HOUSE BILL REPORT
ESSB 6158

As Reported by House Committee On:
None

Title: An act relating to biennial rebasing of nursing facility medicaid payment rates.

Brief Description: Concerning the biennial rebasing of nursing facility medicaid payment rates.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senator Prentice).

Brief History:
Committee Activity: None.

Brief Summary of Bill

- Modifies the nursing facility Medicaid payment system by rebasing direct care, therapy care, support services, and operations component rate allocations based upon calendar year 2005 costs.
- Requires automatic rate rebasing every two years beginning July 1, 2009.
- Removes specific hold harmless payment rates for "vital local providers" and establishes hold harmless payment rates set equal to June 30, 2007, component rates for nursing facilities that meet certain criteria.
- Makes costs associated with the repealed quality maintenance fee unallowable under the Medicaid nursing facility payment system.

Staff: Bernard Dean (786-7130).

Background:

There are about 234 Medicaid-certified nursing home facilities in Washington providing long-term care services to approximately 11,500 Medicaid clients. The payment system for these nursing homes is established in statute and is administered by the Department of Social and Health Services (DSHS).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The rates paid to nursing facilities are based on seven different components. These components include rates paid for direct care, therapy care, support services, operations, property, financing allowance, and variable return.

The direct care rate component includes payments for the wages and benefits of nursing staff, non-prescription medications, and medical supplies. This rate component is most directly related to patient care and comprises roughly 55 percent of the total nursing facility rate. The direct care rate component is based upon "case mix," or the relative care needs of the residents that it serves. The higher the care needs of the clients, the higher the direct care rate. Facilities whose direct care costs are above 112 percent of median costs are paid at 112 percent of the median.

Two other components relate to patient care. The therapy care rate component includes payments for physical therapy, occupational therapy, and speech therapy. The support services rate component includes payments for food, food preparation, laundry, and other housekeeping needs. Support services component rates are lidded at 110 percent of the industry median.

The operations rate component pays for administrative costs, office supplies, utilities, accounting costs, minor building maintenance, and equipment repairs. Operations component rates are lidded at 100 percent of the industry median.

The property and financing allowance rate components relate to the capital cost of a nursing facility. The property rate is a payment made to reflect the depreciation of a facility and other capital assets. Property depreciation periods vary, with most new facilities depreciating over 40 years.

The financing allowance is paid and calculated by multiplying an interest rate by the value of the assets. The applicable interest rate is 10 percent for construction proposed prior to May 17, 1999, and 8.5 percent for construction proposed after that date.

The variable return rate component does not reimburse nursing facilities for a specific cost. Rather, nursing facilities that serve residents at the lowest cost per resident day receive an efficiency incentive of 1 to 4 percent of the total direct care, therapy care, support services, and operations rate components based on the facilities' relative efficiency when measured in comparison with the same costs in other facilities throughout the state. Variable return component rates are currently frozen at the June 30, 2006 level.

The property and financing allowance components of nursing facility rates are rebased annually to reflect actual costs. All other rate components have been rebased at periodic intervals specified in statute. The last full rebasing of nursing facility payment rates occurred on July 1, 2001, when all component rates were recalculated to reflect calendar year 1999 costs. Component rate allocations for direct care and operations are based upon 2003 cost reports and component rate allocations for therapy care and support services rate allocations are based upon 1999 cost reports. During the years between rebasings, rates have been adjusted for economic trends and conditions (i.e., vendor rate increases) as specified in the Biennial Appropriations Act.

Legislation enacted in 2006 to rebase direct care and component rate allocations based upon calendar year 2003 costs included a "hold harmless" provision for facilities designated as "vital local providers." Vital local providers were defined in statute as those nursing facilities that have a home office in the state and that have a sum of Medicaid days for all Washington facilities that was greater than 215,000 in 2003. Vital local providers received the greater of their direct care and operations component rate allocations as of June 30, 2006, or their calendar year 2003 rebased rate allocations.

Summary:

Costs associated with the repealed quality maintenance fee are made unallowable under the Medicaid nursing facility payment system.

Nursing facility component rate allocations for direct care, therapy care, support services, and operations component rate allocations are rebased to calendar year 2005 cost report data, excluding costs associated with the quality maintenance fee that was repealed in 2006.

Automatic biennial rebasing is established in statute for direct care, therapy care, support services, and operations component rate allocations, so that rate-setting for fiscal years 2010 and 2011 would be based upon calendar year 2007 cost data; rate-setting for fiscal years 2012 and 2013 would be based on calendar year 2009 cost data; and so on.

Hold harmless payment rates for "vital local providers" are removed, effective June 30, 2007.

Hold harmless rates are established during the 2007-09 biennium for nursing facilities that meet certain specific criteria. The Department of Social and Health Services will provide "hold harmless" rates equal to June 30, 2007, component rate allocations for direct care, therapy care, support services, and operations rates after rebasing to calendar year 2005 costs to nursing facilities that: (a) have estimated rebased component rate allocations that are less than their June 30, 2007, rates; and (b) have combined adjusted costs per adjusted resident day in the direct care, support services, therapy care, and operations cost centers that were greater than the combined per resident day reimbursement rates for these cost centers in either calendar years 2004 or 2005.

A number of clarifying and technical changes are specified.

Appropriation: None.

Fiscal Note: Requested on April 19, 2007.

Effective Date: The bill contains an emergency clause and takes effect on July 1, 2007.

Staff Summary of Public Testimony:

None.

Persons Testifying: None.

Persons Signed In To Testify But Not Testifying: None.