

**Aging and Long-Term Support Administration**  
**050 - PL - EY - NH RATES FOR LOW ACUITY CLIENTS**

Agency Submittal: 11-2017-19-YR Agency Req

Budget Period: 2017-19

**SUMMARY**

In 2011, the legislature reduced funding to the ten lowest acuity Medicaid nursing home rate groups, both as a cost saving measure and an incentive to transition clients to community settings. However, of the 3,100 who have reduced rates, around 2,300 have care needs truly appropriate for nursing homes. The change from the cost-based nursing home rate system to the price-based system eliminated the prior hold-harmless provisions and nursing homes face 13 percent rate penalties for clients who need nursing home care. The Aging and Long-Term Support Administration (AL TSA) requests \$12.9 million (\$6.4 million GF-State) to limit the low-acuity rate penalty to only the lowest acuity clients.

**PROBLEM STATEMENT**

Medicaid nursing home rates have been changed many times over the years for both policy and fiscal purposes. A good example is the reduction in 2011, when the legislature reduced rates for “low acuity” clients. In this case, acuity refers to the level of assistance a client needs with Activities of Daily Living (ADL), which means assistance with tasks such as eating, bathing, toileting, and getting in and out of bed and are translated into Resource Utilization Group (RUG) scores for the rates system. The very lowest acuity groups (PA1 – PB2) need assistance with zero to five of these activities. It is reasonable to assume that providers and case managers should be working to transition these people out of a nursing home. However, the current reduction applies to people who need assistance with up to 16 of these activities – people who are more appropriately served in a nursing home (see chart below).

Up until June 2016, there were mechanisms in the nursing home rate structure that shielded providers from having to take the full rate reduction for low acuity clients in many cases. However, with the simplification of the rates system, those rate “add-ons” have now been eliminated. This is a good thing for the rates system overall, but leaves providers in the awkward position of having a significant financial penalty for having people in their facilities who should not necessarily be transitioned to a home and community setting. There is a short term fix in the 2016 budget bill ([2ESBH 2376](#), Section 206(5)) that provides temporary rate relief for Fiscal Year 2017 and incorporates an incentive to move at least 96 low acuity clients to community settings, but that provision ends as of June 30, 2017.

	Acuity Classification	Medicaid Clients	Requires Help with this Many ADLs	
More appropriately served in Nursing Homes	PE2	187	15 to 16	Needs More Help with Activities of Daily Living
	PE1	497	15 to 16	
	PD2	236	11 to 14	
	PD1	805	11 to 14	
	PC2	340	6 to 10	
	PC1	1227	6 to 10	
	PB2	31	2 to 5	
	PB1	318	2 to 5	
	PA2	39	0 to 1	
	PA1	515	0 to 1	



**DSHS VISION**  
 People are healthy • People are safe • People are supported • Taxpayer resources are guarded

**DSHS MISSION**  
 To transform lives

**DSHS VALUES**  
 Honesty and Integrity • Pursuit of Excellence • Open Communication • Diversity and Inclusion • Commitment to Service

