FINAL BILL REPORT
SB 5715

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Synopsis as Enacted

Brief Description: Limiting nursing home direct care payment adjustments to the lowest case mix weights in the reduced physical function groups and authorizing upward adjustments to case mix weights in the cognitive and behavior groups.

Sponsors: Senators Rivers, Keiser, Cleveland, Becker, Hunt, Billig, Bailey and Kuderer.

Senate Committee on Health Care
Senate Committee on Ways & Means
House Committee on Appropriations

Background: There are approximately 210 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 the 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.

The nursing home rate methodology, including formula variables, allowable costs, and accounting/auditing procedures, is specified in statute (RCW 74.46). The rates are primarily based on calculations for three different components: direct care, indirect care, and a capital component. Noncapital components are calculated based on facility cost reports and are typically updated biennially in a process known as rebasing. The capital component is also calculated by using facility cost reports but is rebased annually. Facilities may also qualify for a rate add-on if they meet established quality criteria.

Resource Utilization Groups. The nursing home rate methodology utilizes a classification system to align Medicaid payments with the resource needs of nursing home residents. Resource Utilization Groups (RUGs) are derived from data within specific sections of the federal Minimum Data Set (MDS). The MDS assesses a resident's therapy needs, Activities of Daily Living (ADL) impairments, cognitive status, behavioral problems, and medical diagnosis. Ultimately, each client receives a weighted score that approximates the nursing needs, and the ADL needs, for the client. Typical ADL needs include bed mobility, transfer, and toilet use.

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 RUG codes that begin with a "P" indicate that the resident's resource use is driven primarily by reduced physical functions, rather than wound care, therapies, or other special needs.

The RUG codes that begin with a "B" indicate that the resident's resource use is driven primarily by behavioral symptoms and cognitive performance.

Legislative Actions. In the 2011-13 biennial budget—ESSB 5581 (2011), the Legislature directed that Medicaid nursing home residents in the 10 RUG codes from PA1 through PE2 be reimbursed at 87 percent of the average direct care daily rate. This rate modification is sometimes called the 13 percent penalty, or low-acuity penalty. The rate modification was assumed to generate ongoing savings of $22.6 million total funds—$11.3 million General Fund-State—per biennium.

Under the Medicaid nursing home rate methodology in use until July 2017, many nursing homes that received the penalty for PA1 through PE2 residents also received a rate add-on that mitigated the impact of the reduced reimbursement. This rate add-on was called the comparative add-on.

In SHB 1274 (2015) and SHB 2678 (2016), the Legislature modified the nursing home rate methodology, effective July 2017. These modifications reduced the number of rate components, including removal of the comparative add-on.

In 2ESHB 2376 (2016), the 2016 supplemental budget included proviso language that temporarily exempted five of the 10 RUG categories, PC2 through PE2, impacted by the 13 percent penalty. This proviso was cost neutral for fiscal year 2017. To maintain cost-neutrality, DSHS was given the authority to cap the direct care component of the nursing home rate at 118 percent over 2014 direct care costs, move less acute residents to community placements, utilize available funding from case mix adjustments, and increase the penalty on non-exempt RUG categories, if needed. The proviso language will only be in effect for fiscal year 2017.

Summary: The low-acuity penalty is modified. Residents in RUG codes PC2 through PE2 are exempt. Residents in the RUG codes PA1 through PB2 are still subject to the penalty, unless a resident also presents with behavioral RUG codes. Exceptions to the penalty are permitted for residents with limited placement options in the community.

The DSHS is authorized to adjust upward the weighted RUG scores for the BA1 through BB2 codes in the behavioral and cognitive performance group.

Updates are made to reflect the current MDS system and RUG classification in use for Medicaid nursing home rates in Washington.

The direct care component of the nursing home rate is capped at 118 percent of the direct care allowable costs in the base rate year. Nursing homes that are below the statutory minimum staffing standard of 3.4 hours per resident day are not subject to the direct care cap.

The act is null and void unless funded in the operating budget by July 1, 2017.

Votes on Final Passage:

Senate	49	0	
House	97	0	(House amended)
Senate	48	0	(Senate concurred)

Effective: July 23, 2017