Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Nursing Facility Rates/Costs Comparison

RCW 74.46.561(8)(c)

December 1, 2020

Aging and Long-Term Support Administration
Management Services Division/Office of Rates Management
PO Box 45600
Olympia, WA 98504-5600
360) 725-2300
https://www.dshs.wa.gov/altsa

Washington State Department of Social & Health Services
Transforming lives

TABLE OF CONTENTS

BACKGROUND

The legislature, through ESSB 6168, directed DSHS|ALTSA to provide a review of rates paid in 2017, 2018, and 2019 in comparison to reported costs incurred by Nursing Facilities for those same years. The stated purpose of this request is to determine the necessity of regular inflationary adjustments to the Nursing Facility rates.

There are several factors that have contributed to heightened interest in the adequacy of the Medicaid rate in Washington state. Most prominently is concern that the Medicaid rate may be a contributing factor in Nursing Facility closures. Closures, in general, are disruptive to the care of individuals and to systems of support provided by their families, and a continued trend of facility closures may restrict access to high-quality services that Washingtonians need as they age.
Aside from the potential impact the Medicaid rate may have on closures, nationwide strategies to move clients from Nursing Facilities to Home and Community-based Settings, and declining occupancy rates over the past 20 years have lowered revenue for Nursing Facilities. In addition to lower occupancy, the nationwide shortage of direct care providers (Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses, in particular) means that Nursing Facilities must compete for qualified staff with hospitals, primary care settings, and other fee-for-service health care providers that typically pay higher wages. Failing to attract and retain permanent direct care staff means that facilities must employ more expensive staffing to deliver quality care and meet requirements set by the state. Finally, the ***Medicare*** payment structure has changed recently and the payer mix for patients within Nursing Facilities has shifted over time, impacting the balance of Medicaid versus Medicare revenue in Nursing Facilities, and increasing scrutiny on the state-controlled Medicaid rate.

METHODOLOGY

Nursing Facility Rates
The current Nursing Facility rate methodology is primarily based on the reported industry-wide costs of two main components: direct care, and indirect care. The direct care and indirect care components are centered on median industry-wide costs, which have historically been rebased every two years. The direct care component is performance-adjusted for acuity (case mix) and regionally adjusted for countywide wage index information available through the United States Department of Labor's Bureau of Labor Statistics. The indirect care component is paid at 90% of the industry median cost. The final components of the rate are the Capital component, Safety Net Assessment (SNA) and the Quality Enhancement. The Legislature will be considering an inflationary factor that would be applied to direct and indirect care components to narrow the gap between costs incurred and revenue received for the care of Medicaid clients in Nursing Facilities.

Nursing Facility Costs
Cost Reports are submitted to the Office of Rates Management by Nursing Facilities each year and are used to determine the median cost of care (direct and indirect) that will form the basis of each facility's daily rate. The cost reports are examined by Cost Reimbursement Analysts to determine if reported costs are allowable according to Chapter 74.46 RCW and Chapter 388-96 WAC and are necessary, ordinary, and related to patient care. Beyond these evaluations, the Department does not

review reported costs through the lens of business practices or the distribution of that spending, provided it meets the criteria above.

