Toward a Simplified Medicaid Payment System for Nursing Homes in Washington State

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Primary Objectives

- To propose a less complex system for reimbursing nursing homes under Medicaid

- To direct a higher proportion of Medicaid nursing home reimbursement toward nursing and other direct patient care services

Tasks Completed

- Review of Other States' Methodologies
- Inter-state Case Studies
- Evaluation of Washington's Current Methods
- Proposal and Rationale for New Payment System

Long-Term Care Policy, Market, and Performance Study

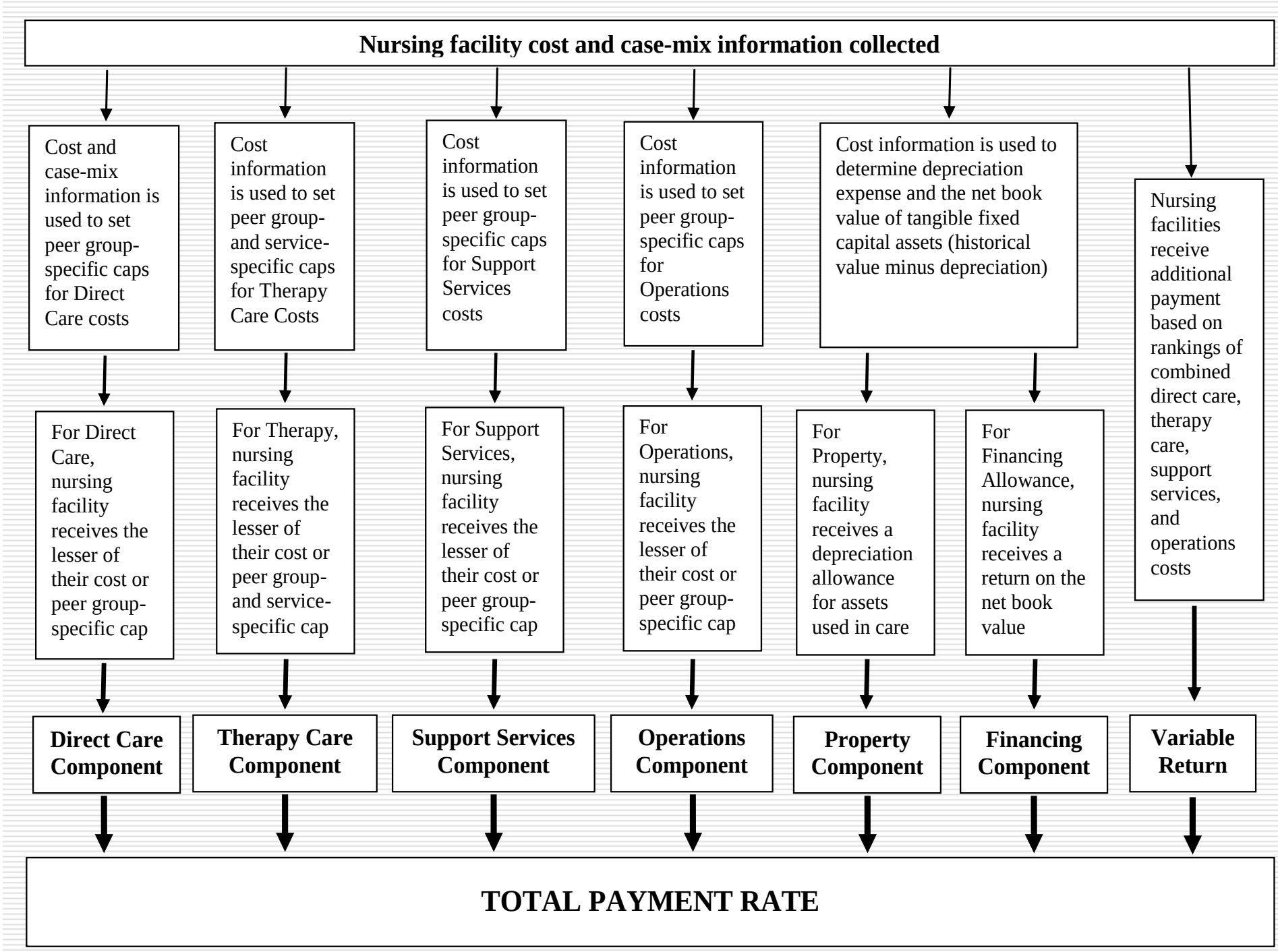
Take Away Lessons

- Payment system with positive attributes:
  - A relatively generous rate
  - Case-mix adjustment
  - Minimum staffing standards
- Leader in community transitions:
  - Proportionally high amount spent on HCBS
- Stronger performer in the NH sector:
  - Medicaid occupancy
  - Staffing
  - Low number of low acuity NH residents

Inter-State Case Studies

System Complexity

- There appears to be widespread belief that the current system needs to be simplified…
- For Medicaid Officials, its due to the:
  - "…the complexity of understanding it, the complexity of trying to predict its budgetary impact, and the complexity of establishing rates on a quarterly basis…"
- For Providers, its due to the:
  - "…the challenge of having to describe the system to legislators so they can embrace it and understand it and be willing to allocate funding to it…"
- For Legislators, its due to the:
  - "…the issue of transparency and the desire to incentivize the system in a more direct way to achieve higher quality and better outcomes…"


Nursing facility cost and case-mix information collected
Cost and case-mix information is used to set peer group-specific caps for Direct Care costs
Cost information is used to set peer group- and service-specific caps for Therapy Care Costs
Cost information is used to set peer group-specific caps for Support Services costs
Cost information is used to set peer group-specific caps for Operations costs
Cost information is used to determine depreciation expense and the net book value of tangible fixed capital assets (historical value minus depreciation)
Nursing facilities receive additional payment based on rankings of combined direct care, therapy care, support services, and operations costs
For Direct Care, nursing facility receives the lesser of their cost or peer group-specific cap
For Therapy, nursing facility receives the lesser of their cost or peer group- and service-specific cap
For Support Services, nursing facility receives the lesser of their cost or peer group-specific cap
For Operations, nursing facility receives the lesser of their cost or peer group-specific cap
For Property, nursing facility receives a depreciation allowance for assets used in care
For Financing Allowance, nursing facility receives a return on the net book value
Direct Care Component
Therapy Care Component
Support Services Component
Operations Component
Property Component
Financing Component
Variable Return
TOTAL PAYMENT RATE

System Complexity

- Both officials in Washington and other states believe their reimbursement systems are complex
- Complexity derives from both basic system characteristics and supplemental features
- There may be a tradeoff between simplifying and incorporating features designed to accomplish desired policy objectives
  - Several respondents pointed to a tradeoff between being “simple and fair,” with fairness requiring a certain degree of complexity
- Most state officials recognize their methods for reimbursing nursing homes were complicated by a desire to achieve particular goals

Evaluation of Washington State's Nursing Home Payment System

Methodology

- Examine the seven Cost Components
  - Contribution to the overall rate
  - By provider types
- Examine the relationship of CMI and Non-Capital Cost Components
  - Simulate rates based on aggregating Non-Capital cost components to which apply CMI-adjustment
- Examine the role of Caps, Peer Groups, Minimum Occupancy
  - Simulate rates under different cap/peer group/minimum-occupancy scenarios

Data Sources

Data used in the July, 2007 rate setting process

- Facility Cost Reports (2005 and 2006)
  - To determine allowable costs
- Minimum Data Set (2005 and 2007Q1)
  - To determine 2005 Facility CMI and Medicaid CMI
- OSCAR
  - To corroborate & complement facility data

Key Variables

- Resident Days (Total and Medicaid)
  - Used to construct costs per resident day
  - Complexity:
    - Adjustments can differ among cost components
    - Minimum Occupancy affects all cost components except for Direct Care (Min Occ. varies by Essential Community Provider)
- Case Mix Index
  - Used to adjust Direct Care costs per resident day
- Peer Groups (for cap calculations)
  - Differ by cost components (up to three: King County, other Urban counties, Non-Urban)

Other Relevant Variables

- Licensed Beds
- Hold Harmless
- Variable Return (Efficiency payment)
  - Rate component that rewards most those with lowest combined adjusted DC, TH, SS and OP costs.

