SENATE BILL REPORT
SB 5526

As of February 20, 2023

Title: An act relating to nursing facility rates.

Brief Description: Concerning nursing facility rates.

Sponsors: Senators Van De Wege, Muzzall, Cleveland, Hunt, Keiser, Liias, Pedersen, Salomon, Shewmake, Valdez and Warnick.

Brief History:
Committee Activity: Health & Long Term Care: 2/09/23, 2/14/23 [DPS-WM].
Ways & Means: 2/21/23.

Brief Summary of First Substitute Bill

- Requires annual rebasing and an annual inflationary adjustment for the direct and indirect care components of the rates beginning in fiscal year 2024.
- Requires a certain percentage of a facility's rate increase over the previous fiscal year be allocated for low-wage direct and indirect care workers, and for Department of Social and Health Services (DSHS) to establish a verification and recovery process for use of those funds.
- Directs DSHS to convene a stakeholder workgroup, and submit a report by December 1, 2025, containing results from a study of the impacts of the low-wage funding on recruitment and retention.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5526 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Rivers, Ranking Member; Muzzall, Assistant Ranking Member; Conway, Dhingra, Holy, Padden, Randall and Van De

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

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Staff: Julie Tran (786-7283)

SENATE COMMITTEE ON WAYS & MEANS

Staff: Maria Hovde (786-7474)

Background: Individuals receiving Medicaid funded long-term services and supports may choose to receive services in their home, in an adult day center, in an adult family home, in an assisted living facility, or in a skilled nursing facility (SNF). The licensed SNFs in Washington serve about 7600 Medicaid clients per month. SNFs 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.

Skilled Nursing Facility Medicaid Rate Methodology. The Medicaid SNF payment methodology is administered by DSHS. The Medicaid rates in Washington are unique to each facility and reflect the client acuity of each SNF's residents. The methodology for SNF payment rates consists of four primary components: direct care, indirect care, capital, and quality incentive.

The direct care component includes nursing and related care provided to residents, such as food, laundry, and dietary services. The direct care rate is paid at a fixed rate based on 100 percent or greater of the statewide median of costs based on the most recent annual cost report, and is capped at 118 percent of the base year costs. The direct care rate is also readjusted every six months to reflect changes in the case mix.

The indirect care rate component includes administrative expenses, maintenance costs, tax reimbursements, and housekeeping services. The indirect care rate is paid at a fixed rate based on 90 percent or greater of the statewide median costs and a minimum occupancy level of 90 percent is assumed.

The capital component must use a fair market rental system to set a price per bed. The capital component must be adjusted for the age of the facility, and must use a minimum occupancy assumption of 90 percent. The quality incentive component must be determined by calculating an overall facility quality score composed of four to six quality measures.

Rates are based on cost reports submitted by SNFs to DSHS at the end of each calendar year. The direct and indirect care rate components are rebased in odd-numbered state fiscal years using cost reports submitted by nursing facilities for the period two calendar years previous. For example, rates were rebased in fiscal year (FY) 2023 using calendar year 2020 cost reports. These rates will remain in effect through FY 2024 until rates are rebased again in FY 2025 using calendar year 2022 cost reports.

If, after rebasing, the percentage increase in the statewide average daily rate is less than the average rate of inflation, as determined by the skilled nursing facility market basket index published by the Centers for Medicare and Medicaid Services (CMS), DSHS is authorized to further increase rates to match the average rate of inflation. For example, if DSHS saw a 2 percent growth in direct and indirect care costs, but a 4.8 percent rate of inflation, it would be authorized to increase the rate by an additional 2.8 percent. DSHS has never had to exercise this authority. While this allows DSHS to ensure that rates at least match the current rate of inflation, the methodology does not include a step of bringing costs from the cost report year up to the current year's dollars.

