
SUBSTITUTE HOUSE BILL 1968

State of Washington 65th Legislature 2017 Regular Session

By House Appropriations (originally sponsored by Representatives Jinkins, Schmick, Tharinger, Harris, Bergquist, Vick, Pettigrew, and Holy)

READ FIRST TIME 02/24/17.

1 AN ACT Relating to limiting nursing home direct care payment
2 adjustments to the lowest case mix weights in the reduced physical
3 function groups and authorizing upward adjustments to case mix
4 weights in the cognitive and behavior groups; amending RCW 74.46.485
5 and 74.46.561; and creating a new section.

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

7 **Sec. 1.** RCW 74.46.485 and 2011 1st sp.s. c 7 s 4 are each
8 amended to read as follows:

9 (1) The legislature recognizes that staff and resources needed to
10 adequately care for individuals with cognitive or behavioral
11 impairments is not limited to support for activities of daily living.
12 Therefore, the department shall:

13 (a) Employ the resource utilization group (~~III~~) IV case mix
14 classification methodology. The department shall use the (~~forty-~~
15 ~~four~~) fifty-seven group index maximizing model for the resource
16 utilization group (~~III~~) IV grouper version (~~5-10~~) MDS 3.05, but
17 the department may revise or update the classification methodology to
18 reflect advances or refinements in resident assessment or
19 classification, subject to federal requirements. The department may
20 adjust by no more than thirteen percent the case mix index for (~~any~~
21 ~~of the lowest ten~~) resource utilization group categories beginning

1 with PA1 through (~~PE2~~) PB2 to any case mix index that aids in
2 achieving the purpose and intent of RCW 74.39A.007 and cost-efficient
3 care, excluding behaviors, and allowing for exceptions for limited
4 placement options; and

5 (b) Implement minimum data set 3.0 under the authority of this
6 section (~~and RCW 74.46.431(3)~~). The department must notify nursing
7 home contractors twenty-eight days in advance the date of
8 implementation of the minimum data set 3.0. In the notification, the
9 department must identify for all semiannual rate settings following
10 the date of minimum data set 3.0 implementation a previously
11 established semiannual case mix adjustment established for the
12 semiannual rate settings that will be used for semiannual case mix
13 calculations in direct care until minimum data set 3.0 is fully
14 implemented.

15 (2) The department is authorized to adjust upward the weights for
16 resource utilization groups BA1-BB2 related to cognitive or
17 behavioral health to ensure adequate access to appropriate levels of
18 care.

19 (3) A default case mix group shall be established for cases in
20 which the resident dies or is discharged for any purpose prior to
21 completion of the resident's initial assessment. The default case mix
22 group and case mix weight for these cases shall be designated by the
23 department.

24 (~~(3)~~) (4) A default case mix group may also be established for
25 cases in which there is an untimely assessment for the resident. The
26 default case mix group and case mix weight for these cases shall be
27 designated by the department.

28 **Sec. 2.** RCW 74.46.561 and 2016 c 131 s 1 are each amended to
29 read as follows:

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

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

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

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

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

32 (a) Beginning July 1, 2016, the fair rental rate allocation for
33 each facility must be determined by multiplying the allowable nursing
34 home square footage in (c) of this subsection by the RS means rental
35 rate in (d) of this subsection and by the number of licensed beds
36 yielding the gross unadjusted building value. An equipment allowance
37 of ten percent must be added to the unadjusted building value. The
38 sum of the unadjusted building value and equipment allowance must
39 then be reduced by the average age of the facility as determined by
40 (e) of this subsection using a depreciation rate of one and one-half

1 percent. The depreciated building and equipment plus land valued at
2 ten percent of the gross unadjusted building value before
3 depreciation must then be multiplied by the rental rate at seven and
4 one-half percent to yield an allowable fair rental value for the
5 land, building, and equipment.

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

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

17 (d) Each facility must be paid at eighty-three percent or greater
18 of the median nursing facility RS means construction index value per
19 square foot for Washington state. The department may use updated RS
20 means construction index information when more recent square footage
21 data becomes available. The statewide value per square foot must be
22 indexed based on facility zip code by multiplying the statewide value
23 per square foot times the appropriate zip code based index. For the
24 purpose of implementing this section, the value per square foot
25 effective July 1, 2016, must be set so that the weighted average FRV
26 [fair rental value] rate is not less than ten dollars and eighty
27 cents ppd [per patient day]. The capital component rate allocations
28 calculated in accordance with this section must be adjusted to the
29 extent necessary to comply with RCW 74.46.421.

