FINAL BILL REPORT
ESSB 5581

C 7 L 11 E 1
Synopsis as Enacted

Brief Description: Concerning nursing homes.

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

Senate Committee on Ways & Means
House Committee on Ways & Means

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 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.

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.

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 that 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, 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: Nursing Home Rate Methodology Changes:

- 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 4.0 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.
- DSHS is authorized to adjust the case-mix index for the ten 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 3.0 percent for large providers and by 2.0 percent for small providers and essential community providers.
- Median cost lids are lowered by 2.0 percentage points for direct care and support services.
- 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. 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 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 1.0 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 1.0 percent increase in the nursing facility payment rate for facilities that meet the quality-incentive benchmarks.

Certain delinquency penalties are provided, including withholding the facility's 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.

Votes on Final Passage:

First Special Session

Senate	27	17
House	54	38

Effective: July 1, 2011.