Results (Facility Costs and Current Rates)

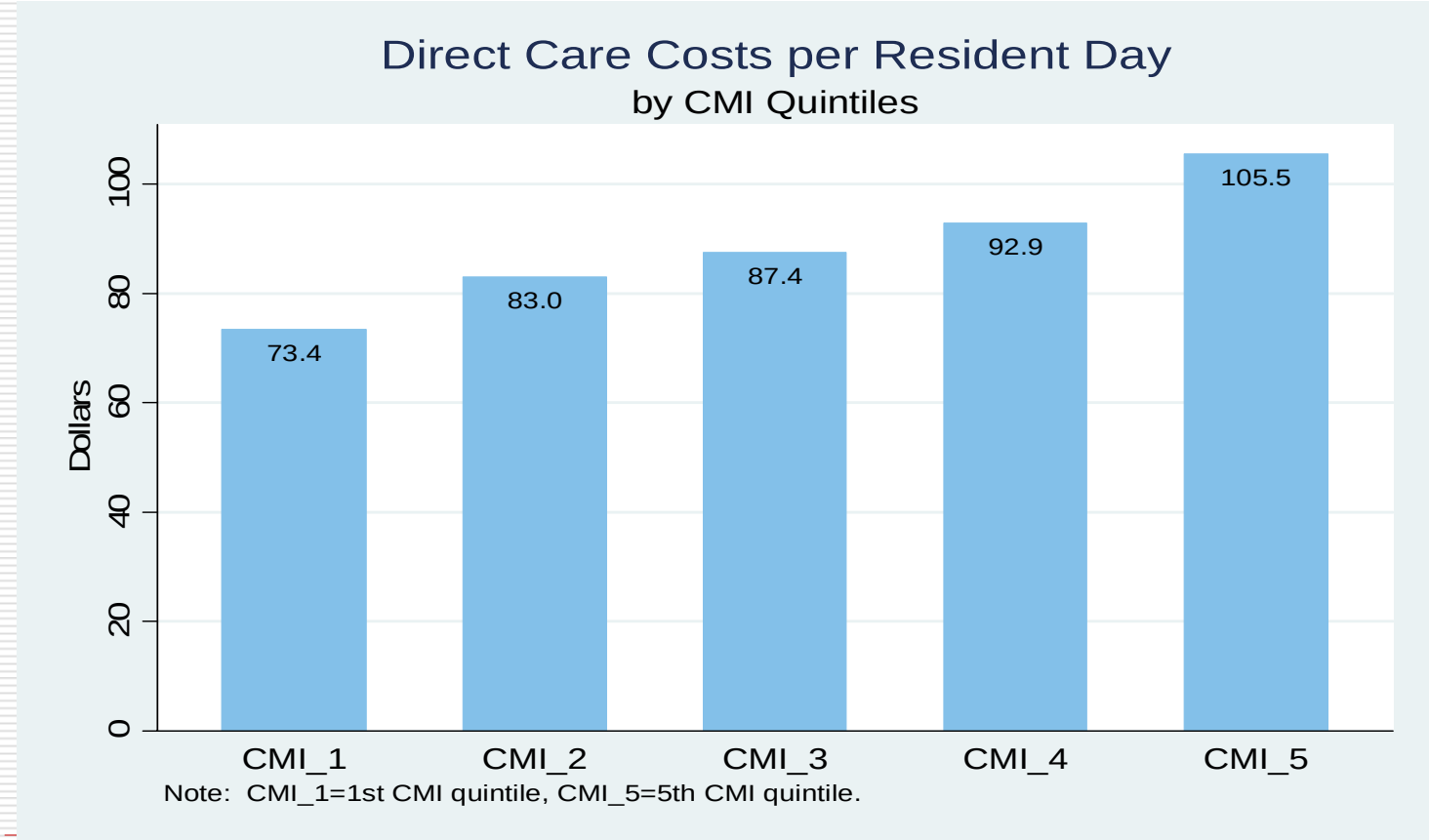
Non-Capital Costs dominate Total Costs:

- Direct Care $96.14 (56.2%)
- Support Services $23.61 (13.8%)
- Operations $34.21 (20.0%)
- All Capital $12.23 (7.1%)

Results

- Direct Care, and Therapy Costs strongly related to facility CMI.
- Support Services and Operations are less sensitive to CMI
- Relationship of all cost components to CMI is strongest in all counties other than King County

Direct Care vs. CMI



Exploring New Rates

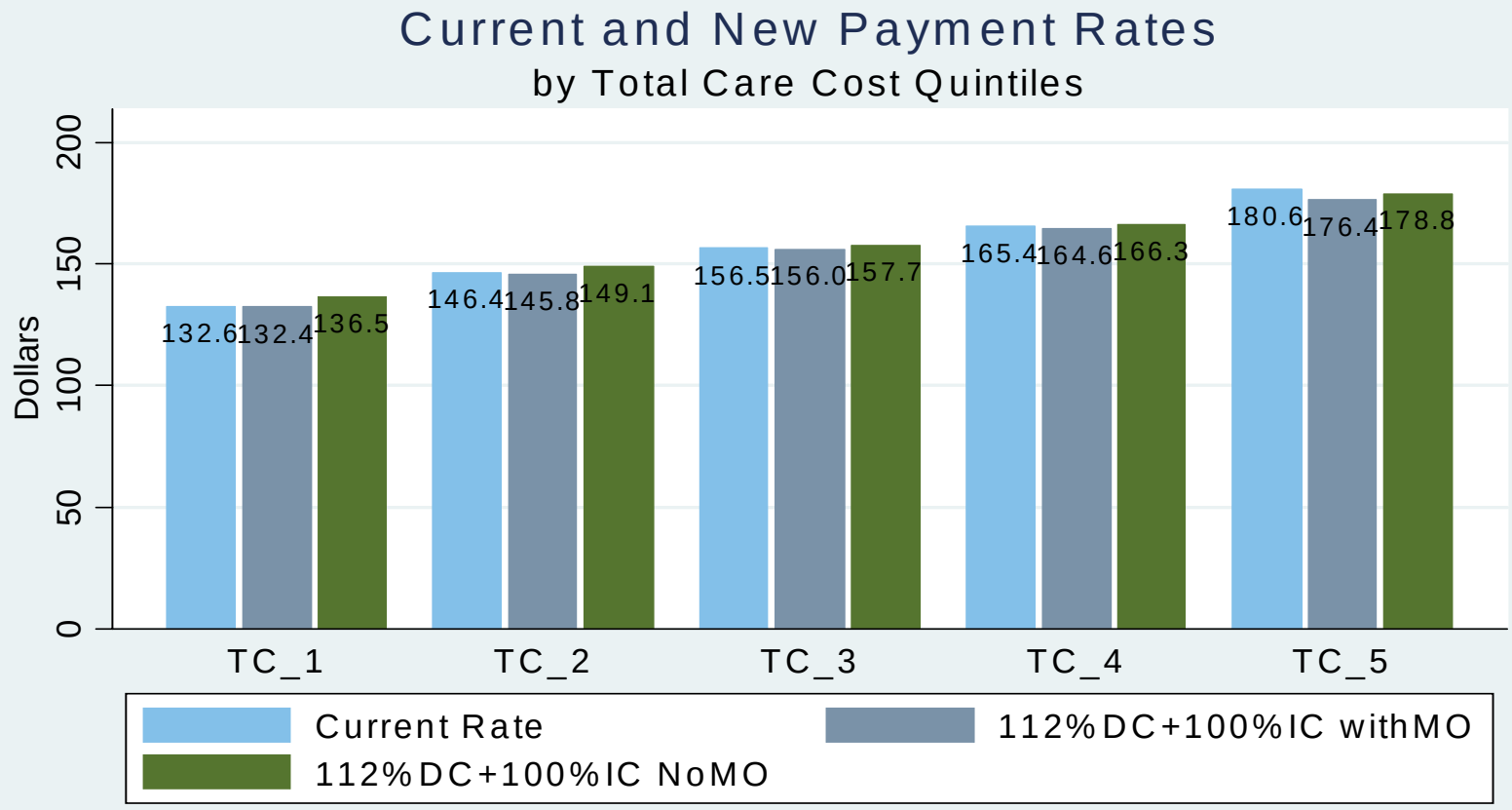
- CMI-Adjusting of Expanded Direct Care (DC+TH+SS).
- No CMI-adjustment of Operations
- Elimination of Minimum Occupancy
- Changes in % of median used in caps

