Report Regarding Recommendations for a New Nursing Facility Payment Methodology

January 2, 2016

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Executive Summary

The Department of Social and Health Services would like to thank all of the individuals who dedicated their time and commitment to this process of proposing modifications to the state's nursing facility payment methodology. The Department would also like to specifically acknowledge the participation of Representative Joe Schmick who attended numerous stakeholder meetings and gave valuable input into this process.

Nursing facilities care for some of the highest need seniors and individuals with disabilities in Washington State. There are currently approximately 10,000 Medicaid-funded nursing facility residents in Washington. The number of Medicaid residents in nursing facilities has remained relatively stable in recent years despite a growing population in Washington in general. This is because Washington has a very robust home and community-based long-term services and supports system of options and many individuals receive care in their own homes and community-based settings. With many lower-needs individuals not entering nursing facilities, the acuity of nursing facility residents has increased in recent years.

c. 2, 2015 Laws, 2d sp. s section 6 states:

> *The department of social and health services shall facilitate a work group process to propose modifications to the price-based nursing facility payment methodology outlined in section 4 of this act and the minimum staffing standards outlined in RCW 74.42.360.*

Therefore, the Department of Social and Health Services, along with the workgroup participants, makes the following recommendations for both implementation and improvement to the methodology system outlined in Substitute House Bill (SHB) 1274. Some of the workgroup recommendations can be executed under SHB 1274 as it is currently written. However some of the recommendations require legislative action including:

- Granting the Department broader authority to pay direct care and indirect care rates at the median or greater;
- Using a regional wage index for direct care;
- Using one median statewide for indirect care;
- Removing the certificate of capital authorization;
- Gathering staff hours for the 3.4 hours per resident day (PRD) requirement from the CMS 5-Star Payroll Based Journal to ease the administrative burden. This requires small changes in the position titles that count for direct care, as outlined in this report;
- Allowing facilities to count Geriatric Behavioral Health Workers, as defined in this report, as part of their 3.4 hours PRD, if needed; and
- A narrowly drafted exceptions process for 24-hour Registered Nurse coverage, as defined in this report.

Substitute House Bill 1274 and What It Requires

There are three main components outlined in SHB 1274: direct care, indirect care, and capital. Additionally, there is a quality incentive add-on that can be up to 5% of the rate. Reducing the number of components moved certain cost centers into components they had not been in previously, e.g. therapy costs were moved into the direct care component.

SHB 1274 addressed staffing in two ways: First, there is a new direct care staffing minimum. "Beginning July 1, 2016, facilities must provide a minimum of 3.4 hours per resident day of direct care." Second, for large non-essential providers, the minimum time a registered nurse (RN) must be on staff is increased to twenty-four hours per day, seven days per week. Small non-essential providers and essential community providers will continue to be required to provide a minimum of sixteen hours per day, seven days per week.

The Office of Financial Management (OFM) has interpreted the FY17 daily weighted rate maintenance level as $210.85 per SHB 1274 Section 4(8). This figure includes the Safety Net Assessment at current levels. Without the Safety Net Assessment, the daily rate is $195.59.

For reference, the current process for establishing Medicaid rates for nursing facilities can be found in Attachment A and SHB 1274 can be found in Attachment D.

Workgroup Participants

Twelve workgroup meetings were held between July 1, 2015 and October 30, 2015. The workgroup consisted of two groups. The first group was the broad stakeholder group. Broad stakeholder meetings were open to anyone who wished to participate and included provider associations, nursing facility providers, nurses, consumer groups, an employee union, and independent consultants as well as a variety of state organizations. Two of the broad stakeholder meetings, which were approximately six hours each, were largely dedicated to looking at the price-based methodologies in other states and discussing what could work in Washington. Two outside consultants, Jim Pettersson of Navigant Consulting and Joe Lubarsky of Eljay LLC, were brought in to present on the systems of other states.

The second subgroup was the executive stakeholder group. This group consisted of one representative from each of the following organizations: Washington Health Care Association (WHCA); LeadingAge Washington; Providence Health and Services; Office of Financial Management (OFM); SEIU 775; and the State Long-Term Care (LTC) Ombuds. Each organization could bring a technical advisor, if desired. Depending on the subject of the meeting various representatives and subject matter experts from DSHS attended each meeting. As was mentioned in the executive summary, above, Representative Joe Schmick, of the 9th Legislative District, attended numerous meetings and gave valuable input.

In addition, a technical subgroup was created to look in detail at the cost report and rate modeling. The subgroup included industry specialists as well as Department experts and the LTC Ombuds in order to address technically complex details outside of the main group. The recommendations of this subgroup were brought to the larger workgroup meetings so the data and conclusions of the subgroup could be discussed.

Processes

The broad stakeholder group and the executive group met on an alternating schedule. This format enabled topics to be discussed at broad stakeholder groups where everyone was allowed to give their input regarding the model. The executive stakeholder group considered the feedback from the broad stakeholder group in making final decisions regarding the recommendations outlined in this document.

The group agreed on a guiding principle that the direct care component would make up at least the current percentage or greater of the overall rate moving forward. Other guiding principles included minimizing rate swings to the extent possible and statute changes necessary to offer the best metrics to improve the model regardless of funding limitations. Finally, the group agreed on direction for DSHS should additional funds not be secured to improve the capital and quality component of the rates to fully implement this improved price-based payment model.

The first meeting set the precedence for how future meetings would be structured and set rules agreed to by the workgroup. These included defining "consensus" among the group, as well as who had the final authority to speak for an organization. The group also agreed that if a topic reached consensus then all members of the executive workgroup promised to uphold that agreement. This means that the recommendations in this report are the recommendations of DSHS, WHCA, LeadingAge, SEIU 775, and the Long-term Care Ombudsman and that all of those organizations will continue to support those recommendations as this new system is developed and implemented.

Workgroup Recommendations

It is important to note that the following are recommendations provided by the executive stakeholder workgroup convened by the Department at the direction of the Legislature through SHB 1274:

Direct Care

The direct care component includes the costs of direct resident care, therapy care, food, laundry, and dietary services.

While the statute is silent on the issue of therapy lids, the workgroup recommends eliminating the lid.

