SSB 5802 - H COMM AMD
By Committee on Appropriations

ADOPTED 03/01/2024

Strike everything after the enacting clause and insert the following:

"Sec. 1. RCW 74.46.020 and 2016 c 131 s 4 are each reenacted and amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Appraisal" means the process of estimating the fair market value or reconstructing the historical cost of an asset acquired in a past period as performed by a professionally designated real estate appraiser with no pecuniary interest in the property to be appraised. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

(2) "Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who are not related organizations and have adverse positions in the market place. Sales or exchanges of nursing home facilities among two or more parties in which all parties subsequently continue to own one or more of the facilities involved in the transactions shall not be considered as arm's-length transactions for purposes of this chapter. Sale of a nursing home facility which is subsequently leased back to the seller within five years of the date of sale shall not be considered as an arm's-length transaction for purposes of this chapter.

(3) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

(4) "Audit" or "department audit" means an examination of the records of a nursing facility participating in the medicaid payment system, including but not limited to: The contractor's financial and statistical records, cost reports and all supporting documentation and schedules, receivables, and resident trust funds, to be performed

as deemed necessary by the department and according to department rule.

(5) "Capital component" means a fair market rental system that sets a price per nursing facility bed.

(6) "Capitalization" means the recording of an expenditure as an asset.

(7) "Case mix" means a measure of the intensity of care and services needed by the residents of a nursing facility or a group of residents in the facility.

(8) "Case mix index" means a number representing the average case mix of a nursing facility.

(9) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility's residents.

(10) "Contractor" means a person or entity licensed under chapter 18.51 RCW to operate a medicare and medicaid certified nursing facility, responsible for operational decisions, and contracting with the department to provide services to medicaid recipients residing in the facility.

(11) "Default case" means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

(12) "Department" means the department of social and health services (DSHS) and its employees.

(13) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

(14) "Direct care component" means nursing care and related care provided to nursing facility residents and includes the therapy care component, along with food, laundry, and dietary services of the previous system.

(15) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct care of a nursing facility's residents.

(16) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

(17) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as

recognized and measured in conformity with generally accepted accounting principles.

(18) "Essential community provider" means a facility which is the only nursing facility within a commuting distance radius of at least forty minutes duration, traveling by automobile.

(19) "Facility" or "nursing facility" means a nursing home licensed in accordance with chapter 18.51 RCW, excepting nursing homes certified as institutions for mental diseases, or that portion of a multiservice facility licensed as a nursing home, or that portion of a hospital licensed in accordance with chapter 70.41 RCW which operates as a nursing home.

(20) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

(21) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

(22) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB) or its successor.

(23) "Grouper" means a computer software product that groups individual nursing facility residents into case mix classification groups based on specific resident assessment data and computer logic.

(24) "High labor-cost county" means an urban county in which the median allowable facility cost per case mix unit is more than ten percent higher than the median allowable facility cost per case mix unit among all other urban counties, excluding that county.

(25) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

(26) "Home and central office costs" means costs that are incurred in the support and operation of a home and central office. Home and central office costs include centralized services that are performed in support of a nursing facility. The department may exclude from this definition costs that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients.

(27) "Indirect care component" means the elements of administrative expenses, maintenance costs, taxes, and housekeeping services from the previous system.

(28) "Large nonessential community providers" means nonessential community providers with more than sixty licensed beds, regardless of how many beds are set up or in use.

(29) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

(30) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

(31) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

(32) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

(33) "Net book value" means the historical cost of an asset less accumulated depreciation.

(34) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles.

(35) "Nonurban county" means a county which is not located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

(36) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

(37) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

(38) "Patient-driven payment method" means a case mix system implemented by the centers for medicare and medicaid services to classify skilled nursing facility patients into payment groups based on specific data-driven patient characteristics.

(39) "Qualified therapist" means:

(a) A mental health professional as defined by chapter 71.05 RCW;

(b) An intellectual disabilities professional who is a therapist approved by the department who has had specialized training or one year's experience in treating or working with persons with intellectual or developmental disabilities;

(c) A speech pathologist who is eligible for a certificate of clinical competence in speech pathology or who has the equivalent education and clinical experience;

(d) A physical therapist as defined by chapter 18.74 RCW;

(e) An occupational therapist who is a graduate of a program in occupational therapy, or who has the equivalent of such education or training; and

(f) A respiratory care practitioner certified under chapter 18.89 RCW.