Simulation Results

- **CMI adjustment of Expanded DC**: very small (negative) effect on rates (biggest among High-Cost Non King County facilities)
- **Elimination of Min Occupancy**: Increase in rates (primarily among Low-Cost facilities) except for High-Cost Non King County facilities

Current vs. New Rates w/ & w/out Minimum Occupancy

(same caps)



Note: TC_1=1st Total Care Cost quintile, TC_5=5th Total Care Cost quintile.

Bailey-Boushay House for AIDS residents excluded.

Budget Neutrality

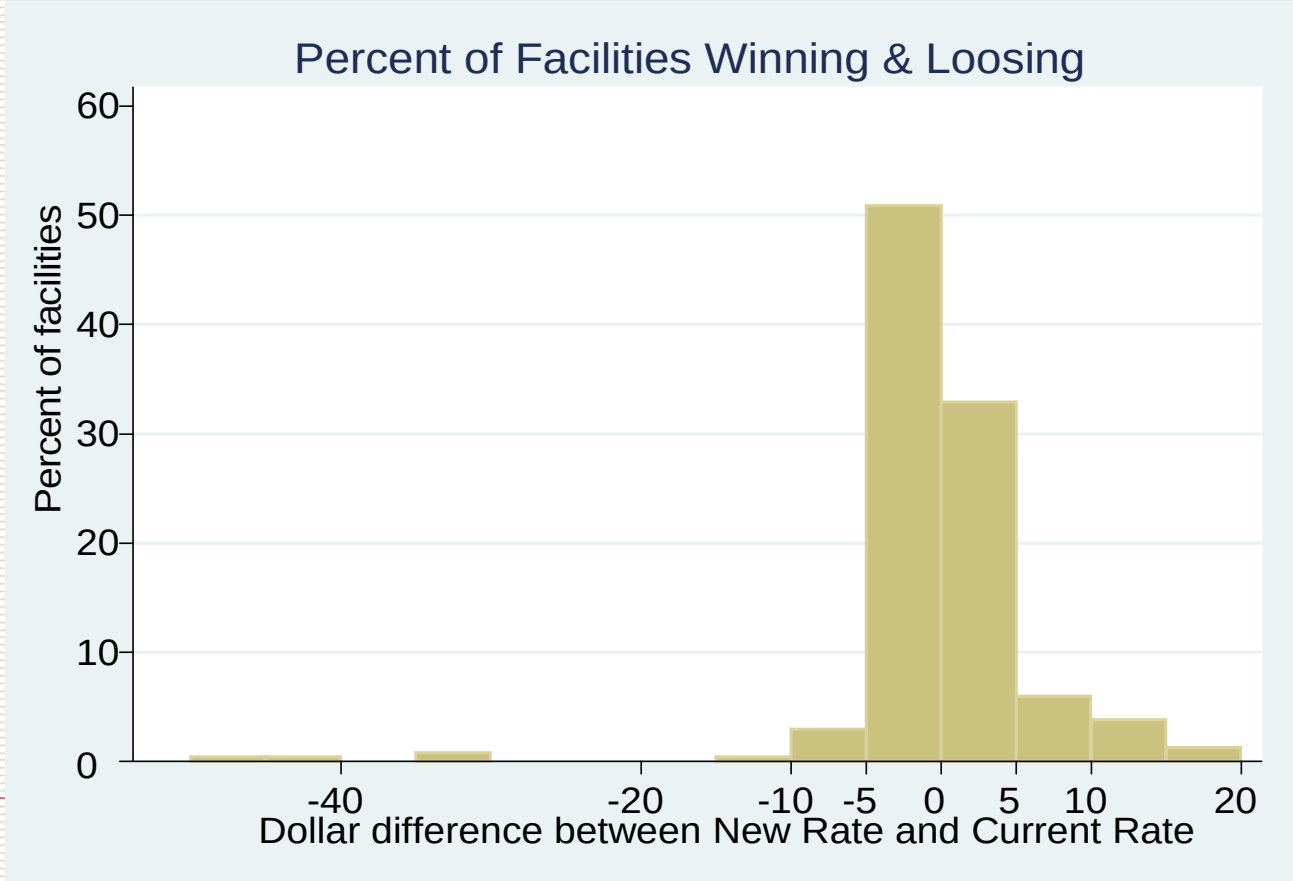
- Calculate effect on overall Medicaid Budget of different No Minimum Occupancy rate scenarios
- Use different cap mechanisms to achieve Budget Neutrality

Medicaid Budget for Different Rate by Peer Group (in $millions)

PEER GROUP	N	CURR	112%DC, 100% IC (2 caps)	110%DC, 100% IC (1 cap)	110%DC, 95% IC (1 cap)	112%DC, 95% IC (1 cap)	110%DC, 90% IC (1 cap)	112%DC, 90% IC (1 cap)
KC	54	189.63	192.22	191.96	190.79	191.50	189.35	190.05
URBAN	133	397.12	399.45	398.83	396.91	398.27	394.70	396.06
NonURB	47	84.36	86.24	85.12	84.59	84.80	83.97	84.18
Total	234	671.12	677.91	675.91	672.30	674.58	668.02	670.30

