FINAL BILL REPORT
ESSB 6872

PARTIAL VETO
C 34 L 10 E 1
Synopsis as Enacted

Brief Description: Concerning medicaid nursing facility payments.

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

Senate Committee on Ways & Means

Background: Skilled nursing facilities (nursing homes) are licensed by the Department of Social and Health Services (DSHS) and provide 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, laundry services, and room and board to three or more residents. Currently, there are over 200 licensed facilities throughout the state. Medicaid rates for nursing facilities (i.e., payments for providing care and services to eligible, low-income residents) are generally based on a facility's costs, its occupancy level, and the individual care needs of its residents.

The nursing home rate methodology, including formula variables, allowable costs, and accounting/auditing procedures, is specified in statute (RCW 74.46) and is based on calculations for seven different components: direct care, therapy care, support services, operations, variable return, property, and a financing allowance. The rate calculations for these seven components are based on actual facility cost reports and are updated either annually or biennially, depending on the specific component. Additional factors that enter into the rate calculations are resident days (the total of the days in residence for all eligible residents), certain median lids (a percent of the median costs for all facilities in a peer group), and geographical location.

Finally, RCW 74.46.421 imposes a rate ceiling, commonly referred to as the budget dial. The budget dial is a single daily rate amount calculated as the statewide weighted average maximum payment rate for a fiscal year. This amount is specified in the Appropriations Act and DSHS must manage all facility specific rates so the budget dial is not exceeded.

Payments to nursing facilities is one of the largest budget units within the Aging and Disability Services Program. The Fiscal Year 2010 nursing home payments are estimated to total about $476 million from all funds with approximately $179 million from general fund-state resources.

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.

Summary: Several changes are made to the nursing facility rate statute, in which changes can be grouped into two major categories: (1) changes to shorten and update the statutory sections (RCW 74.46) that deal with calculating nursing home Medicaid rates; and (2) changes to the methodology used to calculate nursing facility rates.

Changes to shorten and update RCW 74.46. Specifically, the act would:

- Add one new section specifying 11 broad principles – all consistent with the existing payment system – to guide in the implementation of a payment methodology in rule. It also includes a separate grant of rulemaking authority to DSHS.
- Amend various sections – including the sections dealing with rate setting, commonly referred to as Part E. The majority of the Part E sections are retained but amended to reflect subsequent legislative changes and to remove unnecessary material and references. References to the AIDS pilot nursing facility are left in place, retaining the present, unique status of Bailey-Boushay House in Seattle.
- Repeal 52 current sections.
- Leave in place the current budget dial.

Changes to nursing home rate methodology. The nursing facility rate methodology is modified as described below:

- The nursing home payment system administered through the Department of Social and Health Services Aging and Disability Services Administration (ADSA) is restored to seven rate components as it exists under current law.
- The variable return component will be funded at 30 percent of its level under current law and will be repealed on July 1, 2011.
- Minimum occupancy in the operations, property, and finance components will remain at 85 percent for essential community providers and at 90 percent for small nonessential community providers (defined as nonessential providers with 60 or fewer beds) and will be increased to 92 percent for large nonessential community providers (defined as nonessential providers with more than 60 beds).
- ADSA is required to establish a new pay-for-performance supplemental payment structure that provides payment add-ons for high performing facilities. To the extent that funds are appropriated for the purpose, the pay-for-performance structure will include a 1 percent reduction to facilities that have direct care staff turnover above 75 percent and a payment add-on to facilities that maintain direct care staff turnover below 75 percent.
- Facilities are no longer permitted to bank beds (temporarily reducing the number of patient beds for which they are licensed) which, under current statute, reduces the effects of minimum occupancy.
- The cycle for case mix adjustments is changed to every six months instead of every quarter.
- Rebasing is postponed for one year and the cycle for rebasing moves from every odd-year to every even-year.
- Median lids in Direct Care, Support Services, and Operations remain unchanged from current law.

Votes on Final Passage:

First Special Session

Senate	30	14
House	63	34

Effective: July 1, 2010
July 1, 2011 (Section 22)

Partial Veto Summary: The Governor vetoed Section 6 which adjusted the return on investment for all assets to 4.0 percent.