SENATE BILL REPORT
SHB 2678

As Reported by Senate Committee On:
Health Care, February 22, 2016

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: Passed House: 2/11/16, 96-1.
Committee Activity: Health Care: 2/18/16, 2/22/16 [DP].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Cleveland, Ranking Minority Member; Angel, Bailey, Brown, Conway, Frockt, Jayapal, Keiser, Parlette and Rivers.

Staff: Kathleen Buchli (786-7488)

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. The federal funds are matching funds, and are referred to as the Federal Financial Participation, or the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated based on average per-capita income and is usually between 50 and 51 percent for Washington. Typically, the state pays the remainder using the state general fund. Clients may be served in their own homes, in community residential settings, and in skilled nursing facilities.

There are approximately 240 skilled nursing facilities licensed in Washington to serve about 10,000 Medicaid-eligible clients. Skilled nursing facilities 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. The Medicaid nursing home payment system is administered by DSHS.

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.

In 2015, the Legislature passed SHB 1274 which established a value-based system for nursing home rates. Beginning July 1, 2016, payments to nursing homes for services must be based on a system having three main components: direct care, indirect care, and capital. Both the direct care and indirect care components must be regionally adjusted for nonmetropolitan and metropolitan statistical areas, and the indirect care component must be paid at a fixed rate, based on 90 percent of facility-wide median costs. 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. Beginning July 1, 2016, a quality incentive must be offered.

SHB 1274 also established minimum staffing standards for nursing homes and directed DSHS to adopt rules establishing financial penalties for facilities out of compliance with minimum staffing standards.

Summary of Bill: 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 direct care component rate, the indirect care component rate, and the capital component rate must be adjusted to comply with the appropriations act.

Beginning July 1, 2016, the fair rental rate allocation for each facility must be determined according to the calculation provided in statute. These calculations include consideration of the allowable nursing home square footage by the RSMeans rental rate, the number of licensed beds yielding the gross unadjusted building value, an equipment allowance, and average age of the facility.

The quality incentive must be determined by calculating an overall facility quality score composed of four to six quality measures. Initially, this is based on quality measures for the percentage of long-stay residents with moderate to severe pain, pressure ulcers, and urinary tract infections, and who have experienced falls resulting in major injury. The quality incentive rates must be adjusted semi-annually. Beginning July 1, 2017, the percentage of short-stay residents who newly received an antipsychotic medication and the percentage of direct care staff turnover must be added as quality measures.

Financial penalties for non-compliance with minimum 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.

Financial 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 be more than 200 percent of the wage and benefit costs that would have otherwise been expended to achieve the required staffing minimum for the quarter.

An exception must be established allowing geriatric behavioral health workers to be recognized in the minimum staffing requirements as part of the direct care service delivery to individuals suffering from mental illness. DSHS may limit the admission of new residents,

based on medical conditions or complexities when a registered nurse is not onsite and readily available.

A limited exception to the 3.4 hours per resident per day staffing requirement is provided, limited as follows:

- The facility does not qualify for the exemption if it is unable to make the staffing levels due to a deliberate decision of the facility or due to neglect.
- The facility must be making progress towards meeting the staffing requirement such as offering financial incentives or taking steps towards increasing employee retention.
- No exception is provided for facilities after they have met their 3.4 hour requirement.
- Exceptions are only permitted for six months and are not available after June 30, 2018.

A limited exception to the requirement that large nonessential community providers have a registered nurse be on duty directly supervising resident care twenty-four hours per day, seven days per week is provided, limited as follows:

- An exception may be provided to facilities that can demonstrate a good faith effort to hire a registered nurse for the last eight hours of required coverage per day. Wages and benefits offered and the availability of registered nurses in the area must be considered.
- A one-year exception may be granted and be renewable for up to three years. However, DSHS may limit new admissions. Information on the exception must be included in DSHS's nursing home locator.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill provides quality incentives into the nursing facility payment system and gives facilities a bonus for taking higher acuity patients. It simplifies the process, and the quality measures added will create better health outcomes; it provides minimum staff ratios and 24/7 nursing coverage in nursing facilities. It allows rates to be sensitive to regional variations and allows re-aging of buildings. The system is underfunded and more funding needs to be appropriated.

Persons Testifying: PRO: Rep. Schmick, prime sponsor; Robin Dale, WA Health Care Assn; Deb Murphy, Leading Age Washington; Bill Moss, Department of Social and Health Services.

Persons Signed In To Testify But Not Testifying: No one.