Direct Care Requiring Legislative Action

There was consensus that the current direct care language did not give the Department enough discretion in setting the direct care rates. The legislation sets the direct care rate at one hundred percent of the median. A facility-specific direct care rate will be set by multiplying the statewide direct care rate (set at 100% of the median) by the geographic wage index and then by the facility-specific Medicaid case mix index. The suggestion of the group is to change the language of Sec. 4(3) to read: "Direct care must be paid at a fixed rate, based on one hundred percent or greater of the facility-wide case mix neutral median costs." Current rates paid in direct care are 110 percent of the median and laundry and dietary are paid at 108 percent of the median.

Consensus was reached that the use of metropolitan statistical area (MSA) and non-metropolitan statistical area (non-MSA) did not adequately reflect the varying costs across Washington. Therefore the workgroup recommends that a wage index, to be calculated by the Department, be used in place of MSA/non-MSA designations. The direct care rate should be regionally adjusted using a statewide wage

index created using the relative wage rates for RNs, LPNs and NACs by county. Wage data for RNs, LPNs and NACs is available in the Bureau of Labor and Statistics wage data.
An overall average wage by county shall be determined using the statewide average percentage of RN, LPN and NAC hours. Using a regional wage adjustment negates the need to set separate urban and rural medians.

Indirect Care

The indirect component includes administrative expenses, maintenance costs, and housekeeping services.

While the statute is silent on the issue of the home office lid, the workgroup recommends eliminating the lid.

Indirect Care Requiring Legislative Action

There was a consensus that the current indirect care language did not give the Department enough discretion in setting the indirect care rates. Currently the legislation sets the indirect care rate at ninety percent of the median. The suggestion of the group is to change the language of Sec. 4(4) to read: "Indirect care must be paid at a fixed rate, based on ninety percent or greater of the statewide median costs." Additionally, the group recommends using one statewide median without adjusting for metropolitan and nonmetropolitan statistical areas. Using a statewide median helps support rural providers by setting their rate several dollars higher with only a minor decrease in the rural rate. The rate will be set at 90 percent of the median. Current rates paid in operations are 100 percent of the median and housekeeping expenses are paid at 108 percent of the median.

The Indirect rate will be set using the greater of actual occupancy or occupancy imputed at 90 percent of licensed beds. For the purpose of the occupancy adjustment licensed beds will include those beds banked under alternate use.

Capital – Fair Market Rental

The capital component is a real property per bed rental rate.

There are different methods of calculating fair market rental; the workgroup agreed to use the gross fair market rental calculations for the capital component.

The Fair Rental Value rate will be set using a depreciated price per square foot times the facility age as adjusted for significant renovations over the past 20 years times a rental rate of 7.5% adjusted to a minimum occupancy threshold of 90%. The calculation includes the following metrics:

- The FRV will use the actual facility age as adjusted for significant renovations defined as those renovations that exceed $2,000 per bed in any given calendar year. The Department had renovation data available back to 1994. Facility age shall be reduced in future years if the value of the renovation completed in any year exceeds $2,000 times the number of licensed beds. Year-to-year adjustments will be made according to the formula found in Attachment B. At no time will the maximum age of a facility exceed 44 years for the purpose of the FRV calculation.

- In setting the base value, the workgroup debated at length using a flat amount per bed versus a dollar amount per square foot up to a maximum number of square feet per bed. It was

determined that a square foot per bed method better met the goals of encouraging a comfortable living environment. It was determined the maximum square feet per bed will be 450.

- While the group agreed to use per bed square footage as a factor in the capital portion of the rate. The Department currently has some square footage information, but facilities each calculate it differently. Therefore it was decided to use a standard square footage of 400 per bed effective July 1, 2016. In the meantime, the Department would provide clarity on how to accurately and properly calculate nursing home square footage for the next cost report. That information would be used to set the FRV rate effective July 1, 2017.

- The base value per bed will be regionally adjusted using the RS Means construction index.

- The base amount per square foot will be adjusted annually utilizing the national percent change in the RS Means construction index.

- The workgroup determined that a "fair" Fair Rental Value system using the metrics identified herein should generate a capital component at approximately $13.50 per patient day. Should this rate exceed the maintenance level appropriation for capital, the Department shall reduce the weighted average rate by reducing the dollar amount per square foot from $167.78 down to whatever dollar value is necessary to meet the projected maintenance level budget.

Recommendations Based on Maintenance Level Funding

Note: Maximum Square feet per bed is 450 except for the first year, all facilities are inputted at 400 square feet per bed		
	Workgroup Recommendations Without Revenue Box	**DSHS Adjustment to Fit in Revenue Box**
Base Age Data	Cost Report	Cost Report
Allowable Renovation Threshold	$2,000	$2,000
Maximum Facility Age	44	44
Amount per Square Foot	$167.78	$136.25
Maximum Square fee per bed	450	450
Equipment Valuation	10%	10%
Land	10%	10%
Location Adjusted	Yes	Yes
Depreciation	1.50%	1.50%
Rental Rate	7.50%	7.50%
Occupancy	90%	90%
Floor	None	None
Ceiling	None	None
Weighted Average Rate	**$13.51**	**$10.86**

Capital – Fair Market Rental Requiring Legislative Action

The workgroup recommends that the certificate of capital authorization be removed. This will require RCW 74.46.803 *Certificate of capital authorization – rules – emergency situations* and RCW 74.46.807 *Capital authorization – determination* be repealed. Additionally, RCW 74.46.020 *Definitions* and RCW 74.46.431 *Nursing facility medicaid payment rate allocations-Components-Minimum wage-Rules* would need to be amended to reflect the removal of the certificate of capital authorization. Furthermore, the group recommends any reference to the certificate of capital authorization be removed from the biennium operating appropriations section 206. The new system for determining the capital component using fair market rental means that a certificate of capital authorization program is no longer necessary.

Quality Enhancement Add-On

The quality enhancement add-on is for facilities that meet or exceed a standard established for the quality incentive. It may be no larger than 5% of the rate.

For the launch of the program, the workgroup recommends the use of the Minimum Data Set (MDS) measures for the quality enhancement add-on. This data is already collected by CMS and readily available.

To launch the program the Department will measure percent of long-stay residents who self-report moderate to severe pain, percent of high-risk, long-stay residents with pressure ulcers, percent of long stay residents with a urinary tract infection, and percent of long-stay residents experiencing one or more falls with major injury. All providers will have the opportunity to receive some level of a quality enhancement payment. After a period of a year or two, measurements for staffing turnover and percent of low-risk, long-stay residents who lose control of their bowel or bladder will be added.

The executive workgroup recommends that quality measures be reviewed yearly by a quality stakeholder workgroup so that measures can be added or changed if necessary. For example, if a measure is significantly improved over time, the Department, with input from the workgroup, may choose to replace that incentive with another area that still needs improvement.

