

# SENATE BILL REPORT

## SB 5581

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As Reported by Senate Committee On:  
Ways & Means, April 1, 2011

**Title:** An act relating to a nursing home safety net assessment for increased nursing home payments to improve health care access for the citizens of Washington.

**Brief Description:** Creating a nursing home safety net assessment.

**Sponsors:** Senators Keiser, Parlette, Hargrove, Shin, Conway and Kline.

**Brief History:**

**Committee Activity:** Ways & Means: 2/23/11, 3/29/11, 4/01/11 [DPS].

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### SENATE COMMITTEE ON WAYS & MEANS

**Majority Report:** That Substitute Senate Bill No. 5581 be substituted therefor, and the substitute bill do pass.

Signed by Senators Murray, Chair; Kilmer, Vice Chair, Capital Budget Chair; Parlette, Ranking Minority Member Capital; Brown, Conway, Fraser, Honeyford, Kastama, Keiser, Kohl-Welles, Pridemore, Regala and Rockefeller.

**Staff:** Megan Atkinson (786-7446)

**Background:** The current Washington Medicaid program provides health and long-term care assistance to low-income individuals, is administered by the state in compliance with federal laws and regulations, and is jointly funded using state and federal dollars. 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 state General Fund dollars.

Medicaid law and regulations provide for a particular Medicaid funding vehicle that states can utilize to fund a portion of their state share of Medicaid program costs. This funding vehicle is often 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

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required to fund the Medicaid program. Federal regulations define the rules for Medicaid provider taxes.

Nineteen different types of providers are included in the permissible classes of health care providers and as such can be included in a provider tax. Some examples include inpatient hospital services, outpatient hospital services, skilled nursing facility services, and physician services.

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, and the hold harmless provision doesn't 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 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, 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 calculation for the noncapital components (direct care, therapy care, support services, and operations) is 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), 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.

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.

**Summary of Bill (Recommended Substitute): Nursing Home Rate Methodology Changes.**

The changes to the nursing home rate methodology are detailed below:

- eliminates the variable return component; and
- establishes a resident acuity-based add-on to the direct care component.

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 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, 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 act does not shield the lower fee that is to be assessed so that the statistical redistributive tests required by federal law are met.

The act establishes the Skilled Nursing Facility Safety Net Trust Fund (Trust Fund) and directs all proceeds from the fee 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 act instructs DSHS 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, 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.

Finally, nursing facilities are prohibited from itemizing the safety net assessment on invoices to residents or third-party payers.

The sections of the act creating and dealing with the implementation of the safety net assessment and quality incentive payments are null and void if the federal Centers for Medicare and Medicaid Services (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.

**EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Recommended Substitute):** The substitute only makes two changes (described above) to the current nursing facility rate methodology while the original bill incorporated numerous methodology changes.

The substitute includes an exemption for tribal facilities, prohibits facilities from itemizing the charge on invoices, eliminates the specified supplanting of current general fund state support for nursing facilities, and directs DSHS to work collaboratively with CMS to obtain approval of any necessary state plan amendments or waivers.

**Appropriation:** None.

**Fiscal Note:** Available.

[OFM requested ten-year cost projection pursuant to I-960.]

**Committee/Commission/Task Force Created:** No.

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

**Staff Summary of Public Testimony on Original Bill:** PRO: This is a good idea for bringing more revenue into the system. The additional funding should be used to benefit long-term care and the home and community based system. This allows a general fund savings and while this isn't a perfect idea, it is very acceptable and needed. There is no reason not to move this bill forward. Essentially there are only two options for nursing home funding – a rate cut which will be devastating or this proposal and there is no need to pass the fee along to the private pay residents. This safety net proposal is an important part of the solution for nursing homes.

CON: This bill does not shield the private pay residents, and it is not at all like the hospital assessment. It is very important to look at the reforms that are needed in the system. The funding issue is exacerbated from the structure of the current nursing home system.

OTHER: There are significant technical concerns with this proposal.

**Persons Testifying:** PRO: Louise Ryan, Long-Term Care Ombudsman; Walt Bowen, Senior Lobby; Karen Lee, American Assn. of Retired Persons; Jerry Reilly, Eldercare Alliance; Nick Federici, Service Employees International Union 775 NW; Rich Miller, Tim Lehner, Karen Hyatt, WA Health Care Assn.

CON: Vicki Christopherson, Providence Health and Services.

OTHER: Scott Sigman, Aging Services of WA.