Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Ways & Means Committee

HB 1722

Brief Description: Creating a nursing home safety net assessment.

Sponsors: Representatives Green, Hinkle, Pettigrew, Armstrong, Chandler, Van De Wege, Liias and Harris.

Brief Summary of Bill

- Makes various revisions to nursing home payments.
- Eliminates the 1 percent funding structure for the pay-for-performance rate add-on.
- Replaces the variable return component with the disproportionate Medicaid share component.
- Lowers minimum occupancy for all provider types to 85 percent in the rate components of direct care, therapy care, support services, operations, property, and financing allowance.
- Replaces the economic trends and conditions factor identified in the operating budget by the Legislature with an annual inflationary adjustment tied to the skilled nursing facility market basket index.
- Creates a property and business tax add-on rate in the property component.
- Raises the lid on allowable costs from 100 percent to 105 percent in the operations component.
- Requires the design of a quality incentive payment system that must be submitted to the Legislature by December 15, 2011.
- Authorizes Department of Social and Health Services (DSHS) to administer and collect a skilled nursing facility safety net assessment.
- Requires the DSHS to seek federal approval of a waiver for a broad-based and uniform provider assessment fee.
- Identifies facility exemptions from the assessment fee and authorizes the DSHS to amend exemptions to the extent necessary to obtain federal approval.

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.

- Establishes the Skilled Nursing Facility Safety Net Trust Fund in which all proceeds from the assessment will be deposited for the purpose of reimbursements and Medicaid payments for nursing facility services.
- Clarifies that fee proceeds may not be used to replace existing state expenditures with the exception to the non-supplant language for fiscal years 2011, 2012, and 2013.
- Prohibits nursing facilities from increasing charges or billings to the patients or third-party payers as a result as a result of the assessments.

Hearing Date: 2/24/11

Staff: Carma Matti-Jackson (786-7140).

Background:

The current Washington Medicaid program provides health and long-term care assistance to low-income individuals. It is administered by the state in compliance with federal laws and regulations and is jointly financed by the federal and state government. The federal funds are matching funds, and are referred to as the Federal Financial Participation (FFP) or the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated based on average per capita income and is usually between 50 and 51 percent for Washington. Typically the state pays the remainder using the State General Fund.

Under federal law and regulations, states have the ability to use provider-specific revenue to fund a portion of their state share of Medicaid program costs. This is sometimes referred to as a Medicaid provider tax or sometimes as a provider assessment or provider fee. States can use the proceeds from the tax to make Medicaid provider payments and claim the federal matching share of those payments. Essentially, states use the proceeds from the provider tax to offset a portion of the state funds that would have been required to fund the Medicaid program. Federal regulations define the rules for Medicaid provider taxes.

Nursing facilities are included in the permissible class of health care services of which states may assess a provider tax without triggering a penalty against Medicaid expenditures.

Specifically, provider taxes must:
- be imposed on a permissible class of health care services;
- be broad-based or apply to all providers within a class;
- be uniform or apply the same rate to all providers within a class; and
- avoid hold-harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers.

A state can request a waiver from the broad-based and uniform requirements from the Centers for Medicaid and Medicare Services (CMS). The hold-harmless provision does not apply if the tax is at or below 5.5 percent of provider revenues (this threshold of 5.5 percent of revenues applies through federal fiscal year 2011; thereafter, the threshold is 6.0 percent of revenues). If a waiver of the broad-based and uniform requirements is requested, the state must show that the tax is generally redistributive and the amount of the tax is not directly correlated to Medicaid

payments. Federal regulations lay out detailed statistical tests that states must use to show this; essentially, the tests are designed to measure the degree to which the Medicaid program incurs a greater tax burden than if the broad-based and uniform requirements were met or not waived.

Currently 44 states, including Washington, and the District of Columbia have at least one type of Medicaid provider tax.

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, therapies, 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). The rates are based on calculations for seven different components: direct care, therapy care, support services, operations, variable return, property, and a financing allowance. Rate calculation for the noncapital components (direct care, therapy care, support services, and operations) are based on actual facility cost reports and are typically updated biennially in a process known as rebasing. The capital components (property and financing allowance) are also based on actual facility cost reports but are rebased annually. The variable return component is designed to reward efficiency based on the four noncapital components. The variable return component is currently scheduled to be repealed on July 1, 2011.

Additional factors that enter into the rate calculations are resident days (the total of the days in residence for all eligible residents), minimum occupancy requirements, certain median lids (a percent of the median costs for all facilities in a peer group), facility geographical location, and the case mix index of the facility. The case mix index is a weighted scoring of all facility residents that is designed to quantify the relative acuity of the residents.

