**Washington Department of Social and Health Services (DSHS)**

**Analysis of the Washington**

**Nursing Facility**

**Medicaid Payment Methodology – FY 2015 Payment Methodology Maintained Addendum Report**

**Navigant Consulting, Inc.**

**March 2015 Addendum to February 2015 Report – Analysis of Alternative Rates**

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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 Medicaid reimbursement rates for nursing facilities based on the assumption that the rate determination methodology currently in place would remain through the end of SFY 2016. We conducted an analysis comparing the level of reimbursement for each provider to the estimated costs of providing services for State Fiscal Year (SFY) 2016. The results of the analysis are summarized in this report, which serves as an addendum to the report provided to the Department in February of 2015.

# SECTION II: PAYMENT-TO-COST-ANALYSIS

In this section, we describe our analysis of payments under the current Medicaid payment methodology relative to the allowable costs incurred by nursing facilities for serving Medicaid-eligible residents. First, we estimated what Medicaid allowable costs will be for SFY 2016 using historical cost data reported by the State’s nursing facilities, adjusted to reflect trends in inflation to SFY 2016. We then compared the estimated SFY 2016 costs to an estimate of Medicaid payments for the same period, based on weighted average of estimated payment rates for all of SFY 2016.

**Estimation of Costs for State Fiscal Years Ended 2016**

Base Costs

We estimated Medicaid costs using calendar year 2013 adjusted costs and resident days data provided by the Department. The data provided by the Department included the 208[[1]](#footnote-1) 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 2013 and 2016. 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[[2]](#footnote-2). We divided each nursing facility’s average Direct Care cost per day by the average annual facility wide case mix index (CMI) from 2013[[3]](#footnote-3). The resulting amounts to each facility is 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. 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 semi-annual 2014 Medicaid CMI[[4]](#footnote-4). The semi-annual 2014 indexes were the most recent CMI data available. The resulting amount was the average Direct Care cost per day adjusted for the facility’s Medicaid CMI.

Adjustment for Cost Growth

To bring the 2013 costs forward to SFY 2016 under analysis, 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 SFY 2016 and divided by the index at the midpoint of the 2013 cost year. The resulting cost growth factor was 1.056, or a 5.6 percent increase between SFY 2013 and SFY 2016. Using the cost growth factors, we updated each of the average cost per day amounts for the cost components described previously to estimate the SFY 2016 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 SFY 2016.

**Estimation of Rates for State Fiscal Years Ended 2016**

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 SFY 2015 rate methodology for nursing facilities.

Other Considerations

It should be noted that in estimating the costs for SFY 2016, 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 rate setting process.

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

We compared the rates for SFY 2016, 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 SFY 2016 to calculate payment-to-cost ratios.

For each nursing facility, we multiplied the rates for SFY 2016 by the nursing facility’s 2013 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 2013 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.

We categorized the 208 nursing facilities into three groups by type of facility:

1. Standard nursing facilities (195 facilities)
2. Hospital-based nursing facilities (9 facilities)
3. Veterans and tribal nursing facilities (4 facilities)

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 SFY 2016 are shown in Table 4.1 below.

**Table 4.1: Medicaid Payment-to-Cost Ratio, By Facility Type Group – SFY 2016 – Current Rate Methodology**

|  |  |  |
| --- | --- | --- |
| **Type of Facility** | **Number of Facilities** | **SFY 2016 Payment-to-Cost Ratio (Weighted Average)** **Based on Rates Provided by the Department** |
| Standard Nursing Facilities | 195 | 89.7% |
| Hospital-Based Nursing Facilities | 9 | 75.6% |
| Veterans & Tribal Nursing Facilities | 4 | 61.9% |
| All Nursing Facilities | 208 | 88.2% |

We also compared the resulting pay-to-cost ratios for SFY 2016 to the pay-to-cost ratios determined based on the reimbursement rates proposed in the Governor’s budget that will be considered in the upcoming legislative session for SFY 2016 and SFY 2017. The overall results for each year based on the rates under the current payment methodology are shown in Table 4.2 below.