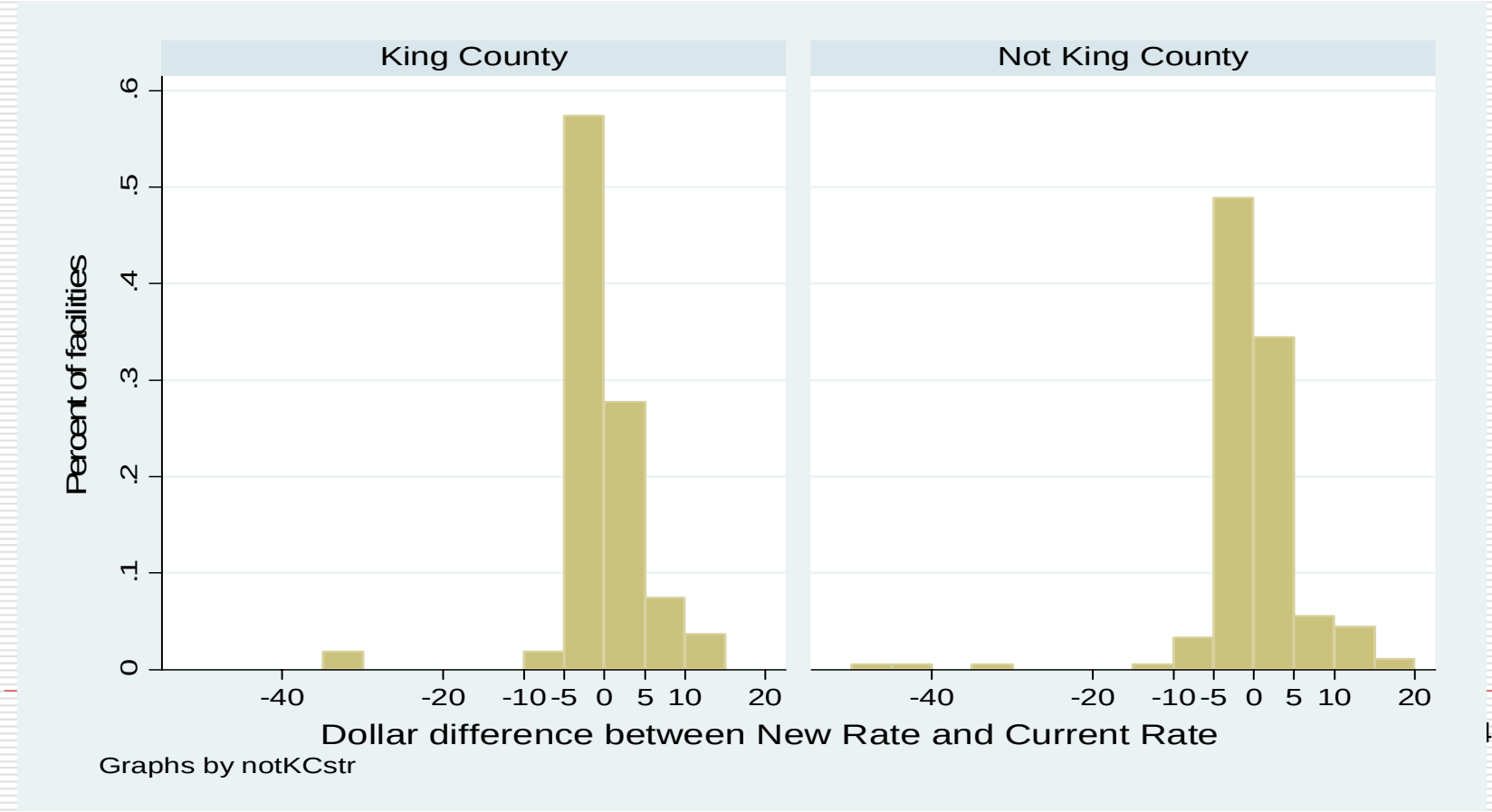
Gain/Loss Distribution

- No Minimum Occupancy, Direct (DC+TH+SS) at 112% of 3 peer group median, Indirect (OP) at 90% of overall median.



Gain/Loss Dbn. by King County

- No Minimum Occupancy, Direct (DC+TH+SS) at 112% of 3 peer group median, Indirect (OP) at 90% of overall median.



Take Away Lessons

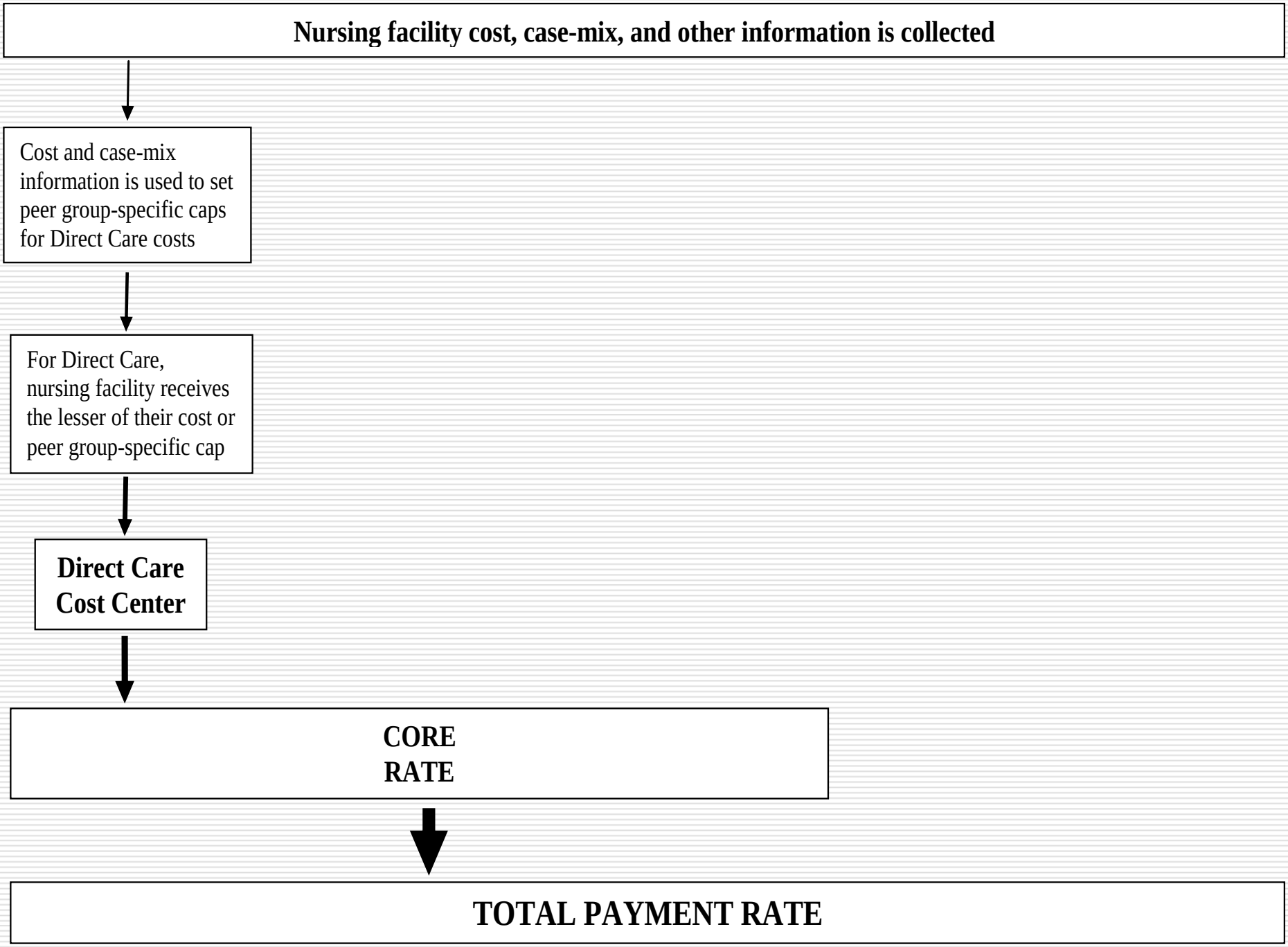
- Grouping of Direct Care, Therapy, Support Services into Expanded Direct Care has little overall effect
- Elimination of Minimum Occupancy increases effect on rates for larger facilities
  - Reduces Direct Care Costs but causes a stronger Increase on Indirect (Operations) Costs resulting on an overall Budget Increase
  - Suggest shifting to 1 peer group for Indirect Care to control negative redistributive effect
  - Adjust of Cap's % needed to achieve Budget Neutrality

