
SENATE BILL 6250

State of Washington

66th Legislature

2020 Regular Session

By Senators Keiser, Conway, Cleveland, Hasegawa, Wilson, C., Das, and Van De Wege; by request of Department of Social and Health Services

Read first time 01/14/20. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to nursing facilities; and amending RCW
2 18.51.091, 18.51.230, 74.42.360, and 74.46.561.

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

4 **Sec. 1.** RCW 18.51.091 and 1987 c 476 s 24 are each amended to
5 read as follows:

6 The department shall (~~make or cause to be made at least one~~
7 ~~inspection of~~) inspect each nursing home (~~prior to license renewal~~
8 ~~and shall inspect community-based services as part of the licensing~~
9 ~~renewal survey~~) periodically in accordance with federal standards
10 under 42 C.F.R. Part 488, Subpart E. The inspection shall be made
11 without providing advance notice of it. Every inspection may include
12 an inspection of every part of the premises and an examination of all
13 records, methods of administration, the general and special dietary
14 and the stores and methods of supply. Those nursing homes that
15 provide community-based care shall establish and maintain separate
16 and distinct accounting and other essential records for the purpose
17 of appropriately allocating costs of the providing of such care:
18 PROVIDED, That such costs shall not be considered allowable costs for
19 reimbursement purposes under chapter 74.46 RCW. Following such
20 inspection or inspections, written notice of any violation of this
21 law or the rules and regulations promulgated hereunder, shall be

1 given to the applicant or licensee and the department. The notice
2 shall describe the reasons for the facility's noncompliance. The
3 department may prescribe by regulations that any licensee or
4 applicant desiring to make specified types of alterations or
5 additions to its facilities or to construct new facilities shall,
6 before commencing such alteration, addition or new construction,
7 submit its plans and specifications therefor to the department for
8 preliminary inspection and approval or recommendations with respect
9 to compliance with the regulations and standards herein authorized.

10 **Sec. 2.** RCW 18.51.230 and 1981 2nd ex.s. c 11 s 4 are each
11 amended to read as follows:

12 The department shall, in addition to any inspections conducted
13 pursuant to complaints filed pursuant to RCW 18.51.190, conduct (~~at~~
14 ~~least one general inspection prior to license renewal of all nursing~~
15 ~~homes in the state without providing advance notice of such~~
16 ~~inspection. Periodically, such inspection shall take place in part~~
17 ~~between the hours of 7 p.m. and 5 a.m. or on weekends)) a periodic
18 general inspection of each nursing home in the state without
19 providing advance notice of such inspection. Such inspections must
20 conform to the federal standards for surveys under 42 C.F.R. Part
21 488, Subpart E.~~

22 **Sec. 3.** RCW 74.42.360 and 2019 c 12 s 2 are each amended to read
23 as follows:

24 (1) The facility shall have staff on duty twenty-four hours daily
25 sufficient in number and qualifications to carry out the provisions
26 of RCW 74.42.010 through 74.42.570 and the policies,
27 responsibilities, and programs of the facility.

28 (2) The department shall institute minimum staffing standards for
29 nursing homes. Beginning July 1, 2016, facilities must provide a
30 minimum of 3.4 hours per resident day of direct care. Direct care
31 staff has the same meaning as defined in RCW 74.42.010. The minimum
32 staffing standard includes the time when such staff are providing
33 hands-on care related to activities of daily living and nursing-
34 related tasks, as well as care planning. The legislature intends to
35 increase the minimum staffing standard to 4.1 hours per resident day
36 of direct care, but the effective date of a standard higher than 3.4
37 hours per resident day of direct care will be identified if and only

1 if funding is provided explicitly for an increase of the minimum
2 staffing standard for direct care.

3 (a) The department shall establish in rule a system of compliance
4 of minimum direct care staffing standards by January 1, 2016.
5 Oversight must be done at least quarterly using the center for
6 medicare and medicaid service's payroll-based journal and nursing
7 home facility census and payroll data.

