By Representative Macri

SSB 5802 - H COMM AMD
By Committee on Appropriations

Strike everything after the enacting clause and insert the following:

"Sec. 1. 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~~)) fiscal year 2025 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.

(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.

(5)(a) Following the discontinuation of the data set containing resource utilization group scores, the department, in collaboration with appropriate stakeholders, shall create a new method for adjusting direct care rates based on changes in case mix, using the patient driven payment model system. It is the intention of the legislature that once the patient driven payment model system is fully implemented, the methodology of the rates reflect a more accurate and equitable reflection of the actual cost of care.

(b) To facilitate a comprehensive and fair transition to the new case mix methodologies, the department shall:

(i) Conduct an analysis to assess the potential impact of the new case mix classification methodology of nursing facility payment rates;

(ii) Based on the impact analysis, create payment adjustments for capturing changes in client acuity. The process must involve engaging a wide range of stakeholders, including facility representatives and resident advocates, to ensure that the adjustments are transparent, fair, and supportive of high quality care;

(iii) Develop a plan to continuously monitor the effects of the new methodologies on payment rates and care quality after implementation. The plan must specify how the department will adjust the methodologies and payment rates as necessary, based on empirical evidence and stakeholder feedback, to maintain fairness and effectiveness; and

(iv) Develop a process for offering technical support for facilities adjusting to the new methodologies. This may include

phased implementation periods to ensure a smooth transition and maintain stability in care provision.

(c) The department shall submit a report detailing the development and anticipated implementation of the new methodology described in this subsection to the governor and the relevant legislative committees by no later than December 1, 2024, for consideration in the 2025-2027 fiscal biennium.

Sec. 2. 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 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~~)) year 2025, 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]~~)) rate in ((~~the 2021-2023~~)) fiscal ((~~biennium~~)) year 2025."

Correct the title.

EFFECT: Requires DSHS to collaborate with stakeholders to develop a new method for adjusting direct care rates using the patient driven payment model, aiming for a more accurate reflection of care costs. The department must analyze the impact of the new case mix methodology on nursing facility payment rates, create payment adjustments based on client acuity, engage stakeholders for transparency, and develop a plan for ongoing monitoring and adjustment to maintain quality and fairness. Additionally, the department is tasked with providing technical support for facilities transitioning to the new system and must submit a report on the methodology's development and implementation to inform future budget decision making.

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