Z-0215.1

HOUSE BILL 1275

State of Washington 67th Legislature 2021 Regular Session

By Representatives Schmick, Macri, Shewmake, Eslick, Hackney, Chambers, Rule, Leavitt, Harris-Talley, and Stonier; by request of Department of Social and Health Services

Read first time 01/19/21. Referred to Committee on Appropriations.

AN ACT Relating to nursing facility medicaid rate rebasing, inflation, and case mix; and amending RCW 74.46.485, 74.46.501, and 74.46.561.

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

Sec. 1. RCW 74.46.485 and 2017 c 286 s 1 are each amended to read as follows:

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

(a) Employ the resource utilization group IV case mix classification methodology. The department shall use the fifty-seven group index maximizing model for the resource utilization group IV grouper version MDS 3.05, but the department may revise or update the ((~~classification~~)) methodology used to establish case mix classification to reflect advances or refinements in resident assessment or classification, ((~~subject to federal requirements~~)) as made available by the federal government. The department may adjust by no more than thirteen percent the case mix index for resource utilization group categories beginning with PA1 through PB2 to any case mix index that aids in achieving the purpose and intent of RCW

74.39A.007 and cost-efficient care, excluding behaviors, and allowing for exceptions for limited placement options; and

(b) Implement minimum data set 3.0 under the authority of this section. The department must notify nursing home contractors twenty-eight days in advance the date of implementation of the minimum data set 3.0. In the notification, the department must identify for all semiannual rate settings following the date of minimum data set 3.0 implementation a previously established semiannual case mix adjustment established for the semiannual rate settings that will be used for semiannual case mix calculations in direct care until minimum data set 3.0 is fully implemented.

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

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

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

Sec. 2. RCW 74.46.501 and 2016 c 131 s 5 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 74.46.561, 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, 2015, through June 30, 2016, the department shall calculate rates using the medicaid average case mix scores effective for January 1, 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, 2016, direct care cost per case mix unit shall be calculated by utilizing 2014 direct care costs, patient days, and 2014 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 74.46.561.~~

~~(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.~~)) The department shall establish a methodology to use the case mix to set the direct care component.

Sec. 3. RCW 74.46.561 and 2020 c 357 s 918 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 countywide 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 ((~~center[s]~~)) 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.

(b) ((~~It is the intention of the legislature that direct and indirect care rates paid in fiscal year 2022 will be rebased using the calendar year 2019 cost reports. For fiscal year 2021, in addition to the rates generated by (a) of this subsection, an additional adjustment is provided as established in this subsection (8)(b). Beginning May 1, 2020, and through June 30, 2021, the calendar year costs must be adjusted for inflation by a twenty-four month consumer price index, based on the most recently available monthly index for all urban consumers, as published by the bureau of labor statistics. It is also the intent of the legislature that, starting in fiscal year 2022, a facility-specific rate add-on equal to the inflation adjustment that facilities received solely in fiscal year 2021, must be added to the rate.~~

~~(c) To determine the necessity of regular inflationary adjustments to the nursing facility rates, by December 1, 2020, the department shall provide the appropriate policy and fiscal committees~~

~~of the legislature with a report that provides a review of rates paid in 2017, 2018, and 2019 in comparison to costs incurred by nursing facilities.~~)) Beginning in fiscal year 2022, direct and indirect care rates shall be rebased every year. For example, direct and indirect care rates paid in fiscal year 2022 shall be rebased using the calendar year 2019 cost reports. Beginning July 1, 2021, the calendar year costs must be adjusted annually on July 1st for inflation by a 24-month consumer price index, based on the most recently available monthly index at the time of rate calculation for all urban consumers, as published by the bureau of labor statistics.

(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.

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