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MA Reimbursement for Nursing Homes (Health Services -- Medical Assistance -- Long-Term Care Services)

CURRENT LAW

Under current law, the Department of Health Services (DHS) reimburses nursing homes for services they provide to individuals who are eligible for medical assistance (MA) according to a prospective payment system that DHS updates annually. This payment system provides funding for nursing homes based on five "cost centers," including: (a) direct care; (b) support services; (c) property tax and municipal services; (d) property; and (e) provider incentives. The Department uses these cost centers to develop rates for each facility. Each facility's rate reflects several factors, such as the nursing home's resident acuity (a measure of residents' functional abilities), and the wage rates paid by nursing homes within each facility's designated geographic region (labor region adjustments). These factors, among others, may affect a nursing facility's costs of providing direct care services.

Nursing homes are provided funding under this payment system from amounts budgeted within the total MA benefits budget to support MA reimbursement payments to nursing homes.

GOVERNOR

The bill provides no increase in funding for MA reimbursement for nursing homes.

DISCUSSION POINTS

Nursing Home Rate Setting and Methods

1. Table 1 shows the number of MA-certified nursing homes and ICFs-ID, and the number of beds in these facilities, by facility type, as of January, 2015. Facilities operated by DHS and the Department of Veterans Affairs are excluded from these figures.

TABLE 1

MA-Certified Nursing Facilities and ICFs-ID, January, 2015

Facility Type	Number of Facilities	Number of Beds
Skilled Nursing		
For Profit	212	18,195
Nonprofit	126	10,021
Government	54	4,865
Total	392	33,081
ICF-ID		
For Profit	1	9
Nonprofit	1	18
Government	6	104
Total	8	131

2. In 2013 (the most recent year for which information is available), the MA program accounted for approximately 63% of total reimbursement payments nursing homes received. In that year, payments from residents' funds ("private pay") accounted for approximately 19% of nursing home payments, Medicare accounted for approximately 13% of nursing home payments, and other sources accounted for approximately 5% of nursing home payments.

Table 2 shows the total amounts the MA program paid to nursing homes, excluding state facilities, for 2011-12 through 2013-14, and current projections for 2014-15. Note that the funding figures are based on date of payment, rather than payments for the days of care provided in the fiscal year.

TABLE 2

Total MA Nursing Home Reimbursement and Days of Care

	All Funds	Days of Care
2011-12	$773,310,600	5,895,068
2012-13	776,809,700	5,570,379
2013-14	724,277,500	5,274,407
2014-15 (projected)	724,755,900	5,098,605

3. As shown in the table, total MA payments to nursing homes have decreased, which is largely a reflection of the declining number of days of care being provided by those facilities.

4. DHS contracts with the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin - Madison to assist the agency in developing nursing home payment rates. CHSRA uses data from annual nursing home cost reports to develop reimbursement per diems

based on the methodology specified in the MA state plan. These nursing home reimbursement methods are updated annually by CHSRA, in collaboration with the Department and nursing home administrators.

5. Under the MA nursing home reimbursement methods, five cost centers are considered when developing facility-specific nursing home rates, each of which accounts for different costs the facility may incur. The reimbursement provided by the MA program for each cost center is structured to align reimbursement with departmental goals for nursing home care. For example, full reimbursement may be provided for a cost center for which the facility has no control over costs, while partial reimbursement may be provided for a cost center for which a facility could implement policies to more efficiently provide services. The cost centers are as follows.

- The direct care cost center reimburses for supplies and services directly related to the provision of care, including registered nurses, nurse practitioners, licensed practical nurses, resident living staff, feeding staff, nurse's assistants, nurse aid training, training supplies, personal comfort supplies, medical supplies, over-the-counter drugs, and the non-billable services of a ward clerk, activity person, social worker, volunteer coordinator, certain teachers or vocational counselors, religious persons, therapy aides, and counselors on resident living. Under this cost center, facilities receive partial cost reimbursement for eligible expenses. This reimbursement is calculated by adjusting a base rate, which is based on actual direct care costs of facilities, to account for inflation, the statutorily available funding for nursing homes, and the relative costs of labor. Facilities may also receive certain supplements under this cost center, such as for serving individuals who are ventilator-dependent. The direct care cost center generally accounts for 50% to 60% of a facility's rate paid by the state.