3.4 Hours Per Resident Day Requirement

Beginning July 1, 2016, facilities must provide a minimum of 3.4 hours per resident day of direct care.

The financial incentive for compliance will be rolled out in stages. During the first quarter of the new staffing requirements (July 1, 2016 – September 30, 2016) the Department will review the numbers. If a facility is below the average they will be sent a letter and required to submit a plan for increasing their staffing to meet the statutory minimum. There are no fines issued this quarter.

In the second quarter of the new staffing requirements (October 1, 2016 – December 31, 2016), the Department will start issuing fines for facilities out of compliance. Beginning October 1, 2016, there will be two levels of fines. If a facility is out of compliance, the Department will calculate what it would cost that facility to hire the missing staff. That cost will include wages, benefits, etc. If a facility is staffing to the required RN level, then the missing staff calculation will use CNA costs only. That cost will be multiplied by 1.5 for the total fine amount for the first quarter out of compliance. If a facility is out of compliance a second quarter, the cost of missing staff for the second quarter will be multiplied by 2. For each quarter missed after that, that quarter's costs for missing staff will be multiplied by 2. There

will be a facility-based lookback of three years since the last violation. Thus a repeat violation that is more than three years since the most recent violation will start over at 1.5.

A concern raised by the workgroup was that these new staffing requirements, when combined with a change to nursing facility rate methodology, is a lot for facilities to learn in a short period of time. It was recommended that there needs to be education for the facilities on the new staffing requirements so they understand how they work, what is counted, etc.

3.4 Hours Per Resident Day Requirement Requiring Legislative Action

The workgroup is concerned with the additional administrative burden to providers and the Department to implement a direct care staffing minimum.
As a result, the workgroup recommends using the current Centers for Medicare and Medicaid (CMS) "5-Star Domains" as a proxy for measuring direct care hours. The 5 Star Domains look at the staffing around federal tags F39-F45 on the CMS-671 form, which are:

- F39 - RN Director of Nursing
- F40 - Nurses with Administrative Duties
- F41 - Registered Nurses
- F42 - Licensed Practical/Licensed Vocational Nurses
- F43 - Certified Nurse Aides
- F44 - Certified Nurse Aides in Training
- F45 - Medication Aides/Technicians

Currently, the reporting for the 5-Star Domains is voluntary, but CMS has scheduled the reporting to become mandatory on July 1, 2016 as part of the Payroll Based Journal. Using payroll and census data for the CMS Payroll Based Journal, the Department would extract data and conduct a quarterly review. This compliance analysis would be done on a quarterly basis and would look at a staffing per day average for that quarter. The Department will be checking the numbers reported to ensure that they are averaging out to actual daily staffing and that the staffing is not varying wildly throughout the quarter.

By using the CMS 5-Star Domains, the staffing measured would be hours worked by employees in job categories and not a detailed measure of the actual hours of direct care work performed by employees. This means that some direct care hours provided by staff not reported to CMS are not captured, while some hours that are not direct care but worked by reported staff are captured. The group agreed that the benefits of using an accessible, existing system that minimizes the administrative burden on both facilities and the Department outweighed the potential minimal inaccuracies.

Though there was not consensus among work group members that RN Director of Nursing (F39) and Nurses with Administrative Duties (F40) spend the majority of their hours providing direct care, for administrative efficiency there was a recommendation among the workgroup members to allow for inclusion of all of their hours providing hands-on care related to activities of daily living and nursing-related tasks, as well as care planning.

The workgroup recommended another category of staff, currently not part of the CMS 5-Start Domains, which can be looked at if needed for a facility to meet the 3.4 hours staffing minimum. This additional category is a Geriatric Behavioral Health Worker. A Geriatric Behavioral Health Worker must have a Bachelor's or Master's degree in social work and have received specialized training devoted to the

mental health problems and treatment of older adults. A worker with only a Bachelor's degree must be directly supervised by an employee who has a Master's in social work or is a registered nurse. They must also have at least three years' direct care experience in a long-term care or behavioral health care setting that cares for individuals with chronic mental health issues, dementia, and/or intellectual and developmental disabilities. They must have advanced practice knowledge in aging, disability, mental illness, Alzheimer's disease, and developmental disabilities. Currently, the legislation states "direct care includes registered nurses, licensed practical nurses, and certified nursing assistants." In the event that a facility does not meet the 3.4 hours of minimum staffing, they could submit documentation in the form of timesheets for Geriatric Behavior Health Workers for the Department to review.
The Department will need to include the definition of Geriatric Behavioral Health Worker as well as the criteria for counting the hours worked as direct care within the Washington Administrative Code.

24-Hour RN Coverage for Large, Non-Essential Community Providers Requiring Legislative Action

Beginning July 1, 2015, large non-essential community providers must have a registered nurse on duty directly supervising resident care twenty-four hours per day, seven days per week.

The workgroup recognizes that there is a workforce shortage of Registered Nurses (RNs) in Washington State. In addition, it can be difficult to locate RNs in certain communities. This is largely mitigated by the fact that the new 24-hour RN coverage mandate only applies to large, non-essential community providers. However, there were concerns raised within the workgroup regarding some providers' ability to locate and hire enough RNs to meet the new requirements. Therefore, the workgroup recommends a limited exceptions process for this new requirement. It would be a one-year exception that is renewable for up to three years. The group recommended re-examination of this process after three years. The facility would need to be offering comparable salary and benefits for the area. In addition, a majority of the facilities in the area would also need to be legitimately struggling with staffing. If the exception is granted, the facility may only admit residents when an RN is present. The definition of admissions used by Residential Care Services was recommended. If a facility receives an exemption, that information, along with the exemptions requirements will be put on the Department's online Nursing Home Locator.

The Department would contract with a third party to conduct a salary and benefits surveys to determine if a facility is paying competitive wages and benefits for their area.

Joint Stakeholder Statement Regarding Funding

It is important to note that the following statements are not the Department of Social and Health Services' recommendations; they are statements provided by the executive stakeholder workgroup convened by the Department at the direction of the Legislature through SHB 1274:

"The stakeholder workgroup has spent countless hours discussing our collective concerns on recommending justifiable and sound payment metrics for the new payment system given the current revenue situation. We collectively reviewed data, modeled many options, and discussed what was needed to fully implement this new price-based payment system. One approach was to come up with sound metrics we could all agree to, whatever the cost might be, so that it could be clearly understood

what is necessary to fully fund the new system. Another approach was to come up with payment metrics simply to fit in a revenue box. When modeled, the stakeholders did not consider the metrics in this latter approach reasonable in part, because they created additional rate swings and harmful levels of revenue losses to many Medicaid providers. As a compromise, the stakeholders came up with payment metrics for the first year of implementation that were as close to the revenue box as possible, but not at the level necessary for fully supporting the price-based system and certainly not at the level for enhancing resident quality in the system the way that SHB 1274 guides us in terms of policy. The Department of Social and Health Services agreed to allow us to include a collective statement on this topic.

