Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health & Human Services Appropriations & Oversight Committee

HB 2752

Brief Description: Restoring some of the nursing facility payment methodology changes made during 2011.

Sponsors: Representatives Darneille, Hasegawa, Pettigrew and Santos.

Brief Summary of Bill

- Lowers the minimum occupancy requirements in the operations, property, and finance components of nursing home rates to 92 percent for large facilities, 90 percent for small facilities, and 85 percent for essential community providers.
- Increases the allowable median cost lids to 112 percent in the direct care component and 110 percent in the support services component.
- Increases the rate of return within the finance rate component to 8.5 percent for all tangible assets.
- Eliminates the Department of Social and Health Services' authority to adjust rates for the 10 lowest acuity client groups.

Hearing Date: 2/2/12

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

Background:

The Washington State Medicaid (Medicaid) program includes long-term care services provided to low-income individuals. Clients may receive Medicaid long-term care services in their own homes, in community residential settings, and in skilled nursing facilities. There are just over 200 skilled nursing facilities licensed in Washington that provide 24-hour long-term care services for approximately 10,000 Medicaid-eligible clients.

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 Medicaid nursing home payment system is administered by the Department of Social and Health Services (DSHS). The payment methodology includes formula variables, allowable costs, and accounting and auditing procedures as specified in statute. Rates in Washington are unique to each nursing facility and are generally based on the facility's allowable costs, occupancy rate, and client acuity (sometimes called the "case mix"). A rate ceiling based on statewide weighted averages, commonly referred to as "the budget dial," is set by the Legislature in the Biennial Appropriations Act. If the actual statewide weighted average nursing facility payments exceed the budget dial, the DSHS is required to proportionally adjust all nursing facility payment rates downward to meet the budget dial.

The payment system consists of several rate components:

- The direct care component includes payment for direct care staff wages and benefits, non-prescription medication, and medical supplies. This component is based on the case mix. The federal government requires states to use the Minimum Data Set (MDS), which captures client data. Using the data, a client is scored into one of 44 groups that tie the payment levels to acuity levels. The DSHS is authorized to adjust the case mix index for the 10 lowest client acuity groups to any case mix index that aids in achieving cost-efficient care. The allowable costs are capped at 110 percent of the median.
- The therapy care component includes payments for physical, occupational, and speech therapy.
- The support services component includes payments for food, food preparation, laundry, and housekeeping. Allowable costs are capped at 108 percent of the median.
- The operations component includes payment for administrative costs, office supplies, utilities, accounting, minor facility maintenance, and equipment repairs.
- The property and finance components pay for facility capital costs. The finance component includes an allowable rate of return of 4 percent on the net book value of a facility's tangible fixed assets.

All rate components except for direct care are subject to minimum occupancy adjustments. If a facility does not meet the minimum occupancy requirements, the rates are adjusted downward. Currently, the minimum occupancy requirements in the operations, property, and finance components are 95 percent for large facilities, 92 percent for small facilities (fewer than 60 beds), and 87 percent for essential community providers (the only nursing facility beds within a 40-mile radius).

Regular cost reports are required from the nursing homes. The DSHS is required to review these reports for costs and payments. Through this process, rates are rebased. The property and finance rate components are rebased annually. All other rate components are typically rebased every odd-numbered year.

In 2011 the nursing home safety net assessment fee and the Skilled Nursing Facility Safety Net Trust Fund (Trust Fund) were established. For fiscal years 2012 and 2013, revenue from the trust fund is used to pay a comparison add-on rate which holds the facility based rates at the June 30, 2010, level or higher.

Summary of Bill:

Beginning fiscal year 2013, several variables in the nursing home rate component methodology are adjusted to pre-2011 levels.

The minimum occupancy requirements in the operations, property, and finance components are lowered as follows:

- from 95 percent to 92 percent for large facilities;
- from 92 percent to 90 percent for small facilities; and
- from 87 percent to 85 percent for essential community providers.

The allowable median cost lids in the direct care and support services components are increased as follows:

- from 110% to 112% for direct care; and
- from 108% to 110% for support services.

The rate of return within the finance rate component is increased from 4 percent to 8.5 percent for all tangible assets.

Beginning fiscal year 2014, the DSHS' authority to adjust rates downward for the 10 lowest client acuity groups is eliminated.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill contains multiple effective dates.