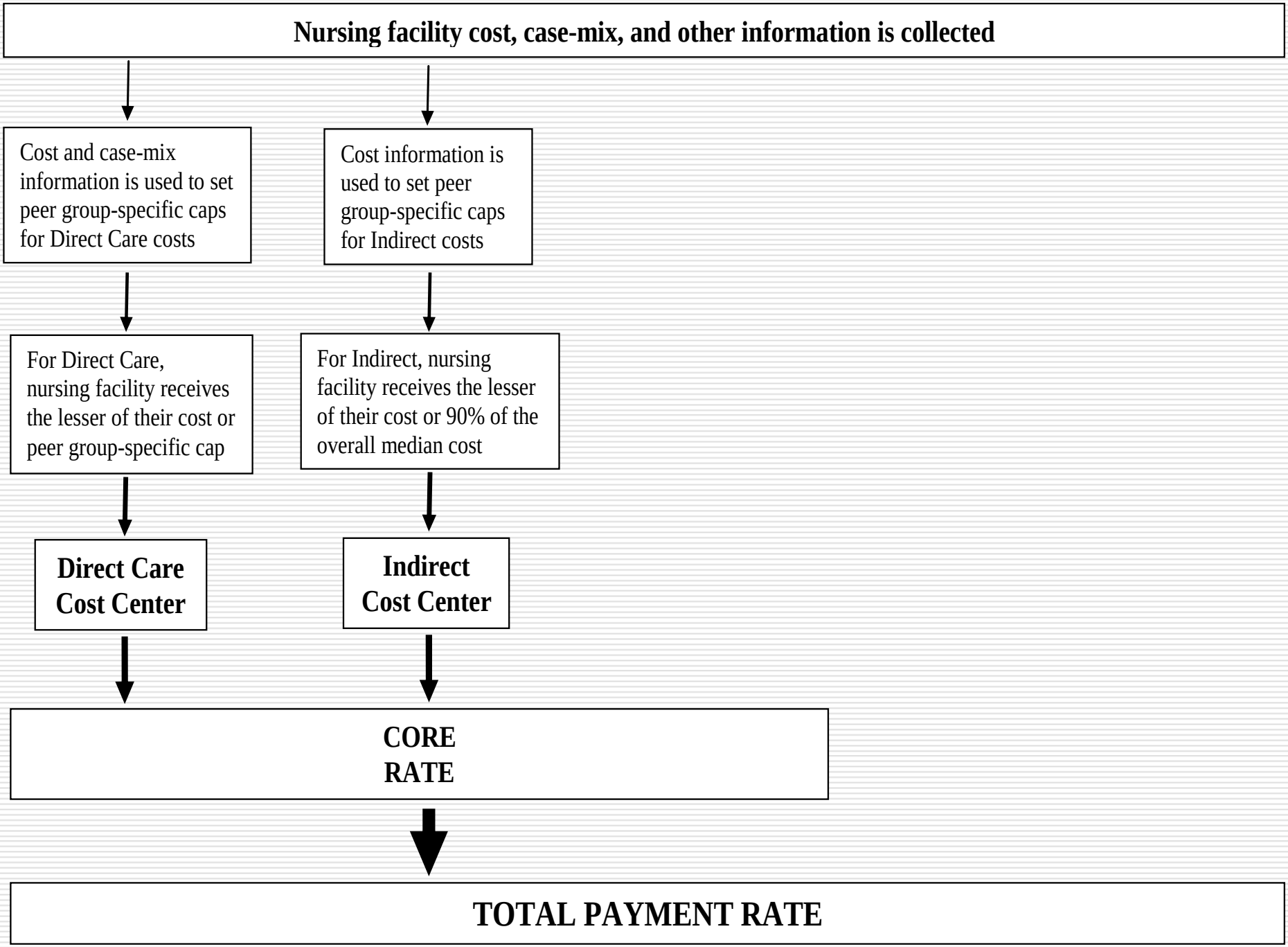
Proposed Medicaid Nursing Home Reimbursement System

Nursing facility cost, case-mix, and other information is collected

CORE RATE

TOTAL PAYMENT RATE


Nursing facility cost, case-mix, and other information is collected
Cost and case-mix information is used to set peer group-specific caps for Direct Care costs
For Direct Care, nursing facility receives the lesser of their cost or peer group-specific cap
Direct Care Cost Center
CORE RATE
TOTAL PAYMENT RATE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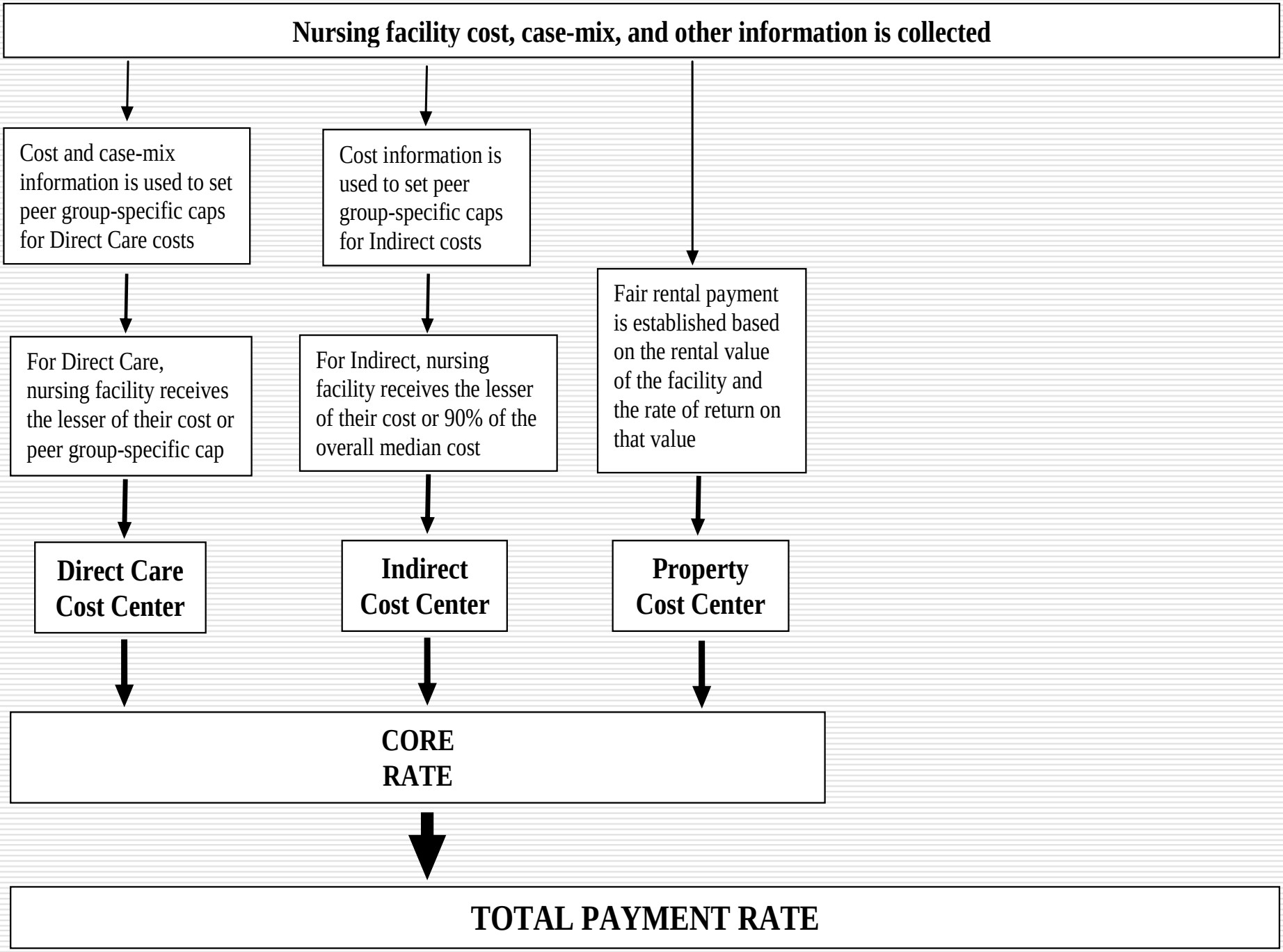
For Indirect, nursing facility receives the lesser of their cost or 90% of the overall median cost
Direct Care Cost Center
Indirect Cost Center
CORE RATE
TOTAL PAYMENT RATE

