SENATE BILL REPORT
SB 6240

As of January 20, 2016

Title: An act relating to nursing home facilities.

Brief Description: Regulating nursing home facilities.

Sponsors: Senators Parlette, Keiser, Becker, Cleveland, Bailey, McAuliffe and Hobbs.

Brief History:
Committee Activity: Health Care: 1/19/16.

SENATE COMMITTEE ON HEALTH CARE

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.

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

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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 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 state-wide median costs.

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 sever pain, pressure ulcers, and urinary tract infections, and who have experienced falls resulting in major injury. The quality score must be point based. Facilities are placed into tiers based on their aggregate quality score. This 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.

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 2, 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. Limited exceptions must be established for facilities demonstrating a good faith effort to hire and retain staff or to hire a registered nurse for the last eight hours of required coverage per day. DSHS may limit the admission of new residents, based on medication conditions or complexities when a registered nurse is not on-site and readily available.

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 is a result of a work group that met over the interim and simplifies the calculation used for nursing facility payments by reducing the number of factors to be considered in making this calculation. This bill is consistent with the recommendations made by the work group in its report. Consensus has not been reached relating to the requirement of staffing for a minimum of 3.4 hours per resident day of direct care. Limited exceptions are allowed in meeting this staffing requirement. We are moving to having the fifth highest staffing requirement in the country. Putting the point structure in the bill for calculating the quality score is problematic and DSHS should be provided authority in rule relating to a point system. The fair market value calculation is subject to the budget dial but it is the only element that is subject to the budget dial, this requirement should be for all components. Concerns have been raised about putting in the RSMeans formula in statute which may be found to be a delegation of the Legislature's authority; it would be better to refer to the RSMeans formula as a guideline for determining the fair market value. The calculations in the bill incentive facilities to put in improvements. The funding for the current system in not adequate and needs to be supplemented by the general fund. The quality incentive enhancements need to be further worked. We oppose the exception to the staffing requirements which would apply to only a few facilities. If the facility has an exemption for the 24 hour nursing care requirement, that information should be posted on-line.

OTHER: We are concerned with the stakeholder process. The bill should only include consensus decisions, but it includes parts that have not been agreed to by all stakeholders. Need an exception for the requirement for 24 hour nursing care. The quality incentives are meant to change from year to year and other factors should be added such as staff turnover and bladder and bowel control of residents. The staffing levels should be put into statute and the hourly requirement should be retained without exemptions or moratoriums. Small rural facilities are impacted by the bill; the hold harmless provisions need to be extended to these facilities beyond one biennium. The exemption to quality staffing standards does not represent the work of the workgroup. Facilities know the staffing requirement is coming and they should already be working to retain staff and the deadlines are needed.

Persons Testifying: PRO: Senator Parlette, prime sponsor; Robin Dale, Washington Health Care Association; Deb Murphy, Leading Age Washington; Bill Moss, Department of Social and Health Services; Patricia Hunter, State Long-Term Care Ombuds.

OTHER: Lani Todd, SEIU 775; Shelly Hughes, SEIU 775/Nursing Home Worker; Jessica Field, SEIU 775/ Nursing Home CNA; Len Mc Comb, Washington State Hospital Association; Hilke Faber, RESIDENT COUNCILS OF WA; Trent House, Providence Health and Services.

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