Using this approach, the stakeholder workgroup recommends a first year model which produces a statewide weighted average rate for fiscal year 2017 of $198.89 excluding the Safety Net Assessment payback. This is approximately $3.52 per resident day above the maintenance level rate of $195.59 and therefore would require an additional general fund state investment of about $6.5 million in policy level for FY 2017. The additional funding, as recommended by the stakeholder workgroup, for fiscal year 2017 moves us closer to achieving the goals of SHB 1274, but it should be recognized as only a starting point.

Unlike most other Medicaid programs in Washington that have begun to see renewed investment by the State in publicly-funded services, the skilled nursing facility program has been paying for more complex care needs out if its own pocket for the last 7 years. Skilled nursing facility providers in Washington have not seen any general fund-state dollars allocated to this program since 2008. In fact, reductions over this time period to the base payment rates have decreased the public funding obligation by $60 million in state general funds that would have otherwise been needed in this program area. Costs for publicly-funded beds that were once covered using tax revenue paid by the citizens for the common public good, are now paid for through the establishment of a $21 per day fee assessed on nursing facilities for most of the clients they serve, including those paying privately for their own care.

As for efficiencies, Washington has done a good job of redirecting clients who utilize Long-Term Services and Supports (LTSS) to lower-cost settings. Out of approximately 60,000 LTSS Medicaid clients, only 16 percent are served in a skilled nursing facility which makes Washington one of the lowest in the nation (see Table 1). According to the Department of Social and Health Services Research and Data Analysis (RDA) division, these rebalancing efforts have created a cost avoidance of $2.7 billion in public funds over the last fifteen years.

While our state has done a good job of reducing surplus nursing home beds in the system, those that remain are an important component needed to meet the demand of the age wave. In reality, there is still a need for partnerships with skilled nursing facilities to provide publicly-funded care. According to the U.S. Department of Health and Human Services, people aged 65 and over face a 40 percent chance of entering a nursing facility, with a 20 percent chance of staying long-term. AARP ranks Washington 2nd in the nation for services to older adults, but 34th in the nation in terms of long-term care spending. The ability to do more with less is finite and we believe we are at a critical juncture. The nursing home of today is not the nursing home of yesterday, and we believe it is more important than ever to focus on improving quality, supporting a robust staffing model, and providing a respectable living environment for the small percentage of this state's vulnerable and poor senior citizens who will need care in skilled nursing facilities. The additional funding, as recommended by the stakeholder workgroup, of $3.52 for fiscal year 2017 moves us closer to achieving these goals, but it should be recognized as a starting point.

Further, the need for skilled nursing care has taken on heightened importance as we collectively focus on shortening and reducing costly hospital stays and rehabilitating our residents so they may remain in the least restrictive setting or safely return to their homes or another community setting, when possible. The increasing complexity of client care as well as the need to provide a safe, healthy, and comfortable environment for residents has required nursing facilities to take on new financial obligations. This includes increased professional staffing and competencies, technological improvements to capture and communicate complex health care needs with other care providers, and the provision of medical equipment and treatment modalities often seen in hospitals. In addition, almost one-half of our skilled nursing facility buildings are over 40 years old and renovations are needed in many of them.

The 2015 Legislature decided it wanted to reform the way payments are calculated to pay for publicly funded skilled nursing facility services. Therefore, in good faith, a broad coalition of stakeholders, including the LTC Ombuds Program, SEIU 775NW, LeadingAge Washington, Providence Health & Services, and the Washington Health Care Association have spent countless hours hammering out the details of this new payment system. However, additional funds are needed to implement this new system while also establishing quality incentives that actually improve care, implementing minimum staffing standards, and providing reasonable payments that incentivize safe and clean living conditions in our nursing homes. The nursing facility providers have been good partners to the state and it is time to renew the investment of public funds in this program. The two highest ranked items in terms of importance in client surveys are first- staffing and staff responsiveness, and second- a respectable physical environment. We owe it to the small percentage of vulnerable and poor senior citizens who will inevitably enter skilled nursing facility services in Washington State and who rely on us for good care. Please appropriate an additional $6.5 million in State general-funds in fiscal year 2017 ($5 million for the capital component and $1.5 million for the direct care component) to ensure a good foundation for this new payment system and to drive quality and improvements in care for all nursing home residents."

Stakeholder Exhibit: Table 1: The number of residents in certified nursing facilities as compared to the state population age 65 and older.

Location	2014 Population 65+	Number of residents in Certified Nursing facilities	Percent
Alaska	72,400	622	0.90%
Hawaii	213,300	2,221	1.00%
Oregon	644,700	7,079	1.10%
Arizona	986,700	11,118	1.10%
Nevada	386,900	4,788	1.20%
New Mexico	359,000	5,453	1.50%
Washington	1,011,800	17,063	1.70%

Utah	321,200	5,522	1.70%
South Carolina	794,400	14,697	1.90%
Idaho	205,600	3,901	1.90%
California	4,747,900	97,970	2.10%
Georgia	1,288,200	27,517	2.10%
Florida	3,268,400	73,275	2.20%
Vermont	113,500	2,690	2.40%
Colorado	653,800	16,347	2.50%
Virginia	1,133,400	28,457	2.50%
North Carolina	1,417,500	35,969	2.50%
Delaware	157,000	4,281	2.70%
Michigan	1,446,400	39,447	2.70%
West Virginia	318,300	8,852	2.80%
Maine	218,200	6,175	2.80%
Maryland	862,200	24,513	2.80%
Tennessee	946,700	27,504	2.90%
Montana	153,500	4,564	3.00%
United States	44,507,600	1,347,983	3.00%
Wisconsin	889,400	27,171	3.10%
Wyoming	75,500	2,340	3.10%
Texas	3,000,900	93,086	3.10%
District of Columbia	80,100	2,523	3.10%
Alabama	712,900	22,743	3.20%
New Hampshire	200,900	6,775	3.40%
Arkansas	501,100	17,596	3.50%
Oklahoma	528,000	18,938	3.60%
New York	2,888,800	105,131	3.60%
New Jersey	1,210,100	45,242	3.70%
Minnesota	707,400	26,616	3.80%
Pennsylvania	2,077,100	79,442	3.80%
Missouri	1,003,800	38,409	3.80%
Kentucky	598,700	23,386	3.90%
Ohio	1,882,300	74,828	4.00%
Louisiana	638,800	25,873	4.10%
Mississippi	388,700	16,139	4.20%
Indiana	931,400	39,028	4.20%
Nebraska	271,600	12,011	4.40%

