Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Appropriations Committee

HB 2042

Brief Description: Modifying the nursing facility medicaid payment system by delaying the rebase of certain rate components and extending certain rate add-ons.

Sponsors: Representatives Cody, Hunter and Sullivan.

Brief Summary of Bill

- Delays the rebase of non-capital rate components from July 1, 2013 to July 1, 2015.
- Extends the sunset of two rate add-ons, comparison and acuity, from June 30, 2013 to June 30, 2015.

Hearing Date: 4/22/13

Staff: James Kettel (786-7123).

Background:

The Washington State Medicaid (Medicaid) program includes long-term care assistance and services provided 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 government. 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 the State General Fund. Clients may be served in their own homes, in community residential settings, and in nursing facilities.

There are approximately 220 nursing facilities licensed in Washington to serve about 10,000 Medicaid-eligible clients. Nursing facilities 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. The Medicaid nursing home payment system is administered by the DSHS. The Medicaid rates in Washington are unique to each facility and are generally based on the

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facility's allowable costs, occupancy rate, and client acuity (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 nursing home rate methodology, including formula variables, allowable costs, and accounting/auditing procedures, is specified in statute (Ch. 74.46 RCW). The rates are based on calculations for six different components: direct care, therapy care, support services, operations, property, and a financing allowance. Rate calculations for non-capital 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.

Direct Care: the direct care rate component represents approximately 50 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 "case mix." The federal government requires use of the Minimum Data Set (MDS), which captures client data. Using MDS data, a client is scored into one of 44 groups that tie the payment 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 used for rate setting in this component are lidded at 110 percent of the median for each peer group. The peer groups are high labor-cost counties (an urban county in which the median allowable facility cost per case mix unit is more than 10 percent higher than all other urban counties), urban counties (located in a metropolitan statistical area), and non-urban counties.

Therapy Care: the therapy care component represents about 1 percent of the total nursing facility payment and includes payments for physical, occupational, and speech therapy.

Support Services: the support services component represents about 10 percent of the total nursing facility payment and includes payments for food, food preparation, laundry, and housekeeping. Allowable costs used for rate setting in this component are lidded at 108 percent of the median for each peer group.

Operations: 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.

Property and Financing Allowance: the property and finance rate components represent about 4 percent of the total nursing facility payment and pay for facility capital costs. The property component is a depreciation allowance for real property improvements, equipment and personal property used for resident care. The finance component is a 4 percent return on the facility's net invested funds, i.e., the value of its tangible fixed assets and allowable cost of land. There is no growth allowance or Certificate of Capital Authorization (CCA) for facility replacement or major renovations through fiscal year 2013. However, a project that does not require a Certificate of Need from the Department of Health also does not require a CCA. The current dollar threshold for a Certificate of Need is approximately $2.4 million.

All rate components, with the exception of direct care, are subject to minimum occupancy adjustments. If resident days are below the minimum, then resident days are increased to the required occupancy level. Since the same amount of cost is divided by a greater number of resident days, this has the effect of reducing per resident day costs, as well as the component rates based on such costs. If the occupancy level is higher than the minimum, then the actual number of resident days is used. The minimum occupancy requirements in the operations, property, and finance components are 95 percent for large facilities, 92 percent for small facilities, and 87 percent for Essential Community Providers (ECP). The minimum occupancy requirement in the therapy care and support services components is 85 percent for all facilities. An ECP is the only nursing facility within a commuting distance radius of at least 40 minutes duration, traveling by automobile. A large facility has 60 or more beds (regardless of how many beds are set up or in use). A small facility has less than 60 beds (regardless of how many beds are set up or in use).

The nursing facility payment system also incorporates several add-on rate adjustments. Adjustments are currently made for facilities serving higher acuity clients since June 30, 2010 (acuity add-on), facilities electing to increase wages or staffing levels for low-wage workers (low-wage worker add-on), facilities with direct care staff turnover less than 75 percent (pay-for-performance add-on), facilities with direct care staff turnover that is 75 percent or higher (high turnover reduction), facilities with rates that are lower than the June 30, 2010, payment level (comparison add-on), and the reimbursement of nursing home safety net assessment paid on Medicaid beds (safety net assessment add-on).

Summary of Bill:

The rebase of non-capital nursing home rate components, as well as the implementation of a more recent version of the Minimum Data Set, is delayed from July 1, 2013, to July 1, 2015. Two rate add-ons, the comparative add-on and the acuity add-on, are scheduled to expire on June 30, 2015, instead of June 30, 2013.

Appropriation: None.

Fiscal Note: Requested on April 17, 2013.

Effective Date: The bill contains an emergency clause and takes effect on July 1, 2013.