FINAL BILL REPORT
ESSB 6158

C 508 L 07
Synopsis as Enacted

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

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

Senate Committee on Ways & Means

Background: There are 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) Aging and Disability Services Administration. The rates paid to nursing facilities are based on seven different components. The noncapital rate components include rates paid for direct care, therapy care, support services, operations, and variable return. Capital rate components include property, and a financing allowance. These rate components are further described below.

Noncapital Rate Components: 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. Prior to legislation enacted in 2006 (EHB 2716), facilities whose direct care costs were below 90 percent of median costs were paid at 90 percent of median costs, also called the "floor."

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 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 per legislation that passed during the 2006 Legislative Session.

Capital Rate Components: 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.

Rebasing of Rate Components: According to statute, the capital (property and financing allowance) components of nursing facility rates are automatically rebased annually to reflect actual costs.

All of the noncapital rate components are only rebased subject to legislation. Based on legislation enacted during the 2006 Legislative Session, component rate allocations for direct care and operations were rebased upon 2003 cost reports. Component rate allocations for therapy care and support services rate allocations remain based upon 1999 cost reports. 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. 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.

2006 Changes to Nursing Home Payments: 2006 legislation (EHB 2716) made a number of changes to the Medicaid nursing home payment system. First, as indicated above, direct care and operations rates were rebased to reflect calendar year 2003 costs. Second, the minimum occupancy standard for the direct care component of the rate was repealed. Third, the direct care floor of 90 percent of median was eliminated, and the ceiling was increased to 112 percent of the industry median. Fourth, variable return rates were frozen at their June 30, 2006, level.

Lastly, the 2006 legislation included a "hold harmless" provision to assure that certain facilities, called "vital local providers" did not receive a lower rate under the revised system than they were receiving as of June 30, 2006. Vital local providers were defined in statute as those nursing facilities that have a home office in the state and have a sum of Medicaid days for all Washington facilities that was greater than 215,000 in 2003.

Relation to the 2007-09 Operating Budget: Separate from Senate Bill 6158, the Legislative Final 2007-09 Biennial Appropriations Act, enacted April 22, 2007, includes funding for an adjustment for economic trends and conditions (i.e., vendor rate increase) of 3.2 percent to all noncapital rate components, effective July 1, 2007. This adjustment is in addition to any changes made under separate policy legislation.

Summary: Nursing facility component rate allocations for the noncapital rate components (direct care, therapy care, support services, and operations) are rebased to calendar year 2005 cost report data, excluding costs associated with the quality maintenance fee that was repealed in 2006. Rate-setting for fiscal years 2008 and 2009 will use calendar year 2005 cost data for the noncapital rates, except as indicated by certain hold harmless provisions discussed below. [Any adjustment to the 2005 costs for economic trends and conditions (i.e., vendor

rate increase) would be addressed separately by the final 2007-09 Biennial Appropriations Act.]

Automatic biennial rebasing is established in statute for the noncapital rate components, so that rate-setting for fiscal years 2010 and 2011 would be based on 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. Only for the 2007-09 biennium, a hold harmless provision is available. Providers who would be "harmed" because their total combined rebased rate less the quality maintenance fee plus any vendor rate increase specified in the Biennial Appropriations Act is less than their "current rate" (their June 30, 2007, rate less the quality maintenance fee) may qualify. These providers will then be paid their "current rate" if they meet the following condition: their actual adjusted costs must have exceeded their Medicaid reimbursement rate for at least one of two years – calendar year 2004 or 2005. If held harmless, their "current rate" would also be adjusted for any economic trends and conditions (i.e., vendor rate) specified by the 2007-09 Biennial Appropriations Act.

Votes on Final Passage:

Senate	48	1
House	94	3

Effective: July 1, 2007