

APPENDIX A

An Overview of Medicaid Rate Setting for Nursing Facilities in Washington

Updated September, 2013

This is an overview of how payment rates are set for Medicaid patients receiving long term care in nursing facilities in Washington. It necessarily omits some details and simplifies some aspects of the process. However, it should assist in understanding the system's basic framework. The last major amendment to the rate methodology was made by the Legislature in c. 7, 2011 Laws, 1st sp. s. The overview also reflects provisions of the state operating budget for SFYs 2014 and 2015 (c. 4, 2013 Laws, 2d sp. s.), and the relatively minor amendments made in c. 3, 2013 Laws, 2d sp. s. The rate methodology is found in Ch. 74.46 RCW; related rules are in Ch. 388-96 WAC.

In Washington, Medicaid rates for long term care nursing facilities are set individually for each specific facility. Rates are based generally on a facility's costs, its occupancy level, and the individual care needs of its residents. However, the primary focus of the system is not to reimburse facility costs; rather, it is to pay for nursing care rendered to Medicaid-eligible residents in accordance with federal and state laws.

Medicaid nursing facility rates are set by the Nursing Home Rates Section of the Office of Rates Management (ORM), part of the Behavioral Health and Service Integration Administration (BHSIA) within Aging and Disability Services (ADS) of the Department of Social and Health Services (DSHS).

The overall Medicaid rate is comprised of rates for as many as nine separate components. The first six below are the main components that have existed for years; the last three are minor components that have been added recently:

- (1) **direct care** – nursing care and related care provided to residents;
- (2) **therapy care** – speech, physical, occupational, and other therapy;
- (3) **support services** – food and dietary services, housekeeping, and laundry;
- (4) **operations** – administration, utilities, accounting, and maintenance;
- (5) **property** – depreciation allowance for real property improvements, equipment and personal property used for resident care;
- (6) **financing allowance** – return on the facility's net invested funds, i.e., the value of its tangible fixed assets and allowable cost of land;
- (7) a **low-wage worker add-on** in the amount of \$1.57 per resident day for facilities electing to accept it. This began on July 1, 2008 and is intended to increase wages and benefits and/or staffing levels in lower-paid job categories;

- (8) a **pay-for-performance supplemental payment add-on** for high-performing facilities. To be eligible, a facility must have a direct care staff turnover rate of 75% or below. The funds to make this payment come from item (9); and
- (9) a **1% reduction to the rates of facilities** that have a direct care staff turnover rate above 75%. Items (8) and (9) began with July 1, 2010 rates.

In addition, for SFYs 2014 and 2015, a hold-harmless rate for facilities is continued. Each facility's rate as calculated on July 1, 2013 under the methodology then in effect is compared to the facility's rate in effect June 30, 2010. If the July 1, 2013 rate is lower, the difference is paid as an add-on. (This is called the "comparative analysis" add-on.) Also, if the July 1, 2013 direct care rate is greater than the June 30, 2010 direct care rate, the facility receives a 10% add-on to its direct care component rate to compensate for taking on more-acute residents. The same calculation and comparison was made for rates in SFYs 2012 and 2013.

Component rates are based on examined and adjusted costs from each facility's **Medicaid cost report**. For the period from July 1, 2007 through June 30, 2009, the direct care, operations, support services, and therapy care rate components were based on the 2005 cost report. From July 1, 2009, through June 30, 2015 those same four rate components are based on the 2007 cost report. Beginning July 1, 2015, those same four rate components will be based on the 2013 cost report. After that, those same four rate components will be automatically rebased every other year, in odd-numbered years, using the cost report from two years prior to the rebase period. So, rates paid on July 1, 2017 will be based on the 2015 cost report. Property and financing allowance components are rebased annually.

All component rates use, directly or indirectly, the number of **resident days** – the total of the days in residence at the facility for all eligible residents - for the applicable report period. Essentially, resident days are divided into allowable costs for the period, to obtain facility costs expressed as per resident day amounts.

For most rate components, resident days are subject to **minimum occupancy** levels. If resident days are below the minimum, they are increased to the imputed occupancy level. Since the same amount of costs is then being divided by a greater number of resident days, this has the effect of reducing per resident day costs and the component rates based on such costs. If the actual occupancy level is higher than the minimum, the actual number of resident days is used. The minimum occupancy for therapy care and support services component rates is 85%. For operations, financing allowance, and property component rates, the minimum occupancy is 87% for **essential community providers** – i.e., facilities at least a forty minute drive from the next closest nursing facility – in recognition of their location in lesser-served areas of the state. Other providers are separated into "small" (60 or fewer licensed beds) and "large" (more than 60 licensed beds) **non-essential community providers**. For **small non-ECPs**, the minimum occupancy for operations, financing allowance, and property component rates is 92%; for those same three component rates, the minimum occupancy for **large non-ECPs** is 95%. For all providers the direct care component rate is based on actual facility occupancy.