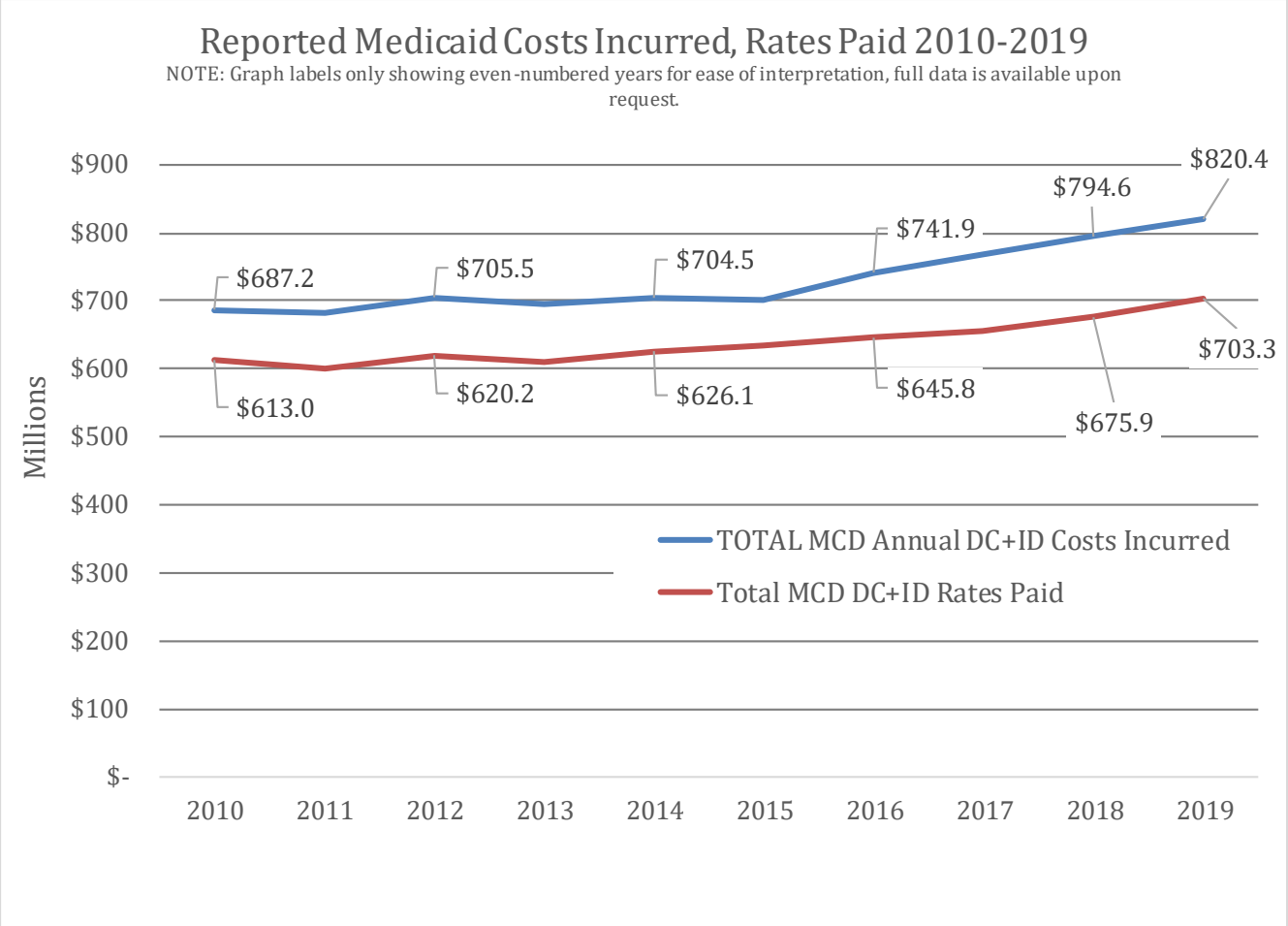
Facilities submit routine costs of care for all clients in their annual cost reports, regardless of payer source, so the Department has developed practices to best estimate the costs that should be attributed to the care of Medicaid clients. Over the years, Department and industry leaders have worked together to develop and refine this methodology for allocating costs to the Medicaid population served in Washington's Nursing Facilities, for the purpose of evaluating the adequacy of the Medicaid rate, compared to reported Medicaid costs.

On July 1, 2016, DSHS instituted a simplified rate. In order to understand any impact the change in methodology may have produced, the Department analyzed costs compared to rates from 2010 to 2019 and have included data on the full span of years here. The Department and stakeholders agreed that including data on the gap between costs and rates prior to 2017 provides a clearer picture of the overall trend. It should be noted that the pre-2016 methodology and current methodology group costs differently and the Department worked with industry stakeholders to develop a method of analyzing cost groupings that most accurately represents the data available. Additionally, the Department acknowledges that factors other than the change in methodology are likely contributing to the widening gap (minimum wage increase, labor market tightening, etc.).