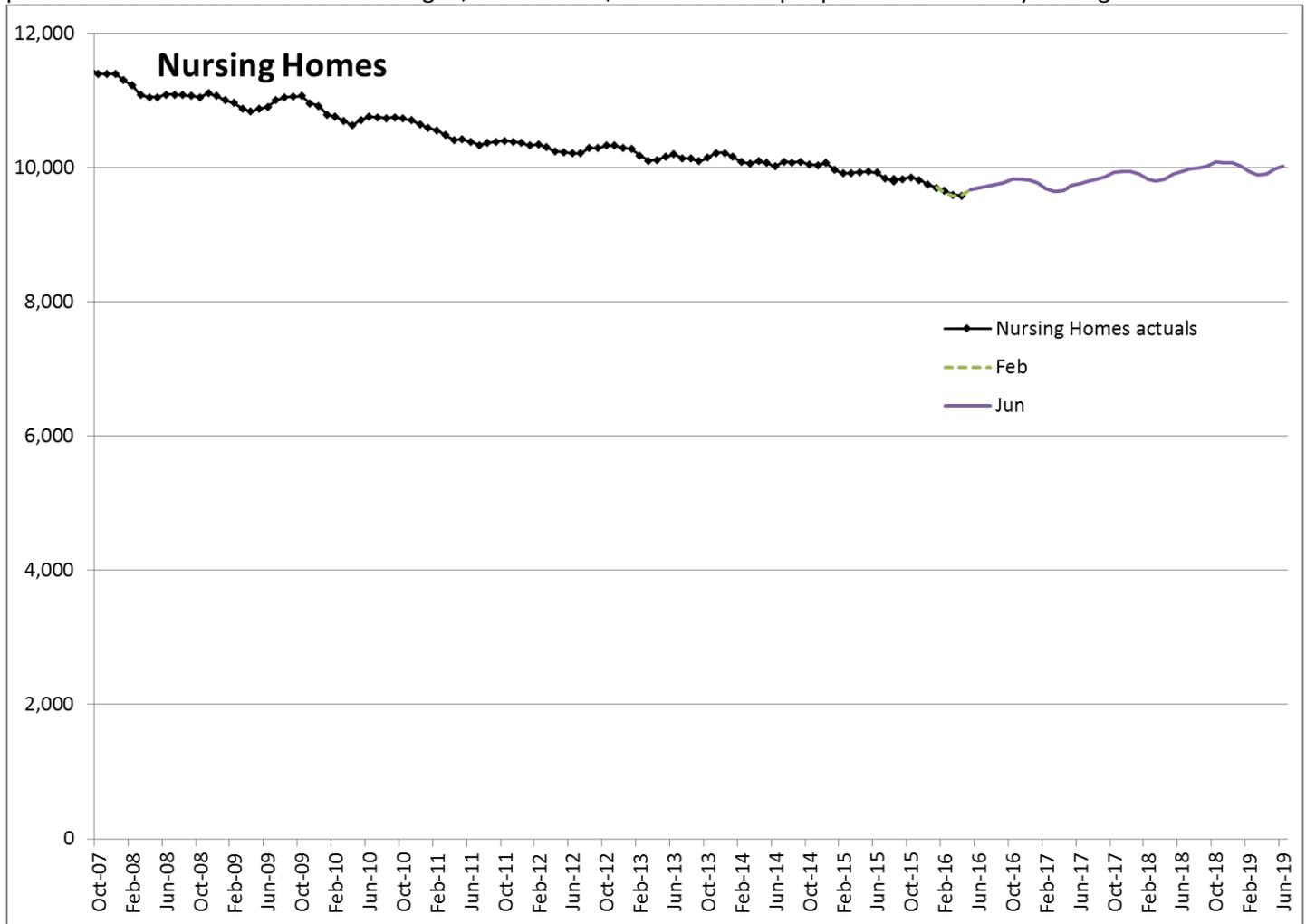
050 - PL - EY - NH Rates for Low Acuity Clients

**PROPOSED SOLUTION**

Aligning the rate calculation methodology for low acuity NH clients with the new price-based NH rate system leaves the current 13 percent rate penalty only for the very lowest acuity clients. Among the lowest acuity clients, those with significant behaviors would also be exempt from the penalty because the alternative is to have them admitted to a state hospital. This will also require continuing the appropriation bill proviso that went into effect in the 2016 Supplemental budget bill stating, "A nursing home provider's direct care rate shall be set so that it does not exceed one hundred eighteen percent of its base year's direct care allowable costs except if the provider is below the minimum staffing standard established in RCW 74.42.360(2)."

**EXPECTED RESULTS**

At a time when the demographics of Washington State are shifting much more toward the very elderly, the need for viable nursing home providers willing to care for Medicaid clients is increasing every year. The current Caseload Forecast Council projection is that FY16 was the historic low. After 20 years of successfully rebalancing the long term service and supports delivery resulting in Medicaid nursing home caseload reductions, the power of demographics is finally going to overtake those efforts and produce an increasing Medicaid nursing home caseload (see chart below). With this rate adjustment, providers will be appropriately paid for Medicaid clients in the PC1 – PE2 RUG groups who need assistance with between six and sixteen ADLs, and nursing homes will remain a viable option for those who need that level of care. Those with clients in the lowest acuity groups, RUG groups PA1 – PB2 will continue to have a 13 percent rate reduction and be encouraged, and assisted, to move those people into community settings.



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**STAKEHOLDER IMPACT**

The two largest nursing home provider associations, Leading Age Washington and the Washington Health Care Association both endorse this action, although it may not be unanimous among their members because some providers will not be happy with the continuation of the 118 percent cap on direct care rates. In addition, key representatives and senators who have participated in both budget negotiations and the nursing home rates workgroup that produced the new, simplified price-based model recognize that this “low acuity penalty” is an unintended consequence of the implementation of the new system and are expected to support this proposal.