8 (b) The department shall establish in rule by January 1, 2016, a
9 system of financial penalties for facilities out of compliance with
10 minimum staffing standards. No monetary penalty may be issued during
11 the implementation period of July 1, 2016, through September 30,
12 2016. If a facility is found noncompliant during the implementation
13 period, the department shall provide a written notice identifying the
14 staffing deficiency and require the facility to provide a
15 sufficiently detailed correction plan to meet the statutory minimum
16 staffing levels. Monetary penalties begin October 1, 2016. Monetary
17 penalties must be established based on a formula that calculates the
18 cost of wages and benefits for the missing staff hours. If a facility
19 meets the requirements in subsection (3) or (4) of this section, the
20 penalty amount must be based solely on the wages and benefits of
21 certified nurse aides. The first monetary penalty for noncompliance
22 must be at a lower amount than subsequent findings of noncompliance.
23 Monetary penalties established by the department may not exceed two
24 hundred percent of the wage and benefit costs that would have
25 otherwise been expended to achieve the required staffing minimum
26 hours per resident day for the quarter. A facility found out of
27 compliance must be assessed a monetary penalty at the lowest penalty
28 level if the facility has met or exceeded the requirements in
29 subsection (2) of this section for three or more consecutive years.
30 Beginning July 1, 2016, pursuant to rules established by the
31 department, funds that are received from financial penalties must be
32 used for technical assistance, specialized training, or an increase
33 to the quality enhancement established in RCW 74.46.561.

34 (c) The department shall establish in rule an exception allowing
35 geriatric behavioral health workers as defined in RCW 74.42.010 to be
36 recognized in the minimum staffing requirements as part of the direct
37 care service delivery to individuals who have a behavioral health
38 condition. Hours worked by geriatric behavioral health workers may be
39 recognized as direct care hours for purposes of the minimum staffing
40 requirements only up to a portion of the total hours equal to the

1 proportion of resident days of clients with a behavioral health
2 condition identified at that facility on the most recent semiannual
3 minimum data set. In order to qualify for the exception:

4 (i) The worker must:

5 (A) Have a bachelor's or master's degree in social work,
6 behavioral health, or other related areas; or

7 (B) Have at least three years experience providing care for
8 individuals with chronic mental health issues, dementia, or
9 intellectual and developmental disabilities in a long-term care or
10 behavioral health care setting; or

11 (C) Have successfully completed a facility-based behavioral
12 health curriculum approved by the department under RCW 74.39A.078;

13 (ii) Any geriatric behavioral health worker holding less than a
14 master's degree in social work must be directly supervised by an
15 employee who has a master's degree in social work or a registered
16 nurse.

17 (d) (i) The department shall establish a limited exception to the
18 3.4 hours per resident day staffing requirement for facilities
19 demonstrating a good faith effort to hire and retain staff.

20 (ii) To determine initial facility eligibility for exception
21 consideration, the department shall send surveys to facilities
22 anticipated to be below, at, or slightly above the 3.4 hours per
23 resident day requirement. These surveys must measure the hours per
24 resident day in a manner as similar as possible to the centers for
25 medicare and medicaid services' payroll-based journal and cover the
26 staffing of a facility from October through December of 2015, January
27 through March of 2016, and April through June of 2016. A facility
28 must be below the 3.4 staffing standard on all three surveys to be
29 eligible for exception consideration. If the staffing hours per
30 resident day for a facility declines from any quarter to another
31 during the survey period, the facility must provide sufficient
32 information to the department to allow the department to determine if
33 the staffing decrease was deliberate or a result of neglect, which is
34 the lack of evidence demonstrating the facility's efforts to maintain
35 or improve its staffing ratio. The burden of proof is on the facility
36 and the determination of whether or not the decrease was deliberate
37 or due to neglect is entirely at the discretion of the department. If
38 the department determines a facility's decline was deliberate or due
39 to neglect, that facility is not eligible for an exception
40 consideration.