- The support services cost center includes costs related to dietary services, housekeeping, laundry, security services, fuel and utility costs, and administrative and general costs. A flat rate is established for support services based on costs for all facilities plus an inflation adjustment. The Department provides a flat rate to encourage facilities to minimize administrative costs. This cost center generally accounts for approximately 25% to 30% of a facility's reimbursement.

- The property taxes and municipal services cost center reimburses facilities for the cost of property taxes. These expenses are reimbursed at cost because they are beyond the control of the facility. This cost center typically accounts for approximately 0% to 5% of a facility's reimbursement.

- The property cost center covers expenses including property insurance, lease costs, land improvements, buildings, fixed and movable equipment, and other long-term physical assets. Reimbursement for this cost center is based on the replacement value for the facility, as determined by a commercial estimator, and nursing homes are reimbursed on a partial cost basis up to a cap. The Department notes that it is not uncommon for a facility's eligible expenses to exceed the cap. This cost center generally accounts for approximately 5% to 10% of the facility's reimbursement.

- The provider incentive cost center pays certain qualifying nursing homes incentive payments for above-average MA and Medicare populations, the ratio of private rooms to total beds,

the acquisition of bariatric moveable equipment, an MA access incentive payment, and incentive adjustments for facilities that have been approved for an innovative capital construction project. This cost center typically accounts for approximately 5% to 10% of a facility's reimbursement.

6. Previously, these cost centers played a greater role in determining the distribution of funding among nursing homes. Facilities could expect to be reimbursed up to their actual expenditures, provided that they did not exceed the targeted cost. However, as funding provided for nursing home reimbursement has lagged behind industry cost growth and inflation, the targeted rates for each cost center have covered a smaller percentage of average actual nursing home costs.

Funding Increase to Reflect Increases in Acuity

7. The continuing increase in the acuity of nursing home residents has played a significant role in the growth in nursing home costs.

8. The rising acuity of nursing home residents is reflected in increases in the nursing home "case mix index." To determine the case mix index, nursing home residents that are not developmentally disabled are assigned to one of 48 different groups based on their acuity level, or diagnosed care needs. Each of these groups has a score, which ranges from 0.25 to 3.00, representing the highest level of diagnosed care needs for the non-developmentally disabled population. These scores are used to produce a measure of the aggregate needs of the nursing home population, or "case mix." An analysis by CHSRA shows that the average case mix index of MA fee-for-service nursing home residents in 2011 was 0.97, while the average case mix of that same population for the first three quarters of 2014 was 1.01.

9. Increases in costs associated with changes in acuity are reflected in the direct care cost center. DHS staff estimate that, in 2012, 70.8% of facilities experienced direct care costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives.

10. In previous budgets, the Legislature has provided annual adjustments to nursing home funding to account for changes in acuity. Although the direct care component includes the nursing home costs that are affected by changes in resident acuity, the acuity-based reimbursement increases provided in previous budgets have been calculated as a percentage of the total nursing home reimbursement rate, rather than as a percentage of the amount budgeted for direct care expenses. Table 3 shows the acuity adjustments that have been provided for fiscal years 2010-11 through 2014-15.

TABLE 3

Nursing Home Rate Increases Provided to Fund Resident Acuity Increases

Year	Percentage Increase to Per Diems for Acuity	Funding Increase (GPR)
2011-12	1%	$2.9 million
2012-13	1	5.8 million
2013-14	2	5.4 million
2014-15	2	10.5 million

11. Because nursing homes are reimbursed from a fixed dollar amount budgeted by the Legislature and the nursing home methods include several factors that have automatic adjustments, nursing homes argue that no adjustment for acuity would result in a decrease in rates for many facilities. In particular, the industry estimates that the funding in the Governor's bill would result in rate reductions for approximately 80% of the state's facilities. It should be noted that, although providing no adjustment for acuity may result in a decrease in rates for many facilities, the magnitude of this decrease is currently unknown. However, given that this decrease would be shared among many facilities, the magnitude of a potential decrease could potentially be fairly minor for some facilities, compared with the total MA reimbursement received by those facilities.