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**OTHER CONNECTIONS**

**Performance Outcomes/Important Connections**

- 1. Does this DP provide essential support to one or more of the Governor's Results Washington priorities?**  
Goal 4: Healthy & Safe Communities - Healthy People - Provide access to good medical care to improve people's lives.
  
- 2. The decision package meets the following DSHS' strategic objectives:**  
2.1: Ensure seniors and individuals with a disability who are in need of long-term services and supports are supported in their communities.
  
- 3. Identify other important connections or impacts below.** (Indicate 'Yes' or 'No'. If 'Yes' identify the connections or impacts related to the proposal.)
  - a) Regional/County impacts? No
  - b) Other local government impacts? No
  - c) Tribal government impacts? No
  - d) Other state agency impacts? No
  - e) Responds to specific task force, report, mandate or executive order? No
  - f) Does request contain a compensation change or require changes to a Collective Bargaining Agreement? No
  - g) Facility/workplace needs or impacts? No
  - h) Capital budget impacts? No
  - i) Is change required to existing statutes, rules or contracts? No
  - j) Is the request related to litigation? No
  - k) Is the request related to Puget Sound recovery? No
  - l) Other important connections? N/A
  
- 4. Please provide a detailed discussion of connections/impacts identified above.**

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**Alternatives/Consequences/Other**

**5. What alternatives were explored by the agency, and why was this alternative chosen?**

The other alternative is to continue the status quo, which means that as of July 1, 2017, nursing home providers will be facing a 13 percent rate reduction for clients who are appropriately served in nursing homes.

A variation that was considered is to pay 100 percent of the model rate for acuity groups PC1 – PE2 without continuing the 118 percent cap on direct care rates. However, this would cost approximately \$5 million more GF-State in the 2017-19 Biennium.

**6. How has or can the agency address the issue or need within its current appropriation level?**

The nursing home rates are part of a forecasted budget unit, and there is no mechanism to make an administrative decision to spend more money on particular rate classifications without additional funding authorized by the legislature.

**7. Does this decision package include funding for any IT-related costs (hardware, software, services, cloud-based services, contracts or IT staff)?**

**No**

**Yes (Include an IT Addendum)**

**Fiscal Detail****050 - PL - EY - NH Rates for Low Acuity Clients**

<b>Operating Expenditures</b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>FY 2020</u></b>	<b><u>FY 2021</u></b>
001-1 General Fund-State	3,244,000	3,193,000	3,193,000	3,193,000
001-C General Fund-Medicaid	3,244,000	3,193,000	3,193,000	3,193,000
<b>Total Cost</b>	<b>6,488,000</b>	<b>6,386,000</b>	<b>6,386,000</b>	<b>6,386,000</b>
<b>Staffing</b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>FY 2020</u></b>	<b><u>FY 2021</u></b>
FTEs	0.0	0.0	0.0	0.0

**Performance Measure Detail**

Activity:	Incremental Changes			
	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>FY 2020</u></b>	<b><u>FY 2021</u></b>
<b>Program: 050</b>				
E064 Nursing Home Services	0	0	0	0
No measures submitted for package				

**Object Detail**

	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>FY 2020</u></b>	<b><u>FY 2021</u></b>
N Grants, Benefits, and Client Services	6,488,000	6,386,000	6,386,000	6,386,000
<b>Total Objects</b>	<b>6,488,000</b>	<b>6,386,000</b>	<b>6,386,000</b>	<b>6,386,000</b>

**DSHS Source Detail****Overall Funding**

<b>Operating Expenditures</b>		<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>	<b><u>FY 2020</u></b>	<b><u>FY 2021</u></b>
<b>Fund 001-1, General Fund-State</b>					
<b><u>Sources Title</u></b>					
0011	General Fund State	3,244,000	3,193,000	3,193,000	3,193,000
<b>Total for Fund 001-1</b>		<b>3,244,000</b>	<b>3,193,000</b>	<b>3,193,000</b>	<b>3,193,000</b>
<b>Fund 001-C, General Fund-Medicaid</b>					
<b><u>Sources Title</u></b>					
19TA	Title XIX Assistance (FMAP)	3,244,000	3,193,000	3,193,000	3,193,000
<b>Total for Fund 001-C</b>		<b>3,244,000</b>	<b>3,193,000</b>	<b>3,193,000</b>	<b>3,193,000</b>
<b>Total Overall Funding</b>		<b>6,488,000</b>	<b>6,386,000</b>	<b>6,386,000</b>	<b>6,386,000</b>

