DRAFT - Long Term Care Residential Rates Taskforce work product
Feedback Matrix (Staff Summary of Feedback)
December 18, 2007

Possible recommendation for discussion purposes	Department[1] - Feedback	WHCA[2]- Feedback	WAHSA[3]- Feedback	Providence Feedback	Adopt Recommendation?		Notes
					Yes	No	
1. Refocus on setting overall long term care policy							
1.1 Sunset current nursing home statute and replace with a framework to allow a simplified system.	▪ Support ▪ This would simplify the process.	▪ Do not support ▪ Task force should work to identify strengths and weakness of current system prior to sun-setting. ▪ System changes should involve facilities owners and operators in the planning.	▪ Do not support. ▪ Would propose instead that stakeholders work on a pure "clean up" of the statute to eliminate unnecessary, outdated sections making the statute shorter and easier to understand.	▪ Not supportive of sun-setting. ▪ Would support some simplification.			
2. Maintain the strengths of the current nursing home reimbursement system							
2.1 Maintain emphasis on reimbursement of direct care, including the settlement process that ensures that funding is spent on direct care.	▪ Agree that this is a priority	Agree. Also thinks the following features of the current system are strengths: ▪ Capital system that rewards providers ▪ Capital system that pays for assets only once.	▪ In general agreement.	▪ In general agreement.			
2.2 Maintain reimbursement based on client acuity, by using case mix indexing.	▪ Agree	▪ Agree, but only for direct care, not other areas.	▪ In general agreement.	▪ In general agreement.			
2.3 Maintain a system that is based on allowable costs (vs. a price-based system), which recognizes facility differences.	▪ Agree	No comment received.	▪ In general agreement.	▪ In general agreement.			

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3. Simplify the nursing home reimbursement system where evidence supports it.							
3.1 Adopt Brown University's recommendation to combine the Direct Care (DC), Therapy Care(TC), and some Support Services (SS) into one component – a new "Direct Care" component.	▪ Support. ▪ The issue would be deciding which costs belong in each of the new cost centers, as this affects what is case-mix adjusted. Lids (percent of median reimbursed) would also need discussion. Would take time to study and work with stakeholders.	▪Not proposing. ▪ If this is done, has a strong preference on the lids used: wants lid of 112% of median for the new Direct Care, which would mean an increase in the current lids for Therapy Care and part of Support Services (now at 110%). Also, TC and SS should NOT be case mix adjusted.	▪Not proposing. ▪ If this is done, has a strong preference on the lids used: wants lid of 112% of median for the new Direct Care, which would mean an increase in the current lids for TC and part of Support Services (now at 110%).	▪ May be supportive, depends on details. ▪ Not proposing at this time. ▪ Further discussion and analysis is needed before any changes are made.			
3.2 Adopt Brown University's recommendation on applying case mix adjustment to therapies and some support services.	▪ Support. ▪ Support Services and Therapy Care definitely have relationship to acuity. ▪ Pro- incentive for taking higher acuity. ▪ Con- possible disagreement among parties about what costs fall under what case mix, and what lids to use.	▪ Does not support case mix adjustments to Support Services or Therapy Care. ▪ They believe there are some costs in these components that are not related to case mix. ▪ Adjusting could reduce attention to patients.	▪ Maybe supportive, but it would depend on details and the level of lids used. Not proposing this change. ▪ If done, supports using case mix for Therapy Care, but is not proposing.	▪ Maybe supportive, depends on details. Not proposing at this time.			

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3.3 Eliminate the minimum occupancy adjustment on operating components for hospital-based nursing homes and essential community providers (these are both providers that have difficulty maintaining occupancy due to rural location and the joint use of beds for hospital purposes).	▪ No specific statement about hospital-based nursing homes or essential community providers. ▪ Generally not supportive of eliminating minimum occupancy. ▪ Although eliminating minimum occupancy may simplify the rate system, it would lead to the state paying for empty beds and licensing more beds than are necessary to meet demand.	▪ No specific statement about hospital-based nursing homes or essential community providers. ▪ Proposes eliminating minimum occupancy for Therapy Care, Support Services, and Operations. Go to 85% for Capital (from 90%). ▪ Believes their proposal would simplify the system and make it fairer, since some costs are not related to occupancy. Also, occupancy for Capital used to be set at 85%, this would restore old law.	▪ If eliminating minimum occupancy is being discussed for hospital-based nursing homes or essential community providers, also might consider altering it somewhat for small nursing homes. Not proposing. ▪ Supports eliminating minimum occupancy for Therapy Care, and part of Support Services, but no changes to Operations or Capital. Not proposing at this time.	▪ Does not support eliminating or changing minimum occupancy at all, including for hospital-based nursing homes or essential community providers.			
3.4 Review policy for and level of capital authorization (CCA) for renovation and remodel of nursing facilities. The authorization for capital expenditures should be changed to prioritization from a first come first served model to a need-based authorization as mandated in SB5905, proposed last session.	▪ Supports. ▪ Pro - Setting priorities would allow the most needed renovations to occur, vs. the current first come first served system.	▪ Concurs with DSHS. ▪ Also wants more funding in this area, in addition to policy change.	▪ Proposes outright elimination of CCA, as in the Brown recommendations. ▪ Also wants more funding in this area, in addition to policy change, but not at the expense of investments in direct care. ▪ Believes eliminating the CCA would simplify the system, and would make necessary renovations easier for providers to accomplish.	▪Concurs with DSHS and WHCA. ▪ Does not support additional funding in this area at this time, has other priorities.			

