REPORT TO THE LEGISLATURE

Proposal for Phased in Implementation of the Patient Driven Payment Model for Nursing Facility Case Mix

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1 INTRODUCTION

Nursing facilities are a critical component in the continuum of care for those in need of long-term services and supports in Washington. Approximately six out of every ten nursing facility residents is on Medicaid and maintaining a Medicaid rate methodology that is responsive to the changing needs of those clients is critical to this network of providers.

During the 2024 session the Legislature, through SSB 5802, directed the Department of Social and Health Services to implement a new method for applying case mix adjustments to the rate and submit two reports on the progress of that implementation.[i] The reports are to include an analysis of the potential impact to rates, proposed adjustments to capture needs not captured in the existing data, and a plan to monitor the effects. This is the first of the two reports.

2 WHAT IS THE PATIENT DRIVEN PAYMENT MODEL

Washington state's nursing facility Medicaid rate methodology uses case mix in the rate calculation[ii]. Case mix is a method of adjusting nursing facility payment rates based on the characteristics of the facility's residents. This adjustment serves many purposes, including incentivizing facilities to take higher acuity residents, more accurately reflecting the cost of care for Medicaid residents as a percentage of a facility's population, and safeguarding taxpayer money by ensuring facility payments are based on the needs of their Medicaid residents. The state does not collect this information directly.[iii] Facilities are required by the Centers for Medicare and Medicaid (CMS) to assess client acuity on a regular basis in addition to in response to a change in acuity. CMS processes this information into acuity classifications. Previously this system was called Resource Utilization Groups, more commonly called RUGs for short. CMS discontinued their calculation of RUGs in favor of a new system, the Patient Driven Payment Model (PDPM).

PDPM also measures client acuity but changes how the information is grouped and weighted. Most notably it shifted from a focus of capturing treatment to capturing diagnoses. States that relied on RUG data to calculate Medicaid rates needed to switch to PDPM, attempt to capture case mix through another channel[iv], or move away from acuity adjustments to the rates. Washington elected to implement PDPM while monitoring industry-wide effects with the understanding that as more data is collected over time there may be some necessary adjustments.

PDPM includes six components, five of which are adjusted based on resident acuity. The components adjusted based on acuity are nursing, physical therapy, occupational therapy, speech-language pathology, and non-therapy ancillary. Medicare and Medicaid do not always cover the same services and not every component is necessarily as relevant to the Medicaid rate as it is to the Medicare rate. For example, Medicare covers the post-acute population where patients are transitioning from a hospital stay back to their prior living environment. These residents tend to require more therapy, have higher medication costs and require the care of a skilled professional on a daily basis. Medicaid residents tend to stay longer and the focus of care is on help with activities of daily living and skilled nursing. This difference in type of care and services needs means importing PDPM to Washington's Medicaid methodology exactly as CMS has implemented it for Medicare would likely not reflect the reality of the client mix.

3 Current Implementation

For initial implementation beginning July 1, 2024, the Department is using only the nursing component for case mix adjustment. Nursing constitutes the majority of spending that is acuity dependent for Medicaid clients. Additionally, without any information on how PDPM would impact rates over time, there was a desire to keep implementation simple at the beginning to minimize variables and understand PDPM more fully.

Because PDPM changed the organization and processing of the raw acuity data, when the Department initially calculated the July 1, 2024, rates many facilities rates experienced large increases or decreases. There was an expectation that PDPM would change the case mix adjustment for most facilities, but the range of change from facility to facility was significant. In order to avoid a sudden disruption to the industry, the Department decided to phase in to "full implementation" by implementing a hold harmless and growth cap, each of which would be adjusted over the coming years.

The hold harmless lessens the impact of potential rate drops due to this change in case mix methodology. The Department recognizes that this abrupt change in rate is due to the change in how it is calculated and does not represent a change in the actual client mix served in a facility. This hold harmless limited the amount that a rate could change negatively due to case mix switching to PDPM. To pay for the hold harmless, a cap on rate gains was implemented. This was possible because some rates would have seen increases equally large. The hold harmless was set at the direct care rate of

each facility on June 30, 2024, inflated by 9%, meaning if a facility's calculated July 1, 2024, direct care rate was lower than their June 30, 2024, direct care rate plus 9%, their July 1, 2024, direct care rate was set at that facility specific hold harmless amount. The rate cap was then calculated by determining the cost of the hold harmless industry-wide and implementing a limitation on growth to the extent necessary to stay within appropriations. That rate cap was calculated to be approximately 15% above the June 30, 2024, direct care rate meaning no provider direct care rate would greater than their June 30, 2024, direct care rate plus approximately 15%.

Calculating rates and operating a business using PDPM is new for everyone right now. We expect to see facilities adapt to this new system which will likely reduce the gap between the "winners," or facilities who saw rate gains due to PDPM, and "losers," or facilities that would have experienced a negative adjustment to their rate due to PDPM.[v] The Department's goal is to keep the impacts from PDPM relatively stable during the transition to allow facilities time to prepare and adjust for a full implementation without a hold harmless or growth cap. This stability will also help the Department understand better the impacts of PDPM on the rate calculation and assess whether adjustments are needed in the calculation overall or to address specific diagnoses or circumstances. The implementation of PDPM was not the only adjustment to the rate beginning July 1, 2024, so the ability to understand its impacts to that extent is not possible with current data.

