the middle of the ranking of all Western states.

**Table 2.7: Nursing Facility Beds per Capita for Senior Population for Western States – 2015**

|  |  |  |
| --- | --- | --- |
| **State** | **Beds per 1000 Population Age 65 and Older** | **Beds per 1000 Population Age 85 and Older** |
| Montana | 37.8 | 300.2 |
| Wyoming | 35.0 | 288.9 |
| Colorado | 28.7 | 243.5 |
| Utah | 27.7 | 238.8 |
| Idaho | 24.4 | 213.0 |
| California | 23.0 | 168.4 |
| New Mexico | 20.8 | 177.5 |
| Washington | 20.4 | 161.6 |
| Oregon | 18.5 | 145.2 |
| Arizona | 14.7 | 125.8 |
| Nevada | 14.3 | 152.5 |
| Alaska | 9.5 | 112.9 |
| Average for Twelve States | 22.9 | 194.0 |
| Average for States excluding Washington | 24.1 | 201.4 |

Sources:

* The Western states listed above were identified and selected by Navigant.
* Beds per 1000 Population Age 65 and Older and Beds per 1000 Population Age 85 and Older: Calculated by Navigant using total beds reported in “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, March 2015 Update, and population estimates for July 1, 2015 released June 2016 by the U.S. Census Bureau, Population Division.

Table 2.7 also shows that there is a significant range of values, which may be affected by the level to which each state has invested in alternative non-institutional home and community-based options. In other words, if more options are available to persons in states with alternative residential settings, it would be reasonable to assume that fewer nursing facility beds would be needed.

Based on 2013 data retrieved in September 2016 made available by AARP, Washington is fourth in the nation in Medicaid home and community-based services spending for older people and adults with physical disabilities as a percentage of total long-term care spending. Figure 2.1 illustrates how Washington has used its 2013 Medicaid long-term care dollars for home and community-based services compared to nursing facility services.

**Figure 2.1: Medicaid Long-Term Spending for Seniors and Adults with Physical Disabilities in Washington**

Source:

"AARP Public Policy Institute | Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service." AARP Public Policy Institute. Web. Sept. 2016.

Figure 2.2 makes the same comparison nationally for 2013, which, when compared to Washington, illustrates that Washington has committed a significantly higher percentage of its Medicaid long-term care resources to alternative settings.

**Figure 2.2: Medicaid Long-Term Spending for Seniors and Adults with Physical Disabilities in the United States**

Source:

"AARP Public Policy Institute | Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service." AARP Public Policy Institute. Web. Sept. 2016.

Understanding that comparisons of nursing facility beds per 1,000 aged population might be affected by the extent to which alternative residential settings are available, we analyzed Washington’s nursing facility capacity on a per capita basis compared with states that have made a similar commitment to these alternatives. To make this comparison, we identified other states that have spent more than 40 percent of Medicaid long-term care funds on home and community-based services.

Table 2.8 compares the number of beds in Washington per 1,000 population age 65 and age 85 and older to other states in the country that have spent more than 40 percent of their Medicaid long-term care dollars on home and community-based alternatives. This table shows that, when sorted by beds per 1,000 population age 65 and older and aged 85 and older, Washington falls in the middle of the ranking.

**Table 2.8: Nursing Facility Beds per Capita for Senior Population in 2015 for States that spent more than 40 Percent of Medicaid long-term funds on HCBS**

| **State** | **Percentage of Medicaid Funds Spent on HCBS** | **2015 Beds per 1,000 Population Age 65 and Older** | **2015 Beds per 1,000 Population Age 85 and Older** |
| --- | --- | --- | --- |
| Texas | 54% | 40.9 | 352.4 |
| Minnesota | 67% | 36.7 | 249.9 |
| California | 57% | 23.0 | 168.4 |
| New Mexico | 94% | 20.8 | 177.5 |
| Washington | 62% | 20.4 | 161.6 |
| Oregon | 61% | 18.5 | 145.2 |
| Arizona | 44% | 14.7 | 125.8 |
| Alaska | 63% | 9.5 | 112.9 |
| Average for Eight States | 63% | 23.1 | 186.7 |
| Average for States excluding Washington | 63% | 23.4 | 190.3 |

Sources:

* The states listed above were identified by Navigant by calculating AARP data ”Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service” as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services.
* The Percentage of Medicaid Funds Spent on HCBS Waivers: "AARP Public Policy Institute | Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service." AARP Public Policy Institute. Web. Sept. 2016.
* Beds per 1000 Population Age 65 and Older and Beds per 1,000 Population Age 85 and Older: Calculated by Navigant using total beds reported in “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, March 2015 Update, and population estimates for July 1, 2015 released June 2016 by the U.S. Census Bureau, Population Division.