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3.5 Simplify current annual cost reporting to ease administrative burden on providers and DSHS. Simplification should be revenue neutral.	▪ Proposed by DSHS. ▪ Pro - may reduce unnecessary work at both DSHS and provider level.	▪ Remove schedules D, E, G-2, H-1, H-3, H-4, L and P.	▪ Neutral--without knowing more detail ▪ Opinion- it is hard to tell if this would actually easy the administrative burden on providers or not.	▪ Support, to the degree that settlement is retained and integrity of the reimbursement system is not compromised. Not proposing this item.			
>>>PROPOSED NEW SUB-SECTION: Adopt the Brown proposal to rebase every three years with uncertainty as to when.	▪ Partially supports: rebase every three years, but do on a predictable vs. uncertain cycle. ▪ Pro- Rebasing every 3 years will help contain costs. Having uncertainty could keep the providers from "gaming" the system. ▪ Con- Uncertainty on timing would make the system more complex and create additional administrative burden.	▪ Does not support: wants to keep the automatic biennial rebasing put into statute in the '07 session. ▪ Believes that rebasing every three years doesn't recognize real increases in costs as frequently and reverses course from law passed last session. ▪ Also, believes that DSHS could "game" the system to keep rates lower.	▪ Concurs with WHCA.	Concurs with WHCA and WAHSA.			
>>>PROPOSED NEW SUB-SECTION: Put Operations (OP) and some support services (SS) into a new Indirect Care cost component (partial Brown recommendation).	▪Support. ▪The issue would be deciding which costs belong in each of the new cost centers, as this affects which Support Services would be case-mix adjusted. ▪ Lids (percent of median reimbursed) would also need discussion. ▪ Would take time to study and work with stakeholders.	▪ Supportive in concept, but not proposing.	▪ Supportive in concept, but does not propose revising the payment system until all parties have the opportunity to understand proposed changes. If done, would want lid set at 110% of median.	Maybe supportive, Depends on details.			

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>>>PROPOSED NEW SUB-SECTION: Future rate enhancements are treated as a supplemental rate, separate from the base rate.	▪ Supports ▪ Pro: Doing add-ons separate from the base rate keeps the base rate simple to administer and understand. ▪ More easily allows the Legislature to sunset the add-ons for accountability.	▪ Does not support separate add-ons for anything except potentially for "pay for performance," and then only after more study. ▪ Believes that new initiatives, such as those to increase employee benefits or mental health services for clients should be part of base rate, vs. as add-ons, otherwise the providers could be "stuck with the bill" and have to continue the initiatives, even if the Legislature discontinued the add-on.	▪ Support, but is not proposing any add-ons at this time.	▪ Supports, but only for direct care-related items. Is not proposing anything at this time, but is very interested in increasing payment for the care needs of patients with mental health issues			
>>>PROPOSED NEW SUB-SECTION: Increase auditing of the Minimum Data Set (MDS).	▪ Does not support. ▪ Feels Brown misunderstood current audits. ▪ Current efforts are sufficient and more would be burdensome to all parties.	▪ Does not support.	▪ Does not support.	▪ Does not support.			
4. Review other features of the nursing reimbursement system.							
4. The department shall report back to the legislature by November 2008 on the cost and benefits of moving to a "fair rental" system for capital costs. The department's study should include a review of CTED and what other state's are doing.	▪ Fair rental should not be implemented without further study. ▪ An alternative – fine tune the current capital system- e.g., review 8.5% of net book value; stop payment on land value after x years; eliminate grandfather clause and salvage value.	▪ Agrees to the need for further study ▪ Does not support moving to "fair rental" without much more time and information.	▪ Agrees to the need for further study. ▪ Not supportive of moving to "fair rental" without much more time and information. ▪ Is open to the idea, however.	▪ Agrees to the need for further study ▪ Has many concerns. ▪ More time and information are needed.			

