ENGROSSED SECOND SUBSTITUTE SENATE BILL 6515

State of Washington 66th Legislature 2020 Regular Session

By Senate Ways & Means (originally sponsored by Senators Van De Wege, Randall, Mullet, Takko, Lovelett, Liias, Conway, Hasegawa, and Wilson, C.)

READ FIRST TIME 02/11/20.

AN ACT Relating to nursing facilities; amending RCW 18.51.091, 18.51.230, 74.42.360, and 74.46.561; adding a new section to chapter 74.46 RCW; creating a new section; and declaring an emergency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The worker must:

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) By August 1, 2023, and every three years thereafter, the department, along with a stakeholder work group established by the department, shall conduct a review of the exceptions process to determine if it is still necessary. As part of this review, the department shall provide the legislature with a report that includes enforcement and citation data for large nonessential community providers that were granted an exception in the three previous fiscal years in comparison to those without an exception. The report must include a similar comparison of data, provided to the department by the long-term care ombuds, on long-term care ombuds referrals for large nonessential community providers that were granted an exception in the three previous fiscal years and those without an exception. This report, along with a recommendation as to whether the exceptions process should continue, is due to the legislature by December 1st of each year in which a review is conducted. Based on the recommendations outlined in this report, the legislature may take action to end the exceptions process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Facilities receiving an aggregate quality score of eighty percent of the overall available total score or higher must be placed in the highest tier (tier V), facilities receiving an aggregate score of between seventy and seventy-nine percent of the overall available total score must be placed in the second highest tier (tier IV), facilities receiving an aggregate score of between sixty and sixty-nine percent of the overall available total score must be placed in the third highest tier (tier III), facilities receiving an aggregate score of between fifty and fifty-nine percent of the overall available total score must be placed in the fourth highest tier (tier II), and facilities receiving less than fifty percent of the overall available total score must be placed in the lowest tier (tier I).

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

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

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

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

(i) 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 centers for medicare and medicaid services quality data.

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

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

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

(8)(a) The direct care and indirect care components must be rebased ((~~in even-numbered years, beginning with rates paid on July 1, 2016. Rates paid on July 1, 2016, must be based on the 2014~~

~~calendar year cost report. On a percentage basis, after rebasing, the department must confirm that the statewide average daily rate has increased at least as much as the average rate of inflation, as determined by the skilled nursing facility market basket index published by the centers for medicare and medicaid services, or a comparable index. If after rebasing, the percentage increase to the statewide average daily rate is less than the average rate of inflation for the same time period, the department is authorized to increase rates by the difference between the percentage increase after rebasing and the average rate of inflation~~)) effective May 1, 2020, or the month following the effective date of this section, whichever comes last, through June 30, 2020, using 2018 calendar year cost report information.

(b) Beginning July 1, 2020, the direct care and indirect care components must be rebased annually. Rates paid shall be established using the most recent adjusted cost report information available. The most recent adjusted cost report information shall be the base year costs.

(c) Beginning July 1, 2020, and annually through June 30, 2023, the department shall modify the direct and indirect care rebased components from the midpoint of the base year to the beginning of the rate year using the most recent calendar year twelve-month average consumer price index for all urban consumers (CPI-U) in the medical expenditure category of nursing homes and adult day services as published by the United States bureau of labor statistics.

(d) Beginning July 1, 2020, the indirect care inflationary rate increase from (c) of this subsection (8) shall be distributed according to the facility's number of outpatient emergency department visits per one thousand long-stay resident days using the centers for medicare and medicaid services' five-star quality rating data as the source of measurement.

(i) Facility performance must be evaluated on two metrics:

(A) Performance compared to national benchmarks determined as follows:

(I) A national score of one hundred thirty-five or greater equates to a performance percentage of one hundred twenty-five percent;

(II) A national score of one hundred five or one hundred twenty equates to a performance percentage of one hundred percent;

(III) A national score of seventy-five or ninety equates to a performance percentage of eighty percent;

(IV) A national score of sixty or below equates to a performance percentage of sixty percent; and

(B) Year-over-year improvement determined as follows:

(I) An improvement of up to nine percent over the previous year's score equates to an improvement percentage of sixty percent;

(II) An improvement of greater than nine percent and less than fifteen percent over the previous year's score equates to an improvement percentage of eighty percent; and

(III) An improvement of fifteen percent or greater over the previous year's score equates to an improvement percentage of one hundred percent.

(ii) Facilities must be placed in one of four tiers based on the average of the performance and improvement percentages. The rate increases must be distributed among the four tiers as follows:

(A) Tier one must include an average percentage that is greater than or equal to one hundred percent and qualifies for up to one hundred twenty-five percent of the available rate increase;

(B) Tier two must include an average percentage that is greater than or equal to ninety percent but less than one hundred percent and qualifies for up to one hundred percent of the available rate increase. Facilities with data deemed insufficient by the centers for medicare and medicaid services must be included in tier two;

(C) Tier three must include an average percentage that is greater than or equal to eighty but less than ninety percent and qualifies for up to eighty percent of the available rate increase; and

(D) Tier four must include an average percentage that is less than eighty percent and qualifies for up to sixty percent of the available rate increase.

(e) Any savings generated from (d) of this subsection (8) must be applied to the quality incentive identified in subsection (6) of this section.

(f) The department may adjust the outpatient emergency department visits performance measure in (d) of this subsection (8) to ensure budget neutrality.

(g) Beginning July 1, 2023, a facility specific rate add-on equal to the inflationary adjustment that the facility received for the direct care component in fiscal year 2023 shall be added to the rate.

(h) Beginning July 1, 2023, the funding provided for the inflationary adjustment for the indirect care component from (c) of this subsection (8) must be annually redistributed as specified in (d) of this subsection (8).

(i) The department shall review the calendar year cost reports from 2018 through 2021 and compare medicaid allowable costs in direct care and indirect care to rates paid to determine the impacts of annual inflationary adjustments. Based on its findings, the department shall make recommendations for ongoing inflation to the legislature. This report is due to appropriate committees of the legislature by December 1, 2022.

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

(10) Compared to the rate in effect June 30, 2016, including all cost components and rate add-ons, no facility may receive a rate reduction of more than one percent on July 1, 2016, more than two percent on July 1, 2017, or more than five percent on July 1, 2018. To ensure that the appropriation for nursing homes remains cost neutral, the department is authorized to cap the rate increase for facilities in fiscal years 2017, 2018, and 2019.

NEW SECTION. **Sec. 5.** A new section is added to chapter 74.46 RCW to read as follows:

The department, in consultation with the health care authority and stakeholders, shall review the impact of the distribution of the inflationary adjustment for the indirect care component and report its findings and recommendations to the appropriate committees of the legislature by December 1, 2021. To the extent practicable, the department's report must include a comparative analysis of the

following metrics before and after the effective date of this section:

(1) Skilled nursing facility residents' emergency department visits;

(2) Case mix acuity;

(3) The number of long-term services and supports medicaid clients that are being served in nursing homes; and

(4) The number of licensed nursing homes and the number of licensed beds.

NEW SECTION. **Sec. 6.** Any savings as a result of overappropriations associated with the rebase for fiscal year 2021 shall be utilized for the purposes of this act.

NEW SECTION. **Sec. 7.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

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