SENATE BILL REPORT
E2SSB 5152

As Passed Senate, June 24, 2015

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: Senate Committee on Ways & Means (originally sponsored by Senators Parlette, Keiser and Becker).

Brief History:
Committee Activity: Health Care: 2/03/15, 2/09/15 [DPS-WM].
Ways & Means: 2/19/15, 4/29/15 [DP2S, w/oRec].
Second Special Session: Passed Senate: 6/24/15, 44-0.

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 5152 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Becker, Chair; Dammeier, Vice Chair; Frockt, Ranking Minority Member; Angel, Bailey, Brown, Cleveland, Conway, Jayapal, Keiser, Parlette and Rivers.

Staff: Kathleen Buchli (786-7488)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5152 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Bailey, Becker, Billig, Brown, Conway, Fraser, Hatfield, Hewitt, O'Ban, Padden, Parlette, Rolfes, Schoesler and Warnick.

Minority Report: That it be referred without recommendation.

Signed by Senators Hasegawa and Kohl-Welles.

Staff: Mark Eliason (786-7454)

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.

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.

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 Engrossed Second Substitute 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.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Health Care): PRO: This language is largely agreed upon and this is an effort to simplify the very complex system that we have. On any given day, 10,000 Medicaid residents receive services in nursing facilities. The current system is broken and a rebase would hurt more than it would help. The bill lays out ways to simplify the nursing facility payment system. We ask that the scheduled rebase not take place. We want to make sure the resources we are provided with are used efficiently and to provide quality service. DSHS supports the bill; it will include a simpler system, be value-based, and provide incentives for facilities to provide a high level of care and to work with DSHS. We recommend that consumers be added to the stakeholder group. The nursing facility payment system needs simplification. The Legislature and the public should have assurances of quality and more accountability. We should include a requirement for quality outcomes and staffing requirements. Nursing home residents, their families, and consumers should be added to the workgroup.

OTHER: Consumers need to be involved. We need immediate rate relief now and we cannot wait for two years. Freezing the rates will not promote quality care. The new system could be costly. Do not sunset the current system until the new system is in place.

Persons Testifying (Health Care): PRO: Senator Parlette, prime sponsor; Robin Dale, WA Health Care Assn.; Dale Patterson, EmpRes Healthcare Management; Bill Moss, DSHS; Walt Bowen, President, Senior Lobby.

OTHER: Hilke Faber, Founder, Advocacy Coordinator Resident Councils of WA; Scott Sigmon, Leading Age WA; Nick Federici, Service Employees International Union 775.

Persons Signed In To Testify But Not Testifying (Health Care): No one.

Staff Summary of Public Testimony (Ways & Means): **On First Substitute Bill**
PRO: The nursing home rate system is very complex, and in addition to being complex, it is broken. To see how broken the system is, if a rebase is allowed to take place this year, more facilities will be harmed by a rebase than helped by a rebase. A system that results in a decreased reimbursement rate after six years of not being reimbursed is the definition of a broken system. It cannot go on. There have been so many tweaks and alterations that the system does not work anymore. The bill lays out in very broad terms a greatly simplified system. Hopefully it will lead to a value-based, outcome-based system that rewards quality of care. While this new system is being developed, we ask that the rebase scheduled for this year be delayed. We ask that the current system be maintained as a bridge until the new system is developed. The guts of the current system are 30 years old and it is time to take a fresh look and we appreciate the provision to add employees and consumer groups to the discussion. We also hope the system will look at the question of adequacy of staffing to make sure there is sufficient staff at the bedside. We hope to participate in making a better system and need to improve the staff-to-patient ratio. We would like to see rate structures better aligned with the department's goals of serving individuals in home and community-based settings. Nursing facilities are a very important part of the long-term care support system and we should recognize that by reimbursing them appropriately for clients who have higher care needs. We should also develop incentives for nursing facilities that work to successfully transition individuals to home and community-based settings.

OTHER: We are not here to oppose but we have three major concerns with this bill: (1) This bill should be silent on the elements of the new payment system but should instead set forth payment principles to frame the discussion; (2) We ask that the current payment system not be repealed until a new payment system is designed and affordability is known; we need to know how big a bucket of money that we are going to have available to us so we don't design a system that we cannot afford into the future; and (3) We would ask for consideration of SB 6010 which would address the immediate payment needs of facilities so that we do not have to wait two years to implement a simplified payment system. We believe we can create a simplified system this year by updating the rates and collapsing a few components. We believe quality and acuity should be recognized and compensated for and prefer the approach in SB 6010. Nursing homes are hard places to work and turnover in staff is high. Low staff ratios put clients and staff at danger. Please consider including staffing standards in this bill. We need to ensure that there is adequate staffing in nursing homes to ensure quality outcomes.

On Second Substitute Bill
PRO: The bill establishes an outline for a price-based system. The medians referenced should be slightly higher. Minimum staffing levels are not currently funded and there should be an exception process for nursing homes that do not meet these minimum staffing requirements if they have made attempts to hire staff and are unable to due to things like their location. We support the plan to continue to have a stakeholder workgroup look at these issues. We are concerned about moving to a price-based system but appreciate that acuity

will be tied to the rate. We support the respectful mitigation strategy and minimum quality standards. We would like to see a higher median and want to make sure that all parties are incentivized. Establishing staffing standards is important.

Persons Testifying (Ways & Means): **<u>On First Substitute Bill</u>**
PRO: Senator Parlette, prime sponsor; Robin Dale, CEO, WA Health Care Assn.; Jerry Reilly, WA Long Term Care Ombuds Program.

OTHER: Scott Sigmon, Leading Age; Kim Clausen, Providence Health & Services; Nick Federici, Jessica Field, Service Employees International Union 775; Bill Moss, DSHS.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.

<u>On Second Substitute Bill</u>
PRO: Robin Dale, David Knutson, Washington Health Care Assn; Kim Clauson, Providence Health and Services; Jerry Reilly, Long Term Care Omduds Program; Scott Sigmon, Leading Age Washington.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.