Recommendation

- *The bundling of direct care, therapy, and (part of) support services into a direct care component and the operations cost and (part of) support services components into an indirect cost center, with payments based largely on case-mix acuity with cost caps applied in a similar manner to the existing payment system on direct care.*
- *Going from 4 to 2 cost components*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Cost and case-mix information is used to set peer group-specific caps for Direct Care costs
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Fair rental payment is established based on the rental value of the facility and the rate of return on that value
For Direct Care, nursing facility receives the lesser of their cost or peer group-specific cap
For Indirect, nursing facility receives the lesser of their cost or 90% of the overall median cost
Direct Care Cost Center
Indirect Cost Center
Property Cost Center
CORE RATE
TOTAL PAYMENT RATE

Recommendation

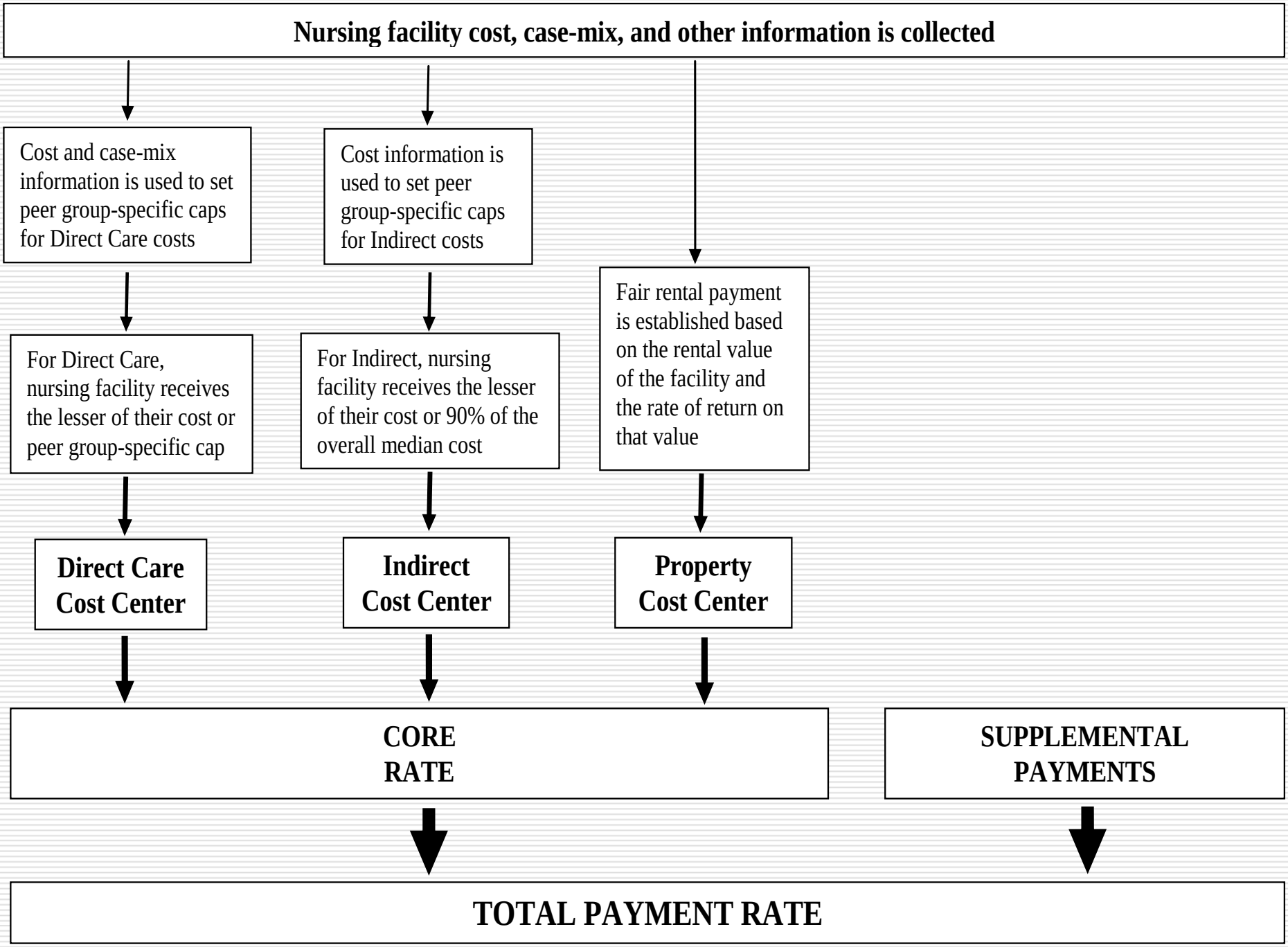
- *The adoption of a fair market value approach for capital-based costs and repeal of certificate-of-capital authorization (CCA) requirements*

Justification

- Capital Costs
  - Portion of per diem rate associate with construction, acquisition or lease of land, buildings or equipment used in resident care
- Current WA Capital Method
  - Historical construction or purchase costs
  - Two components: property (depreciation) and financing allowance (return on net book value)
  - Certificate-of-capital authorization (CCA) required for add-ons
- Proposed Fair Rental Capital Method
  - Pays a simulated rent, or return on the appraised value a facility's assets, in lieu of separate payments for depreciation and interest