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5. Replacing variable return							
5. Replace variable return with performance based payments.	▪ Is supportive of eliminating the variable return. Performance based payments as add-ons need more study, but could possibly start small (improvements in retention and turnover rates) ▪ Pro - would replace the current poorly understood "variable return" with a concrete item to incentivize certain behaviors. ▪ Con - Models in other states (MN) are still in the early stages. It would be too easy to do something ineffective without reviewing more first.	▪ Does not support eliminating the variable return. ▪ Performance-based payments: Utilize Federal CMS pilot: "value-based purchasing" in four or five states will begin in 2008. Washington providers who volunteer for the pilot should receive a financial incentive. The department should monitor and report the outcomes of the CMS pilot in 2010, prior to implementing a new pay-for performance program statewide.	▪ Does not support eliminating variable return at this time, but if it is eliminated, it should be replaced with "pay for performance." ▪ Believes eliminating variable return would eliminate the only flexible funding for providers, funding that mitigates other problems in the rate system. ▪ Is supportive of implementing "pay for performance", but it needs a bit more study first. It could be done as an add-on, or replace variable return after more is known.	▪ Does not support eliminating variable return at this time, as Providence currently uses this to help pay for wages and benefits not covered by Direct Care. ▪ Is interested in performance pay, but believes it needs additional stakeholder work and examination. ▪ Additional funding should be appropriated for performance pay. Perhaps could replace variable return in future.			
6. Distribution of FY09 appropriation of $8.8m (options are not exclusive from each other).							
6.1 Provide a second year cost of living increase for all nursing homes of _?_% which is within the appropriation.	▪ Only support if funding is available after covering adjustments for case mix creep, coverage of the excess over the budget dial, increases in capital authorization, and direct care vendor rate.	▪ Proposes as "balancer" AFTER doing other WHCA proposals to increase capital authorization, eliminate minimum occupancy in Therapy Care (TC), Support Services (SS), Operations (OP), and to reduce it in Capital components.	▪ Proposes for all operating components (Direct Care, SS, TC, OP) as the policy for FY09.	▪ Proposes doing for direct care only, with emphasis on increasing funding for mental health.			
6.2 Increase direct care (DC) more than the other components.	▪ Supports and prefers if a vendor rate increase is selected. Most if not all of any vendor rate increase should be targeted to direct care (DC).	▪ Does not support. ▪ Believes that operations are also patient-related and should not be neglected.	▪ If new funds are lower than $7m GF-S, then would prefer that only DC and Support Services be increased.	▪ Providence's preference.			

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6.3 Increase the level of capital authorization to allow additional prioritized renovations and remodels.	▪ Supports, in conjunction with passing SB 5905 to prioritize the system.	▪ Proposes this increase, in conjunction with passing SB 5905 to prioritize the system.	▪ Does not propose. ▪ Agrees with intent but would want to see this done with additional funding over and above the $8.8m GF-S.	▪ Does not propose. ▪ Doesn't disagree with intent, but direct care is the priority for Providence			
6.4 Use the FY09 appropriation to help pay for the FY08 excesses over the budget dial.	▪ Supports. (DSHS is to some degree bound by earlier budget assumptions.)	▪ Does not support ▪ Believes this should be done with separate funding as "maintenance level."	▪Does not support ▪ Believes this should be done with separate funding & as "maintenance level."	▪ Does not support ▪ Believes this should be done with separate funding & as "maintenance level."			
6.5 Discuss other options.	▪ Increase vendor rate but only after adjusting for "case mix creep," fixing the budget dial, and increasing capital authorization.	▪ Proposes vendor rate increase, but only after funding is used to increase capital authorization, eliminate minimum occupancy for support services, therapy care, operations, and reduce minimum occupancy for capital from 90% to 85%.	▪ Proposes using all the funding for Vendor Rate increase.	▪ Proposes using all the funding for a vendor rate increase for direct care, and/or to enhance rate for mental health needs.			
>>>PROPOSED NEW SUB-SECTION: Adjust for Case Mix "Creep." This is a common adjustment to reflect that acuity is increasing and more funding is needed as a result.	▪ Supports. ▪ Proposed by the department. (DSHS is to some degree bound by earlier budget assumptions.)	▪ Does not support ▪ Believes this should be done with separate funding as "maintenance level."	▪Does not support ▪ Believes should be done with separate funding as "maintenance level."				