Current statute 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 the DSHS must manage all facility specific rates so the budget dial is not exceeded.

Summary of Bill:

There are two main categories of impacts in this bill: (1) changes to the current nursing home rate methodology; and (2) the creation and administration of a nursing home safety net assessment.

Nursing Home Rate Methodology Changes. The changes to the nursing home rate methodology are detailed below:

- The pay-for-performance rate add-on that rewards facilities for low direct care staff turnover is eliminated.

- The variable return component is replaced with a new component referred to as disproportionate Medicaid share. Facilities with the highest Medicaid occupancy would receive the highest percentage of funding. Funds that are attributed to the facilities in the lowest Medicaid occupancy quartile are used to fund a pay-for-performance supplemental payment system. The disproportionate Medicaid share component is rebased annually using the most recent cost reports.
- Minimum occupancy is set for all provider types at 85 percent in the rate components for the therapy care, support services, operations, property, and financing allowance.
- The current economic and trends factor that is identified by the Legislature in the operating budget is replaced with an annual inflation factor based on the skilled nursing facility market basket index published by the United States Department of Health and Human Services.
- A rate add-on is established in the property component for property and business taxes. For each facility, the state and local government real estate taxes, personal property taxes, and business taxes to include business and occupation taxes are summed and then divided by that facility's total resident days. This rate add-on is revised annually.
- The lid on allowable costs in the operations component is raised from 100 percent to 105 percent.
- A quality incentive payment system will be designed by DSHS, the Department of Health, Washington State Health Care Association, and Aging Services of Washington. The system needs to be based on evidence-based treatment, effective purchasing strategies, and nationally recognized quality measures. the design of the incentive payment system must be submitted to the Legislature for approval by December 15, 2011.

The above changes to the rate methodology remain in place if other sections of the act (the sections dealing with the nursing home safety net assessment) are ruled invalid.

Nursing Home Safety Net Assessment. The skilled nursing facility safety net assessment is imposed on certain nursing facilities.

The fee is assessed on a per-resident day basis, it does not apply to Medicare residents, and the DSHS is required to submit a waiver including the following facility exemptions from paying the fee:

- continuing care retirement communities, as defined in the bill;
- nursing facilities with 35 or fewer beds;
- state, county, and public hospital district operated nursing facilities; and
- hospital-based nursing facilities.

In addition, the DSHS must administer the fee in a tiered manner such that a lower fee is assessed for either certain high-volume Medicaid nursing facilities, as defined by the bill, or certain facilities with high resident volumes. This lower fee is to be assessed such that the statistical redistributive tests required by federal law are met. If these tests are not met or the exemptions are not federally approved, the DSHS is authorized to amend the exemptions in order to obtain federal approval.

The Skilled Nursing Facility Safety Net Trust Fund (Trust Fund) is established and all proceeds are directed from the safety net assessment fee into the Trust Fund. The Trust Fund is subject to appropriation and can only be used for:

- immediate pass-through to nursing facilities or rate add-on to reimburse the Medicaid share of the fee;
- maintenance and enhancement of the Medicaid nursing facility rates;
- administration of the collection and disbursement of the fee. However, these administrative expenses cannot exceed 0.5 percent of the proceeds from the fee; and
- beginning with fiscal year 2013, the safety net assessment fee may be increased to support an additional 1 percent rate enhancement for facilities that meet the quality incentive benchmarks.

It is clarified that the fee proceeds may not be used to replace existing state expenditures. An exception is provided to the non-supplant language for fiscal years 2011, 2012, and 2013. Specifically, the act provides that $30 million of the proceeds to the Trust Fund must be used in lieu of State General Fund payments to skilled nursing facilities in fiscal year 2011 and $15 million in each of fiscal years 2012 and 2013.

Payments to nursing facilities from the Trust Fund are not to be included in any adjustments required by the nursing home rate ceiling or the budget dial that is specified in the Biennial Appropriations Act.

The DSHS is instructed to handle certain administrative and operational duties relating to the assessment of the safety net fee and use of the proceeds.

Certain delinquency penalties are provided, including withholding the facilities' medical assistance reimbursement payments, suspension or revocation of the nursing facility license, or imposition of a civil fine.

Nursing facilities are prohibited from increasing charges or billings to patients or third-party payers as a result of the imposition of the safety net assessment.

There is a severability clause relating to the sections that deal with the creation of and the implementation of the safety net assessment and quality incentive payments. These sections are null and void if the CMS does not approve the waiver of the broad-based and uniform requirements or does not approve the state Medicaid plan amendment incorporating the fee into the plan, or if the act is found to be invalid.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains an emergency clause and takes effect immediately.