We also analyzed Washington’s nursing facility capacity on a per capita basis with comparable states in close proximity to Washington that spent more than 50 percent of Medicaid long-term care funds on home and community-based services. Table 2.9 shows that Washington has a comparable number of beds per 1,000 population age 65 and older and age 85 and older to those ratios in California and Oregon.

**Table 2.9: Nursing Facility Beds per Capita for Senior Population for California, Washington and Oregon**

| **State** | **Percentage of Medicaid Funds Spent on HCBS** | **2015 Beds per 1,000 Population Age 65 and Older** | **2015 Beds per 1,000 Population Age 85 and Older** |
| --- | --- | --- | --- |
| California | 57% | 23.0 | 168.4 |
| Washington | 62% | 20.4 | 161.6 |
| Oregon | 61% | 18.5 | 145.2 |
| Average for Three States | 60% | 20.6 | 158.4 |
| Average for States excluding Washington | 59% | 21.7 | 165.0 |

Sources:

* The states listed above were identified by Navigant Consulting, Inc. due to their proximity to Washington and having spent more than 50 percent of Medicaid funds on HCBS waivers.
* The Percentage of Medicaid Funds Spent on HCBS was calculated by Navigant using data from: "AARP Public Policy Institute | Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service." AARP Public Policy Institute. Web. Sept. 2016.
* Beds per 1,000 Population Age 65 and Older and Beds per 1,000 Population Age 85 and Older: Calculated by Navigant using total beds reported in “OSCAR Data Report: Nursing Facility Operational Characteristics Report” by American Health Care Association Research Department, March 2015 Update, and population estimates for July 1, 2015 released June 2016 by the U.S. Census Bureau, Population Division.

**Conclusion**

Based on the analyses described in this section, it appears that there is sufficient access to nursing facility beds in Washington State. Between 2006 and 2015, while the total number of beds decreased by 7.6 percent, nursing facility occupancy rates decreased and the total number of unfilled beds increased each year, except in 2009, 2012, and 2014 when unfilled beds decreased slightly, 1.7 percent from 2008, 0.3 percent from 2011, and 9 percent from 2013. There appears to be some capacity in virtually every county across the State.

Washington’s total bed capacity per 1,000 aged population, which is purposefully restricted based on the WAC (which is supported by the State’s nursing home industry), is very comparable to other states that have made similar commitments to home and community-based services options.

# Section III: Quality

In the previous section we analyzed whether Washington’s Medicaid payment methodology for nursing facilities supports sufficient access to care for Washington’s Medicaid beneficiaries. In this section, we analyze whether Washington’s Medicaid payment methodology supports provision of care at an acceptable level of quality.

**Comparative Analysis of Quality in Washington and Other States**

Our analysis was intended to determine if the level of quality provided in Washington’s nursing facilities is acceptable when compared with other states. To make this comparison, we analyzed data on deficiencies cited in nursing facility surveys for the Medicare and Medicaid programs and compiled by the Centers for Medicare and Medicaid Services (CMS) and reported in its annual Nursing Home Data Compendium.[[5]](#footnote-5)

To add context to this analysis, we first compared the basic care needs of residents in Washington’s nursing facilities to those in nursing facilities in other states that have made significant commitments to home and community-based service options. To measure care needs, we examined the percentage of residents in each state that required assistance with one of the five Activities of Daily Living (ADL), otherwise referred to as ADL impairments, which were published in the CMS’ *2015 Nursing Home Data Compendium*. The five ADLs analyzed in that publication were:

* Mobility
* Dressing
* Eating
* Transferring
* Toileting

ADL impairments were identified for each of these activities if a resident required extensive assistance with that activity.

As shown in Table 3.1, among states identified as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services, Washington has the highest percentage of residents with 4 or more ADL impairments in nursing facilities. This generally indicates that Washington has been effective in transitioning residents into appropriate non-institutional environments, and that those cared for in nursing facility settings generally have higher ADL impairments.

**Table 3.1: Distribution of Activity of Daily Living (ADL) Impairment in Nursing Home Residents – 2014**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Number of ADL Impairment**  **Percent of Residents** | | |
| **State** | **0** | **1-3** | **4 and 5** |
| Washington | 12.0% | 14.0% | 74.1% |
| California | 17.6% | 16.1% | 66.3% |
| Minnesota | 18.0% | 17.3% | 64.6% |
| New Mexico | 27.2% | 18.9% | 53.9% |
| Oregon | 14.9% | 16.7% | 68.4% |
| Texas | 23.9% | 17.1% | 58.9% |
| Arizona | 17.7% | 18.3% | 64.0% |
| Alaska | 20.6% | 18.3% | 61.1% |
| Average for Eight States | 19.0% | 17.1% | 63.9% |
| Average for States Excluding Washington | 20.0% | 17.5% | 62.5% |

Sources:

* The states listed above were identified by Navigant by calculating AARP data ”Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service” as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services.
* Distribution Scope: “Nursing Home Data Compendium” by CMS, 2015 Edition.