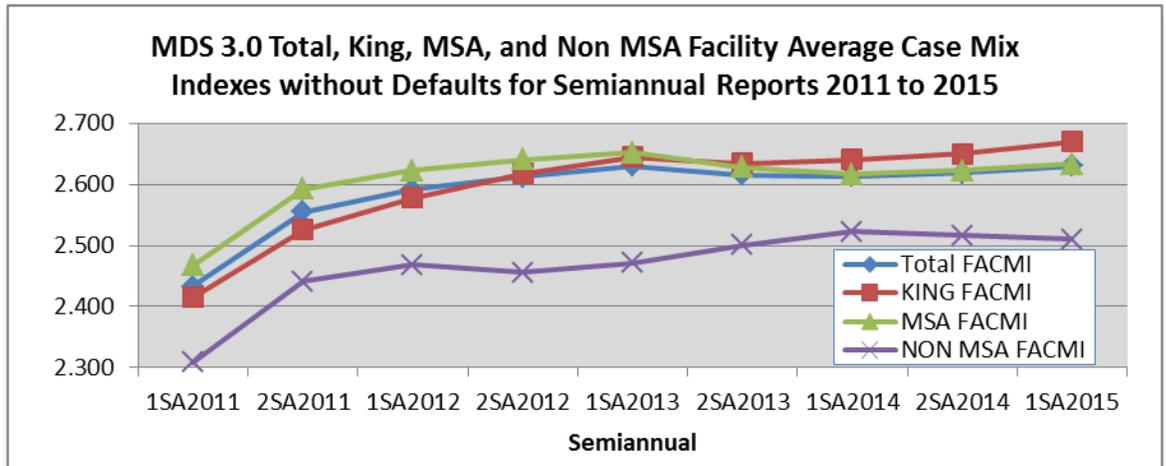
**Fact Sheet: Programs and Initiatives**

**Case Mix of Nursing Home Residents**

**Overview**

The state began incorporating case mix, a measure of debility, in its Medicaid payment methodology in October 1998 using Minimum Data Set (MDS) 2.0 and Resource Utilization Groups (RUG) III. In October 2010, the state changed to MDS 3.0 and RUG IV which is shown in the below charts but not currently used in Medicaid payments. The last MDS 2.0 report ending September 2010 currently continues to be used to set Medicaid Nursing Home rates. MDS 3.0 is scheduled to be used in rate setting July 1, 2016.

While some of the recorded increase may be due to the nursing home’s initial lack of familiarity with the new MDS 3.0 process of documenting debility, the following charts do suggest an overall trend rise in actual debility over the past years. This is possibly due in part to shorter hospital stays and the state’s emphasis on alternative home and community placements for lower needs residents.



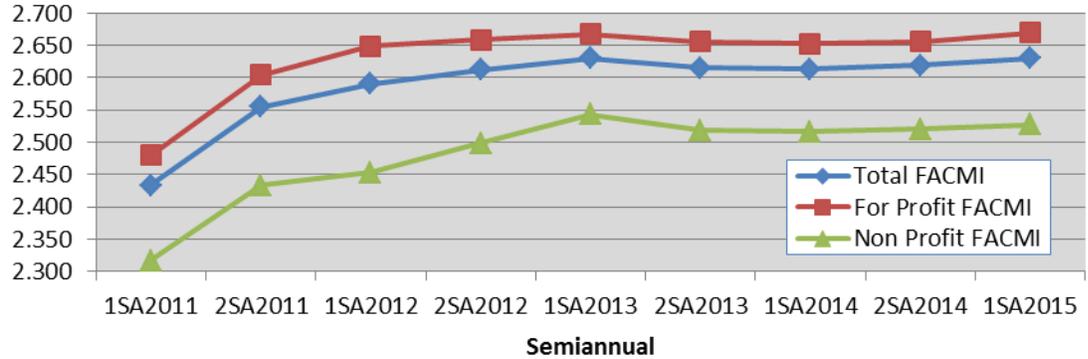
The above chart indicates an overall increasing trend in debility, as measured by the case mix index, for all geographic areas of the state. Note that facilities located in non-metropolitan statistical areas (non-MSA) show an almost identical trend although consistently serving residents having a slightly lower level of needs. Existing data shows no significant difference in debility level by facility size.