Justification

- Simplifies the way capital costs are reimbursed
- Increases predictability for all parties
- Gives providers an incentive to better maintain their buildings—the more improvements and renovations, the lower the effective age and the higher their rate of reimbursement
- Provides state with opportunities to adjust spending over time, whether through the depreciation rate or rate of return, or limits on allowable square footage per bed
- Promotes long-term ownership and greater industry-wide stability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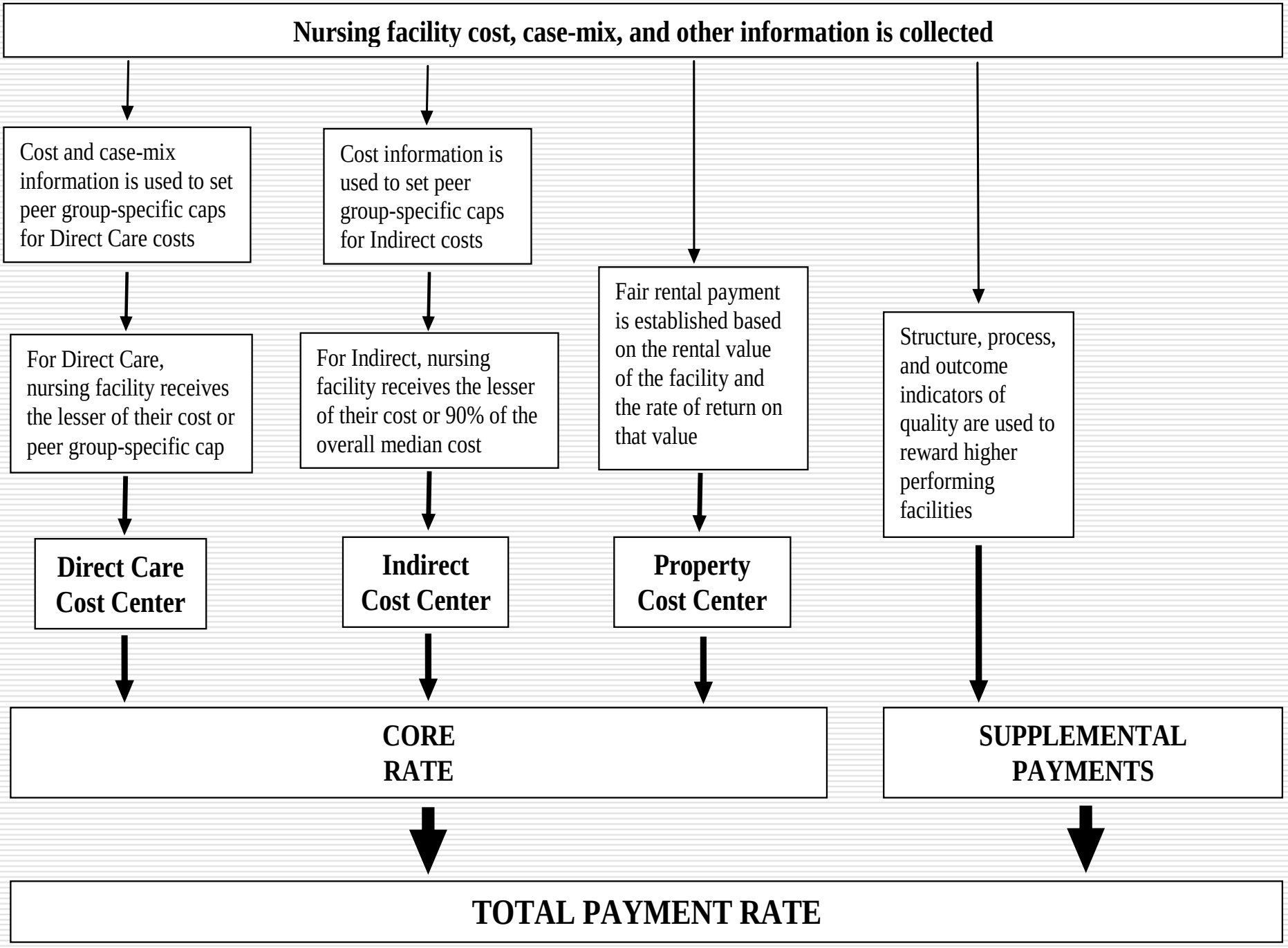
Direct Care Cost Center
Indirect Cost Center
Property Cost Center
CORE RATE
SUPPLEMENTAL PAYMENTS
TOTAL PAYMENT RATE

Recommendation

- *Make supplemental reimbursements consistent with policy objectives without incorporating them into the payment rate model*

- *The implementation of supplemental payments (outside the base rate) to nursing homes based on indicators of performance*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Structure, process, and outcome indicators of quality are used to reward higher performing facilities
For Direct Care, nursing facility receives the lesser of their cost or peer group-specific cap
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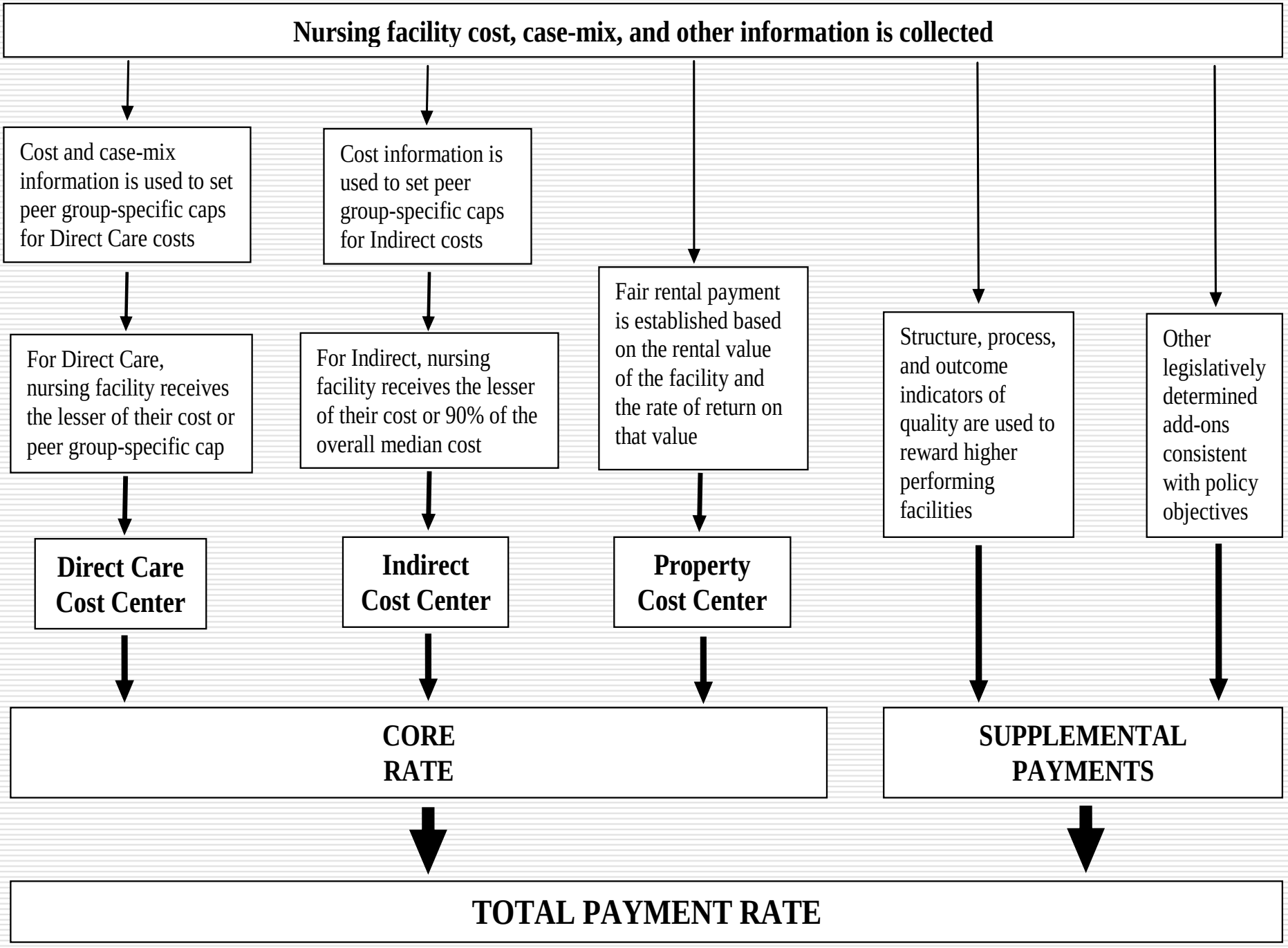
Direct Care Cost Center
Indirect Cost Center
Property Cost Center
CORE RATE
SUPPLEMENTAL PAYMENTS
TOTAL PAYMENT RATE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Fair rental payment is established based on the rental value of the facility and the rate of return on that value
Structure, process, and outcome indicators of quality are used to reward higher performing facilities
Other legislatively determined add-ons consistent with policy objectives
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For Indirect, nursing facility receives the lesser of their cost or 90% of the overall median cost
Direct Care Cost Center
Indirect Cost Center
Property Cost Center
CORE RATE
SUPPLEMENTAL PAYMENTS
TOTAL PAYMENT RATE

