1109-S AMH STOK LUCE 285

SHB 1109 - H AMD **481**
By Representative Stokesbary

ADOPTED 03/29/2019

On page 60, line 33, increase the general fund-state appropriation for fiscal year 2020 by $13,201,000

On page 60, line 34, increase the general fund-state appropriation for fiscal year 2021 by $31,533,000

On page 60, line 35, increase the general fund-federal appropriation by $44,316,000

On page 61, line 1, correct the total.

On page 63, line 30, after "(l)" strike "$20,243,000" and insert "$32,762,000"

On page 63, line 31, after "fiscal year 2020," strike "$41,933,000" and insert "$72,617,000"

On page 63, line 32, after "fiscal year 2021, and" strike "$60,976,000" and insert "$103,344,000"

On page 63, beginning on line 37, after "include funding to increase" strike "the rate by 13.5 percent effective January 1, 2020" and insert "rates by 4.4 percent on July 1, 2019; 12.5 percent on January 1, 2020; and 10.0 percent on January 1, 2021"

On page 65, line 19, after "(s)" strike "$148,000" and insert "$831,000"

On page 65, line 20, after "year 2020," strike "$252,000" and insert "$1,101,000"

On page 65, line 21, after "fiscal year 2021, and" strike "$509,000" and insert "$2,458,000"

On page 67, line 24, increase the general fund-state appropriation for fiscal year 2020 by $36,280,000

On page 67, line 25, increase the general fund-state appropriation for fiscal year 2021 by $20,381,000

On page 67, line 26, increase the general fund-federal appropriation by $66,686,000

On page 67, line 35, correct the total.

On page 76, line 11, after "(28)" strike "$3,559,000" and insert "$19,932,000"

On page 76, line 12, after "fiscal year 2020," strike "$6,039,000" and insert "$26,420,000"

On page 76, line 13, after "for fiscal year 2021, and" strike "$12,216,000" and insert "$58,994,000"

On page 86, line 14, decrease the general fund-state appropriation for fiscal year 2020 by $32,030,000.

On page 86, line 15, decrease the general fund-state appropriation for fiscal year 2021 by $69,766,000.

On page 86, line 16, decrease the general fund-federal appropriation by $250,776,000.

On page 86, line 22, increase the medicaid fraud penalty account-state appropriation by $1,000,000.

On page 86, line 30, correct the total.

On page 98, after line 4, insert the following:

"(49) $918,000 of the general fund-state appropriation for fiscal year 2020, $838,000 of the general fund state appropriation for fiscal year 2021, $5,599,000 of the general fund-federal appropriation, and $1,000,000 of the medicaid fraud penalty account-state is provided solely to support the program integrity unit. This includes 10 additional staff and one-time information technology upgrades. The Authority must use the funding in this subsection to increase recoupments within managed care. The amounts in this section assume that the authority will recoup a similar percentage of total cost from managed care as is recouped in the fee-for-service program."

Renumber remaining sections consecutively and correct internal references.

Correct the title.

On page 362, after line 35, insert the following:

"Sec. 972. RCW 74.46.561 and 2017 c 286 s 2 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 RS means 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 RS means construction index value per square foot for Washington state. The department may use updated RS means 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 FRV [fair rental value] rate is not less than ten dollars and eighty cents ppd [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.

(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 CMS [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 (QM) point determinants of eighty QM points, sixty QM points, forty QM points, and twenty QM points, identified in the most recent available five-star quality rating system technical user's guide published by the center 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 CMS [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 CMS [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 CMS [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) The direct care and indirect care components must be rebased in even-numbered years, beginning with rates paid on July 1, 2016. In addition, rates paid beginning on July 1, 2019, must be rebased on the 2017 calendar year cost report. 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."

Renumber remaining sections consecutively and correct internal references.

Correct the title.

EFFECT: Replaces a 13.5 percent increase for supported living providers on January 1, 2020, with funding for the DSHS-Developmental Disabilities Administration (DDA) to increase rates for supported living providers by 4.4 percent July 1, 2019; by 12.2 percent on January 1, 2020; and by 10.0 percent on January 1, 2021. Maintains language that requires that funding be used to improve the recruitment and retention of quality direct care staff. Requires the DSHS Long-Term Care program to rebase Medicaid rates for nursing homes in FY 2020 using 2017 cost reports, in addition to rebasing rates in FY 2021 using 2018 cost reports as required under

current law. Increases the amount of funding provided for Assisted Living Facility Rates from 57 percent funding of the assisted living rate model to 75 percent funding of the assisted living rate model.

Provides funding for the Health Care Authority to hire 10 additional FTEs for the program integrity unit. Assumes net savings (total funds) of $352.5 Million will be achieved through increased recoupments in the managed care program.

FISCAL IMPACT:

Decreases General Fund-State by $401,000.
Decreases General Fund-Federal by $139,774,000.
Increases other funds by $1,000,000.

--- END ---