2019-21 Biennium. In the enacted 2020 supplemental budget—ESSB 6168, the Legislature authorized a one-time inflationary adjustment of SNF reported calendar year costs using the 24-month consumer price index for all urban consumers, as published by the United States Bureau of Labor Statistics, beginning May 1, 2020, through June 30, 2021. In accordance with stated legislative intent, a facility-specific rate add-on equal to the inflation adjustment that facilities received in FY 2021 was added to the rate beginning in FY 2022. DSHS was directed to submit a report to the Legislature for determining the need for regular inflationary adjustments by comparing rates paid to SNF reported costs for fiscal years 2017-2019.

In December 2020, DSHS released a report to the Legislature, which identified the gap between rates paid and SNF reported costs as $112.9 million to $117.0 million per year during the 2017-2019 period. The report recommended that an annual rebase and periodic inflation adjustments be added to the nursing facility rate methodology in statute, but notes that these two methodology changes alone will not completely close the gap between reported costs and rates paid.

2021-23 Biennium. The Legislature modified the direct and indirect care components as follows. In the enacted biennial budget—ESSB 5092:

- the requirement to adjust the case mix calculations every six months was halted during the biennium;
- the basis of 100 percent or greater of the statewide median costs utilized to calculate the direct care rate was increased to be 105 percent or greater during the biennium; and
- the cap for the base year costs was modified from 118 percent to 130 percent with the stated intent to remove this cap by FY 2027.

In the enacted 2022 supplemental budget—ESSB 5693:

- the cap for the base year costs was increased to 165 percent;
- the temporary basis of 105 percent or greater of the statewide median costs utilized to calculate the direct care rate was increased to 111 percent or greater in FY 2023, and was directed to be used exclusively for wage increases for low-wage direct care workers;

- the basis of 90 percent or greater of the statewide median costs utilized to calculate the indirect care rate was increased to 92 percent in FY 2023; and
- the minimum occupancy assumption utilized to calculate the indirect care rate was decreased from 90 percent to 75 percent for FY 2023.

Summary of Bill (First Substitute): Beginning with rates paid on July 1, 2023, the direct and indirect care components must be rebased every year.

Beginning with the rates paid on July 1, 2023, the calendar year costs must be annually adjusted for inflation by the skilled nursing facility four quarter moving average percent changed for the most recent quarter from the CMS annual market basket index, which is utilized for the prospective payment systems in the federal register.

<u>Direct Care Components.</u> The direct care rate must be paid at a fixed rate, based on 111 percent or greater of the statewide median costs. DSHS must conduct an annual review of the direct care rate on June 30th compared to the direct care rate on July 1st to determine the annual direct care rate increase over the previous fiscal year for each individual facility. Beginning July 1, 2023, 29 percent of a facility's annual direct care rate increase over the previous fiscal year's direct care rate must be allocated solely to address low-wage equity for low-wage direct care workers.

For the purposes of this allocation, "low-wage direct care workers" means certified nursing assistants, dietary workers, laundry workers, medical assistants, nursing assistants registered, cooks, feeding assistants, activity assistants, medical technicians, bath aides, medical records assistants, rehabilitation and restorative aides, social workers and those who work in social services, and other workers who provide direct care to residents and who do not have a managerial role. This allocation cannot be used to fund agency staffing or any overtime costs above the regular rate of pay.

For the purposes of calculating resource utilization groups, DSHS may adjust the case mix calculation as necessary in the event that the U.S. Department of Health and Human Services discontinues or changes the provisions of the minimum data set 3.0.

<u>Indirect Care Components.</u> The indirect care rate must be paid at a fixed rate, based on 92 percent or greater of the statewide median costs. A minimum occupancy assumption equal to 105 percent of the statewide average occupancy of the calendar year prior to the beginning of the fiscal year must be applied to indirect care. Only facilities used to calculate the median will be used to calculate the statewide average occupancy.

DSHS must conduct an annual review of the indirect care rate on June 30th compared to the direct care rate on July 1st to determine the annual direct care rate increase over the previous fiscal year for each individual facility. Beginning July 1, 2023, 10 percent of a facility's annual direct care rate increase over the previous fiscal year's direct care rate must be allocated solely to address low-wage equity for low-wage direct care workers.