12. The industry argues that not providing a rate increase could be detrimental to nursing home access, given that some facilities are already struggling financially under the current MA reimbursement rates. The Department indicates that, when only MA reimbursement is considered, in 2012, the average facility's actual MA-allowable costs exceeded the MA reimbursement by approximately $61 per day. Additionally, in support of this point, the industry indicates that, in 2013-14, the difference between the total cost of the care facilities provided MA residents and MA reimbursement equaled approximately $329.2 million, and that approximately 98% of facilities that received MA reimbursement received MA payments in 2013-14 that failed to meet the cost of care provided to their residents.

13. On the other hand, some may argue that, under current policy, some facilities are able to contain costs within the MA reimbursement provided by the Department. Additionally, the Department indicates that, in 2012, approximately 62% of all nursing facilities avoided a loss when considering all payment sources, including MA, private pay, and Medicare.

14. Moreover, costs vary significantly by facility type, indicating that facility administration may play a role in containing costs within the MA reimbursement rates. In particular, data regarding 2013 cost per patient day for all facilities shows significant variation between the costs of for-profit, non-profit, and government-operated facilities, with for-profit facilities having median direct care costs that are approximately $14 less per patient day than non-profit facilities, and $45 less per patient day than government-operated facilities, and median support service costs that are approximately $6 less per patient day than non-profit facilities, and $10 less per patient day than government-operated facilities.

15. However, this data does not adjust for the acuity differences between patients served by the different facilities, and this may be an indication that the care needs of residents differ by facility type. Additionally, while for-profit facilities may be able to contain costs to a greater extent than their non-profit and government-operated counterparts, this data does not account for quality differences among the different types of facilities. According to the Nursing Homes Consumer Information Report for 2013, published by the DHS Division of Quality Assurance (DQA), the average number of federal deficiencies in for-profit facilities was 7.8, as compared with 7.4 in government-operated facilities and 6.0 in non-profit facilities. A deficiency reflects non-compliance with federal standards established for MA and Medicare-participating facilities.

16. Between 2011-12 and 2014-15, acuity adjustments for nursing homes were provided at the levels of 1% and 2% per year. To be consistent with rate adjustments provided to nursing homes in the past two biennia, the Committee may wish to provide a rate increase of 1% (Alternative A3) for these facilities in each year of the 2015-17 biennium to reflect changes in resident acuity.

17. Alternatively, given the other funding priorities of the Committee, the Committee may wish to provide a 1% acuity adjustment to nursing homes in 2016-17 only (Alternative A2).

18. On the other hand, if the Committee believes that the funding in the bill that would be provided to reimburse nursing homes is sufficient, the Committee could adopt the Governor's recommendation to provide no increase in funding for nursing homes (Alternative A1).

Labor Regions

19. Under 2001 Wisconsin Act 16, the Legislature required the Department to work with representatives of the nursing home industry and organized labor to develop a comprehensive plan that identified varying regions of the state with respect to labor costs for nursing home staff for the purpose of determining variations in MA reimbursement for nursing homes' allowable direct care costs. The final plan, approved under a Joint Committee on Finance passive review process, required the Department to use a labor region adjustment based on the Medicare labor region designations, weighted to MA patient day costs, based on Wisconsin facility-specific average wages, excluding county-owned nursing homes, but including nursing homes under phase-down agreements.

20. Under this policy, reimbursement provided to nursing homes under the direct care cost center is adjusted based on the relative cost of wages in the region in which the facility is located. This region is known as a labor region. There are currently 17 labor regions, including one rural labor region that contains 42 counties. The attachment provides a listing of the labor regions, as well as the labor factor for each labor region.

