

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5802

68th Legislature
2024 Regular Session

Passed by the Senate March 5, 2024
Yeas 49 Nays 0

President of the Senate

Passed by the House March 1, 2024
Yeas 95 Nays 0

**Speaker of the House of
Representatives**

Approved

Governor of the State of Washington

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5802** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

SUBSTITUTE SENATE BILL 5802

AS AMENDED BY THE HOUSE

Passed Legislature - 2024 Regular Session

State of Washington 68th Legislature 2024 Regular Session

By Senate Ways & Means (originally sponsored by Senators Muzzall, Hasegawa, Lovelett, Nobles, Rivers, and Robinson; by request of Department of Social and Health Services)

READ FIRST TIME 02/05/24.

1 AN ACT Relating to providing flexibility in calculation of
2 nursing rates for the purposes of implementing new centers for
3 medicare and medicaid services data; amending RCW 74.46.485,
4 74.46.496, and 74.46.501; and reenacting and amending RCW 74.46.020.

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

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

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

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

17 (2) "Arm's-length transaction" means a transaction resulting from
18 good-faith bargaining between a buyer and seller who are not related
19 organizations and have adverse positions in the market place. Sales
20 or exchanges of nursing home facilities among two or more parties in
21 which all parties subsequently continue to own one or more of the

1 facilities involved in the transactions shall not be considered as
2 arm's-length transactions for purposes of this chapter. Sale of a
3 nursing home facility which is subsequently leased back to the seller
4 within five years of the date of sale shall not be considered as an
5 arm's-length transaction for purposes of this chapter.

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

9 (4) "Audit" or "department audit" means an examination of the
10 records of a nursing facility participating in the medicaid payment
11 system, including but not limited to: The contractor's financial and
12 statistical records, cost reports and all supporting documentation
13 and schedules, receivables, and resident trust funds, to be performed
14 as deemed necessary by the department and according to department
15 rule.

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

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

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

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

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

28 (10) "Contractor" means a person or entity licensed under chapter
29 18.51 RCW to operate a medicare and medicaid certified nursing
30 facility, responsible for operational decisions, and contracting with
31 the department to provide services to medicaid recipients residing in
32 the facility.

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

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

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

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

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

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

14 (17) "Equity" means the net book value of all tangible and
15 intangible assets less the recorded value of all liabilities, as
16 recognized and measured in conformity with generally accepted
17 accounting principles.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (39) "Qualified therapist" means:

- 34 (a) A mental health professional as defined by chapter 71.05 RCW;
35 (b) An intellectual disabilities professional who is a therapist
36 approved by the department who has had specialized training or one
37 year's experience in treating or working with persons with
38 intellectual or developmental disabilities;

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

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

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

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

10 ~~((39))~~ (40) "Quality enhancement component" means a rate
11 enhancement offered to facilities that meet or exceed the standard
12 established for the quality measures.

13 ~~((40))~~ (41) "Rate" or "rate allocation" means the medicaid per-
14 patient-day payment amount for medicaid patients calculated in
15 accordance with the allocation methodology set forth in ~~((part E of~~
16 ~~this chapter))~~ RCW 74.46.421 through 74.46.531.

17 ~~((41))~~ (42) "Rebased rate" or "cost-rebased rate" means a
18 facility-specific component rate assigned to a nursing facility for a
19 particular rate period established on desk-reviewed, adjusted costs
20 reported for that facility covering at least six months of a prior
21 calendar year designated as a year to be used for cost-rebasing
22 payment rate allocations under the provisions of this chapter.

23 ~~((42))~~ (43) "Records" means those data supporting all financial
24 statements and cost reports including, but not limited to, all
25 general and subsidiary ledgers, books of original entry, and
26 transaction documentation, however such data are maintained.

27 ~~((43))~~ (44) "Resident assessment instrument," including
28 federally approved modifications for use in this state, means a
29 federally mandated, comprehensive nursing facility resident care
30 planning and assessment tool, consisting of the minimum data set and
31 resident assessment protocols.

32 ~~((44))~~ (45) "Resident assessment protocols" means those
33 components of the resident assessment instrument that use the minimum
34 data set to trigger or flag a resident's potential problems and risk
35 areas.

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

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

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

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

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

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

16 **Sec. 2.** RCW 74.46.485 and 2021 c 334 s 991 are each amended to
17 read as follows:

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

22 (a) ~~((Employ the resource utilization group IV case mix~~
23 ~~classification methodology. The department shall use the fifty-seven~~
24 ~~group index maximizing model for the resource utilization group IV~~
25 ~~grouper version MDS 3.05, but in the 2021-2023 biennium the~~
26 ~~department may revise or update the methodology used to establish~~
27 ~~case mix classifications to reflect advances or refinements in~~
28 ~~resident assessment or classification, as made available by the~~
29 ~~federal government. The department may adjust by no more than~~
30 ~~thirteen percent the case mix index for resource utilization group~~
31 ~~categories beginning with PA1 through PB2 to any case mix index that~~
32 ~~aids in achieving the purpose and intent of RCW 74.39A.007 and cost-~~
33 ~~efficient care, excluding behaviors, and allowing for exceptions for~~
34 ~~limited placement options; and~~

