FINAL BILL REPORT
SHB 2515

C 225 L 18
Synopsis as Enacted

Brief Description: Updating the medicaid payment methodology for contracted assisted living, adult residential care, and enhanced adult residential care.

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

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

Background:

General.
The Washington Medicaid program includes long-term care assistance and services provided to individuals who meet functional and financial eligibility criteria. The Department of Social and Health Services (DSHS) administers Washington's Medicaid long-term care program in compliance with federal laws and regulations and is jointly financed by the federal and state government. Clients may be served in their own homes, in community residential settings, or in skilled nursing facilities (nursing homes).

Assisted Living Facilities.
Assisted Living Facilities (ALFs) are one community setting in which individuals who are Medicaid-eligible for nursing homes may choose to be served. The ALFs are licensed by the DSHS to provide housing and basic services to seven or more residents and may provide assistance with activities of daily living or intermittent nursing services. Some ALFs contract with the DSHS to provide specific packages of services and are known as Adult Residential Care (ARC) or Enhanced Adult Residential Care (EARC). Medicaid rates paid to ALFs are not set through the collective bargaining process.

History and Current Assisted Living Facility Medicaid Rate Methodology.
Current ALF rates originated with work done in the early 2000s to establish an acuity-based payment system that would incentivize serving lower-acuity clients in less-costly community settings rather than in nursing homes. In 2001 the DSHS conducted a time study to determine the average amount of staff time to serve clients of varying acuity levels. Using the results of the time study, the DSHS developed an acuity-based assessment system known

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as the Comprehensive Assessment Reporting and Evaluation (CARE) classification system and a corresponding payment methodology that weighted rates against estimated client care needs. Since inception of the CARE system and corresponding rate levels, the number of rate levels have remained lower than the number of CARE levels (currently there are 17 CARE levels and 13 payment levels). Rates vary based on three geographic service areas for King County, Metropolitan Statistical Area (MSA) counties, and non-MSA counties. The current ALF rate methodology is not prescribed in statute or rule, and there is no schedule for rebasing or updating it with current data.

The enacted 2017-19 Operating Budget directed the DSHS to convene a group of stakeholders in a collaborative effort to redesign the Medicaid payment methodology for ALFs, including ARC and EARC. The work group submitted its recommendations to the Legislature in December 2017.

Summary:

The DSHS must establish, in rule, a Medicaid payment methodology for ALFs, including ARC and EARC. The DSHS must make payments based on the new methodology beginning July 1, 2019, based on funding made available by the Legislature, which must be phased in to full implementation.

The new payment system must have three core components: client care, operations, and room and board.

Client Care.
Client care represents the labor component of the payment system, and must include variables to represent staff time, wages, and fringe benefits.

- The time variable is used to weight staff time against client acuity as represented in the DSHS' client classification system (CARE). The time variable must initially be established using the 2001 time study and the DSHS's estimates of average staff hours per client by job position.
- The wage variable recognizes the staff positions needed to perform the functions required by the ALF, ARC, and EARC contracts. The wage variable must be adjusted according to service areas based on actual labor costs, and so that no baseline wage is below the state minimum wage at the time of implementation. There must be no less than two service areas, including a high labor cost service area.
- The fringe benefit variable represents employee benefits and payroll taxes. The percentage of fringe benefits must be established using the statewide nursing facility cost ratio of benefits and payroll taxes to in-house wages.

Operations.
The operations component represents costs that are reimbursable under federal Medicaid rules and must be calculated at 90 percent or greater of the statewide median nursing facility cost for supplies, nonlabor administrative expenses, staff education and training, and occupational overhead.

Room and Board.

The room and board component reimburses providers for costs, primarily raw food and shelter costs, that are not reimbursable under federal Medicaid rules. Beginning July 1, 2020, the room and board component must be updated annually subject to the DSHS and Health Care Authority rules related to client financial responsibility.

Rebase Schedule.
Rates paid on July 1, 2019, will be based on data from 2016. The client care and operations components will be rebased in even-numbered calendar years using data from two years prior, beginning July 1, 2020.

Review of Physical Plant Contract Requirements.
By October 30, 2018, the DSHS shall review physical plant contract requirements for each ALF residential care setting (regular AL, ARC, and EARC) to determine if adjustments to the room and board component are necessary in order to reflect relative differences in costs between settings.

Votes on Final Passage:

House	97	1
Senate	48	0

Effective: June 7, 2018