1 (iii) To determine eligibility for exception approval, the
2 department shall review the plan of correction submitted by the
3 facility. Before a facility's exception may be renewed, the
4 department must determine that sufficient progress is being made
5 towards reaching the 3.4 hours per resident day staffing requirement.
6 When reviewing whether to grant or renew an exception, the department
7 must consider factors including but not limited to: Financial
8 incentives offered by the facilities such as recruitment bonuses and
9 other incentives; the robustness of the recruitment process; county
10 employment data; specific steps the facility has undertaken to
11 improve retention; improvements in the staffing ratio compared to the
12 baseline established in the surveys and whether this trend is
13 continuing; and compliance with the process of submitting staffing
14 data, adherence to the plan of correction, and any progress toward
15 meeting this plan, as determined by the department.

16 (iv) Only facilities that have their direct care component rate
17 increase capped according to RCW 74.46.561 are eligible for exception
18 consideration. Facilities that will have their direct care component
19 rate increase capped for one or two years are eligible for exception
20 consideration through June 30, 2017. Facilities that will have their
21 direct care component rate increase capped for three years are
22 eligible for exception consideration through June 30, 2018.

23 (v) The department may not grant or renew a facility's exception
24 if the facility meets the 3.4 hours per resident day staffing
25 requirement and subsequently drops below the 3.4 hours per resident
26 day staffing requirement.

27 (vi) The department may grant exceptions for a six-month period
28 per exception. The department's authority to grant exceptions to the
29 3.4 hours per resident day staffing requirement expires June 30,
30 2018.

31 (3) (a) Large nonessential community providers must have a
32 registered nurse on duty directly supervising resident care twenty-
33 four hours per day, seven days per week.

34 (b) (i) The department shall establish a limited exception process
35 ((to facilities)) for large nonessential community providers that can
36 demonstrate a good faith effort to hire a registered nurse for the
37 last eight hours of required coverage per day. In granting an
38 exception, the department may consider the competitiveness of the
39 wages and benefits offered as compared to nursing facilities in
40 comparable geographic or metropolitan areas within Washington state,

1 the provider's recruitment and retention efforts, and the
2 availability of registered nurses in the particular geographic area.
3 A one-year exception may be granted and may be renewable (~~for up to~~
4 ~~three consecutive years~~); however, the department may limit the
5 admission of new residents, based on medical conditions or
6 complexities, when a registered nurse is not on-site and readily
7 available. If a (~~facility~~) large nonessential community provider
8 receives an (~~exemption~~) exception, that information must be
9 included in the department's nursing home locator. (~~After June 30,~~
10 ~~2019~~)

11 (ii) No later than August 1, 2023, and every three years
12 thereafter, the department, along with a stakeholder work group
13 established by the department, shall conduct a review of the
14 exceptions process to determine if it is still necessary. As part of
15 this review, the department shall provide the legislature with a
16 report that includes enforcement and citation data for large
17 nonessential community providers that were granted an exception in
18 the three previous fiscal years in comparison to those without an
19 exception. The report must include a similar comparison of data,
20 provided to the department by the long-term care ombuds, on long-term
21 care ombuds referrals for large nonessential community providers that
22 were granted an exception in the three previous fiscal years and
23 those without an exception. This report, along with a recommendation
24 as to whether the exceptions process should continue, is due to the
25 legislature on December 1st of each year in which a review is
26 conducted. Based on the recommendations outlined in this report, the
27 legislature may take action to end the exceptions process.

28 (4) Essential community providers and small nonessential
29 community providers must have a registered nurse on duty directly
30 supervising resident care a minimum of sixteen hours per day, seven
31 days per week, and a registered nurse or a licensed practical nurse
32 on duty directly supervising resident care the remaining eight hours
33 per day, seven days per week.

34 (5) For the purposes of this section, "behavioral health
35 condition" means one or more of the behavioral symptoms specified in
36 section E of the minimum data set.

37 **Sec. 4.** RCW 74.46.561 and 2019 c 301 s 1 are each amended to
38 read as follows:

1 (1) The legislature adopts a new system for establishing nursing
2 home payment rates beginning July 1, 2016. Any payments to nursing
3 homes for services provided after June 30, 2016, must be based on the
4 new system. The new system must be designed in such a manner as to
5 decrease administrative complexity associated with the payment
6 methodology, reward nursing homes providing care for high acuity
7 residents, incentivize quality care for residents of nursing homes,
8 and establish minimum staffing standards for direct care.

