SENATE BILL REPORT
SHB 1274

As of Second Reading

Title: An act relating to implementing a value-based system for nursing home rates.

Brief Description: Implementing a value-based system for nursing home rates.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Cody, Jinkins, Johnson, Harris and Tharinger).

Brief History: Passed House: 6/24/15, 95-2.
Committee Activity: Ways & Means:

SENATE COMMITTEE ON WAYS & MEANS

Staff: Mark Eliason (786-7454)

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, 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 skilled nursing facilities.

There are approximately 240 skilled nursing facilities licensed in Washington to serve about 10,000 Medicaid-eligible clients. Skilled 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 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, DSHS must proportionally adjust downward all nursing facility payment rates to meet the budget dial.

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.

The nursing home rate methodology, including formula variables, allowable costs, and accounting/auditing procedures, is specified in statute (RCW 74.46). The rates are based on calculations for six different components: direct care, therapy care, support services, operations, 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. All rate components, with the exception of direct care, are subject to minimum occupancy adjustments. If a facility does not meet the minimum occupancy requirements, the rates are adjusted downward. Also, the nursing facility payment system periodically includes add-on rate adjustments.

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 sometimes referred to as a Medicaid provider assessment or sometimes as a provider tax or provider fee. States can use the proceeds from the assessment 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 the Medicaid provider assessment.

Summary of Bill: The current nursing home rates payment system is continued, including all rate add-ons into FY16. The rebase of noncapital rate components from FY16 to FY17 is delayed. The existing payment methodology is repealed on June 30, 2016, and a new payment methodology is established in FY17. The new system establishes three core components: direct care, indirect care, and capital). It also includes a payment enhancement for quality-of-care that is not more than 5 percent of the statewide average daily rate. Direct care and indirect care components are rebased in FY17 and every two years thereafter with direct care continuing to be subject to the reconciliation and settlement process. A mitigation strategy is implemented during the transition to the new rates system that limits decreases and caps increases through FY19.

Beginning in FY17, a minimum staffing standard of 3.4 hours per resident day is established with an intention to increase this standard to 4.1 if funding is specifically provided. A separate account is created on July 1, 2015, in the custody of the State Treasurer that will include funds from penalties and the reconciliation and settlement of direct care. The Secretary of DSHS or designee may authorize expenditures from the account to provide facilities with technical assistance, specialized training, or to increase the quality enhancement established in the new system. DSHS is granted rule-making authority to implement the new system and must convene a workgroup to develop recommendations, if necessary, to make refinements to the new system. DSHS must submit a report to the Legislature by January 2, 2016.

Appropriation: None

Fiscal Note: Available. New fiscal note requested June 23, 2015

Committee/Commission/Task Force Created: No

Effective Date: The bill contains an emergency clause and takes effect on July 1, 2015.