FINAL BILL REPORT
SHB 2678

C 131 L 16
Synopsis as Enacted

Brief Description: Regulating nursing home facilities.

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

House Committee on Appropriations
Senate Committee on Health Care

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.

Creation of a Value-based System For Nursing Home Rates.
In 2015, a value-based system for nursing home rates was established 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

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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. The direct care component must be adjusted for nonmetropolitan and metropolitan statistical areas. The fixed rate at which direct care is paid is based on 100 percent of facility-wide case mix neutral medium costs.

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 during which 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.
The Department was directed 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 of 2016.

Summary:

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 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.

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.

Quality measures must be reviewed on an annual basis by a stakeholder work group established by the Department and may be added to 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 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.

Votes on Final Passage:

House 96 1
Senate 46 0

Effective: June 9, 2016