For the purposes of this allocation, "low-wage indirect care workers" means central supply workers, housekeeping workers, subcontracted housekeeping workers, reception workers, staffing coordinators, building maintenance workers, transportation, facilities, and maintenance workers, and other workers not providing direct care to residents and who do not have a managerial role.

Low-Wage Direct and Indirect Workers Funding. DSHS must provide a verification and recovery process on the allocated funds to low-wage direct care and low-wage indirect care workers. For the process, DSHS must perform a comparative analysis from one year to the next and validate that each provider has increased average wages for one or more designated low-wage worker categories by no less than the facility-specific amounts the provider received solely for low wage equity.

Any funds recovered through this verification and recovery process must be reinvested into the quality incentive component as determined by DSHS, in collaboration with appropriate stakeholders. This verification and recovery process is a distinct and separate process from the existing settlement process for the nursing facility Medicaid payment system.

Each facility must report to DSHS the average wage and the hourly wage range for low-wage direct care and low-wage indirect care workers. For the collected data on facility-specific low-wage workers' wages, DSHS must conform to the Safe Harbor guidelines outlined by the US Department of Justice and the Federal Trade Commission. The collected data must be aggregated so that no single facility can be identified, each statistic reported must have at least five facilities reporting data, and no single facility should represent more than 25 percent of any statistic reported.

The individual facility wage data reported to DSHS for these purposes are not subject to disclosure under the Public Records Act. The consolidated findings from the verification and recovery process are subject to disclosure under the Public Records Act.

Stakeholder Work Group. DSHS must convene a stakeholder work group to study the impacts of the low-wage funding and review whether the low-wage funding has improved the ability of facilities to retain staff in the affected categories, and whether the low-wage funding has enabled the facilities to attract and hire additional low-wage staff.

The stakeholder work group is comprised of the two statewide nursing home associations, and the labor organization that represents long-term care workers. The stakeholder work group must review and determine if a portion of the low-wage worker funding, or additional and separate enhanced funding, should be allocated specifically for low-wage worker benefits such as child care, transportation, medical insurance, or retirement benefits. DSHS must submit a report to the Legislature by December 1, 2025, that contains the results of the study and includes recommendations for expanding the use of low-wage worker funding, or applying new funds, to support the provision of benefits to these affected workers.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Replaces references to "company" with "facility."

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: This bill brings long-term stability to nursing homes and makes it easier to recruit and retain more staff by providing ongoing funding for wage increases and increased rates for nursing homes. Medicaid is the safety net that people trust to be there when they need it. Those working in nursing homes face the challenges of the staff shortages and inadequate compensation due to the underfunding of the Medicaid system. This drives higher turnover and impacts the quality of care that is able to be provided. This issue also connects to the hospital overcrowding and the inability to discharge patients when it is appropriate to do so. Hospitals cannot admit as many medically urgent citizens and the wait times in the ER are high. It isn't just the low-income seniors who suffer when Medicaid rates for SNFs are inadequate. Hospitals are still relying on predatory agencies to get the bare minimum of staff needed on the floor to provide care and it costs too much money. There will continue to be a nursing facility staffing crisis until the wages increase and people can make this job into a career where they enter and are able to stay. There needs to be a continuous effort to increase wages and benefits in order to pay workers for their work as they do some of the most important and challenging work imaginable. The long-term care jobs need to be fairly funded and fairly valued. They deserve wages that allow them to work a single job that covers their housing and cost of living. This bill ensures that SNFs can compete for workers and that funding is more responsive to the cost of care.

Persons Testifying (Health & Long Term Care): PRO: Senator Kevin Van De Wege, Prime Sponsor; Joann Roderiques -lemon; Rhonda Pebbles, Certified Nursing Assistant; Madeleine Foutch, SEIU 775; Radiance Johnson, Med Tech; Shelly Hughes; Carma Matti-Jackson, Washington Health Care Association; Tonja Myers.

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