35 ~~(b) Implement minimum data set 3.0 under the authority of this~~
36 ~~section. The department must notify nursing home contractors twenty-~~
37 ~~eight days in advance the date of implementation of the minimum data~~
38 ~~set 3.0. In the notification, the department must identify for all~~
39 ~~semiannual rate settings following the date of minimum data set 3.0~~

1 ~~implementation a previously established semiannual case mix~~
2 ~~adjustment established for the semiannual rate settings that will be~~
3 ~~used for semiannual case mix calculations in direct care until~~
4 ~~minimum data set 3.0 is fully implemented.)) Beginning July 1, 2024,
5 implement a method for applying case mix to the rate. This method
6 should be informed by the minimum data set collected by the centers
7 for medicare and medicaid services;~~

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

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

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

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

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

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

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

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

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

38 ~~((4))~~ (3) A default case mix group may also be established for
39 cases in which there is an untimely assessment for the resident. The

1 default case mix group and case mix weight for these cases shall be
2 designated by the department.

3 **Sec. 3.** RCW 74.46.496 and 2011 1st sp.s. c 7 s 5 are each
4 amended to read as follows:

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

12 ~~(2) ((The case mix weights shall be based on the average minutes
13 per registered nurse, licensed practical nurse, and certified nurse
14 aide, for each case mix group, and using the United States department
15 of health and human services nursing facility staff time measurement
16 study. Those minutes shall be weighted by statewide ratios of
17 registered nurse to certified nurse aide, and licensed practical
18 nurse to certified nurse aide, wages, including salaries and
19 benefits, which shall be based on cost report data for this state.~~

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

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

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

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

37 ~~(4) The case mix weights in this state may be revised if the
38 United States department of health and human services updates its
39 nursing facility staff time measurement studies. The case mix weights~~

1 shall be revised, but only when direct care component rates are cost-
2 rebased as provided in subsection (5) of this section, to be
3 effective on the July 1st effective date of each cost-rebased direct
4 care component rate. However, the department may revise case mix
5 weights more frequently if, and only if, significant variances in
6 wage ratios occur among direct care staff in the different caregiver
7 classifications identified in this section.

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

13 **Sec. 4.** RCW 74.46.501 and 2021 c 334 s 992 are each amended to
14 read as follows:

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

20 (2)(a) In calculating a facility's two average case mix indexes
21 for each quarter, the department shall include all residents or
22 medicaid residents, as applicable, who were physically in the
23 facility during the quarter in question based on the resident
24 assessment instrument completed by the facility and the requirements
25 and limitations for the instrument's completion and transmission
26 (January 1st through March 31st, April 1st through June 30th, July
27 1st through September 30th, or October 1st through December 31st).

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

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

37 (4) In determining the number of days a resident is classified
38 into a particular case mix group, the department shall determine a

1 start date for calculating case mix grouping periods as specified by
2 rule.

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

9 (6) ~~((a))~~ Although the facility average and the medicaid average
10 case mix indexes shall both be calculated quarterly, the cost-
11 rebasing period facility average case mix index will be used
12 throughout the applicable cost-rebasing period in combination with
13 cost report data as specified by RCW 74.46.561, to establish a
14 facility's allowable cost per case mix unit. ~~((To allow for the
15 transition to minimum data set 3.0 and implementation of resource
16 utilization group IV for July 1, 2015, through June 30, 2016, the
17 department shall calculate rates using the medicaid average case mix
18 scores effective for January 1, 2015, rates adjusted under RCW
19 74.46.485(1) (a), and the scores shall be increased each six months
20 during the transition period by one-half of one percent. The July 1,
21 2016, direct care cost per case mix unit shall be calculated by
22 utilizing 2014 direct care costs, patient days, and 2014 facility
23 average case mix indexes based on the minimum data set 3.0 resource
24 utilization group IV grouper 57. Otherwise, a))~~ A facility's medicaid
25 average case mix index shall be used to update a nursing facility's
26 direct care component rate semiannually.

27 ~~((b) Except during the 2021-2023 fiscal biennium, the facility
28 average case mix index used to establish each nursing facility's
29 direct care component rate shall be based on an average of calendar
30 quarters of the facility's average case mix indexes from the four
31 calendar quarters occurring during the cost report period used to
32 rebase the direct care component rate allocations as specified in RCW
33 74.46.561.~~

34 ~~(c) Except during the 2021-2023 fiscal biennium, the medicaid
35 average case mix index used to update or recalibrate a nursing
36 facility's direct care component rate semiannually shall be from the
37 calendar six-month period commencing nine months prior to the
38 effective date of the semiannual rate. For example, July 1, 2010,
39 through December 31, 2010, direct care component rates shall utilize~~

1 ~~case mix averages from the October 1, 2009, through March 31, 2010,~~
2 ~~calendar quarters, and so forth.~~

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

--- END ---