((~~(39)~~)) (40) "Quality enhancement component" means a rate enhancement offered to facilities that meet or exceed the standard established for the quality measures.

((~~(40)~~)) (41) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in ((~~part E of this chapter~~)) RCW 74.46.421 through 74.46.531.

((~~(41)~~)) (42) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(42)~~)) (43) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(43)~~)) (44) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(44)~~)) (45) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

((~~(45) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.~~))

(46) "Secretary" means the secretary of the department of social and health services.

(47) "Small nonessential community providers" means nonessential community providers with sixty or fewer licensed beds, regardless of how many beds are set up or in use.

(48) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

(49) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

(50) "Urban county" means a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government.

Sec. 2. RCW 74.46.485 and 2021 c 334 s 991 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 in the 2021-2023 biennium the department may revise or update the methodology used to establish case mix classifications to reflect advances or refinements in resident assessment or classification, 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.~~)) Beginning July 1, 2024, implement a method for applying case mix to the rate. This method should be informed by the minimum data set collected by the centers for medicare and medicaid services;

(b) Subject to the availability of amounts appropriated for this specific purpose, employ the case mix adjustment method to adjust rates of individual facilities for case mix changes;

(c) Upon the discontinuation of resource utilization group's scores, and in collaboration with appropriate stakeholders, create a new case mix adjustment method for adjusting direct care rates based on changes in case mix using the patient-driven payment method;

(d) By December 1, 2024, provide an initial report to the governor and appropriate legislative committees outlining a phased implementation plan; and

(e) By December 1, 2026, provide a final report to the appropriate legislative committees. These reports must include the following information:

(i) An analysis of the potential impact of the new case mix classification methodology on nursing facility payment rates;

(ii) Proposed payment adjustments for capturing specific client needs that may not be clearly captured in the data available from the centers for medicare and medicaid services; and

(iii) A plan to continuously monitor the effects of the new methodologies on each facility to ensure certain client populations or needs are not unintentionally negatively impacted.

(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)~~)) (3) 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. 3. RCW 74.46.496 and 2011 1st sp.s. c 7 s 5 are each amended to read as follows:

(1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter or six-month period during a calendar year shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) ((~~The case mix weights shall be based on the average minutes per registered nurse, licensed practical nurse, and certified nurse aide, for each case mix group, and using the United States department~~

~~of health and human services nursing facility staff time measurement study. Those minutes shall be weighted by statewide ratios of registered nurse to certified nurse aide, and licensed practical nurse to certified nurse aide, wages, including salaries and benefits, which shall be based on cost report data for this state.~~

~~(3) The case mix weights shall be determined as follows:~~

~~(a) Set the certified nurse aide wage weight at 1.000 and calculate wage weights for registered nurse and licensed practical nurse average wages by dividing the certified nurse aide average wage into the registered nurse average wage and licensed practical nurse average wage;~~

~~(b) Calculate the total weighted minutes for each case mix group in the resource utilization group classification system by multiplying the wage weight for each worker classification by the average number of minutes that classification of worker spends caring for a resident in that resource utilization group classification group, and summing the products;~~

~~(c) Assign the lowest case mix weight to the resource utilization group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.~~

~~(4) The case mix weights in this state may be revised if the United States department of health and human services updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.~~

~~(5) Case mix weights shall be revised when direct care component rates are cost-rebased as provided in RCW 74.46.431(4).~~)) The case mix weights shall be based on finalized case mix weights as published by the centers for medicare and medicaid services in the federal register.

Sec. 4. RCW 74.46.501 and 2021 c 334 s 992 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 cut-off 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~~)) A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually.

((~~(b) Except during the 2021-2023 fiscal biennium, 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) Except during the 2021-2023 fiscal biennium, 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.~~

~~(d) The department shall establish a methodology to use the case mix to set the direct care component [rate] in the 2021-2023 fiscal biennium.~~))"

Correct the title.

EFFECT: Allows for the department to adopt the Patient-Driven Payment Model (PDPM) for nursing facilities, subject to appropriation, for rate setting effective July 1, 2024. This model, based on individual patient characteristics, will replace the volume-driven system in place today. The PDPM will be used for classifying patients into payment groups and adjusting rates.

--- END ---