21. The labor region adjustment is intended to allow facilities in labor regions with higher labor costs to receive higher levels of reimbursement for direct care costs to reflect the difference in labor costs of providing services across different regions. In determining the level of reimbursement that a facility will receive, the Department first establishes a nursing services target, which is a statewide dollar amount that serves as the basis for the maximum direct care MA reimbursement a facility may receive. The Department multiples this target by a "labor factor" that signifies the

relative labor costs for each labor region. If a labor factor is relatively large for a labor region, a greater amount of nursing home direct care costs may be eligible for MA reimbursement. Similarly, if a labor factor is relatively small for a labor region, a smaller amount of nursing home direct care costs may be eligible for MA reimbursement.

The Department then compares the facility's reported direct care costs with the statewide nursing services target that has been adjusted based on several factors, including the labor adjustment described previously. Facilities whose costs exceed the adjusted nursing services target minus two dollars are reimbursed for direct care costs at the amount of the adjusted statewide target. Facilities whose costs are less than this adjusted rate minus two dollars receive their costs for direct care. Accordingly, facilities in labor regions with higher labor factors may potentially be reimbursed at a higher rate, depending on the facility's costs. The Department indicates that the higher reimbursement provided to some facilities in certain labor regions is intended to ensure that MA reimbursement can provide comparable levels of service across the state.

22. A significant component of nursing home costs relate to labor. In particular, in 2013, the percentage of median allowable nursing home costs for all facilities related to labor was approximately 64%. Accordingly, adjusting facility reimbursement based on the wage levels of the region in which the facility is located can have a significant impact on the facility's overall MA reimbursement.

23. In recent budgets, the Legislature has included provisions that modify the geographic boundaries of the labor regions. These provisions have had the effect of moving facilities from labor regions with lower labor factors (in many cases, the rural labor region) to labor regions with higher labor factors, with the intent of providing for increased rates for the facilities in these regions. Because these facilities receive reimbursement out of a total sum budgeted for nursing homes, this type of change has redistributive effects, generally resulting in a decrease in funding for facilities in all other labor regions by the amount of the funding increase for the facilities in the county whose labor region is changed. Table 4 lists counties whose nursing home labor regions have been changed from the initial Medicare labor region designations.

TABLE 4

Nursing Home Labor Region Changes

County	Moved to
Sauk	Madison
Rock	Madison
Dodge	Madison
Dunn	Minneapolis
Richland	Madison
Green*	Madison

*Green County moved 50% to the Madison labor region on July 1, 2014, and will move 100% to the Madison labor region on July 1, 2015. This move reflects a decision by the Centers for Medicare and Medicaid Services to move Green County to this region, rather than action by the Legislature.

24. Some may argue that the initial labor regions that were established resulted in boundaries that disadvantaged facilities located on the border of a labor region, which may have to compete for employees with facilities receiving higher reimbursement that may use this higher reimbursement to pay higher wages. Proponents of these adjustments would argue that modifications to the initial labor regions were necessary to allow facilities that were previously in labor regions with lower labor factors to pay higher wages and attract qualified workers. An analysis of data from the Nursing Homes Consumer Information Report for 2013 published by the DHS Division of Quality Assurance was inconclusive with respect to whether rural facilities experienced higher staff turnover, as compared with urban and metro facilities, which generally have higher wage rates.

25. On the other hand, a consequence of modifying the initial labor regions that were based on the Medicare labor region designations is that, as increasing numbers of facilities are being moved from the rural labor region to urban labor regions with higher labor factors, other facilities may receive lower reimbursement. This effect may be of particular consequence for facilities in the rural labor region. Additionally, because these adjustments are being made on a case-by-case basis, it may be argued that the current labor regions no longer reflect the true variation in labor costs throughout the state.

26. Due to the high level of interest in modifications to the labor region methodology in recent years, the Committee could direct the Department to evaluate the labor region methodology and to propose changes to the methodology, as necessary, based on the results of the evaluation. Such a study could include an evaluation of whether a labor adjustment continues to be necessary, and, if such an adjustment is deemed necessary, whether there is a more appropriate methodology that would ensure that labor regions result in adjustments in the direct care cost center that reflect labor costs for nursing homes in each county (Alternative B2). This alternative may be adopted in combination with any of the other alternatives provided.