Understanding that those in nursing facilities in Washington have high needs, we then examined the number and percentage of survey deficiencies in Washington’s nursing facilities. Surveys are conducted to ensure that nursing facilities are meeting State and federal standards which spell out how care must be provided to nursing home residents. Surveys are performed by teams of State employees (usually three or four people) who are specialists in nursing home care. The surveyors have backgrounds in nursing, social work, dietetics, sanitation, health care administration and counseling. These individuals must pass a test administered by the federal government to qualify as nursing home surveyors.

A deficiency is a determination by DSHS that a nursing home has violated one or more specific licensure or certification regulations. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm. Deficiencies are cited as a result of an on-site inspection. It is important to note that the severity of survey deficiencies can vary significantly, and that the national average of surveys that resulted in no deficiency in 2014 was only 10.2 percent (5.4 percent in Washington). This means that on average nationally, 89.8 percent of all surveys had some deficiency noted (94.6 percent in Washington). However, some deficiencies are more serious than others.

Exhibit 3.1 shows the scope and severity matrix which identifies the scope and severity ratings that can be applied to survey deficiencies for nursing facilities. A score is assigned to each deficiency based on the level of severity and scope of the deficiency. The scores range from “A”, being the least serious ranking and “L”, being the most serious ranking.

**Exhibit 3.1 Scope and Severity Grid for Rating Nursing Home Deficiencies**



Source:

Scope and Severity Grid for Rating Nursing Home Deficiencies: “Nursing Home Data Compendium” by CMS, 2015 Edition.

To measure the significance of survey deficiencies in Washington nursing facilities, we initially analyzed those that fell into categories H, I, K or L, which we believe to measure the most severe of deficiencies that are not isolated instances. Table 3.2 shows the percentage of nursing facility survey deficiency citations resulting in the most serious deficiencies that constitute substandard quality of care for Washington and other states identified as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based service options.

This table shows that the percentage of Washington’s nursing facility survey deficiency citations in these categories were comparable, and often times lower than the percentages of the other states analyzed.

**Table 3.2: Percentage Distribution of Scope and Severity of Health Deficiency Citations in Nursing Homes – 2014**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Distribution by Scope/Severity** | | | |
| **State** | **H** | **I** | **K** | **L** |
| Washington | 0.1 | 0.0 | 0.1 | 0.0 |
| California | 0.1 | 0.0 | 0.1 | 0.1 |
| Minnesota | 0.1 | 0.0 | 0.1 | 0.0 |
| New Mexico | 1.3 | 0.0 | 0.9 | 1.1 |
| Oregon | 0.0 | 0.0 | 0.6 | 0.0 |
| Texas | 1.1 | 0.0 | 1.8 | 0.4 |
| Arizona | 0.0 | 0.0 | 0.3 | 0.2 |
| Alaska | 0.0 | 0.0 | 0.5 | 1.0 |
| United States Average | 0.2 | 0.0 | 0.4 | 0.2 |
| Average for Eight States | 0.3 | 0.0 | 0.6 | 0.4 |
| Average for States excluding Washington | 0.4 | 0.0 | 0.6 | 0.4 |

Sources:

* The states listed above were identified by Navigant by calculating AARP data ”Medicaid LTSS Spending for Older People and Adults with Physical Disabilities, by Type of Service” as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services.
* Distribution by Scope/Severity: “Nursing Home Data Compendium” by CMS, 2015 Edition.

Understanding that these data are from Federal Fiscal Year (FFY) 2014, we confirmed with DSHS representatives the distribution of deficiency citations does not change significantly from period to period.Table 3.3 shows the trend in the percentage of nursing facility surveys that indicated health deficiencies in Washington nursing facilities from 2007 to 2014. This table shows that beginning in 2009, the number of deficiency citations increased slightly through 2012 and subsequently decreased through 2014 for several of the deficiency scopes shown below. Note that for the most part, citations were lower in 2014 than in 2013.

**Table 3.3: Percentage Nursing Home Survey Resulting in Deficiency Citations in Washington – 2007 to 2014**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Deficiency Scope** | **2007** | **2008** | **2009** | **2010** | **2011** | **2012** | **2013** | **2014** |
| Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents | 24.8 | 20.1 | 15.5 | 17.7 | 20.1 | 17.0 | 17.2 | 9.0 |
| Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents | 2.1 | 1.6 | 1.7 | 3.0 | 5.7 | 1.4 | 1.6 | 0.9 |
| Surveys Resulting in a Citation for Substandard Quality of Care | 3.3 | 2.9 | 1.7 | 3.4 | 5.7 | 0.9 | 2.6 | 1.4 |
| Surveys Resulting in a Citation for Use of Restraints | 4.5 | 2.9 | 1.7 | 1.7 | 1.7 | 2.4 | 0.5 | 0.9 |
| Surveys Resulting in a Deficiency for Failure to Treat or Prevent Pressure Ulcers | 23.6 | 21.3 | 21.1 | 20.3 | 14.4 | 12.3 | 12.5 | 12.2 |

Source:

Distribution Scope: “Nursing Home Data Compendium” by CMS, 2015 Edition.