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7. Changes in community based residential services.							
7.1 The department shall research and report on alternatives to boarding homes/assisted living. (To include options for aging in place, cluster care programs, partnerships between HUD and Medicaid, and other methods to bring home care services more efficiently to apartments where seniors live (COPES).)	▪ Support.	▪ Many regulations prevent Boarding Homes and Assisted Living Facilities from allowing aging in place. Prior to looking for alternatives, the regulations should be reviewed and some should be repealed. ▪ Consider tax credits for boarding home/assisted living providers.		▪ Supports the development of PACE sites and HUD partnerships.			
7.2 Target community residential reimbursement changes to expand access to community services for additional clients.	▪ Support. ▪ One option is that it be targeted toward the complex, hard to place clients.	▪ The rates model should be fully funded to determine if this resolves the access issue. ▪ Expand specialized dementia care program in boarding homes to delay entry into skilled nursing facilities.		▪ Support the development of additional resources and programs.			
7.3 Review private pay clients who spend down their resources and become Medicaid eligible. Create reimbursement incentives for Medicaid occupancy or disallowances on capital funding for community residential facilities that do not care for Medicaid.	▪ Support. ▪ At a minimum a process should be developed that allows clients to be grandfathered in when a facility discontinues its Medicaid contract.	▪ Possibly strengthen the mandate that Medicaid rollover policies be disclosed prior to admission. The mandate was designed to protect consumers. ▪ Some residents make themselves Medicaid eligible by transferring their assets; this should be addressed too.		▪Support the development of improved and sustainable financing strategies that do not require people to become impoverished to access needed health care services.			

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7.4 Recommend expanding reimbursement to 12 or more payment levels to match the current CARE assessment tool.	▪ Support. NOTE: Some Adult Family Home providers have testified in support of expanding the payment levels, but they may not be proposing at this time.	▪ This only makes sense if additional funding is added to the system, as the current payment system is not fully funded.	▪ Proposing a bill to require "fully funding" a 12-level CARE payment system, with hold harmless, and to update the cost basis.	▪ Maybe. ▪ Supports payment tied to acuity. ▪ Is opposed to a payment system that burdens the provider with paperwork.			
7.5 The department shall monitor the impact on collective bargaining on adult family home access and worker attraction/retention and propose changes in the 2010 session. Collective bargaining for the other residential care setting may be proposed if appropriate	▪ The department does not agree with this recommendation	▪ DSHS is probably not the appropriate agency for monitoring collective bargaining.		▪ Do not support.			
>>>PROPOSED NEW SUB-SECTION: Update community residential payment rates to a more recent cost basis. (Current basis are 1999 and 2003 costs.)	▪ If the cost basis is not updated, then a vendor rate increase should be considered. NOTE: Some Adult Family Home providers have testified in support of updating the cost basis, but may not be proposing at this time.		▪ Proposing a bill to update the cost basis and guarantee in statute that it would be updated every 2 years. Also wants to fully fund the 12 CARE payment levels.				

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>>>PROPOSED NEW SUB-SECTION: Discuss additional vendor rate increases for community residential (FY09 budget currently provides for 2% for Adult Family Homes and Boarding Homes/Assisted Living.)	▪ DSHS suggests this might be a consideration if the cost basis is not updated. NOTE: Some Adult Family Home providers have testified in support of an additional vendor rate increase for Adult Family Homes for FY09, due to new liability insurance costs, and since collective bargaining has not yet occurred.	▪ Is proposing an additional vendor rate increase for Boarding Homes/Assisted Living on top of the current 2% already provided for FY09. ▪ Also wants a "restoration" of the capital add-on rate for facilities built to enhanced standards.	▪ Would prefer funding for vendor rate increases instead be used for "fully funding" 12 CARE payment levels, with a hold harmless, and to update the cost basis. (They are open to the FY09 vendor rate funding being used in that way instead, plus want more funding.)				

[1]DSHS ADSA staff were asked by Task Force members for their suggestions and feedback on the Brown University recommendations, alternatives to the Brown recommendations, and on how to spend the FY09 appropriation of $8.8 M GF-S. This document summarizes their response, but is not to be taken as a DSHS "proposal." Suggestions may not be reflective of the Governor's upcoming 2008 Supplemental Operating Budget.

[2] Washington Health Care Association (WHCA), the state association for most of the for-profit nursing facilities and boarding homes.

[3] Washington Association of Housing and Services for the Aging (WAHSA), the state association for most of the non-profit nursing facilities and boarding homes.

NOTE: This document represents a legislative staff summary of feedback submitted to date only in response to the specific "possible recommendations for discussion purposes." Contact staff if you would like a more complete description of feedback received, ,or you may contact the entities directly for a full summary of all of their proposals