SENATE BILL REPORT
SHB 1249

As of March 14, 2011

Title: An act relating to ensuring efficient and economic medicaid nursing facility payments.

Brief Description: Regarding medicaid nursing facility payments.

Sponsors: House Committee on Ways & Means (originally sponsored by Representatives Cody, Pettigrew, Hunter and Darneille; by request of Department of Social and Health Services).

Brief History: Passed House: 3/01/11, 56-42.
Committee Activity: Ways & Means: 3/14/11.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Megan Atkinson (786-7446)

Background: The Washington State Medicaid (Medicaid) program includes long-term care assistance and services provided to low-income individuals. Clients may be served in their own homes, in community residential settings, and in skilled nursing facilities.

There are approximately 220 skilled nursing facilities licensed in Washington that provide 24-hour long-term care services for approximately 9939 Medicaid-eligible clients. The Medicaid nursing home payment system is administered by the Department of Social and Health Services (DSHS). The Medicaid rates in Washington are unique to each facility and are generally based on the facility's allowable costs, occupancy rate, and client acuity (sometimes called the case mix). In the biennial appropriations act, the Legislature sets a statewide weighted average Medicaid payment rate, sometimes referred to as the budget dial. If the actual statewide nursing facility payments exceed the budget dial, the DSHS is required to proportionally adjust downward all nursing facility payment rates to meet the budget dial.

The payment system consists of seven different rate components: direct care, therapy care, support services, operations, property, financing allowance, and variable return:

- The direct care component represents approximately 57 percent of the total nursing facility payment and includes payment for direct care staff wages and benefits, non-prescription medication, and medical supplies. This component is based on the relative care needs of the residents, also known as the case mix. The federal government requires use of 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

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levels to acuity levels. Semi-annually, the DSHS reviews this data and adjusts facility payments based on the patient acuity of the clients being served. Allowable costs are capped at 112 percent of the median.

- The therapy care component represents about 1 percent of the total nursing facility payment and includes payments for physical, occupational, and speech therapy. Allowable costs are capped at 112 percent of the median.
- The support services component represents about 13 percent of the total nursing facility payment and includes payments for food, food preparation, laundry, and housekeeping. Allowable costs are capped at 110 percent of the median.
- The operations component represents about 20 percent of the total nursing facility payment and includes payment for administrative costs, office supplies, utilities, accounting, minor facility maintenance, and equipment repairs. Allowable costs are capped at the median.
- Property and finance rate components represent about 8 percent of the total nursing facility payment and pay for facility capital costs. The finance component includes an allowable rate of return on the net book-value of a facility's tangible fixed assets of 8.5 percent for assets acquired on or after May 17, 1999, and 10 percent for assets acquired before May 17, 1999. The statute currently allows less than 2 percent per-year growth in the capital components of property and financing allowance. The growth allowance for major replacements or renovations is frozen through fiscal year 2011.
- The variable return rate component represents about 1 percent of the nursing facility payment and does not reimburse specific costs. It is calculated based on a percentage of the combined costs of direct care, therapy care, support services, and operations. The facilities with the lowest costs receive the highest dollar amount. The facilities with the highest costs receive the lowest dollar amount. This component is capped at 30 percent of the June 30, 2006, level and is scheduled for elimination July 1, 2011.

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 92 percent for large facilities, 90 percent for small facilities (fewer than 60 beds), and 85 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. Rates are regularly rebased (adjusted for changes in costs) through this process. The property and finance rate components are rebased annually. All other rate components except for variable return are rebased every even-numbered year.

Summary of Bill: Rebasing is postponed for one year and the cycle for rebasing moves to every odd-numbered year. The rebase schedule is thus 2007, 2009, 2013, 2015, 2017, and so on.

The variable return component is eliminated March 1, 2011, instead of July 1, 2011.

The finance component's rate on return for all tangible assets is reduced to 4.0 percent regardless of 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. In addition, the DSHS is authorized to determine the date of transition to the federally required data system upgrade of MDS 3.0. The look-back period and adjustment for client acuity changes that took place during the transition phase to the new MDS 3.0 data system is eliminated.

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. No changes are made to minimum occupancy in the rate components of direct care, support services, and therapy care.

The allowable cost lids used for rate setting in the direct care and support services components are lowered by 2 percent of the median.

For the period of March 1, 2011, to June 30, 2011, the rate setting methodology for the operations component will cap allowable costs according to the efficiency and the economic operation of the facility. Nursing facilities will be arrayed into cost quartiles and allowable costs in the operations component will be adjusted as downward between 68 percent and 88 percent for the three highest cost quartiles.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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