Illinois	1,611,400	72,542	4.50%
Massachusetts	890,500	41,044	4.60%
Kansas	387,100	18,046	4.70%
Rhode Island	169,200	8,020	4.70%
Connecticut	500,800	24,203	4.80%
South Dakota	127,100	6,374	5.00%
Iowa	429,400	24,849	5.80%
North Dakota	83,800	5,603	6.70%

Data extrapolated from Kaiser Family Foundation's interactive online data reports. See sources below.

Kaiser Data Sources

Population:
Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplement).

Numbers of Residents in Certified Nursing Facilities:
FC. Harrington, H. Carrillo, and R. Garfield. Department of Social and Behavioral Sciences, University of California, San Francisco, and Kaiser Family Foundation. "*Nursing Facilities, Staffing, Resident and Facility Deficiencies 2009 through 2014*

Dissent

Dissent pieces were authored by their respective organizations.

Tax Pass Through

Washington Health Care Association

"The original version of HB 1274 addressed a "tax pass through" in the following sentence: "*The indirect care component must be adjusted to reflect the payment of real estate, personal property, and business and occupational taxes in establishing the rate.*" In addition, the issue was raised in stakeholder meetings that were conducted during the legislative session. Despite the fact that the issue of a "tax pass through" directly impacts the indirect care component, and was squarely addressed during the legislative session, some members of the SNF Reimbursement Reform Stakeholder Group determined that the issue of a "tax pass through" is outside scope the stakeholder workgroup's authority. WHCA disagrees."

LeadingAge Washington

"The law as reflected by Substitute House Bill 1274 does not include a tax pass through component. The tax pass through language was amended out of the bill by the legislature before it was enacted into law. Section 4 (2) of SHB 1274 requires a price be set using "industry-wide costs." Those industry-wide

costs are then to be housed in one of three components, Direct Care, Indirect Care or Fair Market Value. A tax pass through is contrary to the price-based payment principles and framework set by the legislature because it attempts to recognize a single cost outside of the established price. We agree with other stakeholders on the DSHS ruling that the tax pass through is outside the scope of the stakeholder workgroup's authority."

3.4 Hours Per Resident Day Exceptions

Washington Health Care Association

"The 3.4 "hours per resident day" (HPRD) figure is one that was arrived at without any detailed analysis. The figure is a "best guess" based on cost report data that has never been questioned or audited. WHCA believes that there are approximately 30 facilities that currently find themselves under the 3.4 HPRD requirements. But, unfortunately, we will not really know how many facilities will be impacted until the recording and reporting of the data begins. We need to be careful as we move forward.

Washington is moving from a system that had no minimal "hours per resident day" (HPRD) staffing requirements to a new system that has the fifth highest requirement in the nation.
Other states that have implemented such high HPRD standards have allowed sufficient time for providers to meet these new standards. For example, Florida allowed a multi-year phase-in, and even then, it had to back off from its overly-optimistic staffing minimums due to a shortage of qualified workers.

In Washington, there are providers who will be required to increase staffing while being paid a Medicaid rate that will not cover the cost of the staffing increases because the benefits of the new system will not be fully phased in until July 1, 2019. In addition, for some providers, finding adequate staffing will be a challenge given their facility's location and a tight job market. Granting a limited exception that allows a small number of facilities the time to let their staffing ratios catch up to their rates will help mitigate the funding issue—it will not address that labor market issue.

WHCA is not asking for a multi-year phase in of the 3.4 HPRD standard. Rather, WHCA supports a limited exception that allows those few facilities currently below 3.4 HPRD the time to allow their Medicaid rates to catch up to the new staffing requirements. Some communities will be able to do this quickly; others will need a little more time."

Conclusion

The nursing facility methodology change found in SHB 1274 is a modification that affects many parties. The proposed alterations and implementation ideas brought forth in this report reflect months of planning and compromise among the stakeholders and state agency staff. It is with that in mind that the executive workgroup asks that the report and its recommendations be carefully considered.

LIST OF ATTACHMENTS

Attachment A: A summary of the nursing facility Medicaid payment methodology under the current law.

Attachment B: A formula that the Department will use to calculate the ages of facilities

Attachment C: 5-Star Quality Rating System Technical Users' Guide – published by the federal Centers for Medicare and Medicaid Services

Attachment D: SHB 1274

Attachment A
Methodology that SHB 1274 replaces

Medicaid rates for long term care nursing facilities are set individually for each specific facility. Rates are based generally on a facility's costs, its occupancy level, and the individual care needs of its residents.

Component	Details	Date implemented
Direct care	Nursing and related care	10/1/1998
Therapy care	Speech, physical, occupational and other therapy, set at	10/1/1998
Support services	Food and dietary services, housekeeping, laundry,	10/1/1998
Operations	Administration, utilities, accounting, maintenance,	10/1/1998
Property	Depreciation allowance for real property improvements, equipment and personal property used for resident care	10/1/1998
Financing allowance	Return on the facility's net invested funds	5/17/1999
Low wage worker add-on	Optional. Intended to increase wages and benefits and/or staffing levels in lower paid job categories.	7/1/2008
Second low wage worker add-on	Optional. Similar to the previous low wage worker add-on, but some eligible job categories are different	7/1/2014
Pay-for-performance add-on	To be eligible a facility must have a direct care staff turnover rate of 75% or below.	7/1/2010
1% reduction of rates to facilities that have a direct care staff turnover higher than 75%	The money reduced in rates for facilities with high turnover is used to cover the cost of the pay-for-performance add-on	7/1/2010
Direct care rate add-on	One-time, temporary extended for one year	7/1/2014
Support services rate add-on	One-time, temporary extended for one year	7/1/2014
Therapy care add-on	One-time, temporary extended for one year	7/1/2014
Comparative add-on	Rates calculated 7/1/15 were compared to rates on 6/30/10. If the rate was lower the difference was paid in this add-on.	7/1/2011
Acuity add-on	If a facility's direct care rate on 7/1/15 was higher than on 6/30/10 their direct care rate was increased 10% to account for taking higher acuity residents.	7/1/2011
Safety Net Assessment add-on	A payment component that covers the cost of the Safety Net Assessment fee charged to the facilities for Medicaid resident days in nursing facilities.	7/1/2011

