H-1912.1

SUBSTITUTE HOUSE BILL 1637

State of Washington 57th Legislature 2001 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Edmonds, Skinner, O'Brien, McMorris, Conway, Kenney, Campbell, Kagi, Pflug, Kirby, Pennington, Cody, Ruderman, Schoesler, Lovick, Jackley, Schual-Berke, Anderson, Keiser, Schindler, Romero, Casada, Rockefeller, Miloscia, Morell, Mulliken, Santos, Van Luven and Hurst)

Read first time . Referred to Committee on .

AN ACT Relating to enhancing the wages and benefits of long-term care paraprofessional workers providing care to the elderly and disabled; amending RCW 70.47.060, 74.46.165, and 74.46.431; adding new sections to chapter 74.39A RCW; adding a new section to chapter 43.20A RCW; adding a new section to chapter 28B.15 RCW; adding a new section to chapter 74.46 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that long-term care providers in the state of Washington are reporting unprecedented labor vacancies, particularly for those paraprofessionals who provide direct hands-on care to some of the most medically vulnerable citizens of our state.

It is the intent of this act to increase the stability of long-term care paraprofessional employment by supporting enhanced wages and benefits for those long-term care paraprofessional workers who provide direct hands-on care for state-funded clients in nursing homes, boarding homes, adult family homes, community residential settings for the developmentally disabled or mentally ill, or clients' own homes.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.39A RCW to read as follows:

As used in sections 3 and 4 of this act:

(1) "Long-term care paraprofessional worker" means:

(a) A nonlicensed worker providing direct hands-on care to a medicaid client in a nursing home under chapter 18.51 RCW, boarding home under chapter 18.20 RCW, adult family home under chapter 70.128 RCW, or developmental disability residential program under chapter 71.12 RCW; or

(b) A nonlicensed worker providing direct hands-on care to a functionally disabled person in the person's own home through medicaid personal care as described in RCW 74.09.520, community options program entry system waiver services as described in RCW 74.39A.030, or chore services as described in RCW 74.39A.110 as an individual provider or employee of a home care agency under chapter 70.127 RCW.

(2) "Long-term care para professional worker" does not include janitorial staff, food service staff, or any other nondirect care staff working in a nursing home, group home, or boarding home facility, or an owner, operator, or manager of a nursing home, group home, boarding home, or adult family home.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.39A RCW to read as follows:

(1) The department of social and health services shall establish a wage enhancement program to enhance the wages of long-term care paraprofessional workers. Facilities, organizations, and agencies that employ or contract with long-term care paraprofessional workers may voluntarily participate in the program. Under the program, the department of social and health services shall provide participating facilities, organizations, and agencies with funds to enhance the wages of long-term care paraprofessional workers based on the proportion of worker hours that may be reasonably apportioned to the care of medicaid clients compared to the total number of hours of care for all clients of the facility or home. Wage enhancement funds shall be available for both current workers and additional long-term care paraprofessional workers. Participating facilities, organizations, and agencies shall provide worker and medicaid client data as determined necessary by the department of social and health services. The department shall develop standards for determining how the wage enhancement funds are to be

distributed to participating facilities, organizations, and agencies, and reporting requirements needed to determine how wage enhancement funds provided under this act shall be distributed to each long-term care paraprofessional worker. Facilities, organizations, and agencies participating in the wage enhancement program shall report to the department retrospectively on how the funds were distributed. All funds provided to a participating facility, organization, or agency must be used only to directly enhance the wages of long-term care paraprofessional workers. Participating facilities, organizations, and agencies are prohibited from arbitrarily reducing the wages of any long-term care paraprofessional worker on or after July 1, 2001, through July 2, 2002. Any funds received under this act that are not expended for the purposes of this act must be returned to the department.

(a) On July 1, 2001, participating facilities, organizations, and agencies shall increase by one dollar per hour, plus an amount equal to mandatory federal and state payroll taxes, the wages paid to each long-term care paraprofessional worker employed or contracted with by the facility, organization, or agency.

(b) On July 1, 2002, participating facilities, organizations, and agencies shall increase the wages paid to all long-term care paraprofessional workers by an average amount of one dollar per hour, plus an amount equal to mandatory federal and state payroll taxes. Participating facilities, organizations, and agencies shall determine the amount of the wage enhancement for each eligible long-term care paraprofessional worker in accordance with wage increase criteria guidelines adopted by each participating facility, organization, or agency. The wage increase criteria guidelines must include consideration of tenure, shift, and technical performance of duties, unless otherwise established by contract or bargaining agreement and consistent with existing state and federal law.

(2) The department shall determine the wage increase amount for persons working in the individual provider program. The department shall distribute the funding for the July 1, 2002, wage increase so that each participating employer receives an amount equal to the cost of providing a wage increase of one dollar per hour to each long-term care paraprofessional worker, plus an amount equal to mandatory federal and state payroll taxes.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.20A RCW to read as follows:

The department of social and health services shall distribute to all long-term care paraprofessional workers as defined in section 2 of this act information regarding the federal earned income tax credit program. The department's efforts must include outreach and technical assistance designed to allow all long-term care paraprofessional workers who are qualified to receive assistance through the earned income tax credit program.

Sec. 5. RCW 70.47.060 and 2000 c 79 s 34 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for

their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (9) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (10) of this section.

(b) To the extent funds are specifically appropriated for this purpose, two thousand individual provider long-term care paraprofessional workers, as defined in section 2 of this act, who provide care to medicaid clients and who meet the requirements for a subsidized enrollee in RCW 70.47.020(4), shall be required to pay no more than the minimum premium share for subsidized enrollees.