Again, understanding that these data are only published through Federal Fiscal Year (FFY) 2014, we confirmed with the Department representatives that deficiency citations do not change significantly from period to period.

As an additional indicator of quality we also reviewed nursing facility Five-Star overall quality ratings across states identified in prior sections as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services. The overall quality ratings are based on each facility’s performance in three different measures which each receive a rating from one to five. The first quality measure included in the overall quality rating is health inspections. In this quality measure, nursing facilities are rated based on the number, scope, and severity of deficiencies identified in each nursing facility during the three most recent annual inspection surveys.

The second quality measure included as part of overall quality measure is staffing. The performance ratings are based on a measure of the number of registered nurse hours to total staffing hours per day. The CMS Staffing Study found association between nurse staffing ratios and the quality of care in a nursing facility. Further, CMS identified specific staffing ratios which, if not met, expose residents to a higher risk of quality problems. Information about the staffing in each facility is based on the CMS Certification and Survey Provider Enhanced Reports (CASPER) system.

The last component of the overall quality measure is a measure of various quality metrics. The quality measures cover a broad range of health status as well as function indicators for both long-term nursing facility residents and short-term nursing facility residents. A total of sixteen different quality measures are included in measuring this component. Most are based on data reported in the Minimum Data Set (MDS) and a few are based on MDS and Medicare claims measures that are all published on the Nursing Home Compare website.

Table 3.4 below summarizes the average nursing facility overall quality rating across states identified as having spent more than 40 percent of their Medicaid long-term care funds on home and community-based services. The average nursing facility quality ratings for each state were calculated by Navigant by determining the average statewide overall quality rating across all nursing facilities within each state.

**Table 3.4: Nursing Facility Overall Quality Ratings**

|  |  |
| --- | --- |
| **State** | **Average Nursing Facility Overall Quality Rating** |
| Washington | 3.47 |
| California | 3.55 |
| Minnesota | 3.50 |
| New Mexico | 2.86 |
| Oregon | 3.41 |
| Texas | 2.62 |
| Arizona | 3.49 |
| Alaska | 3.36 |
| U.S. Average | 3.16 |

Source:

Nursing Facility Overall Quality Ratings: Star Ratings published on the Nursing Home Data Compare website.

Based on the average statewide quality ratings, it appears that Washington falls in the middle of the ranking. There are three states with higher average overall quality ratings and four states with lower average ratings. Therefore, it appears that nursing facility quality, as measured by the Five-Star overall quality ratings, in Washington is in line with quality across other states identified and is higher than the average nursing facility quality nationwide.

**Conclusion**

Based on the analyses shown in this section, it appears that quality of care, as measured by the metrics described, compares favorably to other states analyzed. It appears that the percentage of citations leading to actual harm or immediate jeopardy to residents across several severities in for Washington is lower than the national average as well as the average percentage across the states identified earlier in this section. In addition, it appears that nursing facility quality is in line with nursing facility quality across the states identified in the report and is higher than the nationwide average quality as measured by the Five-Star overall quality ratings for nursing facilities.

Understanding that there is a lag in the timing of the reporting of these deficiency criteria (the most current from 2014), it is difficult to correlate such changes to changes in the Medicaid rates paid for services. While we believe that the quality of care provided in Washington’s nursing facilities is generally adequate, we would recommend that the Department continue to monitor subsequent survey results to determine if the same trends continue.

# Section IV: Payment Rate Analysis

In this section, we describe our analysis of payments under the current Medicaid payment methodology in relation to the allowable costs incurred by nursing facilities for serving Medicaid-eligible residents. First, we estimated what Medicaid allowable costs will be for SFYs 2018 and 2019 using historical cost data from CY 2015 reported by the State’s nursing facilities, adjusted to reflect trends in inflation to SFYs 2018 and 2019. We then compared the estimated SFYs 2018 and 2019 costs to an estimate of Medicaid payments for the same period, based on the weighted average of payment rates for all of SFYs 2018 and 2019.

In addition, we examine Medicare and commercial reimbursement rate levels for nursing facility services in Washington. We then compare these rates to Washington’s Medicaid reimbursement rates for SFYs 2018 and 2019.