**Information Contact**

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2016

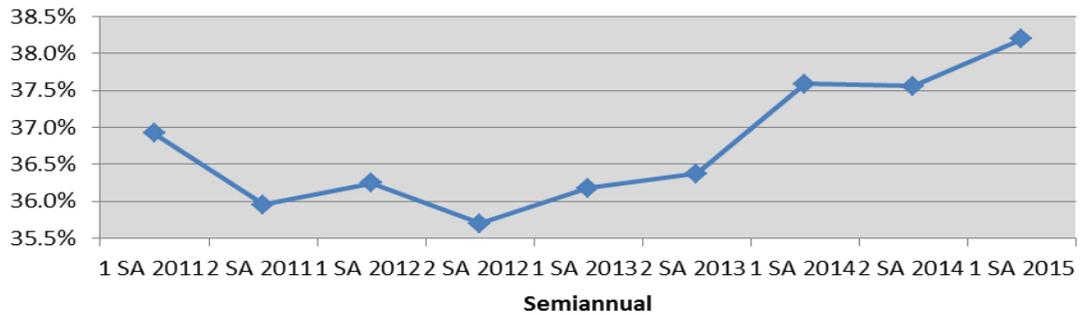
**MDS 3.0 Total, For Profit, and Non Profit Facility Average Case Mix Indexes without Defaults for Semiannual Reports 2011 to 2015**



The above chart indicates that the for profit facilities serve slightly higher levels of needs than the non-profit facilities in terms of average resident debility level.

The ten lowest care need levels in the MDS 3.0, designated “PA” to “PE” include residents that have the greatest potential for placement in alternative community settings.

**MDS 3.0 Percent of Total Medicaid Resident Days in Low Care RUGS PA to PE**



The above chart indicates an overall trend increase in the percentage of the ten lowest care need Medicaid residents. However, the increase in the ten lowest care levels “PA” to “PE” have not affected overall average increases in debility level.

The rates paid to nursing homes will be based on MDS 3.0 starting July 1, 2016, so these changes in the acuity levels could potentially have an affect on rates.

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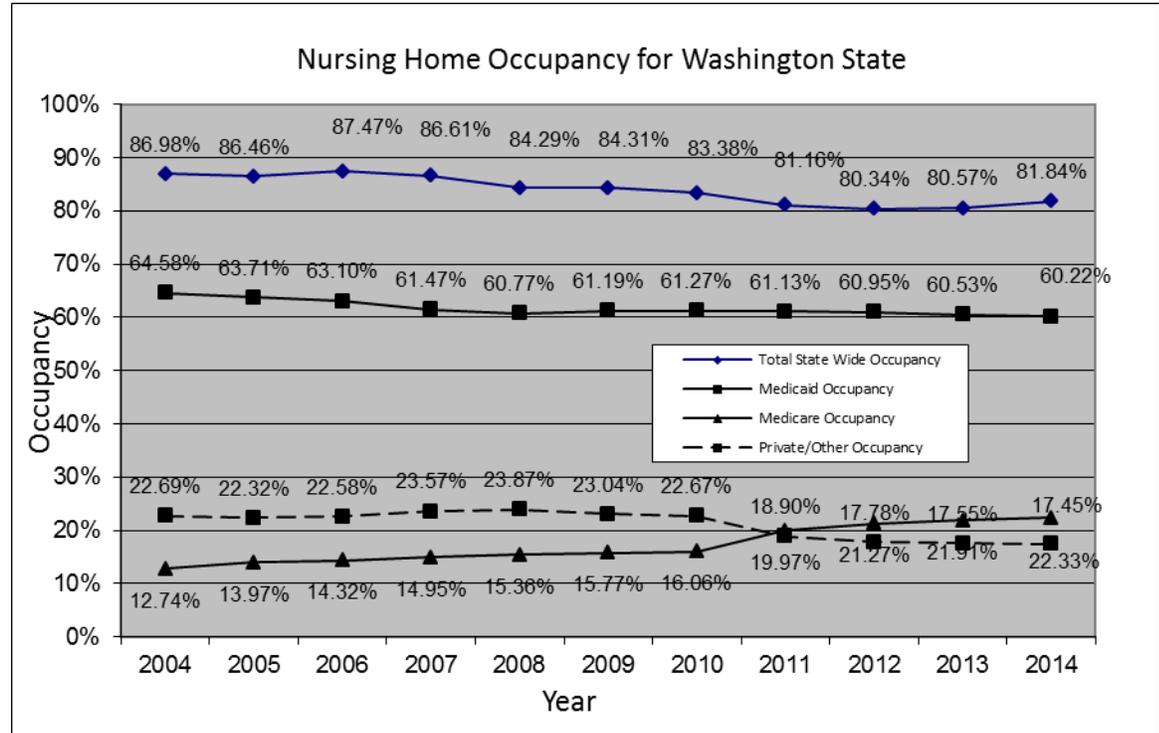
2016