Attachment B

Slide presentation of: Impact on Age Due to Renovation

Source above: Joseph M. Lubarsky 7/30/2015 Presentation of "Fair Market Rental Approach"

100 Bed Facility- 25 Years Old		
Cost of Renovation	$	500,000
Accumulated Depreciation per Bed at Time of Renovation	**$**	**33,750**
New Bed Equivalent		**14.82**

	Number of Beds	**Age**	**Weighted Average Age**
Existing Beds	85.18	25	2,130
New Bed Equivalent	14.82	0	-
Total Beds	100		21.30

Impact on FRV Value-Assume 1.5% Depreciation/Year	**Value Before Renovation**	**Value After Renovation**	**Difference**
New Bed Value	$ 9,000,000	$ 9,000,000	
Depreciation	$ (3,375,000)	$(2,875,000)	
Rental Value	$ 5,625,000	$ 6,125,000	**$ 500,000**

Explanation of how a revision of age is calculated for a facility per year:

Per the Slide in columns A to G presented by Joseph Lubarsky on 7/30/2015:

1 Price Per Bed set at $90,0000

2 Accum Depr. for new renovation is calculated $90,000 * 25 yrs. * 1.5% = 33,750

3 500,000 renovation / 33,750 accum depr = 14.82 new bed equivalent

4 100 beds - 14.82 = 85.18 Existing Beds.

5 85.18 * 25 yrs. = 2,130

6 Divide by 100 Total beds = 21.30 new age which reduced the original 25 yr. age

Adjusted Age for Each Facility is summarized in the "Summary" sheet.

Using the above steps:

1 Renovations were determined using the difference between each year for reported

adjusted Costs (RC14) for #1402 Building, #1403 Building Improvements, #1404 Fixed Equipment, and #1408 Leasehold Improvements.

2 Each increase per year in step 1 was divided by 2015 DOH Licensed beds to determine if renovation Price Per Bed was equal or greater than $2,000.

3 The base year and age was 2014 year and 2014 reported age.

4 The calculation done above using the below Medians reduced the 2014 reported age starting with 1994 and trickling the new revised age to each year until 2014. The worksheets for 1994 to 2014 used an estimated Price Per Bed RS Means Median using actual RS Mean 2015 as an estimator using National Historical Cost Indexes for a Square Footage Price Per Bed Median.

5 After steps 1 to 4 the final age is then reduced to 44 years if the revised age is more than 44 years old.

RS Means

Year	3/4 Column	Median	National Historical Cost Indexes	Percentage Change
1994	44,000	34,000		50.00%
1995	44,958	34,740	105.6	51.09%
1996	46,363	35,826	108.9	52.69%
1997	47,470	36,681	111.5	53.94%
1998	48,364	37,372	113.6	54.96%
1999	49,641	38,359	116.6	56.41%
2000	50,620	39,116	118.9	57.52%
2001	52,025	40,201	122.2	59.12%
2002	53,941	41,682	126.7	61.30%
2003	55,218	42,669	129.7	62.75%
2004	58,500	43,688	132.8	64.25%
2005	63,500	48,261	146.7	70.97%
2006	66,000	51,387	156.2	75.57%
2007	70,500	54,282	165.0	79.83%
2008	73,500	56,255	171.0	82.73%
2009	79,000	60,039	182.5	88.29%
2010	78,000	59,743	181.6	87.86%
2011	78,500	61,091	185.7	89.84%
2012	82,000	63,822	194.0	93.86%
2013	84,000	64,776	196.9	95.26%
2014	86,000	66,783	203.0	98.21%
2015	88,000	68,000	206.7	

The result of the overall revised age is summarized in the Summary sheet in Green.

Attachment B

The original 2014 age is in Blue.
The levers are in the Summary sheet at the top:

Minimum Price Per Bed	Cap on Price Per Bed	AccumDepr	Age Limit
$2,000	$1,000,000	1.50%	44

Attachment C

Design for *Nursing Home Compare* Five-Star Quality Rating System:

Technical Users' Guide

February 2015

Introduction

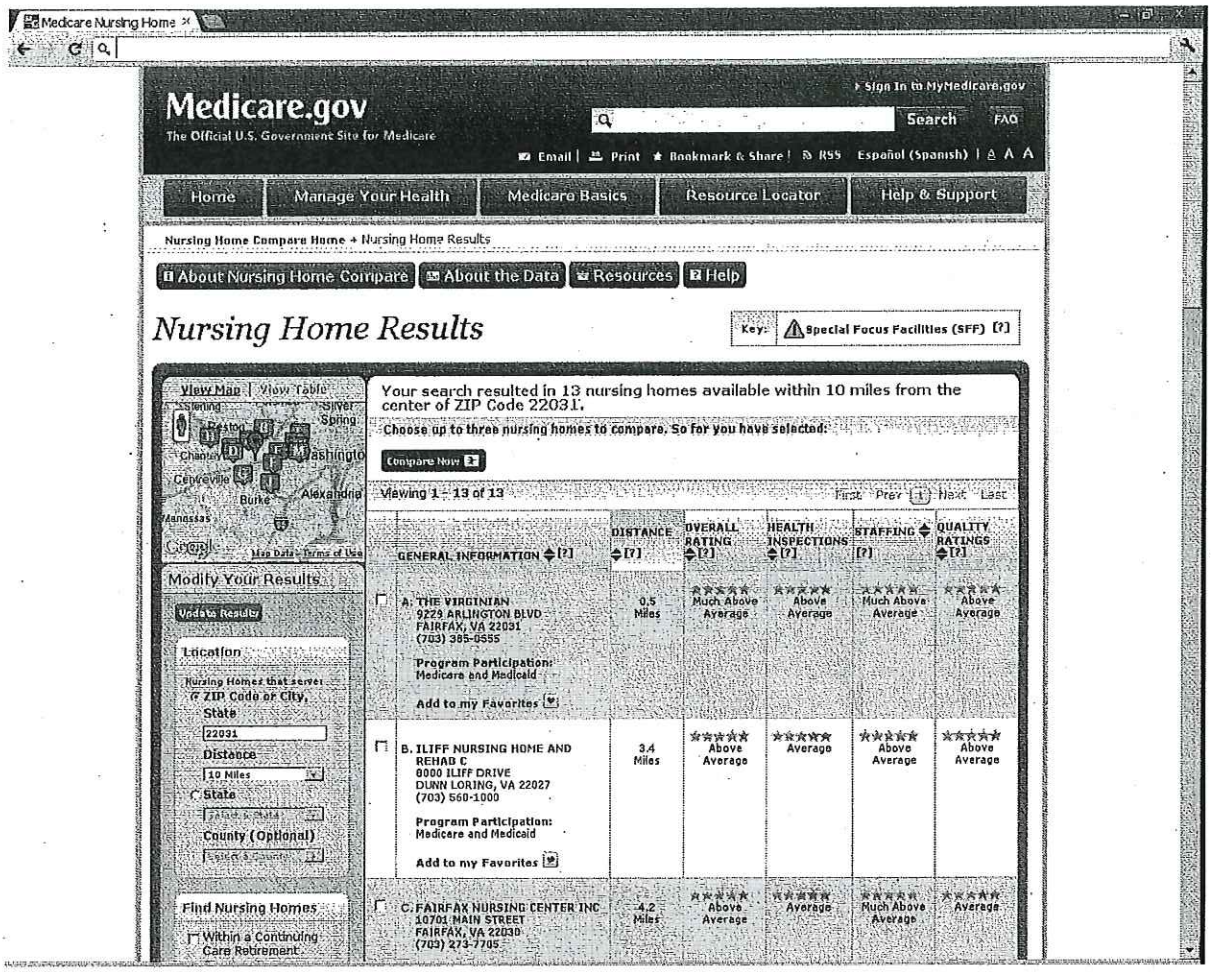
In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes.

