Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Ways & Means Committee

HB 3021

Brief Description: Establishing the medicaid nursing facility quality assurance trust fund.

Sponsors: Representatives Green, Ericksen, Kessler, Kretz, Seaquist, Chandler, Van De Wege, Armstrong, Sullivan, Miloscia, Simpson, Williams, Rolfes, Bailey, Johnson, Hinkle, Ross, Finn, Moeller, Liias, Appleton, Wallace, Conway and Kenney.

Brief Summary of Bill

- Establishes a quality assurance fee assessment on nursing facilities that will expire on June 30, 2013.
- Establishes a Medicaid quality assurance fund and restricts its expenditures to the use of nursing home payments.
- Defines Continuing Care Retirement Communities (CCRC) and high volume Medicaid nursing facilities.
- Requires the Department of Social and Health Services (DSHS) to seek fee exemptions from Centers for Medicaid and Medicare Services (CMS) for CCRCs, nursing facilities with 35 or fewer beds, State or county operated facilities, and hospital-based facilities.
- Establishes a payment structure in which high volume Medicaid nursing facilities will pay a lesser fee amount.
- Specifies the bill is null and void if the waivers or the state plan amendment are not approved by CMS or if any of the expenditure conditions are violated.

Hearing Date: 2/3/10

Staff: Carma Matti-Jackson (786-7140).

Background:

Washington State's Long-Term Care Medicaid Program.

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 Washington State Medicaid program includes long-term care assistance and services provided to low-income individuals. Clients may be served in their own homes, in community residential settings, and in skilled nursing facilities.

There are just over 250 skilled nursing facilities licensed in Washington that provide 24-hour long-term care services for approximately 10,900 Medicaid eligible clients. The Medicaid rates in Washington are unique to each facility and are generally based on the facility's costs, occupancy rate, and client acuity (sometimes called the "case mix"). The Medicaid nursing home payment system is administered by the Department of Social and Health Services (DSHS or Department). 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.

Medicaid rates are jointly financed by the Federal and state government. State dollars that are provided for care are "matched" by the federal government through Federal Financial Participation (FFP), or 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.

<u>Provider Taxes or Fees</u>.
Under federal law and regulations, states have the ability to use provider-specific taxes to fund a portion of their state share of Medicaid expenditures. This is sometimes referred to as a quality maintenance fee or a quality assurance fee. In this process states can authorize revenue collections from specified categories of providers, use the proceeds from these revenues to make Medicaid provider payments, and claim the federal matching share of those payments. In order to qualify for the federal matching funds, the provider tax cannot exceed 6.0 percent of the total provider revenues (5.5 percent through September 2011). Federal regulations also require that the provider tax:

- 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.

Nursing facilities are included in the permissible class of health care services that states may tax without triggering a penalty against Medicaid expenditures. The broad-based and uniformity requirements are waivable under certain criteria defined and approved by the Centers for Medicaid and Medicare Services (CMS). So long as the provider tax does not exceed the threshold for the allowable percentage of tax revenues to total revenues, the hold harmless provision does not apply.

Currently, 37 states and Washington D.C. have implemented provider taxes for nursing facilities. Of those, 16 have approved waivers exempting specific provider types. Washington last enacted a nursing home quality maintenance fee in 2003. The fee was repealed in 2006.

Summary of Bill:

A quality assurance fee will be assessed on nursing facilities. The DSHS is required to seek waivers and provide exemptions (pending federal approval) for the following:

- Continuing Care Retirement Community (CCRC), as defined by the bill;
- nursing facilities with 35 or fewer beds;
- state and county operated nursing facilities; and
- any nursing facility that is hospital-based or operated by a public hospital district.

A CCRC is defined as a facility that provides a continuum of services provided by one entity but has 55 percent or less nursing home beds on the campus. Facilities with high volumes of Medicaid clients or high numbers of total annual resident days will be assessed a lesser fee amount, pending approval from CMS.

The DSHS will calculate the fees for each facility on a per-resident day basis, excluding Medicare patient days. The assessed fees shall not exceed 2.8 percent of the net patient service revenues. The Department will provide a standardized form for payment submissions and the providers will pay the fee monthly. Delinquency penalties may be imposed to include withholding medical assistance reimbursements, license suspension or revocation, or fines up to $1,000 for each delinquent payment.

All revenue received from the quality assurance fee must be deposited into the newly created Medicaid quality assurance trust fund. At no time will the revenues revert to the state general fund. Fee revenues must be used as a rate add-on or immediate pass-through to reimburse the Medicaid share of the nursing facilities' Medicaid allowable costs. Revenues from the quality assurance fee may not be used to replace existing state expenditures to nursing facilities on rates paid on the date this act takes effect or for subsequent rate settings. Expenditures out of the quality assurance trust may not be included in the calculation of the annual statewide weighted average nursing facility payment rate (the budget dial). Any moneys that are available in the quality assurance trust fund, but not used by the end of a fiscal year, must be accumulated and applied to nursing home payments the following fiscal year. Any monies that are derived from future increases to the quality assurance fee shall be used only to increase nursing facility Medicaid rates without application of the budget dial.

The quality assurance fee will expire on June 30, 2013. The bill is null and void if CMS does not approve the waiver requests or the state Medicaid plan amendment to allow the fee, or if any of the expenditure conditions are violated. In the case of non-approval, all fee revenue will be returned to the nursing facilities on a pro rata basis.

Appropriation: None.

Fiscal Note: Requested on January 20, 2010.

Effective Date: The bill contains an emergency clause and takes effect immediately. However, the bill may become null and void if specified contingencies occur.