**Table 4.2: Medicaid Payment-to-Cost Ratio, By Facility Type Group, By Year – Rate Methodology Included in Governor’s Budget**

|  |  |  |
| --- | --- | --- |
| **Type of Facility** | **Number of Facilities** | **Payment-to-Cost Ratio (Weighted Average)** **Based on Rates Provided by the Department** |
| SFY 2016 | SFY 2017 |
| Standard Nursing Facilities | 196 | 91.2% | 89.7% |
| Hospital-Based Nursing Facilities | 9 | 75.4% | 73.9% |
| Veterans & Tribal Nursing Facilities | 4 | 59.5% | 58.6% |
| All Nursing Facilities | 209 | 89.4% | 88.0% |

Based upon these analyses, it appears that the proposed SFY 2016 rates under the current methodology will reduce the pay-to-cost ratios for the standard nursing facilities and the weighted ratios for all nursing facilities. In SFY 2016, the pay-to-cost ratio for standard nursing facilities decreases by approximately 1.5 percent. In addition, the overall pay-to-cost ratio for all nursing facilities decreases in SFY 2016 by 1.2 percent. However, it should be noted that while the pay-to-cost ratio for all nursing facilities and in aggregate is decreasing, the pay-to-cost ratios actually increase slightly by approximately 0.2 percent for hospital-based nursing facilities, and by approximately 2.4 percent for veteran and tribal nursing facilities.

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 2016 Rates

*Overall Results – All Nursing Facilities*

As shown in the table above, the rates expected to be in effect for SFY 2016 following the current methodology will result in a statewide average payment-to-cost ratio of 88.2 percent. The standard nursing facilities are expected to have a slightly higher ratio of 89.7 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 and 3, and virtually the same as that of Quartile 4. This statistic generally indicates that the rate setting system “rewards” facilities with higher occupancies, although this appears to be an exception when looking at Quartile 4.

*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 96.3 and 114.9 percent. Twenty-three nursing facilities have payment-to-cost ratios of 100 percent or higher.

See Appendix A for additional detail on the analysis of the SFY 2016 rates.

**Conclusion**

Our analysis shows that Washington’s current Medicaid payment methodology will pay, in SFY 2016, approximately 89.7 percent of Medicaid allowable costs incurred by nursing facilities that are not hospital-based, veterans or tribal facilities, and 88.2 percent when including those facilities. We estimate that 23 nursing facilities would receive 100 percent or more of their Medicaid allowable cost, with an additional 36 facilities receiving more than 95 percent of cost, and another 44 receiving 90 percent or more. Our analyses of access to and quality of care, described in Sections 2 and 3 of the February 2015 report, respectively, indicate that the current methodology provides rates for services that have been sufficient to maintain adequate access to care of reasonable quality. We should note, however, that the data related to the frequency of survey deficiencies shows some slight increases for some deficiency categories.

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.

It is expected that rates in SFY 2016, that are based on the current methodology, will result in slightly lower payment-to-cost coverage for SFY 2016 than previously determined in the February 2015 report provided to the Department. However, it should be noted that while the pay-to-cost ratio for all nursing facilities is decreasing, the pay-to-cost ratios actually increases by approximately 0.2 percent for hospital-based nursing facilities, and by approximately 2.4 percent for veteran and tribal nursing facilities when compared to the pay-to-cost ratios for these facilities under the current reimbursement methodology.

Overall, it would be difficult to predict the impact of no funding or rate increases upon access and quality in the State’s nursing facilities. We believe that it may motivate the facilities to operate more efficiently by reducing expenditures and possibly require facilities to increase rates for private pay residents, and/or increase other non-operating revenue such as investment income and donations.

1. Note that one facility (Avamere Georgian House) closed on January 22, 2015 and is excluded from the analysis. This provider was included in the February report provided to the Department. [↑](#footnote-ref-1)
2. 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-2)
3. 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-3)
4. This CMI was calculated “with defaults” as described in the previous footnote. [↑](#footnote-ref-4)