This document provides a comprehensive description of the design for the *Nursing Home Compare* Five-Star Quality Rating System. This design was developed by CMS with assistance from Abt Associates, invaluable advice from leading researchers in the long-term care field who comprise the Technical Expert Panel (TEP) for this project, and numerous ideas contributed by consumer and provider groups. All of these organizations and groups have continued to contribute their input as the rating system has been refined and updated to incorporate newly available data. We believe the Five-Star Quality Rating System continues to offer valuable and comprehensible information to consumers based on the best data currently available. The rating system features an Overall Quality Rating of one to five stars based on facility performance for three types of measures, each of which has its own five-star rating:

- ***Health Inspections - Measures based on outcomes from State health inspections:*** Facility ratings for the health inspection domain are based on the number, scope, and severity of deficiencies identified during the three most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations. All deficiency findings are weighted by scope and severity. This measure also takes into account the number of revisits required to ensure that deficiencies identified during the health inspection survey have been corrected.
- ***Staffing - Measures based on nursing home staffing levels:*** Facility ratings on the staffing domain are based on two measures: 1) Registered nurse (RN) hours per resident day; and 2) total staffing hours (RN+ licensed practical nurse (LPN) + nurse aide hours) per resident day. Other types of nursing home staff such as clerical or housekeeping staff are not included in these staffing numbers. These staffing measures are derived from the CMS CASPER Certification and Survey Provider Enhanced Reports (CASPER) system, and are case-mix adjusted based on the distribution of MDS 3.0 assessments by RUG-III group.
- ***QMs - Measures based on Minimum Data Set (MDS) quality measures (QMs):*** Facility ratings for the quality measures are based on performance on 11 of the 18 QMs that are currently posted on the *Nursing Home Compare* web site, and that are based on MDS 3.0 resident assessments. These include 8 long-stay measures and 3 short-stay measures.

In recognition of the multi-dimensional nature of nursing home quality, *Nursing Home Compare* displays information on facility ratings for each of these domains alongside the overall performance rating. Further, in addition to the overall staffing five-star rating mentioned above, a five-star rating for RN staffing is also displayed separately on the Nursing Home Compare website, when users seek more information on the staffing component.

An example of the rating information included on *Nursing Home Compare* is shown in the figure below. Users of the web site can drill down on each domain to obtain additional details on facility performance.



A companion document to this Technical Users' Guide (*Nursing Home Compare* – Five Star Quality Rating System: Technical Users' Guide – State-Level Cut Point Tables) provides the data for the state-level cut points for the star ratings included in the health inspection. The data table in the companion document will be updated monthly. Cut points for the staffing ratings and for the QM ratings have been fixed and do not vary monthly. Data tables giving the cut points for those ratings are included in the Appendix of this Technical Users' Guide.

Methodology for Constructing the Ratings

Health Inspection Domain

Nursing homes that participate in the Medicare or Medicaid programs have an onsite standard ("comprehensive") survey annually *on average*, with very rarely more than fifteen months elapsing between surveys for any one particular nursing home. Surveys are unannounced and are conducted by a team of health care professionals. State survey teams spend several days in the nursing home to assess whether the nursing home is in compliance with federal requirements. Certification surveys provide a comprehensive assessment of the nursing home, including assessment of such areas as medication management, proper skin care, assessment of resident needs, nursing home administration, environment,

kitchen/food services, and resident rights and quality of life. The methodology for constructing the health inspection rating is based on the most recent three standard surveys for each nursing home, results from any complaint investigations during the most recent three-year period, and any repeat revisits needed to verify that required corrections have brought the facility back into compliance. The Five-Star Quality Rating System uses more than 200,000 records for the health inspection domain alone.

Scoring Rules

A health inspection score is calculated based on points assigned to deficiencies identified in each active provider's current health inspection survey and the two prior surveys, as well as deficiency findings from the most recent three years of complaints information and survey revisits.

- ***Health Inspection Results***: Points are assigned to individual health deficiencies according to their scope and severity – more points are assigned for more serious, widespread deficiencies, and fewer points for less serious, isolated deficiencies (see Table 1). If the deficiency generates a finding of substandard quality of care, additional points are assigned. If the status of the deficiency is "past non-compliance" and the severity is "immediate jeopardy" (i.e., J-,K- or L-level), then points associated with a G- level deficiency are assigned. Deficiencies from Life Safety surveys are not included in calculations for the Five-Star rating. Deficiencies from Federal Monitoring surveys are not reported on *Nursing Home Compare* or included in *Five Star* calculations either.
- ***Repeat Revisits - Number of repeat revisits required to confirm that correction of deficiencies have restored compliance***: No points are assigned for the first revisit; points are assigned only for the second, third, and fourth revisits and are proportional to the health inspection score for the survey cycle (Table 2). If a provider fails to correct deficiencies by the time of the first revisit, then these additional revisit points are assigned up to 85 percent of the health inspection score for the fourth revisit. CMS experience is that providers that fail to demonstrate restored compliance with safety and quality of care requirements during the first revisit have lower quality of care than other nursing homes. More revisits are associated with more serious quality problems.

