HOUSE BILL REPORT
SHB 2678

As Passed Legislature

Title: An act relating to nursing home facilities.

Brief Description: Regulating nursing home facilities.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Schmick, Cody and Van De Wege).

Brief History:
Committee Activity:
Appropriations: 1/25/16, 1/28/16 [DPS].
Floor Activity:
Passed House: 2/11/16, 96-1.
Passed Senate: 3/1/16, 46-0.
Passed Legislature.

Brief Summary of Substitute Bill

- Modifies the nursing facility payment methodology to implement consensus recommendations from the nursing facility payment methodology work group established in Chapter 2, Laws of 2015 (Substitute House Bill 1274).
- Includes the following modifications:
  - creation of a floor for the direct and indirect care component rate allocations;
  - definition of a fair market rental system for use in the capital component rate allocation;
  - establishment of quality measures and a quality rating system for the quality incentive rate enhancement;
  - an outline of penalties in regards to the minimum direct care staffing standard for nursing facilities; and
  - a detailed exception process, applicable through June 30, 2018, for nursing facilities that are not meeting the minimum direct care staffing standard but are demonstrating good faith efforts to do so.

HOUSE COMMITTEE ON APPROPRIATIONS

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.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 30 members: Representatives Dunshee, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Cody, Condotta, Dent, Fitzgibbon, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Robinson, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger, Van Werven and Walkinshaw.

Minority Report: Do not pass. Signed by 1 member: Representative G. Hunt.

Minority Report: Without recommendation. Signed by 1 member: Representative Taylor.

Staff: Mary Mulholland (786-7391).

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. Clients may be served in their own homes, in community residential settings, and in skilled nursing facilities.

Nursing Facilities.
There are approximately 210 skilled nursing facilities licensed in Washington to serve about 10,000 Medicaid clients. Skilled nursing facilities are licensed by the Department of Social and Health Services (Department) 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 Department. The Medicaid rates in Washington are unique to each facility and have generally been based on the facility's allowable costs, occupancy rate, and client acuity (sometimes called the case mix). The biennial appropriations act 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 Department is required to proportionally adjust downward all nursing facility payment rates to meet the budget dial.

Chapter 2, Laws of 2015 (Substitute House Bill 1274).
Creation of a Value-based System For Nursing Home Rates.
In 2015 the Legislature passed Substitute House Bill (SHB) 1274, which established a value-based system for nursing home rates to begin July 1, 2016. The stated purpose of the new system is to decrease administrative complexity associated with the payment methodology, reward nursing homes for serving high-acuity residents, incentivize quality care for residents of nursing homes, and establish minimum staffing standards for direct care. Under the new system, six rate components were collapsed and reduced to three rate components: direct care, indirect care, and capital. The capital component must use a fair market rental system to set a price per bed and be adjusted for the age of the facility, using a minimum occupancy assumption of 90 percent.

Minimum Staffing Standards.
Beginning July 1, 2016, a quality incentive must be offered and a minimum staffing standard of 3.4 hours per resident day (HPRD) of direct care is established. The Department was directed to adopt rules establishing financial penalties for facilities out of compliance with the minimum direct care staffing standard.

In addition, requirements were established for the minimum number of weekly hours that nursing facilities must have a Registered Nurse (RN) on duty directly supervising resident care. Large nonessential community providers, defined as any nursing facility with over 60 licensed beds that is not the only nursing facility within a commuting radius of 40 minutes by car, must have a RN on duty directly supervising resident care 24 hours per day, seven days per week.

The Nursing Home Payment Methodology Work Group.
Finally, SHB 1274 directed the Department to facilitate a work group process to propose modifications to the new nursing home payment methodology. The work group submitted a report on modifications agreed to by consensus, including a description of areas of dissent and areas requiring legislative action, to the Legislature in January 2016.

Summary of Substitute Bill:

The nursing home payment methodology is modified to reflect consensus recommendations of the nursing home payment methodology work group.

Direct Care and Indirect Care Components.
The direct care component must be regionally adjusted using county-wide wage index information available through the United States Department of Labor's Bureau of Labor Statistics rather than using the nonmetropolitan and metropolitan statistical areas. The fixed rate at which direct care is paid must be based on 100 percent or greater of statewide case-mix neutral median costs, rather than on 100 percent of facility-wide case-mix neutral median costs.

The requirement that the indirect care component be adjusted for nonmetropolitan and metropolitan statistical areas is removed. Indirect care must be paid at a fixed rate based on 90 percent or greater of statewide median costs rather than on 90 percent of facility-wide median costs.

The direct and indirect care component rate allocations must be adjusted to the extent necessary to meet the budget dial.

