Washington State Health Care Authority

Report to the Legislature

Home Care Safety Net Assessment

Substitute House Bill 1435; Section 2; Chapter 209; Laws of 2023

Adding a new section to chapter 70.127 RCW and adding a new section to chapter 74.39A RCW

December 1, 2024

Home Care Safety Net Assessment

Acknowledgments

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Background

Substitute House Bill (SHB) 1435 (2023), Home Care Safety Net Assessment, became effective July 23, 2023. The purpose of the bill is to:

- "Form a workgroup and develop a home care safety net assessment proposal to secure federal matching funds under federally prescribed programs available through the state Medicaid plan or a waiver."
- Collect financial information from "consumer directed employer and in-home services agencies that provide home care services, hospice services, or home health services" for financial modeling purposes.

The bill specified the following data analysis requirements using the collected financial information:

- "The data analysis must include the development of various financial modeling options that may meet federal regulations for approval of the assessment."
- The Health Care Authority (HCA) "may contract with a private entity to provide data analysis of the financial information submitted by the in-home services agencies and consumer directed employers as necessary to inform the work group's development of a home care safety net proposal."

We contracted Milliman as our private entity to assist with data analysis of the financial information that we collected for the following four categories of care:

- **Consumer Directed Employer (CDE)** – Per RCW 74.39A, CDE is a private entity that contracts with the Washington State Department of Social & Health Services to be the legal employer of individual providers (IPs). IP is a person under a contract with the CDE to provide personal care or respite care services to persons who are functionally disabled or otherwise eligible for such services (RCW 74.39A 240).
- **Home care** – Per RCW 70.127.010, home care services means nonmedical services and assistance provided to ill, disabled, or vulnerable individuals that enable them to remain in their residences. Home care services include but are not limited to:
  - Personal care such as assistance with dressing, feeding, and personal hygiene to facilitate self-care.
  - Homemaker assistance with household tasks, such as housekeeping, shopping, meal planning and preparation, and transportation.
  - Respite care assistance and support provided to the family.
  - Other nonmedical services or delegated tasks of nursing under RCW 18.79.260(3)(e).
- **Home health** – Per RCW 70.127.010, home health services means services provided to ill, disabled, or vulnerable individuals. These services include but are not limited to nursing services, home health aide services, physical therapy services, occupational therapy services, speech therapy services, respiratory therapy services, nutritional services, medical social services, and home medical supplies or equipment services.
- **Hospice** – Per RCW 70.127.010, hospice services means symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual

and family in a place of temporary or permanent residence and may include the provision of home health and home care services for the terminally ill individual.

The purpose of collecting and analyzing financial information from the agencies listed above is to evaluate the feasibility of a home care safety net assessment to secure federal matching funds through the state Medicaid plan or waiver. If successful, the federal matching funds would be redistributed back to the Medicaid provider agencies to, in turn, increase compensation and funding to Medicaid staffing.

Survey

The bill required that the work group collect the following information:

- In-home services client revenue, separated by type of service and payer, from the 12-month period between July 1, 2022, and June 30, 2023.
- Total client revenue for home care services is expressed as client revenue for CDE, home care, home health, and hospice services paid by:
  - Medicaid
  - Medicare
  - Private pay
  - Commercial insurance
  - The Veterans Administration
  - All other payers

To collect the information, the Department of Health (DOH) created and launched a survey on October 20, 2023, and requested responses by January 1, 2024. The survey included the following background information:

- Background and purpose
- Link to the bill
- Details regarding information requested
- WAC definitions for home care agency, home care services, home health agency, home health services, hospice agency, hospice services, and consumer directed employer

We received 167 responses by January 1, 2024, which is a 36 percent response rate. To increase the response rate and expand the data collection, we relaunched the survey, giving agencies until February 9, 2024, to respond. We received an additional 102 responses, bringing our response rate up to 60 percent. To support HCA's analysis, our contracted entity, Milliman, reviewed survey results that were compiled and submitted by HCA.

Data

From our analysis of the survey data (with a reporting period aligned with state fiscal year (SFY) 2023), we learned that 47percent of total revenue received, or close to $2.1 billion, was from the Consumer Directed Employer (CDE), which is 100 percent Medicaid funded. Agencies providing home care services contributed 21 percent of the reported revenue, as did agencies providing home health services. Hospice agencies contributed the remaining 11 percent of total revenue reported.

Table 1: Total SFY 2023 revenue by service type

	CDE	Home health	Home care	Hospice	Total
Total Revenue	$2.1B	$921M	$909M	$462M	$4.3B

Table two indicates the reported revenue per payer type. As you can see, Medicaid makes up $2.91 billion of the $4.3 billion in revenue reported, or 67 percent. $2.1 billion of the Medicaid dollars was reported by the CDE.

Table 2: Total SFY 2023 revenue by payer type

	Medicaid	Medicare	Private pay	Commercial insurance	Veterans Administration (VA)	All other payers	Total
Total revenue	$2.9B	$798M	$168M	$257M	$53M	$166M	$4.3B

In tables three through five, we show the reported aggregate revenue by payer for each category of care. Note that we incorporated the CDE revenue into table three for home care, as the IPs contracted with the CDE to provide personal care or respite care services.