**Estimation of Costs for State Fiscal Years Ended 2018 and 2019**

Base Costs

We estimated Medicaid costs using calendar year 2015 adjusted costs and resident days data provided by the Department. The data provided by the Department included the 207 nursing facilities that currently participate in the Medicaid program, and included five cost categories: Direct Care (DC) costs, Therapy Care (TC) costs, Support Services (SS) costs, Operations (OP) costs, and Property (PR) costs. These amounts were “adjusted” amounts that according to the Department included only “Medicaid allowable” costs. These amounts were also adjusted to reflect the change in provider assessment costs between 2015 and 2018, and 2019. We divided each cost category by adjusted total days to calculate an average cost per day for each of the five cost categories.

Adjustment for Case-Mix Index (CMI)

We adjusted the Direct Care cost component to take into account each nursing facility’s average case-mix index[[6]](#footnote-6). We divided each nursing facility’s average Direct Care cost per day by the average annual facility-wide case-mix index (CMI) from 2015[[7]](#footnote-7). The resulting amount was the average Direct Care cost per day adjusted to a facility CMI of 1.0.

We then adjusted the Direct Care cost category to reflect the resource needs of Medicaid residents during the same period. To do this, we multiplied each nursing facility’s average Direct Care cost per day (which had been previously adjusted to reflect a facility CMI of 1.0) times the average facility-specific Medicaid CMI from the period of October 2015 through March 2016[[8]](#footnote-8). These indexes were the most recent Medicaid CMI data available. The resulting amount was the average Direct Care cost per day adjusted for the facility’s Medicaid CMI.

Adjustment for Provider Assessment Costs

For this analysis it is also necessary to adjust costs to account for changes in the assessment costs for providers between 2015 and 2018, and 2019. To make this adjustment, the first step is to remove CY 2015 assessment costs reported by providers in the cost report data from the CY 2015 operating costs reported since these costs represent the assessment costs incurred in CY 2015 under the assessment rate effective during that period. We then estimated assessment costs for 2018 and 2019 based on the assessment rate that will be in effect for 2018 and 2019 and the number of days in CY 2015 that would be subject to the assessment. These estimated assessment costs were then added to the providers’ overall costs for 2018 and 2019 in the analysis.

Adjustment for Cost Growth

To bring the 2015 costs forward to SFYs 2018 and 2019, we applied a cost growth factor. The cost growth factor was calculated using the change in the CMS Prospective Payment System Skilled Nursing Facility Input Price Index. We identified the index at the midpoint of each analysis year (SFY 2018 and SFY 2019) and divided by the index at the midpoint of the 2015 cost year. The resulting cost growth factor for SFY 2018 was 1.067, or a 6.7 percent increase between CY 2015 and SFY 2018. The cost growth factor for SFY 2019 was 1.098, or a 9.8 percent increase between CY 2015 and SFY 2019. Using the cost growth factor, we updated each of the average cost per day amounts for the cost components described previously to estimate the SFYs 2018 and 2019 amounts.

After applying the cost growth factor to each component, we added together all the cost components, including the Direct Care cost component adjusted for the most current Medicaid CMI described above, to calculate the total estimated average cost per day for SFYs 2018 and 2019.

**Estimation of Rates for State Fiscal Years Ended 2018 and 2019**

The rates utilized in this analysis were calculated and provided to us by the Department. It is our understanding that the rate estimates are based on the methodology described in Section I of this report and in Appendix A and Appendix B.

Other Considerations

It should be noted that in estimating the costs for SFYs 2018 and 2019, we did not make any adjustment for potential “case-mix creep”, or inherent increase in CMI over time. We also did not adjust for potential “settlements” that are part of the new rate setting process. Lastly, we did not make any adjustments for the BLS regional wage index that is applied by the Department to the direct care component of the rates.

**Analysis of Payment-to-Cost Coverage**

We compared the rates for SFYs 2018 and 2019, calculated by and provided to us by the Department, to the average cost per day adjusted for the facility’s Medicaid CMI and for the cost growth percentages described in the cost section above. For each nursing facility, we analyzed the rates for SFYs 2018 and 2019 separately, to calculate payment-to-cost ratios.

For each nursing facility, we multiplied estimated rates described above for each year by the nursing facility’s 2015 adjusted Medicaid days to estimate total payments. Similarly, we multiplied each nursing facility’s average cost per day adjusted for the facility’s Medicaid CMI, and adjusted for cost growth, by the nursing facility’s 2015 adjusted Medicaid days to estimate total costs. We used the total payments and total costs to calculate weighted average payment-to-cost ratios for various groups of facilities.

For each rate year, we categorized the 207 nursing facilities into three groups by type of facility:

1. Standard nursing facilities (194 facilities)
2. Hospital-based nursing facilities (9 facilities)
3. Veterans and tribal nursing facilities (4 facilities)

Currently the Department has 211 Medicaid nursing facilities, however, four did not have cost reports to include in the cost comparison analysis of this report. We analyzed these groups separately because of the differences in cost structures between the groups. We then examined the characteristics of nursing facilities in each group. The overall results for each year are shown in the table below.