9 (2) The new system must be based primarily on industry-wide
10 costs, and have three main components: Direct care, indirect care,
11 and capital.

12 (3) The direct care component must include the direct care and
13 therapy care components of the previous system, along with food,
14 laundry, and dietary services. Direct care must be paid at a fixed
15 rate, based on one hundred percent or greater of statewide case mix
16 neutral median costs, but shall be set so that a nursing home
17 provider's direct care rate does not exceed one hundred eighteen
18 percent of its base year's direct care allowable costs except if the
19 provider is below the minimum staffing standard established in RCW
20 74.42.360(2). Direct care must be performance-adjusted for acuity
21 every six months, using case mix principles. Direct care must be
22 regionally adjusted using county wide wage index information
23 available through the United States department of labor's bureau of
24 labor statistics. There is no minimum occupancy for direct care. The
25 direct care component rate allocations calculated in accordance with
26 this section must be adjusted to the extent necessary to comply with
27 RCW 74.46.421.

28 (4) The indirect care component must include the elements of
29 administrative expenses, maintenance costs, and housekeeping services
30 from the previous system. A minimum occupancy assumption of ninety
31 percent must be applied to indirect care. Indirect care must be paid
32 at a fixed rate, based on ninety percent or greater of statewide
33 median costs. The indirect care component rate allocations calculated
34 in accordance with this section must be adjusted to the extent
35 necessary to comply with RCW 74.46.421.

36 (5) The capital component must use a fair market rental system to
37 set a price per bed. The capital component must be adjusted for the
38 age of the facility, and must use a minimum occupancy assumption of
39 ninety percent.

1 (a) Beginning July 1, 2016, the fair rental rate allocation for
2 each facility must be determined by multiplying the allowable nursing
3 home square footage in (c) of this subsection by the RSMeans rental
4 rate in (d) of this subsection and by the number of licensed beds
5 yielding the gross unadjusted building value. An equipment allowance
6 of ten percent must be added to the unadjusted building value. The
7 sum of the unadjusted building value and equipment allowance must
8 then be reduced by the average age of the facility as determined by
9 (e) of this subsection using a depreciation rate of one and one-half
10 percent. The depreciated building and equipment plus land valued at
11 ten percent of the gross unadjusted building value before
12 depreciation must then be multiplied by the rental rate at seven and
13 one-half percent to yield an allowable fair rental value for the
14 land, building, and equipment.

15 (b) The fair rental value determined in (a) of this subsection
16 must be divided by the greater of the actual total facility census
17 from the prior full calendar year or imputed census based on the
18 number of licensed beds at ninety percent occupancy.

19 (c) For the rate year beginning July 1, 2016, all facilities must
20 be reimbursed using four hundred square feet. For the rate year
21 beginning July 1, 2017, allowable nursing facility square footage
22 must be determined using the total nursing facility square footage as
23 reported on the medicaid cost reports submitted to the department in
24 compliance with this chapter. The maximum allowable square feet per
25 bed may not exceed four hundred fifty.

26 (d) Each facility must be paid at eighty-three percent or greater
27 of the median nursing facility RSMeans construction index value per
28 square foot. The department may use updated RSMeans construction
29 index information when more recent square footage data becomes
30 available. The statewide value per square foot must be indexed based
31 on facility zip code by multiplying the statewide value per square
32 foot times the appropriate zip code based index. For the purpose of
33 implementing this section, the value per square foot effective July
34 1, 2016, must be set so that the weighted average fair rental value
35 rate is not less than ten dollars and eighty cents per patient day.
36 The capital component rate allocations calculated in accordance with
37 this section must be adjusted to the extent necessary to comply with
38 RCW 74.46.421.

39 (e) The average age is the actual facility age reduced for
40 significant renovations. Significant renovations are defined as those

1 renovations that exceed two thousand dollars per bed in a calendar
2 year as reported on the annual cost report submitted in accordance
3 with this chapter. For the rate beginning July 1, 2016, the
4 department shall use renovation data back to 1994 as submitted on
5 facility cost reports. Beginning July 1, 2016, facility ages must be
6 reduced in future years if the value of the renovation completed in
7 any year exceeds two thousand dollars times the number of licensed
8 beds. The cost of the renovation must be divided by the accumulated
9 depreciation per bed in the year of the renovation to determine the
10 equivalent number of new replacement beds. The new age for the
11 facility is a weighted average with the replacement bed equivalents
12 reflecting an age of zero and the existing licensed beds, minus the
13 new bed equivalents, reflecting their age in the year of the
14 renovation. At no time may the depreciated age be less than zero or
15 greater than forty-four years.