Table 3: Distribution of home care revenue by payer type

	Medicaid	Medicare	Private pay	Commercial	VA	All other	Total
Total revenue	$2.7B	$12M	$144M	$11M	$29M	$46M	$2.9B

Note: CDE is 100 percent Medicaid-funded and is included in the home care chart above.

Home care revenue is heavily Medicaid funded (73 percent), followed by Private Pay (16 percent). Of the 165 home care agencies that reported revenue, 55 are Medicaid providers (33 percent).

Table 4: Distribution of SFY 2023 hospice revenue by payer type

	Medicaid	Medicare	Private Pay	Commercial	VA	All Other	Total
Total revenue	$34M	$370M	$888K	$39M	$6M	$12M	$462M

Hospice is primarily funded by Medicare (80.3 percent), followed by commercial insurance (8.4 percent) and Medicaid (7.3 percent).

Table 5: Distribution of SFY 2023 home health revenue by payer type

	Medicaid	Medicare	Private Pay	Commercial	VA	All Other	Total
Total revenue	$150M	$415M	$24M	$207M	$18M	$107M	$921M

Home health is primarily funded with Medicare dollars (45 percent), followed by commercial insurance (23 percent), and Medicaid (16 percent).

Federal requirements

CFR 433.56 contains a list of permissible "classes of health care services and providers" upon which states may impose health care-related taxes. Out of the service classes included in SHB 1435, only "Home health" services are listed as a permissible class in CFR 433.56. Permissible classes under CFR 433.56 also include "Nursing services", which are applicable to some of the categories of care of interest to the work group. CFR 433.56 also includes "other health care items or services not listed above on which the State has enacted a licensing or certification fee," but places limits for the size of assessment of these services, as "the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program." All health care-related taxes are subject to the six percent indirect hold harmless limit under CFR 433.56(f), where assessments for a health care class must be less than or equal to six percent of the revenues received by the taxpayer.

Home care and hospice services are not specifically listed as permissible classes of health care services and providers in CFR 433.56. We contacted the Centers for Medicare and Medicaid Services (CMS) for clarification before we could proceed with the data analysis and work group recommendations.

CMS response regarding home care providers and home health care service providers:

> With regards to the question asking if home care providers would be considered home health care service providers: Under Medicaid, home health nursing and aide services must be provided by a home health agency that meets the Medicare Conditions of Participation (42 CFR 440.70). The fees should be capped at the cost of the licensing and program certification of the provider. The "other" category is for a licensing and certification fee that a state imposes on a health care item or service that is not covered by the rest of the list of permissible classes at 42 CFR 433.56. It does not allow a state to tax these services generally. There is a permissible class entitled, "Home Health Care Services." If it fits within this category, it can be taxed. If it doesn't, it can't.

How CMS defines hospice services:

> As required in the Medicare Conditions of Participation for Hospice at 42 CFR 418.100(c), hospice must provide certain specified care and services and must do so in a manner that is consistent with accepted standards of practice. Those services include nursing services (including aide services), medical social services, physician services, counseling services (spiritual, dietary, and bereavement), volunteer services, therapy services as appropriate, short-term inpatient care, and medical supplies. For hospice, nursing services, physician services, and drugs and biologicals (as specified in § 418.106) must be made routinely available on 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.
>
> Private duty nursing services as defined in 42 CFR 440.80 means nursing services for beneficiaries who require more individual and continuous care than is available from a

visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

CMS responses to the work group's inquiries indicate that a home health agency would be permissible but an assessment on other provider types included in SHB 1435 (other than licensing and certification fees) would not. The work group's options for possible taxation modeling became severely limited based on CMS guidelines and definitions.

The work group also considered federal regulations regarding the structure of health care-related taxes, which are described as following.

Broad-based and uniform considerations

Under current federal regulations, states may use health care-related taxes as a source of nonfederal share of Medicaid if they meet the following requirements or qualify for a waiver (per 42 CFR 433.68):

1. **Broad based:** A broad-based tax is imposed on all the nongovernmental health care entities, items, and services within a class and throughout the jurisdiction of the applicable unit of government. For example, a tax cannot be exclusive to hospitals that treat a high proportion of Medicaid patients.
2. **Uniform:** A uniform tax applies consistently in the amount and scope to the entities, items, and services to which it applies. For example, the tax rate cannot be higher on managed care plans' Medicaid revenue than on its non-Medicaid revenue.
3. **Does not hold taxpayers harmless**: Taxpayers cannot be held harmless; that is, they cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute. Additionally, Medicaid and non-Medicaid payments from states to providers must not vary based on the amount of tax revenue collected from these providers.[1]

States must receive CMS approval for health care-related assessments to receive federal matching funds for Medicaid payments (where the nonfederal share is funded by the assessment). If the assessment is not considered broad-based and uniform, states are required to obtain an assessment waiver from CMS. This assessment waiver involves statistical tests to demonstrate assessments are generally redistributive across providers required under 42 CFR 433.68.