The **direct care** component rate averages approximately 56% of each facility's total Medicaid rate. Since October 1, 1998, all facilities' direct care component rates have been set using **case mix** principles. Data is taken from facility-completed, mandatory assessments of individual residents. Using a software program that groups residents according to their care needs, ORM determines for each facility both a facility average case mix index for all residents (FACMI) and a Medicaid average case mix index for Medicaid residents only (MACMI). The case mix index indicates the intensity of need for services by the residents.

ORM is required to array direct care costs per case mix unit separately for three **peer groups** of nursing facilities, depending on their location in 1) high labor cost counties – currently, only King County, 2) urban counties – those in a “metropolitan statistical area” (MSA) as defined by the federal government, and 3) nonurban counties – those not in an MSA. The **median** cost per case mix unit of each peer group – i.e., the point at which half of the facilities are above, and half below - is then determined. A facility's direct care cost per case mix unit is adjusted, if necessary, to bring it down to a ceiling of 110% of the facility's peer group median cost per case mix unit.

Previously, direct care component rates were updated effective the first day of each calendar quarter, to reflect changes in a facility's case mix. Beginning July 1, 2010, case mix adjustments are done semiannually. The FACMI used to establish each facility's direct care component rate is based on the average of calendar quarters of the facility's average case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate. The MACMI used to adjust the direct care component rate will be taken from the calendar six-month period beginning nine months prior to the effective date of the semiannual rate. However, to allow for the transition to MDS 3.0 and RUG IV, for July 1, 2013 through June 30, 2015, the MACMI effective January 1, 2013 will be used, increased by one-half of one percent every six months. The July 1, 2015 direct care cost per case mix unit will use 2013 direct care costs and 2013 FACMI based on MDS 3.0 and RUG IV grouper 57.

The rates for various other components are also subject to corridors or **lids**. For example, in establishing the **therapy care** component rate, ORM separately arrays one-on-one and consulting costs for each of the four types of therapy, both for urban and non-urban counties. Each facility's allowable costs for each category are **lidded** – i.e., set at the lower of the facility's actual cost or 110% of the applicable median.

The **support services** and **operations** component rates are based on a facility's allowable costs, subject to median lids. The lid in support services is set at 108% of the median costs for all facilities in a peer group. The lid in operations is set at the median cost. All lids are computed using the applicable minimum occupancy assumptions.

The **property** component rate reflects allowable depreciation expense for assets used in the provision of patient care. Finally, and with a few exceptions, the **financing**

allowance component rate is calculated by applying a factor of 4% to the net invested funds of each facility.

Nursing facilities wishing to undertake construction of a new or replacement building, or a major renovation project, must obtain a **certificate of capital authorization (CCA)** before depreciation or spending related to the project will be reflected in their property or financing component rates. Only projects requiring a Certificate of Need (CON), or a CON exemption, from the Department of Health are subject to the CCA requirement. Currently, projects costing less than \$2,403,990 do not require a CON and, therefore, do not require a CCA either. In 2008, the Legislature amended the law to establish a set of priorities for CCA applications; see RCW 74.46.803. For each of SFYs 2008, 2009, and 2010, total CCAs were limited to \$16 million per year. For SFYs 2011, 2012, and 2013 no CCAs were authorized, and none have been authorized for SFYs 2014 and 2015. It should be emphasized that these funds are not appropriations from the state. Rather, a CCA is an authorization for a facility to spend its own funds on a major construction project, without which authorization those funds will not be reflected in the facility's rate.

Adjustments are made to payment rates to reflect economic trends and conditions. These are generally called **vendor rate increases** and are defined in the biennial appropriations act. The Legislature granted such an adjustment for economic trends and conditions to the direct care, operations, support services, and therapy care components of 3.2%, effective July 1, 2007, and 1.99% effective July 1, 2008. In the biennial operating budget adopted in 2009, the Legislature clarified that a vendor rate increase granted in one year is not to be compounded with a vendor rate increase from any other year. There was no vendor rate increase for SFYs 2010 through 2013, and there will not be any for SFY 2014 or SFY 2015.