16 (f) A nursing facility's capital component rate allocation must
17 be rebased annually, effective July 1, 2016, in accordance with this
18 section and this chapter.

19 (g) For the purposes of this subsection (5), "RSMeans" means
20 building construction costs data as published by Gordian.

21 (6) A quality incentive must be offered as a rate enhancement
22 beginning July 1, 2016.

23 (a) An enhancement no larger than five percent and no less than
24 one percent of the statewide average daily rate must be paid to
25 facilities that meet or exceed the standard established for the
26 quality incentive. All providers must have the opportunity to earn
27 the full quality incentive payment.

28 (b) The quality incentive component must be determined by
29 calculating an overall facility quality score composed of four to six
30 quality measures. For fiscal year 2017 there shall be four quality
31 measures, and for fiscal year 2018 there shall be six quality
32 measures. Initially, the quality incentive component must be based on
33 minimum data set quality measures for the percentage of long-stay
34 residents who self-report moderate to severe pain, the percentage of
35 high-risk long-stay residents with pressure ulcers, the percentage of
36 long-stay residents experiencing one or more falls with major injury,
37 and the percentage of long-stay residents with a urinary tract
38 infection. Quality measures must be reviewed on an annual basis by a
39 stakeholder work group established by the department. Upon review,

1 quality measures may be added or changed. The department may risk
2 adjust individual quality measures as it deems appropriate.

3 (c) The facility quality score must be point based, using at a
4 minimum the facility's most recent available three-quarter average
5 centers for medicare and medicaid services quality data. Point
6 thresholds for each quality measure must be established using the
7 corresponding statistical values for the quality measure point
8 determinants of eighty quality measure points, sixty quality measure
9 points, forty quality measure points, and twenty quality measure
10 points, identified in the most recent available five-star quality
11 rating system technical user's guide published by the center for
12 medicare and medicaid services.

13 (d) Facilities meeting or exceeding the highest performance
14 threshold (top level) for a quality measure receive twenty-five
15 points. Facilities meeting the second highest performance threshold
16 receive twenty points. Facilities meeting the third level of
17 performance threshold receive fifteen points. Facilities in the
18 bottom performance threshold level receive no points. Points from all
19 quality measures must then be summed into a single aggregate quality
20 score for each facility.

21 (e) Facilities receiving an aggregate quality score of eighty
22 percent of the overall available total score or higher must be placed
23 in the highest tier (tier V), facilities receiving an aggregate score
24 of between seventy and seventy-nine percent of the overall available
25 total score must be placed in the second highest tier (tier IV),
26 facilities receiving an aggregate score of between sixty and sixty-
27 nine percent of the overall available total score must be placed in
28 the third highest tier (tier III), facilities receiving an aggregate
29 score of between fifty and fifty-nine percent of the overall
30 available total score must be placed in the fourth highest tier (tier
31 II), and facilities receiving less than fifty percent of the overall
32 available total score must be placed in the lowest tier (tier I).

33 (f) The tier system must be used to determine the amount of each
34 facility's per patient day quality incentive component. The per
35 patient day quality incentive component for tier IV is seventy-five
36 percent of the per patient day quality incentive component for tier
37 V, the per patient day quality incentive component for tier III is
38 fifty percent of the per patient day quality incentive component for
39 tier V, and the per patient day quality incentive component for tier
40 II is twenty-five percent of the per patient day quality incentive

1 component for tier V. Facilities in tier I receive no quality
2 incentive component.

3 (g) Tier system payments must be set in a manner that ensures
4 that the entire biennial appropriation for the quality incentive
5 program is allocated.