(c) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

((~~(c)~~)) (d) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator.

(3) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan for either subsidized enrollees, or nonsubsidized enrollees, or both. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and

dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(10) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever

the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

(16) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

(17) To administer the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington state health insurance pool.

NEW SECTION. **Sec. 6.** A new section is added to chapter 28B.15 RCW to read as follows:

(1) The governing boards of the state universities, the regional universities, The Evergreen State College, and the community colleges may waive all or a portion of the tuition and services and activities fees for long-term care paraprofessional workers as defined in section 2 of this act. The enrollment of these persons is pursuant to the following conditions:

(a) Such persons shall register for and be enrolled in courses on a space-available basis, and no new course sections shall be created as a result of the registration;

(b) Enrollment information on persons registered pursuant to this section shall be maintained separately from other enrollment information and shall not be included in official enrollment reports, nor shall such persons be considered in any enrollment statistics that would affect budgetary determinations; and

(c) Persons registering on a space-available basis shall be charged a registration fee of not less than five dollars.

(2) In awarding waivers, an institution of higher education may award waivers to eligible persons employed by the institution before considering waivers for eligible persons who are not employed by the institution.

(3) In establishing eligibility to receive waivers, institutions of higher education may not discriminate between full-time long-term care paraprofessional workers and half-time or more long-term care paraprofessional workers.

Sec. 7. RCW 74.46.165 and 1998 c 322 s 10 are each amended to read as follows:

(1) Contractors shall be required to submit with each annual nursing facility cost report a proposed settlement report showing underspending or overspending in each component rate during the cost

report year on a per-resident day basis. The department shall accept or reject the proposed settlement report, explain any adjustments, and issue a revised settlement report if needed.

(2) Contractors shall not be required to refund payments made in the operations, property, and return on investment component rates in excess of the adjusted costs of providing services corresponding to these components.

(3) Participating facilities will return to the department any unspent funds in the wage enhancement component rate. The facility will return to the department any overpayment amounts in each of the direct care, therapy care, and support services rate components that the department identifies following the audit and settlement procedures as described in this chapter, provided that the contractor may retain any overpayment that does not exceed 1.0% of the facility's direct care, therapy care, and support services component rate. However, no overpayments may be retained in a cost center to which savings have been shifted to cover a deficit, as provided in subsection (4) of this section. Facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time, during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care, therapy care, and support services component rate. The terms "not in substantial compliance" and "substandard quality of care" shall be defined by federal survey regulations.

(4) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, shall be done separately for each component rate, and neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any. However, in computing a preliminary or final settlement, savings in the support services cost center may be shifted to cover a deficit in the direct care or therapy cost centers up to the amount of any savings. Not more than twenty percent of the rate in a cost center may be shifted.

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall represent the maximum payment for nursing facility services rendered to

medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

(6) RCW 74.46.150 through 74.46.180, and rules adopted by the department prior to July 1, 1998, shall continue to govern the medicaid settlement process for periods prior to October 1, 1998, as if these statutes and rules remained in full force and effect.

(7) For calendar year 1998, the department shall calculate split settlements covering January 1, 1998, through September 30, 1998, and October 1, 1998, through December 31, 1998. For the period beginning October 1, 1998, rules specified in this chapter shall apply. The department shall, by rule, determine the division of calendar year 1998 adjusted costs for settlement purposes.

Sec. 8. RCW 74.46.431 and 1999 c 353 s 4 are each amended to read as follows:

(1) Effective July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have seven components: Direct care, therapy care, support services, operations, property, financing allowance, and variable return. Effective July 1, 2001, there shall be an additional wage enhancement medicaid payment rate allocation for facilities electing to participate. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) All component rate allocations shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use.

(3) Information and data sources used in determining medicaid payment rate allocations, including formulas, procedures, cost report periods, resident assessment instrument formats, resident assessment methodologies, and resident classification and case mix weighting methodologies, may be substituted or altered from time to time as determined by the department.

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, direct care component rate allocations; adjusted cost

report data from 1999 will be used for July 1, 2001, through June 30, 2004, direct care component rate allocations.

(b) Direct care component rate allocations based on 1996 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

(c) Direct care component rate allocations based on 1999 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2004, therapy care component rate allocations.

(b) Therapy care component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004, support services component rate allocations.

(b) Support services component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted

cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004, operations component rate allocations.

(b) Operations component rate allocations shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act.

(8) For July 1, 1998, through September 30, 1998, a facility's property and return on investment component rates shall be the facility's June 30, 1998, property and return on investment component rates, without increase. For October 1, 1998, through June 30, 1999, a facility's property and return on investment component rates shall be rebased utilizing 1997 adjusted cost report data covering at least six months of data.

(9) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of five dollars and fifteen cents per hour or the federal minimum wage.

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(12) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

NEW SECTION. **Sec. 9.** A new section is added to chapter 74.46 RCW to read as follows:

Effective July 1, 2001, nursing facility providers shall have the option of participating in a program to enhance the wages and benefits of nonlicensed paraprofessional staff as defined in and authorized by chapter 74.39A RCW. Pursuant to procedures and rules adopted by the department, any nursing facility wishing to participate may do so, and the department shall calculate for each participating facility a wage enhancement component rate intended to fund the additional cost of authorized wage increases for qualifying employees, which shall be adjusted to reflect the ratio of medicaid hours of care to total hours of care delivered at the facility. The department shall monitor wage enhancement rate payments and shall recover all such funds not spent for approved wage increases. Payments made in the wage enhancement component rate shall not be subject to the provisions of RCW 74.46.421, but shall not exceed the appropriation made for this purpose.

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