Previously, facilities could engage in **bed banking** under Ch. 70.38 RCW by temporarily reducing the number of patient beds for which they were licensed. This option could result in an upward revision of component rates. When beds were **unbanked** – i.e., returned to licensed status – component rates could be subject to downward revision, if indicated. Beginning July 1, 2010, facilities may still bank beds but bed banking has no effect on rates. For purposes of computing occupancy levels, licensed beds will include any beds banked under Ch. 70.38 RCW. Beds that are **relinquished** are permanently removed, and are not included in the number of licensed beds.

In a process called **settlement**, direct care, therapy care, and support services component rates are compared to each facility's expenditures in those categories for each report period. A facility may retain any overpayment up to 1.0% in each of these three rate components. There is a limited ability to shift cost savings from one component to cover a deficit in another component. After any allowable shifting is done, a facility must return overpayments of more than 1.0% to DSHS. The purpose of the settlement process is to provide facilities an additional incentive to spend their rate for the necessary care and well being of their residents.

Finally, 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 reduce 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 2014 at \$171.35, and for SFY 2015 at \$171.58.**

In the biennial budget act passed in 2009, the Legislature originally set the budget dial rate for SFY 2010 at \$156.37, and for SFY 2011 at \$158.74. However, in July of 2009, DSHS was sued in U.S. District Court in Tacoma over the Legislature's action in setting the dial figure at these levels; see Washington Health Care Association v. Dreyfus. In that case, the court issued a Temporary Restraining Order (TRO) enjoining DSHS from applying the budget dial provision of RCW 74.46.421 to Medicaid nursing facility rates as of July 1, 2009. In the supplemental budget passed in 2010, the Legislature re-set the budget dial rate for SFY 2010 at \$169.85, thereby essentially funding the rates resulting from the TRO for the entire fiscal year. At the same time, the Legislature re-set the budget dial for SFY 2011 at \$166.24; that figure resulted from the changes to the rate methodology made in c. 34, 2010 Laws 1st sp. sess. As a result of these actions, all of the plaintiffs in Washington Health Care Association v. Dreyfus agreed to dismiss their claims, with the exception of four facilities run by one operator. The state then moved to dismiss the action entirely, the operator did not respond to that motion, and the action was dismissed.

In 2010, three facility operators filed another action in U.S. District Court in Tacoma, Eagle Healthcare, Inc. v. Dreyfus. This action was very similar to the one filed in 2009, but was directed against the July 1, 2010 rates, and the Legislature's actions which resulted in them. The District Court refused the plaintiffs' request for a TRO against the July 1, 2010 rate changes. Plaintiffs appealed to the U.S. Court of Appeals for the Ninth Circuit, and on August 27 that court issued an order enjoining the July 1, 2010 changes. However, by its own terms that order was terminated on September 27 when the federal Centers for Medicare and Medicaid Services (CMS) approved Washington's Medicaid State Plan Amendment that included the July 1, 2010 changes. Early in the 2011 session, the Legislature reduced the budget dial again; the resulting rates were issued, to be effective April 1, 2011. However, the Eagle plaintiffs requested a TRO against them, and this time the district court (by a substitute judge) granted it. The court applied the TRO to all facilities, not just the Eagle plaintiffs. Later in 2011, the Legislature again "backfilled" the rates for the final quarter of SFY 2011. The U.S. District Court first stayed all proceedings in Eagle Healthcare, Inc. v. Dreyfus, pending a ruling by the U. S. Supreme Court in cases from California. In October, 2012 the Eagle Healthcare litigation was ended by a stipulated order of dismissal. Eagle Healthcare effectively upheld the original July 1, 2010 rates.

In 2011, the Legislature enacted a Safety Net Assessment (SNA) – essentially, a fee imposed on nursing facilities for each non-Medicare resident day at the facility. Funds raised by the SNA, and the federal matching funds they attract, are used to maintain and enhance Medicaid nursing facility rates. The SNA is currently set at two levels: \$14 and \$1 per resident day. Approximately 155 facilities pay the higher amount, and about 10 pay the lower. About 60 facilities are exempt under a variety of statutory provisions. The Department sought and received a waiver from CMS in relation to the SNA. An up-front payment to reimburse the SNA paid in relation to Medicaid residents is added to nursing facility rates. The SNA law is found in Ch. 74.48 RCW.

The website of ORM is located at <http://www.altsa.dshs.wa.gov/professional/rates>. ORM has made a sustained effort to put as much information as possible on the site, including a listing of the daily Medicaid rates paid to all Medicaid-contracted nursing facilities in Washington (broken out by component rates), and the “public disclosure disc” compilation of information from the 2012 Medicaid cost reports filed by each facility. Portions of the Nursing Facility Information System are available to the public at <http://adsaweb/nfis>.