6 (h) Facilities with insufficient three-quarter average centers
7 for medicare and medicaid services quality data must be assigned to
8 the tier corresponding to their five-star quality rating. Facilities
9 with a five-star quality rating must be assigned to the highest tier
10 (tier V) and facilities with a one-star quality rating must be
11 assigned to the lowest tier (tier I). The use of a facility's five-
12 star quality rating shall only occur in the case of insufficient
13 centers for medicare and medicaid services minimum data set
14 information.

15 (i) The quality incentive rates must be adjusted semiannually on
16 July 1 and January 1 of each year using, at a minimum, the most
17 recent available three-quarter average centers for medicare and
18 medicaid services quality data.

19 (j) Beginning July 1, 2017, the percentage of short-stay
20 residents who newly received an antipsychotic medication must be
21 added as a quality measure. The department must determine the quality
22 incentive thresholds for this quality measure in a manner consistent
23 with those outlined in (b) through (h) of this subsection using the
24 centers for medicare and medicaid services quality data.

25 (k) Beginning July 1, 2017, the percentage of direct care staff
26 turnover must be added as a quality measure using the centers for
27 medicare and medicaid services' payroll-based journal and nursing
28 home facility payroll data. Turnover is defined as an employee
29 departure. The department must determine the quality incentive
30 thresholds for this quality measure using data from the centers for
31 medicare and medicaid services' payroll-based journal, unless such
32 data is not available, in which case the department shall use direct
33 care staffing turnover data from the most recent medicaid cost
34 report.

35 (7) Reimbursement of the safety net assessment imposed by chapter
36 74.48 RCW and paid in relation to medicaid residents must be
37 continued.

38 (8) (a) The direct care and indirect care components must be
39 rebased (~~(in even-numbered years)~~) every year, beginning with rates
40 paid on July 1, (~~(2016)~~) 2020. (~~(Rates paid on July 1, 2016, must be~~

1 ~~based on the 2014 calendar year cost report. On a percentage basis,~~
2 ~~after rebasing, the department must confirm that the statewide~~
3 ~~average daily rate has increased at least as much as the average rate~~
4 ~~of inflation, as determined by the skilled nursing facility market~~
5 ~~basket index published by the centers for medicare and medicaid~~
6 ~~services, or a comparable index. If after rebasing, the percentage~~
7 ~~increase to the statewide average daily rate is less than the average~~
8 ~~rate of inflation for the same time period, the department is~~
9 ~~authorized to increase rates by the difference between the percentage~~
10 ~~increase after rebasing and the average rate of inflation.)) For~~
11 ~~fiscal year 2021, the calendar year costs must be adjusted by a~~
12 ~~twenty-four month consumer price index, based on the most recently~~
13 ~~available monthly index for all urban consumers, as published by the~~
14 ~~bureau of labor statistics. Rates paid on July 1, 2020, must be based~~
15 ~~on costs from calendar year 2018.~~

16 (b) In order to determine the necessity of regular inflationary
17 adjustments to the nursing facility rates, the department shall
18 provide the legislature with a report that provides a review of rates
19 paid in 2017, 2018, and 2019 in comparison to the incurred costs
20 reported by nursing facilities. This report is due to appropriate
21 committees of the legislature on December 1, 2020.

22 (9) The direct care component provided in subsection (3) of this
23 section is subject to the reconciliation and settlement process
24 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
25 rules established by the department, funds that are received through
26 the reconciliation and settlement process provided in RCW
27 74.46.022(6) must be used for technical assistance, specialized
28 training, or an increase to the quality enhancement established in
29 subsection (6) of this section. The legislature intends to review the
30 utility of maintaining the reconciliation and settlement process
31 under a price-based payment methodology, and may discontinue the
32 reconciliation and settlement process after the 2017-2019 fiscal
33 biennium.

34 (10) Compared to the rate in effect June 30, 2016, including all
35 cost components and rate add-ons, no facility may receive a rate
36 reduction of more than one percent on July 1, 2016, more than two
37 percent on July 1, 2017, or more than five percent on July 1, 2018.
38 To ensure that the appropriation for nursing homes remains cost

1 neutral, the department is authorized to cap the rate increase for
2 facilities in fiscal years 2017, 2018, and 2019.

--- **END** ---