**Table 4.1: Medicaid Payment-to-Cost Ratio, By Facility Type Group, By Year**

|  |  |  |
| --- | --- | --- |
| **Type of Facility** | **Payment-to-Cost Ratio (Weighted Average)**  **Based on Rates Provided by the Department** | |
| **SFY 2018** | **SFY 2019** |
| Standard Nursing Facilities | 90.8% | 91.6% |
| Hospital-Based Nursing Facilities | 74.3% | 74.3% |
| Veterans & Tribal Nursing Facilities | 59.1% | 56.2% |
| All Nursing Facilities | 89.0% | 89.7% |

Based on our analysis, the payment-to-cost ratio for nursing facilities on average is increasing between SFY 2018 and SFY 2019 because the reimbursement rates on average are increasing at a greater percentage rate than the inflation rate that we applied when estimating costs for FY 2019. The increase in SFY 2019 rates appears to be driven by the increase in the direct care and indirect care components of the rate. Between SFY 2018 and SFY 2019, the direct care component in aggregate increases by approximately $6.03 on average and the indirect care component of the rate in aggregate increases by approximately $1.55 on average.

For each year, we further categorized the standard nursing facilities into one of four quartiles based on the nursing facility’s payment-to-cost ratio. Nursing facilities with the highest payment-to-cost ratios were categorized into Quartile 1, while those with the lowest payment-to-cost ratios were categorized into Quartile 4. We then examined the characteristics of nursing facilities in each category.

State Fiscal Year 2018 Rates

*Overall Results – All Nursing Facilities*

As shown in the table above, the rates expected to be in effect for SFY 2018 following the current methodology result in a statewide average payment-to-cost ratio of 89.0 percent. The standard nursing facilities are expected to have a slightly higher ratio of 90.8 percent.

*Occupancy – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that average and median occupancy for facilities in Quartile 1 is higher than the occupancy rates for Quartiles 2, 3 and 4. This statistic generally indicates that the rate setting system “rewards” facilities with higher occupancies.

*Medicaid Percentage – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that facilities in Quartile 1 (highest payment-to-cost ratios) tend to have a high Medicaid percentage, while facilities in Quartile 4 (lowest payment-to-cost ratios) have the lowest Medicaid percentage. This statistic generally indicates that the rate setting system “rewards” facilities with higher Medicaid percentages. Note that the median value generally follows the same trend.

*Cost Per Day – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that the median cost per day adjusted to a facility CMI of 1.0 increases with each successive quartile. That is, facilities in Quartile 1 (highest payment-to-cost ratios) have the lowest cost per day and facilities in Quartile 4 (lowest payment-to-cost ratios) have the highest cost per day. This statistic indicates that the rate setting system “rewards” facilities with lower cost per day.

*Highest Quartile – Standard Nursing Facilities*

Examining the nursing facilities in the highest quartile (Quartile 1) shows that all of the 49 nursing facilities have payment-to-cost ratios between 96.9 and 116.9 percent. Twenty-nine nursing facilities have payment-to-cost ratios of 100 percent or higher.

See Appendix C for additional detail on the analysis of the SFY 2018 rates.

State Fiscal Year 2019 Rates

*Overall Results – All Nursing Facilities*

As shown in the table above, the rates expected to be in effect for SFY 2019 following the current methodology result in a statewide average payment-to-cost ratio of 89.7 percent. The standard nursing facilities are expected to have a slightly higher ratio of 91.6 percent.

*Occupancy – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that average and median occupancy for facilities in Quartile 1 is higher than the rates for Quartiles 2, 3 and 4. This statistic generally indicates that the rate setting system “rewards” facilities with higher occupancies.

*Medicaid Percentage – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that facilities in Quartile 1 (highest payment-to-cost ratios) tend to have a high Medicaid percentage, while facilities in Quartile 4 (lowest payment-to-cost ratios) have the lowest Medicaid percentage. This statistic generally indicates that the rate setting system “rewards” facilities with higher Medicaid percentages. Note that the median value generally follows the same trend.

*Cost Per Day – Standard Nursing Facilities*

Examining the results by payment-to-cost quartile shows that the median cost per day adjusted to a facility CMI of 1.0 increases with each successive quartile. That is, facilities in Quartile 1 (highest payment-to-cost ratios) have the lowest cost per day and facilities in Quartile 4 (lowest payment-to-cost ratios) have the highest cost per day. This statistic indicates that the rate setting system “rewards” facilities with lower cost per day.

*Highest Quartile – Standard Nursing Facilities*

Examining the nursing facilities in the highest quartile (Quartile 1) shows that all of the 49 nursing facilities have payment-to-cost ratios between 97.7 and 115.4 percent. Thirty-five nursing facilities have payment-to-cost ratios of 100 percent or higher.

See Appendix D for additional detail on the analysis of the SFY 2019 rates.