ALTERNATIVES

A. Acuity Adjustment for Nursing Homes

1. Adopt the Governor's recommendation to provide no acuity increase for nursing homes.

2. Increase funding by $7,617,400 ($3,186,300 GPR and $4,431,100 FED) in 2016-17 to provide a 1% acuity increase to nursing homes in 2016-17.

ALT A2	Change to Bill
GPR	$3,186,300
FED	4,431,100
Total	$7,617,400

3. Increase funding by $7,160,600 ($2,990,300 GPR and $4,170,300 FED) in 2015-16

and $15,311,000 ($6,404,500 GPR and $8,906,500 FED) in 2016-17 to provide a 1% acuity increase to nursing homes in 2015-16 and an additional 1% acuity increase in 2016-17.

ALT A3	Change to Bill
GPR	$9,394,800
FED	13,076,800
Total	$22,471,600

B. Nursing Home Labor Regions

1. Maintain current law.

2. Direct the Department to study the labor region methodology, and to propose changes to the labor region methodology, as necessary, such that any proposed labor region methodology results in adjustments to direct care costs that reflect labor costs for nursing homes in each county no later than July 1, 2016.

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Attachment

ATTACHMENT

2014-15 Nursing Home Labor Region Factors, By County and Labor Region

County	Labor Region	Factor
Adams	Rural	0.951
Ashland	Rural	0.951
Barron	Rural	0.951
Bayfield	Rural	0.951
Buffalo	Rural	0.951
Burnett	Rural	0.951
Clark	Rural	0.951
Crawford	Rural	0.951
Door	Rural	0.951
Florence	Rural	0.951
Forest	Rural	0.951
Grant	Rural	0.951
Green Lake	Rural	0.951
Iron	Rural	0.951
Jackson	Rural	0.951
Jefferson	Rural	0.951
Juneau	Rural	0.951
Lafayette	Rural	0.951
Langlade	Rural	0.951
Lincoln	Rural	0.951
Manitowoc	Rural	0.951
Marinette	Rural	0.951
Marquette	Rural	0.951
Menominee	Rural	0.951
Monroe	Rural	0.951
Oneida	Rural	0.951
Pepin	Rural	0.951
Polk	Rural	0.951
Portage	Rural	0.951
Price	Rural	0.951
Rusk	Rural	0.951
Sawyer	Rural	0.951
Shawano	Rural	0.951
Taylor	Rural	0.951
Trempealeau	Rural	0.951
Vernon	Rural	0.951
Vilas	Rural	0.951
Walworth	Rural	0.951
Washburn	Rural	0.951
Waupaca	Rural	0.951
Waushara	Rural	0.951
Wood	Rural	0.951
Brown	Green Bay	0.956
Kewaunee	Green Bay	0.956
Oconto	Green Bay	0.956
Fond du Lac	Fond du Lac	0.957
Chippewa	Eau Claire	0.96
Eau Claire	Eau Claire	0.96
Calumet	Appleton	1.002
Outagamie	Appleton	1.002
Racine	Racine	1.004
Winnebago	Oshkosh	1.014
Green	Green	1.017
La Crosse	La Crosse	1.032
Kenosha	Kenosha	1.034
Sheboygan	Sheboygan	1.036
Marathon	Wausau	1.041
Milwaukee	Milwaukee	1.073
Ozaukee	Milwaukee	1.073
Washington	Milwaukee	1.073
Waukesha	Milwaukee	1.073
Douglas	Duluth	1.079
Columbia	Madison	1.083
Dane	Madison	1.083
Dodge	Madison	1.083
Iowa	Madison	1.083
Richland	Madison	1.083
Sauk	Madison	1.083
Rock	Janesville	1.083
Dunn	Minneapolis	1.173
Pierce	Minneapolis	1.173
St. Croix	Minneapolis	1.173