Capital Component.
A Fair Rental Value (FRV) rate formula is established to set a price per bed for the capital component rate allocation of each facility. The formula takes into account the allowable nursing home square footage, a regional adjustment using the RS Means rental rate, the number of licensed beds yielding the gross unadjusted building value, an equipment allowance, and the average age of the facility. The average age of the facility is the actual facility age as adjusted for renovations that exceed $2,000 per bed in any given calendar year. Significant renovations may reduce a facility's average age and have the potential to increase

the facility's capital component rate allocation. A facility's FRV rate allocation must be rebased annually, effective July 1, 2016. The value per square foot effective July 1, 2016, must be set so that the weighted average FRV rate is not less than $10.80 per patient bed day. The capital component rate allocation must be adjusted to the extent necessary to meet the budget dial.

Statutory language regarding the certificate of capital authorization program and financing allowance component rate allocations are removed since they are no longer applicable under the new payment methodology.

Quality Incentive Rate Enhancement.
A quality incentive rate enhancement, equal to 1 to 5 percent of the statewide average daily rate, must be determined by calculating an overall facility quality score composed of four to six quality measures. For fiscal year (FY) 2017, facility quality scores are based on Minimum Data Set (MDS) measures collected by the federal Center for Medicare and Medicaid Services (CMS) for the percentage of long-stay residents who self-report moderate to severe pain, pressure ulcers, and urinary tract infections, and who have experienced falls resulting in major injury.

Beginning in FY 2018, two quality measures are added regarding the percentage of short-stay residents who newly receive antipsychotic medication, and the percentage of direct care staff turnover. Data sources for both quality measures are defined.

Quality measures must be reviewed on an annual basis by a stakeholder work group established by the Department, and may be added or changed. The quality score must be point-based. Each facility is placed into one of five tiers based on its aggregate quality score for all measures as a percentage of the potential total score. The tier system determines the amount of each facility's per-patient day quality incentive component. Payments must be set in a manner that ensures that the entire biennial appropriation for the quality incentive program is allocated. The quality incentive rates must be adjusted semiannually on July 1 and January 1 of each year using, at a minimum, the most recent available three-quarter average MDS data from CMS. For facilities with insufficient three-quarter average MDS data on applicable quality measures, the Department may use the facility's five-star quality rating from CMS to assign the facility to a tier.

Minimum Staffing Standards.
Penalties.
Financial penalties for non-compliance with the minimum direct care staffing standard (3.4 HPRD) may not be issued during the July 1, 2016, through September 30, 2016, implementation period. Facilities found in non-compliance during the implementation period must be provided with a written notice identifying the staffing deficiency and requiring the facility to provide a correction plan.

Monetary penalties begin October 1, 2016, and must be established based on a formula that calculates the cost of wages and benefits for the missing staff hours. The first penalty must be smaller than subsequent non-compliance penalties. Penalties may not exceed 200 percent of the wage and benefit costs that would have otherwise been expended to achieve the required direct care staffing minimum for the quarter.

Exceptions.
The Department must establish, in rule, an exception allowing geriatric behavioral health workers who meet certain requirements to be recognized towards the minimum direct care staffing standard as part of service delivery to individuals suffering from mental illness.

The Department must also establish a limited exception to the minimum direct care staffing standard for facilities demonstrating a good faith effort to hire and retain staff. Specific criteria for this exception are identified, including:

- The Department must survey facilities below, at, or slightly above the 3.4 HPRD requirement on staffing levels over three periods from October 2015 through June 2016 to determine initial facility eligibility for the exception. Only facilities below the 3.4 HPRD requirement during all three periods are eligible for exception consideration. Facilities that demonstrated staffing declines over the survey periods, whether deliberate or due to neglect in the Department's determination, are prohibited from being eligible for the exception.
- The Department must review the facility's plan of correction to determine eligibility for exception approval.
- The Department must determine that the facility is making sufficient progress towards reaching the 3.4 HPRD staffing requirement before it may renew the facility's exception.
- When reviewing to grant or renew an exception, the Department must consider factors including but not limited to financial incentives offered by the facility to its staff, robustness of the recruitment process, and county employment data, among other factors.
- Only facilities that have their direct care component rate increase capped, as provided for in current law to ensure cost-neutrality of nursing facility rate changes through FY 2019, are eligible for the exception.
- The Department is prohibited from granting or renewing a facility's exception if the facility meets the staffing requirement then subsequently drops below it.
- Each exception may be granted for a six-month period.

The Department's authority to establish such exceptions expires on June 30, 2018.

In addition, the Department must establish a limited exceptions process for large nonessential community providers demonstrating a good faith effort to hire a RN for the last eight hours of required coverage per day. The exception may be granted for one year and is renewable for up to three consecutive years. When a RN is not on-site and readily available, the Department may limit the admission of new residents to a facility based on medical conditions or complexities. Information on the facilities receiving this exception must be posted on the Department's online nursing home locator. After June 30, 2019, the Department must review the exception to determine if it is still necessary.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The legislation before you will bring Washington closer to a price-based system for nursing facility payment rates and will improve quality of care for residents. The proposed new system is a simplification of the current system.