Justification

- **Makes explicit the monetary extent of the reimbursement increase**
  - no hidden effects through unforeseen changes to the rate
- **Can be modified annually**
  - Becoming part of the rate, as currently, they have effects for more years than originally intended
- **Can target specific facilities**
  - No unwanted effects to facilities through rate changes

Recommendation

- *Rebasing the rates at least once every three years, but introducing some uncertainty as to when the rebasing will occur*

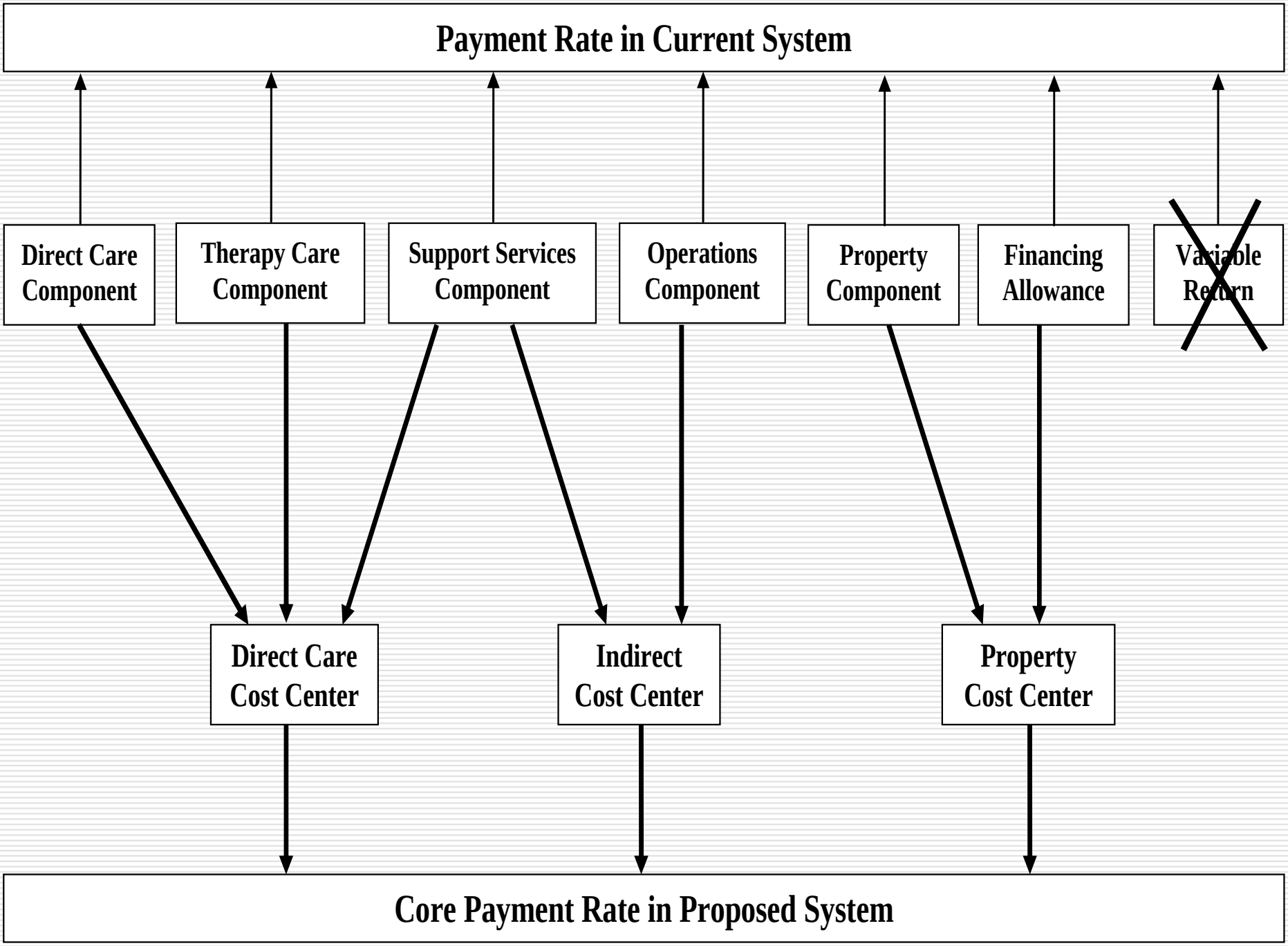
Justification

- **DSHS spends too much time collecting, processing, adjusting and settling cost disputes**
  - Constant processing of annual rebasing leads to errors
  - Settlement process is unpleasant and inefficient (high cost to DSHS for the potential saving)
- **Allow more time for verifying the accuracy of reported costs**
- **Uncertainty of rebasing year will help keep providers honest**

Recommendation

- *Given the importance of case-mix acuity in the proposed system, improving the collection and auditing of Minimum Data Set Assessments*

Transition from Current to Proposed Medicaid Nursing Home Reimbursement System


Payment Rate in Current System
Direct Care Component
Therapy Care Component
Support Services Component
Operations Component
Property Component
Financing Allowance
Variable Return
Direct Care Cost Center
Indirect Cost Center
Property Cost Center
Core Payment Rate in Proposed System

Recommendation

- *A graduated implementation of the recommendation listed above over several years, with a subsequent evaluation of costs, access, and quality following the payment change*