30 (e) The average age is the actual facility age reduced for
31 significant renovations. Significant renovations are defined as those
32 renovations that exceed two thousand dollars per bed in a calendar
33 year as reported on the annual cost report submitted in accordance
34 with this chapter. For the rate beginning July 1, 2016, the
35 department shall use renovation data back to 1994 as submitted on
36 facility cost reports. Beginning July 1, 2016, facility ages must be
37 reduced in future years if the value of the renovation completed in
38 any year exceeds two thousand dollars times the number of licensed
39 beds. The cost of the renovation must be divided by the accumulated
40 depreciation per bed in the year of the renovation to determine the

1 equivalent number of new replacement beds. The new age for the
2 facility is a weighted average with the replacement bed equivalents
3 reflecting an age of zero and the existing licensed beds, minus the
4 new bed equivalents, reflecting their age in the year of the
5 renovation. At no time may the depreciated age be less than zero or
6 greater than forty-four years.

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

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

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

17 (b) The quality incentive component must be determined by
18 calculating an overall facility quality score composed of four to six
19 quality measures. For fiscal year 2017 there shall be four quality
20 measures, and for fiscal year 2018 there shall be six quality
21 measures. Initially, the quality incentive component must be based on
22 minimum data set quality measures for the percentage of long-stay
23 residents who self-report moderate to severe pain, the percentage of
24 high-risk long-stay residents with pressure ulcers, the percentage of
25 long-stay residents experiencing one or more falls with major injury,
26 and the percentage of long-stay residents with a urinary tract
27 infection. Quality measures must be reviewed on an annual basis by a
28 stakeholder work group established by the department. Upon review,
29 quality measures may be added or changed. The department may risk
30 adjust individual quality measures as it deems appropriate.

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

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

9 (e) Facilities receiving an aggregate quality score of eighty
10 percent of the overall available total score or higher must be placed
11 in the highest tier (tier V), facilities receiving an aggregate score
12 of between seventy and seventy-nine percent of the overall available
13 total score must be placed in the second highest tier (tier IV),
14 facilities receiving an aggregate score of between sixty and sixty-
15 nine percent of the overall available total score must be placed in
16 the third highest tier (tier III), facilities receiving an aggregate
17 score of between fifty and fifty-nine percent of the overall
18 available total score must be placed in the fourth highest tier (tier
19 II), and facilities receiving less than fifty percent of the overall
20 available total score must be placed in the lowest tier (tier I).

21 (f) The tier system must be used to determine the amount of each
22 facility's per patient day quality incentive component. The per
23 patient day quality incentive component for tier IV is seventy-five
24 percent of the per patient day quality incentive component for tier
25 V, the per patient day quality incentive component for tier III is
26 fifty percent of the per patient day quality incentive component for
27 tier V, and the per patient day quality incentive component for tier
28 II is twenty-five percent of the per patient day quality incentive
29 component for tier V. Facilities in tier I receive no quality
30 incentive component.

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

34 (h) Facilities with insufficient three-quarter average CMS
35 [centers for medicare and medicaid services] quality data must be
36 assigned to the tier corresponding to their five-star quality rating.
37 Facilities with a five-star quality rating must be assigned to the
38 highest tier (tier V) and facilities with a one-star quality rating
39 must be assigned to the lowest tier (tier I). The use of a facility's
40 five-star quality rating shall only occur in the case of insufficient

1 CMS [centers for medicare and medicaid services] minimum data set
2 information.

3 (i) The quality incentive rates must be adjusted semiannually on
4 July 1 and January 1 of each year using, at a minimum, the most
5 recent available three-quarter average CMS [centers for medicare and
6 medicaid services] quality data.

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

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

23 (7) Reimbursement of the safety net assessment imposed by chapter
24 74.48 RCW and paid in relation to medicaid residents must be
25 continued.

26 (8) The direct care and indirect care components must be rebased
27 in even-numbered years, beginning with rates paid on July 1, 2016.
28 Rates paid on July 1, 2016, must be based on the 2014 calendar year
29 cost report. On a percentage basis, after rebasing, the department
30 must confirm that the statewide average daily rate has increased at
31 least as much as the average rate of inflation, as determined by the
32 skilled nursing facility market basket index published by the centers
33 for medicare and medicaid services, or a comparable index. If after
34 rebasing, the percentage increase to the statewide average daily rate
35 is less than the average rate of inflation for the same time period,
36 the department is authorized to increase rates by the difference
37 between the percentage increase after rebasing and the average rate
38 of inflation.

39 (9) The direct care component provided in subsection (3) of this
40 section is subject to the reconciliation and settlement process

1 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
2 rules established by the department, funds that are received through
3 the reconciliation and settlement process provided in RCW
4 74.46.022(6) must be used for technical assistance, specialized
5 training, or an increase to the quality enhancement established in
6 subsection (6) of this section. The legislature intends to review the
7 utility of maintaining the reconciliation and settlement process
8 under a price-based payment methodology, and may discontinue the
9 reconciliation and settlement process after the 2017-2019 fiscal
10 biennium.

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

18 NEW SECTION. **Sec. 3.** If specific funding for the purposes of
19 this act, referencing this act by bill or chapter number, is not
20 provided by June 30, 2017, in the omnibus appropriations act, this
21 act is null and void.

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