Health and Human Services Commission

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How Basic Nursing Facility Rates are Set

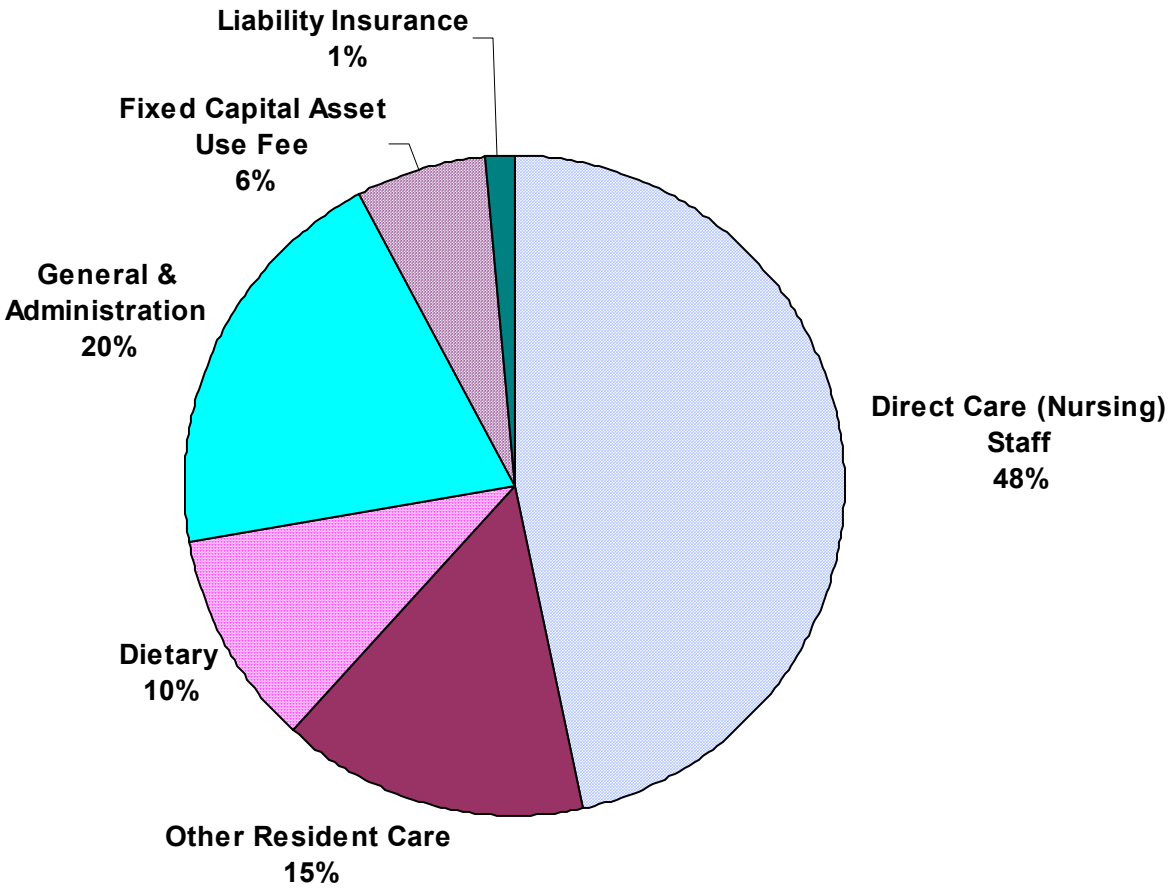
- Medicaid contracted nursing facilities are required to submit annual cost reports, which are audited and adjusted for factors such as inflation and low occupancy.

- Basic rate components are based on statistics derived from adjusted costs of all facilities in the cost report database:
  - Direct Care Staff Compensation – rates vary by resident case mix
  - Other Resident Care – rates vary by resident case mix
  - Dietary
  - Administration and Other Operating
  - Facility - Fixed Capital Asset Use Fee
  - Liability Insurance

- Final rates are subject to appropriated funding.

- Beginning with SFY 2002-2003, rates are determined for the biennium.

Breakdown of Estimated Average SFY 2003 Nursing Facility Rate



Background - Direct Care Staffing & Staff Spending Accountability

- H.B. 1, Article II, DHS, Rider 38 (76th Legislature) specified that $15.8 million GR for each year of the SFY 2000-2001 biennium ($31.6 million GR for the biennium) appropriated for nursing home rate increases was contingent upon those funds being utilized as incentives for increased direct care staffing and direct care wages and benefits in nursing homes. Rider 37 further stated that the purpose of this appropriation was to improve the quality of care.

- H.B. 1, Article II, DHS, Rider 44 (77th Legislature) specified that, of the $175 million GR appropriated for rate increases during SFY 2002-2003, $20 million GR for each year of the biennium ($40 million GR total for the biennium) may only be expended to improve the quality of care in nursing homes.

- These Riders support the general perception that quality care may be compromised without adequate numbers of direct care staff and without adequate wage and benefit levels to attract and retain qualified and motivated direct care personnel.

Direct Care Staff Spending Accountability

- All providers are subject to an 85 percent spending requirement on funding for direct care staff compensation, regardless of whether they participate in enhanced staffing. This requirement supports legislative direction to ensure that appropriations for increased direct care staffing and/or spending are used for that purpose.

- Spending recoupments may be offset in the following ways:
  - If facility costs are above the fixed capital asset use fee, spending recoupments may be offset up to $2.00 per resident day unless surplus revenue from the dietary rate component is available to cover these costs.
  - If dietary spending exceeds the dietary rate component, spending recoupments may be offset up to $2.00 per resident day unless there is surplus revenue from the fixed capital asset fee is available to cover these costs.
  - Quality scores may reduce or eliminate any recoupments.