**Nursing Home Occupancy**

**Overview**

The nursing home occupancy rate is determined by dividing the total number of patient bed days per year by the total licensed bed days in the year. State law allows nursing homes to take off line, or “bank,” beds not currently used to provide nursing home care while retaining bed licensure. Banked beds are not included in the calculation.

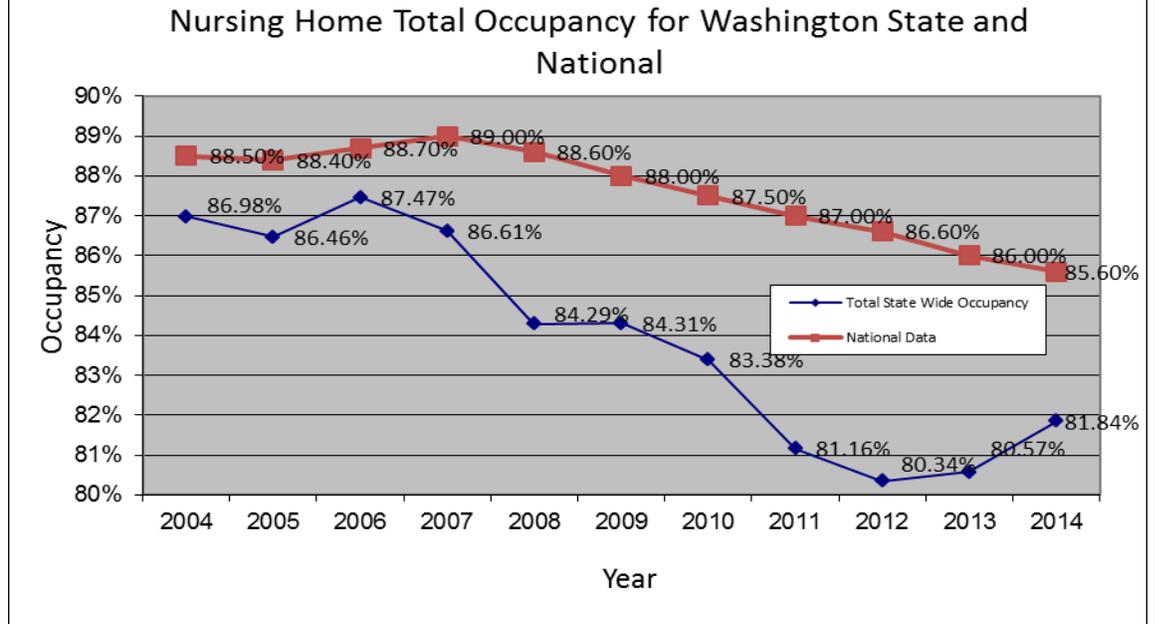
**Data**



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2016



National Data: Trends in Nursing Facility Characteristics, AHCA, March 2015

Washington's total occupancy rate is approximately 4.39% lower than the national median. Bed banking or similar adjustments are assumed to not be prevalent in the national data. This suggests that the gap between Washington and the national data may be greater than depicted.

**Why are Washington nursing home occupancy rates lower than the national median?**

It is difficult to determine specifically what factors have resulted in this low occupancy rate. However, the state's aggressive efforts to promote cost-effective home and community alternatives, along with growth of a well-regulated Assisted Living Facility and Adult Family Home industry have certainly been key elements.

**MDS 3.0 Implementation for Nursing Home Reimbursement**

The Medicaid nursing home rates for July 1, 2011 through June 30, 2016 use minimum data set (MDS) 2.0 and resource utilization group (RUG) III increased semiannually one-half of a percent to allow for the transition to MDS 3.0 and implementation of RUG IV.

The July 1, 2016, direct care cost per case mix unit will be calculated by utilizing the 2014 direct care costs, patient days, and 2014 facility average case mix indexes based on the MDS 3.0 RUG IV grouper 57. Please refer to [2015 Session ESSB 6052](#) and [SHB 1274](#) for specific details.

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2016