The Washington Health Care Association represents 80 percent of the skilled nursing facilities in Washington. Last year, SHB 1274 initiated the first reforms of the nursing facility payment system in over 20 years. The reforms include a quality incentive that utilizes a tiered system to reward nursing facilities that improve quality over time. The FRV system simplifies and replaces two components from the old system, and represents the simulated rental value of a bed. Nursing facility owners will no longer have to grapple with issues like change in ownership, allowable debt, and leases, among other issues in regards to the capital component of the rate.

As currently written, a time-limited exception would be established to the 3.4 hours per resident day minimum staffing standard for direct care. The state is moving from no minimum staffing standard to the fifth-highest minimum staffing standard in the nation virtually overnight. The Department estimates that there are approximately 10 nursing facilities that will struggle to meet the minimum staffing standard over time. The Department's estimate is based on cost report data, which has never been used before to measure staffing and therefore the estimate may be imprecise. The full scope of staffing shortages and facilities that are struggling will be known after the first three months of implementation. It is known from other state's struggles that imposing a minimum staffing standard can be problematic. For example, Florida has the third-highest staffing standard in the county at 3.6 hours of direct care per resident day, and it took nine years to reach the standard. Florida planned to implement their standard over a three-year period but kept running into problems. Washington should not make the same mistake. A time-limited, reasonable exception process for the few nursing facilities that have trouble meeting the standard is appropriate and should be kept in the bill.

The nursing facility payment methodology work group that met throughout the summer and fall met again last Friday, after a hearing on an identical bill in the Senate (Senate Bill 6240). Work group members are in agreement on all potential amendments except for the limited exception to the direct care minimum staffing standard. The work group hopes to reach agreement on all of its recommended amendments by Tuesday, January 26.

Nursing facilities should be encouraged to come into compliance with the minimum staffing standard as quickly as possible without jeopardizing the well-being of the residents. There is a goal in statute of reaching 4.1 hours per patient day for the direct care minimum staffing standard. Continuity of care by the bedside with sufficient staffing numbers, provided with respect, is very important.

There are three main areas of the legislation that would benefit non-profit skilled nursing facilities. The first is the use of regionally adjusted wages. This is important as the state

begins to experience the impacts of local minimum wage laws in some counties. The regional adjustment will provide for a more fair allocation of resources to facilities that need it to support higher wages. Second, the re-aging of facilities based on physical infrastructure investments helps ensure that amounts paid in nursing facility rates are covering at least some of those investments. The proposed modifications will continue to incentivize physical renovations, which is important to supporting resident quality-of-life and creating a good work environment for nursing facility staff. Third, the quality component of the new system ensures that nursing facilities that are performing well receive recognition of their performance in their rate. Although gains have been made, there is still a long ways to go in terms of appropriately funding nursing facilities. No new State General Fund has been allocated to the program for about eight years. All stakeholders in the work group acknowledged this in the report submitted on January 2, 2016. Additional funding is needed to pay appropriate rates and to continue to incentivize quality. All stakeholders request $6.4 million State General Fund this year to better support direct care and investments in physical plants.

(Opposed) None.

(Other) The credibility and compromise that occurred in the work group was based on the idea that the proposed legislation coming out of the work group would reflect the work group's consensus. The language that allows a limited exception process for nursing facilities that do not meet the minimum staffing standard for direct care was not a consensus recommendation from the work group. This language made it in to the legislation before you in violation of the work group's ground rules. The minimum staffing standard is very important and steps back from the progress already made should not be taken. If there is a limited exception process, very strict criteria on what facilities receive the exception would be needed.

There was some discussion in the work group over what nursing facility staff hours could be counted towards hours of direct care. Some stakeholders backed off on their concerns in this regard so that consensus could be reached.

Approximately eight, small, rural, largely Critical Access Hospitals represented by the Washington State Hospital Association are affected by the proposed modifications in the nursing facility payment methodology. One example is the Newport facility in the northeast corner of Washington. They are currently losing almost $360,000 per year on their skilled nursing facility. Under the proposed legislation, and after hold-harmless provisions in current law end, they will take an additional $228,000 annual loss on their nursing facility. It is not clear that the nursing facility will survive. This could be addressed by an exemption for hospitals like the Newport facility, which would mean that some other hospitals would do better in terms of rates and this would have almost no cost to the state. If exemptions are not possible, the hold-harmless provision could continue for some hospitals. Much of the rate impacts for individual nursing facilities are driven by the facility's mix of client acuity. Rewarding acuity is a noble concept, but if a nursing facility is the only option within 20 miles for someone's aging parent, the nursing facility also needs to serve lower-acuity clients. A little bit more attention needs to be paid to these situations.

Persons Testifying: (In support) Representative Schmick, prime sponsor; Robin Dale, Washington Health Care Association; Deb Murphy, Leading Age Washington; Bill Moss, Department of Social and Health Services; and Gerald Reilly, Long Term Care Ombudsman.

(Other) Lani Todd and Nick Federici, Service Employees International Union 775; and Len McComb, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: