S-3173.1

SECOND SUBSTITUTE SENATE BILL 5152

State of Washington 64th Legislature 2015 1st Special Session

By Senate Ways & Means (originally sponsored by Senators Parlette, Keiser, and Becker)

READ FIRST TIME 05/01/15.

AN ACT Relating to implementing a value-based system for nursing home rates; amending RCW 74.46.431, 74.46.501, and 74.42.360; adding new sections to chapter 74.46 RCW; creating a new section; repealing RCW 74.46.431, 74.46.435, 74.46.506, 74.46.508, 74.46.511, 74.46.515, and 74.46.521; providing effective dates; providing an expiration date; and declaring an emergency.

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

Sec. 1. RCW 74.46.431 and 2013 2nd sp.s. c 3 s 1 are each amended to read as follows:

(1) Nursing facility medicaid payment rate allocations shall be facility-specific and shall have six components: Direct care, therapy care, support services, operations, property, and financing allowance. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) Component rate allocations in therapy care and support services for all facilities shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for essential community providers shall be based upon a minimum facility occupancy of eighty-

seven percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for small nonessential community providers shall be based upon a minimum facility occupancy of ninety-two percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for large nonessential community providers shall be based upon a minimum facility occupancy of ninety-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

(3) Information and data sources used in determining medicaid payment rate allocations, including formulas, procedures, cost report periods, resident assessment instrument formats, resident assessment methodologies, and resident classification and case mix weighting methodologies, may be substituted or altered from time to time as determined by the department.

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the direct care component rate allocation shall be rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the direct care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for

calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the therapy care component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the therapy care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Therapy care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the therapy care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be

applied solely or compounded to the therapy care component rate allocation established in accordance with this chapter.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the support services component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the support services component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Support services component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the support services component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the support services component rate allocation established in accordance with this chapter.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the operations component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the operations care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic

trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter.

(8) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(9) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: Inflation adjustments for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(10) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

(11) Effective July 1, 2010, there shall be no rate adjustment for facilities with banked beds. For purposes of calculating minimum occupancy, licensed beds include any beds banked under chapter 70.38 RCW.

(12) Facilities obtaining a certificate of need or a certificate of need exemption under chapter 70.38 RCW after June 30, 2001, must have a certificate of capital authorization in order for (a) the

depreciation resulting from the capitalized addition to be included in calculation of the facility's property component rate allocation; and (b) the net invested funds associated with the capitalized addition to be included in calculation of the facility's financing allowance rate allocation.

Sec. 2. RCW 74.46.501 and 2013 2nd sp.s. c 3 s 2 are each amended to read as follows:

(1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question based on the resident assessment instrument completed by the facility and the requirements and limitations for the instrument's completion and transmission (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

(b) The facility average case mix index shall exclude all default cases as defined in this chapter. However, the medicaid average case mix index shall include all default cases.

(3) Both the facility average and the medicaid average case mix indexes shall be determined by multiplying the case mix weight of each resident, or each medicaid resident, as applicable, by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification or group, and then averaging.

(4) In determining the number of days a resident is classified into a particular case mix group, the department shall determine a start date for calculating case mix grouping periods as specified by rule.

(5) The cutoff date for the department to use resident assessment data, for the purposes of calculating both the facility average and the medicaid average case mix indexes, and for establishing and updating a facility's direct care component rate, shall be one month and one day after the end of the quarter for which the resident assessment data applies.

(6)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the cost-rebasing period facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. To allow for the transition to minimum data set 3.0 and implementation of resource utilization group IV for July 1, ((~~2013~~)) 2015, through June 30, ((~~2015~~)) 2017, the department shall calculate rates using the medicaid average case mix scores effective for January 1, ((~~2013~~)) 2015, rates adjusted under RCW 74.46.485(1)(a), and the scores shall be increased each six months during the transition period by one-half of one percent. The July 1, ((~~2015~~)) 2017, direct care cost per case mix unit shall be calculated by utilizing ((~~2013~~)) 2015 direct care costs, patient days, and ((~~2013~~)) 2015 facility average case mix indexes based on the minimum data set 3.0 resource utilization group IV grouper 57. Otherwise, a facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in RCW 74.46.431.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate semiannually shall be from the calendar six-month period commencing nine months prior to the effective date of the semiannual rate. For example, July 1, 2010, through December 31, 2010, direct care component rates shall utilize case mix averages from the October 1, 2009, through March 31, 2010, calendar quarters, and so forth.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.46 RCW to read as follows:

(1) For fiscal year 2016 and subject to appropriation, the department shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2015, using the payment methodology defined in this chapter, to the facility-based rates in effect June 30, 2010. If the facility-based payment rate calculated

on July 1, 2015, is smaller than the facility-based payment rate on June 30, 2010, the difference must be provided to the individual nursing facilities as an add-on per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, for fiscal year 2016, if it is found that the direct care rate for any facility calculated under this chapter is greater than the direct care rate in effect on June 30, 2010, then the facility must receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than it has in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6).

NEW SECTION. **Sec. 4.** A new section is added to chapter 74.46 RCW 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 of facility-wide case mix neutral median costs. Direct care must be performance-adjusted for acuity every six months, using case mix principles. Direct care must be regionally adjusted for nonmetropolitan and metropolitan statistical areas. There is no minimum occupancy for direct care.

(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 of facility-wide median

costs. Indirect care must be regionally adjusted for nonmetropolitan and metropolitan statistical areas.

(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.

(6) A quality incentive must be offered as a rate enhancement beginning July 1, 2016. An enhancement no larger than five 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. The department must recommend four to six measures to become the standard for the quality incentive, and must describe a system for rewarding incremental improvement related to these four to six measures, within the report to the legislature described in section 6 of this act. Infection rates, pressure ulcers, staffing turnover, fall prevention, utilization of antipsychotic medication, and hospital readmission rates are examples of measures that may be established for the quality incentive.

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

(8) 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.

(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 shall adopt rules as are necessary and reasonable to effectuate and maintain the new system for establishing nursing home payment rates described in section 4 of this act and the minimum staffing standards described in RCW 74.42.360. The rules must be consistent with the principles described in section 4 of this act and RCW 74.42.360. In adopting such rules, the department shall solicit the opinions of nursing facility providers, nursing facility provider associations, nursing facility employees, and nursing facility consumer groups.

NEW SECTION. **Sec. 6.** (1) The department of social and health services shall facilitate a work group process to propose modifications to the price-based nursing facility payment methodology outlined in section 4 of this act and the minimum staffing standards outlined in RCW 74.42.360. The department shall keep a public record of comments submitted by stakeholders throughout the work group process. The work group shall consist of nursing facility provider associations, a representative from a not-for-profit hospital system that operates three or more nursing facilities and is not a member of either statewide nursing facility provider association, nursing facility employees, consumer groups, worker representatives, and the office of financial management. The department shall make its final recommendations to the appropriate legislative committees by January

2, 2016, and shall include a dissent report if agreement is not achieved among stakeholders and the department. The department shall include at least one meeting dedicated to review and analysis of other states with price-based methodologies and must include information on how well each state is achieving quality care outcomes and any specific quality metrics targeted for enhanced payments in comparison to the price-based rates paid to that state's nursing facilities.

(2) This section expires August 1, 2016.

Sec. 7. RCW 74.42.360 and 1979 ex.s. c 211 s 36 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 includes registered nurses, licensed practical nurses, and certified nursing assistants. 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 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. 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 section 4 of this act.

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

(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.

NEW SECTION. **Sec. 8.** A new section is added to chapter 74.46 RCW to read as follows:

A separate nursing facility quality enhancement account is created in the custody of the state treasurer. Beginning July 1, 2016, all receipts from the reconciliation and settlement process provided in RCW 74.46.022(6), as described within section 4 of this act, must be deposited into the account. Beginning July 1, 2016, all receipts from the system of financial penalties for facilities out of compliance with minimum staffing standards, as described within RCW 74.42.360, must be deposited into the account. Only the secretary, or the secretary's designee, may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. The department shall use the special account only for technical assistance for nursing facilities, specialized training for nursing facilities, or an increase to the quality enhancement established in section 4 of this act.

NEW SECTION. **Sec. 9.** The following acts or parts of acts, as now existing or hereafter amended are each repealed, effective June 30, 2017:

(1) RCW 74.46.431 (Nursing facility medicaid payment rate allocations—Components—Minimum wage—Rules) and 2015 1st sp.s. c . . . s 1 (section 1 of this act), 2013 2nd sp.s. c 3 s 1, 2011 1st sp.s. c 7 s 1, 2010 1st sp.s. c 34 s 3, 2009 c 570 s 1, 2008 c 263 s 2, 2007 c 508 s 2, 2006 c 258 s 2, 2005 c 518 s 944, 2004 c 276 s 913, 2001 1st sp.s. c 8 s 5, 1999 c 353 s 4, & 1998 c 322 s 19;

(2) RCW 74.46.435 (Property component rate allocation) and 2011 1st sp.s. c 7 s 2, 2010 1st sp.s. c 34 s 5, 2001 1st sp.s. c 8 s 7, 1999 c 353 s 10, & 1998 c 322 s 29;

(3) RCW 74.46.506 (Direct care component rate allocations—Determination—Quarterly updates—Fines) and 2011 1st sp.s. c 7 s 7, 2010 1st sp.s. c 34 s 12, 2007 c 508 s 3, 2006 c 258 s 6, & 2001 1st sp.s. c 8 s 10;

(4) RCW 74.46.508 (Direct care component rate allocation—Increases—Rules) and 2010 1st sp.s. c 34 s 13, 2003 1st sp.s. c 6 s 1, & 1999 c 181 s 2;

(5) RCW 74.46.511 (Therapy care component rate allocation—Determination) and 2010 1st sp.s. c 34 s 14, 2008 c 263 s 3, 2007 c 508 s 4, & 2001 1st sp.s. c 8 s 11;

(6) RCW 74.46.515 (Support services component rate allocation—Determination—Emergency situations) and 2011 1st sp.s. c 7 s 8, 2010 1st sp.s. c 34 s 15, 2008 c 263 s 4, 2001 1st sp.s. c 8 s 12, 1999 c 353 s 7, & 1998 c 322 s 27; and

(7) RCW 74.46.521 (Operations component rate allocation—Determination) and 2011 1st sp.s. c 7 s 9, 2010 1st sp.s. c 34 s 16, 2007 c 508 s 5, 2006 c 258 s 7, 2001 1st sp.s. c 8 s 13, 1999 c 353 s 8, & 1998 c 322 s 28.

NEW SECTION. **Sec. 10.** 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 July 1, 2015.

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