4 WORKGROUP

The Department met with representatives from the associations during the initial decision making process on the implementation of FY25 rates. After July 1, 2024, larger workgroups were held to discuss the long-term implementation plan. Attendees included leaders of both industry associations, cost report consultants and preparers, nursing facility employees who coordinate and complete the MDS assessments, and SEIU 775.[vi] The workgroup largely faced the same hurdles as the Department in that PDPM implementation was so new that any proposed adjustments were made on anticipated data or results. There were a handful of proposals, but none were significantly different from what the Department implemented for the rates beginning July 1, 2024 It was noted that some states had utilized a mix of various PDPM components, weighting them according to perceived percentage of spending or importance. Some more specific adjustments were proposed, for example adjusting the case mix of a resident with HIV/AIDS more than PDPM already does.

5 PROPOSAL

The Department recommends continuing the usage of only the nursing component for Medicaid rate case mix adjustment at this time. It is important to establish an understanding of the effects of PDPM on the rate and how each component could change before enacting further changes to the case mix methodology. As noted previously, other changes were made to the rate calculation for the July 1, 2024 rate, so the collection of this data over time will help sort the impacts from one-time changes and the continuing effects of PDPM.

The Department will monitor the impact of the nursing component on the rate to see if the rates "normalize" as facilities become accustomed to the new calculations, meaning the gap between the biggest drops and largest gains decreases. It may also show a consistent response to PDPM implementation indicating that, at least for those facilities, the initial PDPM calculations were accurate reflections of their case mix and spending.

Additionally, the Department receives all the component data from CMS even if only the nursing component is utilized in the calculation. We will be running models to examine the effects that implementing various combinations and weightings of the other components would have on the rates. This will also involve examining the additional calculations against the costs submitted by facilities to determine if any particular component, or combination or proportion of components is more easily identifiable as reflecting cost of care.

While examining this data over the coming years, the Department also recommends maintaining the hold harmless and the growth cap, with a phase out period. This is based on current data, however monitoring the effects will include regular evaluation of the continued need for a hold harmless.

With regard to smaller tweaks for specific situations or diagnoses, the Department recommends continuing our current enhanced rate programs but not implementing any new adjustments. Currently there isn't enough data to know if additional adjustments are needed in PDPM. The continued monitoring of PDPM implementation includes examination of facilities that receive current enhanced rates, as well as proposed enhanced rates, to see if PDPM is accurately capturing those specific cases sufficiently to be covered in the regular rate adjustments or if an enhanced rate is still needed.

6 NEXT STEPS

In the immediate future, the Department will continue to monitor the effects of PDPM on the nursing facility rates and start processing the data. This will include continuing the hold harmless and the growth cap to stabilize the transition as much as possible for facilities. The Department will also continue to work closely with the groups represented in the workgroup to keep them informed of the findings.

A follow-up report is due in 2026, which will be based on the data and information we gather over the coming years. At that time, we will be better able to identify negative impacts that have arisen and make recommendations for any adjustments we feel would improve the usage of PDPM in Washington.

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[i] SSB 5802, Chapter 245, Laws of 2024. Sec. 2(1)(d)-(e)
(d) By December 1, 2024, provide an initial report to the governor and appropriate legislative committees outlining a phased implementation plan; and (e) by December 1, 2026, provide a final report to the appropriate legislative committees. These reports must include the following information: (i) An analysis of the potential impact of the new case mix classification methodology on nursing facility payment rates; (ii) Proposed payment adjustments for capturing specific client needs that may not be clearly captured in the data available from the centers for medicare and medicaid services; and (iii) A plan to continuously monitor the effects of the new methodologies on each facility to ensure certain client populations or needs are not unintentionally negatively impacted.

[ii] For background, on October 1, 1998, Washington adopted a case mix based nursing home payment system. The initial system used RUG III and MDS 2.0. CMS updated the MDS to version 3.0 on October 1, 2010. As a result, Washington froze the case mix score beginning July 1, 2011. A new case mix system using MDS 3.0, and RUG-IV was intended to begin on July 1, 2013.

[iii] While the state does not collect MDS information directly, there are state employees called Case Mix Accuracy Review (CMAR) Nurses who conduct periodic reviews to ensure the MDS is being completed accurately.

[iv] Capturing data that could be used to generate an alternative to the federal PDPM data would require significant resources, time, and staff not only for the state but for facilities as well. None in the workgroup were interested in recreating the rigorous data collection already being done for CMS.

[v] A negative impact to a rate calculation from PDPM would not necessarily lead to a rate reduction as other factors, such as inflation or direct care medians, may have a greater positive impact. In the most likely scenario, the "losers" experience less growth in their rate than otherwise might be expected but still see an increase in dollars overall.

[vi] The Office of the Long-Term Care Ombuds was invited as well but did not attend any meetings.