**Comparison to Other Payer Rates**

In this section we compare Washington’s reimbursement rates to those of other payers. Specifically, we analyzed the average rate paid to Washington nursing facilities by other payers including Medicare, self-pay, and commercial insurance. In addition, we reviewed Washington Medicaid’s reimbursement rates for the five most frequent RUG classifications of Medicaid recipients to Medicare reimbursement rates for the same RUG classifications. Finally, we compared Washington Medicaid’s average reimbursement rate to the reimbursement rates of other states.

Comparison to Medicare Rates

It should be noted that drawing conclusions from a comparison of Medicaid reimbursement rates to Medicare reimbursement rates in general can be challenging, and there are a few factors that should be taken into consideration when making such a comparison. One of the key factors to consider is that the relative acuity of the Medicaid and Medicare populations are typically significantly different. The average acuity of Medicare patients are typically higher than those of Medicaid patients because Medicare patients are typically admitted to a facility to receive more intense therapy services following an acute hospitalization or other episode. Medicaid residents are typically in a nursing facility for a much longer period of time, for ongoing nursing care as they age or approach end of life. And while we have made our comparisons of these rates using similar acuity levels, it is not reasonable to assume that even within the same acuity levels, Medicaid and Medicare resident resource needs are the same.

In addition, it should be noted that Medicaid rates in Washington are generally determined based on the Medicaid costs of services provided by nursing facilities in the State of Washington. Medicare rates are established on a standardized national basis (with some adjustments for regional differences in wages), which have been consistently higher than Medicaid rates across the country.

We compared Washington’s Medicaid daily reimbursement rate across the five most frequent RUG classifications of Medicaid recipients to the Medicare reimbursement rates for these same services. The rates compared were the most recently available Medicare rates for King County to the SFY 2018 Medicaid reimbursement rates. These rates are reflected in Table 4.2.

**Table 4.2: Comparison of Medicaid and Medicare Rates by RUG Classification**

|  |  |  |
| --- | --- | --- |
| **RUG Classification** | **SFY 2018 Medicaid Rate** | **Medicare Rate** |
| PC1 | $171.91 | $316.80 |
| PD1 | $190.65 | $367.36 |
| RVC | $305.74 | $580.24 |
| RMB | $273.80 | $416.96 |
| PA1 | $127.14 | $223.49 |

Based on the information reflected in Table 4.2, it appears that the Medicare reimbursement rates for these RUG classifications are higher than the Medicaid reimbursement rates, but as discussed previously, we don’t believe such a comparison to be particularly meaningful when evaluating the adequacy of the Medicaid rates in Washington.

Comparisons to Other Payers

To determine the average reimbursement rates paid in Washington from other payers, we relied on the 2015 cost report data submitted by providers. Nursing facilities are required to report revenues received from Medicaid, Medicare, self-pay, Veterans Administration (VA), and commercial insurance as well as the recipient days associated with these revenues. Using the reported revenue and recipient days data by nursing facilities, we calculated the average case-mix adjusted daily reimbursement rate for each nursing facility for Medicaid, and for all non-Medicaid services combined. We also adjusted the Medicaid and the combined non-Medicaid amounts for differences in acuity by dividing the amounts by the Medicaid case-mix index and the combined non-Medicaid case-mix index respectively using the case-mix data provided to us by the Department.

Based on the data reported by nursing facilities in the 2015 cost reports, the average case-mix adjusted Medicaid daily reimbursement was $93.89. The average daily reimbursement from all other payers combined was $127.72. It should be noted that the difference in payment per day appears reasonable understanding that the amount for all other payers includes both Medicare payment amounts, which we have demonstrated to be significantly higher than the Medicaid rates. The all other payer amount also includes amounts that are paid by individuals with either commercial long-term care insurance, and amounts received from self-pay residents, both of which we would expect to exceed amounts paid by Medicaid.

Comparisons to Medicaid Rates in Other States

Finally, we also compared Washington’s average Medicaid reimbursement rate for nursing facility services for SFY 2018 to the average Medicaid reimbursement rates for these services in several other states. We compared Washington’s rates to the reimbursement rates of Arizona, Florida, Illinois, Minnesota, Montana, Oregon, and Utah. Oregon, Minnesota, and Utah were evaluated at the request of the Department. Florida and Illinois were identified as states with some of the largest senior populations that had available published data that could be used for the purposes of this comparison. Montana and Arizona were identified as states in the Western region with available published data that could be used for this comparison.

It is important to note that due to the differences between the rate setting methodologies of these states and the amount of information made available, it is difficult to do a simple comparison of the average rates reimbursed by states to nursing facilities. In addition, although it is preferable to conduct comparison of weighted average reimbursement rates rather than average reimbursement rates, most states did not have this information available. Recognizing these limitations, for the purposes of this comparison, we reviewed the available average reimbursement rates across these states. Based on the most recently available information for these states, we found that Washington’s average reimbursement rate for SFY 2018 of $211.85 is the third highest reimbursement rate across these states. It would therefore appear that Washington’s average Medicaid rate is not significantly lower than the average reimbursement rate of most of the other states.

