HOUSE BILL REPORT
ESSB 5581

As Reported by House Committee On:
Ways & Means

Title: An act relating to nursing homes.

Brief Description: Concerning nursing homes.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Keiser, Parlette, Hargrove, Shin, Conway and Kline).

Brief History:
Committee Activity:
Ways & Means: 5/17/11 [DP].

Brief Summary of Engrossed Substitute Bill

- Modifies nursing home rate components to reduce calculations produced within the payment methodology.
- Establishes a supplemental payment methodology to produce rates equal to those paid on June 30, 2010.
- Implements a direct care rate add-on paid to facilities that have experienced increases in client acuity since June 30, 2010.
- Establishes the Skilled Nursing Facility Safety Net Trust Fund to be used to support Medicaid nursing facility payments.
- Authorizes the 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 for the provider assessments to include facility exemptions as specified in the bill and authorizes the DSHS to amend exemptions to the extent necessary to obtain federal approval.
- Requires that all proceeds from the assessment will be deposited for the purpose of reimbursements and Medicaid payments for nursing facility services.
- Requires a rate add-on to reimburse the Medicaid share of the safety net assessment as a Medicaid-allowable cost.

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.

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass. Signed by 15 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Carlyle, Cody, Dickerson, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Springer and Sullivan.

Minority Report: Do not pass. Signed by 11 members: Representatives Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Chandler, Haigh, Parker, Ross, Schmick, Seaquist and Wilcox.

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 governments. The federal funds are matching funds, and are referred to as the Federal Financial Participation 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 State General Fund dollars.

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 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 on 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 percent of revenues). If a waiver of the broad-based and uniform requirements is requested, then 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 (chapter 74.46 RCW). 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 State Omnibus Operating Appropriations Act, and the DSHS must manage all facility specific rates so the budget dial is not exceeded.

Summary of Bill:

Nursing Home Rate Methodology Changes.
The following nursing home rate methodology changes are made:

- Rebasing is postponed for one year and the cycle for rebasing moves to every odd-numbered year.

- The finance component's rate on return for all tangible assets is reduced to 4 percent regardless of the date of purchase. This is changed from 8.5 percent for purchases on or after May 17, 1999, and 10 percent for purchases before May 17, 1999.
- The DSHS is authorized to adjust the case mix index for the 10 lowest acuity resource utilization groups to any case mix index that aids in achieving cost-efficient care.
- Minimum occupancy requirements are raised in the rate components of operations, property, and financing allowance by 3 percent for large providers and by 2 percent for small providers and essential community providers.
- Median cost lids are lowered by 2 percentage points for direct care and support services.
- The DSHS is instructed to provide rate add-ons based on a comparison of the 2010 and 2011 rates and also for homes that experienced increases in client acuity, as demonstrated by changes in their direct care component.

Nursing Home Safety Net Assessment.
A nursing home safety net assessment fee is created. The fee is assessed on a per-resident day basis, does not apply to Medicare residents, and certain types of facilities are exempt from paying the fee. The exemptions are:

- continuing-care retirement communities, as defined in the act;
- nursing facilities with 35 or fewer beds;
- state, county, tribal, 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, 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 from the fee are directed into this 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; and
- administration of the collection and disbursement of the fee; however, these administrative expenses cannot exceed one-half of 1 percent of the proceeds from the fee.

The DSHS is instructed to handle certain administrative and operational duties relating to the assessment of the safety net fee and regarding the use of the proceeds. In addition, the DSHS is instructed to work with the Department of Health, and two professional stakeholder organizations—the Washington State Health Care Association and Aging Services of Washington—to design a system of skilled nursing facility quality incentive benchmarks and related payments. The design of these incentive payments must be submitted to the Legislature by December 15, 2011. The act provides that, beginning with fiscal year 2013,

the safety net assessment fee may be increased to support an additional 1 percent increase in the nursing facility payment rate for facilities that meet the quality incentive benchmarks.

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 itemizing the safety net assessment on invoices to residents or third-party payers.

The sections creating and dealing with the implementation of the safety net assessment and quality incentive payments are null and void if the federal 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.

Appropriation: None.

Fiscal Note: Requested on May 12, 2011.

Effective Date: The bill contains an emergency clause and takes effect on July 1, 2011.

Staff Summary of Public Testimony:

(In support) This is a way to bring federal money into the system to prevent deep reductions to nursing homes. Because of the reductions that the industry has already taken, more reductions cannot be sustained. Reductions have negative impacts on staffing levels. People who reside in nursing homes have worked all their lives, contributed to society, and deserve quality care. The provider assessment proposed in this bill has been ruled by the Lieutenant Governor to be a fee, not a tax. It is not a novel idea and it is not risky. Forty-four other states use this mechanism to sustain Medicaid providers. The bill is written in a way that it brings no financial risk or burden to the state and it does not represent a financial windfall for the nursing homes. It simply restores rates to a level that are sustainable. This proposal has been duly vetted by the Legislature and is based on the needs, priorities, and resources of the state. It requires the industry to come together and establish policy for a sustainable system. The bill puts mechanisms in place for the future to deal with underlying issues of underfunding and policy concerns. Facilities that would have received reductions under the components are instead receiving increases in their rates.

(With concerns) This is a difficult, but not new, issue for the Legislature. The need for generating funding is recognized, but we oppose the overall concept on how the revenue is generated. The fee is too high and is above what is needed to restore the component reductions to maintenance level. There are concerns with a potential sweep of funds for use of purposes outside of the nursing home system. There are also concerns about the future sustainability of the system as the federal government considers closing these types of opportunities for the states. While the assessment is supported, there are concerns of the results if the assessment does not materialize and the rate components become effective.

Many facilities would receive disproportionate cuts. Facilities that serve specialized populations are particularly at risk. The goal to increase funding to nursing facilities is supported because the system has been underfunded for a number of years and assistance is needed. However, exemptions need to be included in the backstop component reductions in case they come into effect. High Medicaid facilities and facilities that serve special populations would suffer losses that would not be sustainable and should be exempted from this bill.

(Opposed) This mechanism was tried in 2003 and the CMS did not approve the exemptions as they were submitted. This caused such concern that the Legislature repealed the tax. Federal rules define this assessment mechanism as a provider tax. The experience in other states is that funding is taken for other purposes, particularly in Oregon, where facilities do not see much of that revenue in its nursing facility rates now. While increases in rates are nice, the federal government is talking about eliminating the assessment mechanism in regulations because it creates a huge hole in the federal budget. If the assessment is eliminated, it creates a huge cliff which providers will have to endure in rate reductions. The tax is too high and the rate add-on is a risk. There is a better way to achieve savings in nursing home system and long-term care continuum and set up a more sustainable system by eliminating excess capacity. This bill simply sustains the system in place rather than addressing policy issues.

Persons Testifying: (In support) Jessica Field, Service Employees International Union 775 NW; and Rich Miller and Tim Lehner, Washington Health Care Association.

(With concerns) Scott Sigman, Aging Services of Washington; Sam Wan, Kin On Health Center; Jeffrey Hattori, Seattle Keiro; Jeff Neumann, Sea Mar; and Jeff Lohen, Kline Galland.

(Opposed) Vicki Christopherson, Providence Health Services.

Persons Signed In To Testify But Not Testifying: None.