Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Appropriations Committee

HB 2678

Brief Description: Regulating nursing home facilities.

Sponsors: Representatives Schmick, Cody and Van De Wege.

Brief Summary of Bill

- Modifies the nursing facility payment methodology including, but not limited to, consensus recommendations from the nursing facility payment methodology work group established in Substitute House Bill 1274 (2015) that were determined by the work group to require legislative action.
- 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 initial quality measures for the quality incentive rate enhancement; and
  - an outline of penalties and exceptions in regards to the minimum staffing standards for nursing facilities.

Hearing Date: 1/25/16

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

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.

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, 2015 Laws (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 Bill:

The nursing home payment methodology is modified. The modifications include, but are not limited to, consensus recommendations of the nursing home payment methodology work group described in the January 2016 report as requiring legislative action.

Direct care and indirect care components

The direct care component must be regionally adjusted using county-wide wage index information available through the U.S. 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 facility-wide 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.

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 is removed since this program is replaced by the FRV system.

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. Initially, 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. 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. Facilities are placed into five tiers based on their aggregate quality score. The tier system must be used to determine the amount of each facility's per patient day quality incentive. 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. Facilities with insufficient three-quarter average MDS data for the selected quality measures must be assigned to a tier based on their five-star quality rating from CMS.

Minimum staffing standards

Penalties

Financial penalties for non-compliance with minimum direct care staffing standards 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 in the minimum staffing requirements as part of direct care 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. The Department's authority to establish such exceptions expires on June 30, 2018.

Finally, 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.

Appropriation: None.

Fiscal Note: Available.

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