Table 4.3 below reflects the average Medicaid reimbursement rates across the states reviewed for this comparison.

**Table 4.3: Average Medicaid Reimbursement Rate Across States**

|  |  |
| --- | --- |
| **State** | **Reimbursement Rate** |
| Washington | $211.85 |
| Oregon | $281.08 |
| Minnesota | $177.82 |
| Utah | $183.30 |
| Florida | $228.79 |
| Illinois | $148.52 |
| Montana | $175.65 |
| Arizona | $147.83 |

**Conclusion**

Our analysis shows that Washington’s current Medicaid payment methodology will pay, in SFY 2018, approximately 92.2 percent of Medicaid allowable costs incurred by nursing facilities that are not hospital-based, veterans or tribal facilities, and 91.6 percent when including those facilities. We estimate that 29 nursing facilities would receive 100 percent or more of their Medicaid allowable cost, with an additional 45 facilities receiving more than 95 percent of cost, and another 42 receiving 90 percent or more. Our analyses of access to and quality of care, described in Sections II and III of this report, respectively, indicate that the current methodology provides rates for services that have been sufficient to maintain adequate access to care of reasonable quality. It is expected that the rates in SFY 2019 will result in very similar payment-to-cost ratios to those for SFY 2018.

The current system appears to have been designed to effectively pay a higher proportion of costs to the providers who are the most efficient, as measured by lower average Medicaid cost per day, adjusted for differences in case-mix, and as measured by total occupancy rates and Medicaid utilization. In other words, nursing facilities with lower case-mix adjusted cost per day, higher occupancy and higher Medicaid utilization tend to fare better under the current system when compared to the costs of providing services.

In addition, we compared Washington’s rates to those paid by Medicare and other payers, and to the rates paid in several other states. We found that Washington’s rates were reasonable when compared to other states and aggregated results from other payers. We did not necessarily believe a comparison to Medicare rates to be reasonable or conclusive.

We recommend that, with the anticipated rates for SFYs 2018 and 2019, the State continue to carefully and closely monitor any changes in access and quality so that appropriate responses can be made in a timely manner. We also recommend that the State carefully monitor the survey process, and the resulting occurrences of survey deficiencies, to make certain that such deficiencies do not change over time.

1. Nursing facilities calculate their bed days available each year by multiplying the number of licensed beds in operation by the number of days the beds were operational. Facilities report available bed days on their annual cost reports. [↑](#footnote-ref-1)
2. Assumes 365 days in the calendar year for 2006, 2007, 2009, 2010, 2011, 2013, 2014, 2015 and 366 days in the calendar year for 2008 and 2012. [↑](#footnote-ref-2)
3. These occupancy rates vary from those presented in Table 2.3 because they are from different data sources. Occupancy rates shown in Table 2.3 are calculated using bed days available as reported by nursing facilities each year in their annual cost reports submitted to the Department. The source for the all states’ data is the Online Survey, Certification and Reporting (OSCAR) which is a data network that CMS maintains in cooperation with the state long-term care surveying agencies. OSCAR is a compilation of all the data elements collected by surveyors during the inspection survey conducted at nursing facilities for the purpose of certification for participation in the Medicare and Medicaid programs. [↑](#footnote-ref-3)
4. Note that while the State currently uses the statistic “nursing facility beds per 1000 population aged 70 and older” for purposes of measuring bed need in Washington, similar statistics for other states were not available in the data relied upon to prepare this report. [↑](#footnote-ref-4)
5. Data in the Nursing Home Data Compendium are from the Online Survey, Certification and Reporting (OSCAR) which is a data network that the CMS maintains in cooperation with the state long-term care surveying agencies. OSCAR is a compilation of all the data elements collected by surveyors during the inspection survey conducted at nursing facilities for the purpose of certification for participation in the Medicare and Medicaid programs. [↑](#footnote-ref-5)
6. A case-mix index is a measure, expressed as a factor, which is indicative of the expected “relative” resources that will be required to care for individuals in a nursing facility. Using data extracted from a nationally standardized resident assessment instrument, a case-mix score is determined for each nursing facility resident, which indicates the resources required for that resident compared to the average of all residents. A facility’s case-mix index is the average of the case-mix scores for all residents in the facility at a given point in time. [↑](#footnote-ref-6)
7. This case-mix index was calculated “without defaults”. As we understand, a CMI calculated “without defaults” excludes any individuals with a missing case-mix score. A CMI “with defaults” would include those individuals in the counts and add a 1.0 case-mix score for the individual. [↑](#footnote-ref-7)
8. This CMI was calculated “with defaults” as described in the previous footnote. [↑](#footnote-ref-8)