- Additional measures to mitigate spending requirements are under consideration.

Enhanced Staffing Rates

- Implemented May 1, 2000, with subsequent modifications to increase provider flexibility.
- Providers may request additional funding to increase direct care staffing above minimum requirements, where minimum requirements are based on statewide average staffing levels funded prior to implementation.
- Funding for enhancements is limited by appropriations.
- A participating provider receiving enhanced rates must meet enhanced staffing levels or may face recoupment of enhanced funds, reduction in participation level and, in extreme cases, removal from participation.
- A provider who does not meet staffing requirements but who spends the additional funding on higher wages or benefits for direct care staff may offset recoupment of enhanced funding.
- Recouped funds based on spending and staffing requirements are reinvested with facilities exceeding the staffing levels to which they committed.

An Example of Spending Accountability in a Facility Not Participating in Enhanced Staffing

- A nursing home with 60 Medicaid residents and not participating in the enhancement program would receive approximately $880,000 in SFY 2003 for direct care staff compensation.

- Approximately $132,000 (15 percent of revenue linked to direct care staff) could be used for purposes other than direct care staff compensation--for example, administrative costs, liability insurance or profits.

- If this home's direct care staff spending is below the 85 percent requirement of approximately $748,000, but this home has mortgage or lease costs in excess of the fixed capital asset use fee, the required spending could be reduced up to an additional amount of approximately $44,000 to offset recoupments.

- In the above example, about $176,000 from the basic Medicaid payment for direct care staff does not have to be spent on direct care staff and is not subject to recoupment.

An Example of Enhanced Staffing

- A nursing facility with 60 Medicaid residents enrolled for the maximum level of enhanced staffing funds would receive approximately $177,000 in addition to the basic rates during SFY 2003. These funds may be used to:
  - hire, for example, 1 additional RN, 1 additional LVN and 4 additional nurse aides, or some other combination of additional direct care staff;
  - increase direct care staff wages and/or benefits; or
  - implement some combination of additional direct care staff and wage/benefit increases for direct care staff.
- To avoid any recoupment, this home would be required to maintain the minimum staffing ratio associated with its residents' case mix and to expend any funds associated with unmet staffing requirements on direct care staff wages and/or benefits.

SFY 2002-2003 Appropriations for Rate Increases

- SB 1 appropriated $175 million GR ($438 million All Funds) to increase nursing facility rates. This funded an estimated overall average rate of about $96.25 for the biennium, or an 11.5 percent increase over the SFY 2001 average.

- $135 million GR was dedicated to increase the general base rate (facility, dietary, administration, medical supplies and equipment, laundry and basic staff compensation costs).

- $40 million GR for the biennium ($20 million each year) was designated for quality improvement and funded increases in enhanced staffing rate levels. Providers participating in enhanced rates were able to receive up to approximately $4.00 per resident day above the previous enhancement level of $2.00, with the restriction that funds be used to pay for enhanced direct care staffing and/or enhanced direct care staff compensation.

Current Rates for Liability Insurance

- HB 154 requires that rates based on costs of liability insurance be paid only to those facilities that carry liability coverage.

- Current rates for liability insurance were established within appropriations by:
  - determining the total funding that tied back to liability costs in the cost report database;
  - conducting a provider survey to determine the number of homes with purchased liability insurance coverage and estimating the number of residents they serve; and
  - calculating rates to distribute the available funding to covered facilities.

- For SFY 2002-2003 homes with liability insurance coverage receive $2.20 per resident day for professional liability and $0.20 for general liability, or $2.40 per resident day for both types of coverage.

- During this biennium liability insurance coverage levels have varied from a high of about 65 percent of homes in early SFY 2002 to about 51percent at the beginning of SFY 2003.

Liability Insurance & the DHS LAR

- HB 1839 requires all nursing facilities to carry liability insurance coverage by September 1, 2003, with coverage limits of $1 million per occurrence and $3 million total.

- LAR fiscal impact analyses are based on CY 2002 Texas Joint Underwriting Association (JUA) rates projected to SFY 2004-2005, assuming:
  - 10 percent annual increases,
  - minimum coverage limits required by HB 1839, and
  - $25,000 deductible—the highest deductible under the JUA rate structure.

- JUA rates vary by 5 Tiers, with higher-numbered Tiers being associated with higher-risk homes and higher insurance rates.

- JUA estimated that about 67 percent of homes would qualify for Tiers I and II. The DHS SFY 2004-2005 LAR figure of about $55 million GR for liability insurance is based on the assumption that all homes are paid at Tier II rates.

Medicaid Rates and Nursing Facility Costs

- The intent of the methodology is to cover costs at reasonable levels that support efficient operations and continued access for Medicaid residents.
- A number of providers' costs are not fully covered due to factors such as exceptionally high costs for administration or facility leases and/or low occupancy.
- The statewide flat rate paid for facility costs—the fixed capital asset use fee—has the drawback of paying the same rate to all homes without regard to the age or condition of individual facilities.
- Current rates for professional liability insurance cover the costs of some providers who have access to the lowest insurance premium rates, but do not fully cover the costs of many others with higher premiums.
- The more prescriptive the rate methodology in areas such as staffing and spending requirements and mandatory liability insurance coverage, the more difficult it becomes to operate unless appropriations for rate increases keep up with costs.