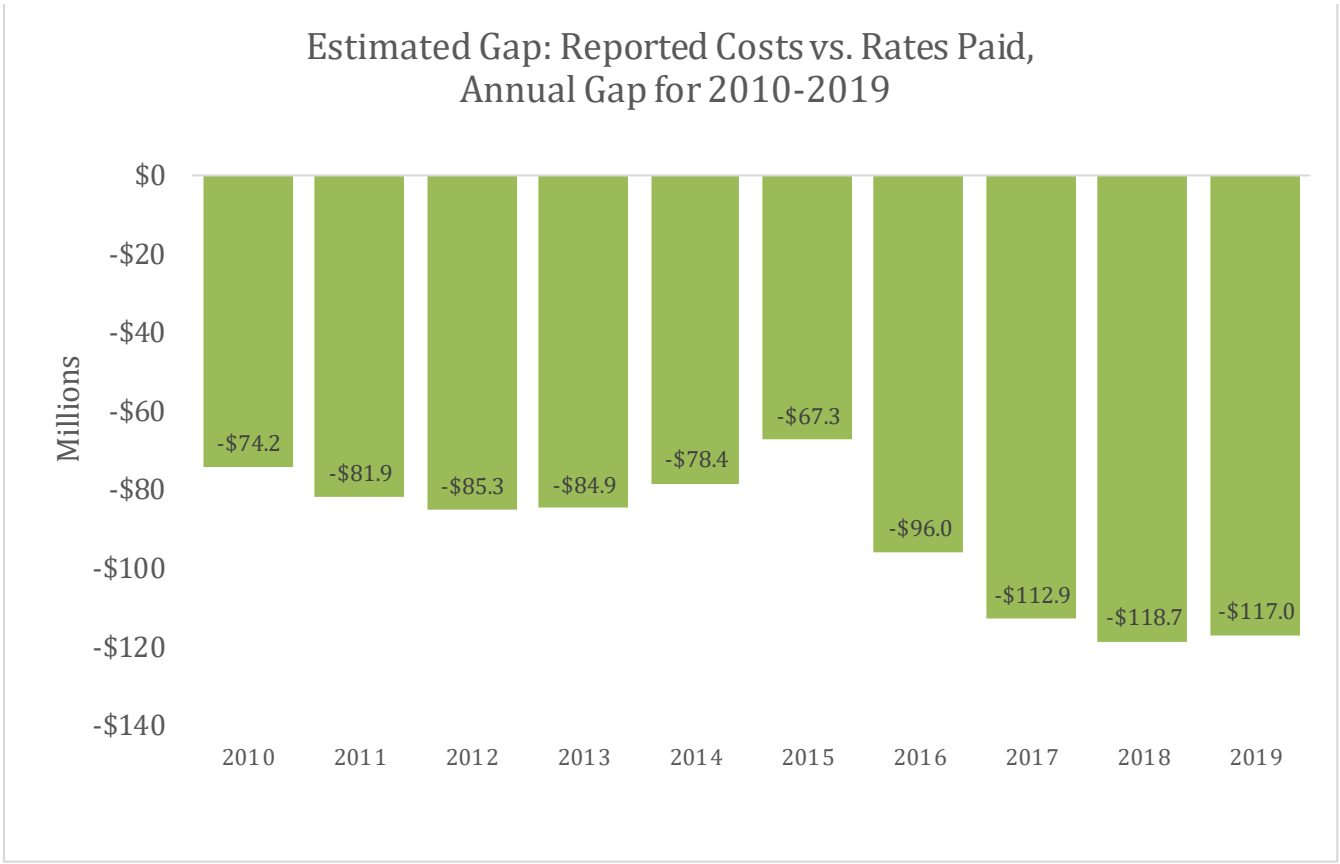
ANALYSIS

Biennial rebasing and biannual rate-setting schedules mean that the direct and indirect care portions of the rate could be based on median costs from up to 4 years prior. For example, the January 1 – June 30, 2020 Nursing Facility ***rates*** utilize median ***costs*** from calendar year 2016. Only on July 1, 2020 did Nursing Facility rates move to utilizing median costs from the *2018* cost reports, narrowing the gap between when costs are occurring and the cost-basis used for rate setting to two years instead of four.

The Department has proposed annual rebasing be made permanent and the Legislature declared their intent to do so by including annual rebasing in the 2020 budget bill. A permanent shift to annual rebasing would mean July 1, 2021 rates could be based on costs from calendar year 2019 costs (instead of 2018). However, moving to annual rebasing alone will not address the calculated gap between reported Medicaid costs and Medicaid rates that has seen notable growth since 2016. Another way to conceptualize the shift over the past 10 years is to note that the percentage of estimated costs covered by the rates in 2010 was about 89% and dropped to 86% in 2019.
The following graph represents the most current analysis of the gap between Medicaid rates paid and reported costs attributable to Medicaid clients from 2010 – 2019.



The next graph represents the difference between Medicaid rates paid and estimated Medicaid costs incurred by Nursing Facilities in Washington State. As you can see, the gap between costs and rates was within the range of $60 to $80 million dollars from 2010 to 2015. In 2016, when the rate methodology changed midyear, the gap rose to $90 million, and it has been growing steadily each year since then.



CONCLUSION

The Department and Nursing Facility industry stakeholders have advocated for annual rebases with an inflationary factor to be added to the direct and indirect care components of the rate. The legislature has endorsed these changes through the 2020 budget bill and will have the opportunity to make them permanent going forward. Annual rebasing and adding an inflationary factor would ensure that rates paid to facilities are based on costs from a more recent time ***and*** simultaneously take into account inflation that may have occurred between the cost year utilized for rate-setting and when facilities are actually being paid. The most recent proposal for a permanent annual rebase and an inflation factor add approximately $40M into the system, which would reduce the gap. However, the Department acknowledges that these changes alone are unlikely to *completely* close the gap between rates paid to Nursing Facilities, and the estimated costs of serving Medicaid clients in Nursing Facilities.