Assessment modeling

Given that CMS would not consider an assessment on home care or hospice service providers as a permissible health care-related tax, it severely limits the possible modeling options available for the work group's consideration.

Our survey yielded financial data from 111 home health agencies. Table five in the prior section details the amounts of SFY 2023 revenue reported by payer type for home health services. The results indicate that home health services are largely paid for with Medicare dollars (45 percent). Table six shows estimates of

[1] MACPAC (May 2021). *Issue brief: Health Care-Related Taxes in Medicaid.* Health Care-Related Taxes in Medicaid (macpac.gov)

a maximum six percent broad-based and uniform assessment (without payer exemptions or tiered assessment rates) for home health, summarized by payer type.

Table 6: Estimated maximum assessment (six percent) for home health by payer type

	Medicaid	Medicare	Private Pay	Commercial Insurance	VA	All other payers	Total
Total Revenue	$150M	$415M	$24M	$207M	$18M	$107M	$921M
6% of Revenue	$9M	$25M	$1M	$12M	$1M	$7M	$55M
Percent per payer type	16%	45%	2%	22%	3%	12%	100%

Based on the figures above, Medicare would be the highest taxed payer category at 45 percent of home health revenue, followed by commercial insurance at 22 percent, and Medicaid at 16 percent. Note that an assessment based only on Medicaid volume would not meet CMS requirements under CFR 433.68, and tiered assessment rates or exemptions would undergo CMS scrutiny and would require passing statistical tests to demonstrate the assessment is generally redistributive.

Table seven contains the distribution of payer types across the 111 home health agencies that provided survey responses. Some agencies provide services for more than one payer, which is reflected in the table.

Table 7: Number of agencies reporting home health payments by payer type

Medicaid	Medicare	Private Pay	Commercial	VA	All Others
76	65	77	65	24	70

Based on collection of data from 111 home health agencies.

Based on table seven, this demonstrates that of the 111 responding home health agencies, 76 accept Medicaid and the remaining 35 do not. This indicates that approximately 32 percent of home health agencies assessed under a broad-based assessment would not receive any benefit in the form of enhanced Medicaid payments (and by extension, we assume would have a net loss from the assessment).

Table eight shows the calculations demonstrating the potential federal matching dollars if the maximum six percent broad-based and uniform assessment was applied for home health agencies.

Table 8: Illustrative example of a funding increase under maximum assessments for home health

Service category (column A)	Assessments (amount contributed with an estimated 6% assessment) (column B)	Estimated federal share of Medicaid funding increases (column C)	Estimated total computable Medicaid funding increases (column D)	Medicaid base payments (column E)	Estimated gross Medicaid payment increase (column F)	Estimated net Medicaid payment increase ((column G)
		C = (B / (100% - 67.4%)) - B	D = B + C	Reported for 2023	F = D / E	G = (D – B) / E
Home care	$0	$0	$0	$2.7B		
Home health	$55M	$114M	$170M	$150M	113%	76%
Hospice	$0	$0	$0	$34M		
Total	**$55M**	**$114M**	**$170M**	**$2.9B**		

Note: Estimated federal share of Medicaid funding increases (column C) assumes a 67.4 percent blended match rate.

Work group feedback

We held two work group meetings and discussed potential advantages, disadvantages and options for imposing an assessment fee. Below are some concerns the work group voiced.

First, instead of implementing an assessment fee on home health agencies only, could we consider establishing a class of services based on the agencies that are subject to the same licensing fees (collected through DOH) and imposing a tax based on that class?

Based on CMS' responses, the classes that are permissible to tax are limited to the classes listed in 42 CFR 433.56, which includes home health but does not include hospice, home care, or the CDE. The "other health care items or services" category in 42 CFR 433.56 allows specifically for states to impose licensing and certification fees on other items or services beyond the classes listed but does not allow for other assessments. Given the limited scope of the "other health care items or services" category, 42 CFR 433.56 does not include any classes that could be used as the basis for establishing a class to tax based on a group of agencies that are subject to the same licensing fees.

Second, there is concern about the impact on private-pay home care agencies that do not accept Medicaid because they would have to increase prices to recoup funding lost from imposing this tax.

Based on CMS feedback and our understanding of CMS regulations, we do not believe a home care assessment would be permissible (beyond the current licensing fees).

Conclusion

The original intent of SHB 1435 was to evaluate the potential assessment on home care agencies, home health agencies, hospice agencies, and the consumer directed employer (CDE). Upon closer examination of CMS rules and regulations, of these provider types, the only permissible health care-related tax under current federal regulations that could potentially be considered is home health services.

Our analysis indicates that a broad-based and uniform assessment could provide the opportunity for Medicaid funding increases for home health services, but that potentially one-third of all home health agencies would have a net loss (as they do not participate in Medicaid). To impose a home care or hospice assessment, CMS would need to make both of these permissible classes since they currently are not.