We calculate a total health inspection score for facilities based on the facility's weighted deficiency score and number of repeat revisits needed. Note that a lower survey score corresponds to fewer deficiencies and revisits, and thus better performance on the health inspection domain. In calculating the total domain score, more recent surveys are weighted more heavily than earlier surveys: the most recent period (cycle 1) is assigned a weighting factor of 1/2, the previous period (cycle 2) has a weighting factor of 1/3, and the second prior survey (cycle 3) has a weighting factor of 1/6. The weighted time period scores are then summed to create the survey score for each facility.

Complaint surveys are assigned to a time period based on the calendar year in which the complaint survey occurred. Complaint surveys that occurred within the most recent 12 months preceding the current website update date receive a weighting factor of 1/2; those from 13-24 months ago have a weighting factor of 1/3, and those from 25-36 months ago have a weighting factor of 1/6. There are some deficiencies that appear on both standard and complaint surveys. To avoid potential double-counting, deficiencies that appear on complaint surveys that are conducted within 15 days of a standard survey (either prior to or after the standard survey) are counted only once. If the scope or severity differs on the two surveys, the highest scope-severity combination is used. Points from complaint deficiencies from a given period are added to the health inspection score before calculating revisit points, if applicable.

For facilities missing data for one period, the health inspection score is determined based on the periods for which data are available, using the same relative weights, with the missing (third) survey weight

distributed proportionately to the existing two surveys. Specifically, when there are only two standard health surveys, the most recent receives 60 percent weight and the prior receives 40 percent weight. Facilities with only one standard health inspection are considered not to have sufficient data to determine a health inspection rating and are set to missing for the health inspection domain. For these facilities, no composite rating is assigned and no ratings are reported for the staffing or QM domains even if these ratings are available.

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (60 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.

Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.

* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a 'G-level" deficiency (i.e. 20 points) are assigned.

Source: Centers for Medicare & Medicaid Services

Table 2
Weights for Repeat Revisits

Revisit Number	Noncompliance Points
First	0
Second	50 percent of health inspection score
Third	70 percent of health inspection score
Fourth	85 percent of health inspection score

Note: The health inspection score includes points from deficiencies cited on the standard annual survey and complaint surveys during a given survey cycle.

Rating Methodology

Health inspections are based on federal regulations, which surveyors implement using national interpretive guidance and a federally-specified survey process. Federal staff train state surveyors and oversee state performance. The federal oversight includes quality checks based on a 5% sample of the state surveys, in which federal surveyors either accompany state surveyors or replicate the survey within 60 days of the state and then compare results. These control systems are designed to optimize consistency

in the survey process. Nonetheless there remains some variation between states. Such variation derives from many factors, including:

- ***Survey Management:*** Variation among states in the skill sets of surveyors, supervision of surveyors, and the survey processes;
- ***State Licensure***: State licensing laws set forth different expectations for nursing homes and affect the interaction between State enforcement and federal enforcement (for example, a few states conduct many complaint investigations based on state licensure, and issue citations based on State licensure rather than on the federal regulations);
- ***Medicaid Policy:*** Medicaid pays for the largest proportion of long term care in nursing homes. State nursing home eligibility rules, payment, and other policies in the state-administered Medicaid program create differences in both quality of care and enforcement of that quality.

For the above reasons, Five-Star quality ratings on the health inspection domain are based on the relative performance of facilities within a state. This approach helps control for variation among states. Facility ratings are determined using these criteria:

- The top 10 percent (lowest 10 percent in terms of health inspection deficiency score) in each state receive a five-star rating.
- The middle 70 percent of facilities receive a rating of two, three, or four stars, with an equal number (approximately 23.33 percent) in each rating category.
- The bottom 20 percent receive a one-star rating.

Cut points are re-calibrated each month so that the distribution of star ratings within States remains relatively constant over time. However, the rating for a given facility is held constant until there is a change in the weighted health inspection score for that facility, regardless of changes in the statewide distribution. Items that could change the health inspection score include the following:

- A new health inspection survey;
- A complaint investigation that results in one or more deficiency citations;
- A 2nd, 3rd or 4th revisit;
- Resolution of an Informal Dispute Resolutions (IDR) or Independent Informal Dispute Resolutions (IIDR) resulting in changes to the scope and/or severity of deficiencies;
- The "aging" of complaint deficiencies. Specifically, as noted above, complaint surveys are assigned to a time period based on the calendar year in which the complaint survey occurred; thus, when a complaint deficiency ages into a prior period, it receives less weight in the scoring process, resulting in a lower health inspection score and potentially a change in health inspection rating.

In the very rare case that a State or territory has fewer than five facilities upon which to generate the cut points, the national distribution of health inspection scores is used. Cut points for the health inspection ratings are available in the companion document to this Technical Users' Guide: *Nursing Home Compare* – Five Star Quality Rating System: Technical Users' Guide – State-Level Cut Point Tables. The data can be found in Table CP1.

Staffing Domain

There is considerable evidence of a relationship between nursing home staffing levelsand resident outcomes. The CMS Staffing Study found a clear association between nurse staffing ratios and nursing home quality of care, identifying specific ratios of staff to residents below which residents are at substantially higher risk of quality problems.[1]

The rating for staffing is based on two case-mix adjusted measures:

1. Total nursing hours per resident day (RN + LPN + nurse aide hours)
2. RN hours per resident day

The source data for the staffing measures is CMS form CMS-671 (Long Term Care Facility Application for Medicare and Medicaid) from CASPER. The resident census is based on the count of total residents from CMS form CMS-672 (Resident Census and Conditions of Residents). The specific fields that are used in the RN, LPN, and nurse aide hours calculations are:

- RN hours: Includes registered nurses (tag number F41 on the CMS-671 form), RN director of nursing (F39), and nurses with administrative duties (F40).
- LPN hours: Includes licensed practical/licensed vocational nurses (F42)
- Nurse aide hours: Includes certified nurse aides (F43), aides in training (F44), and medication aides/technicians (F45)

Note that the CASPER staffing data include both facility employees (full time and part time) and individuals under an organization (agency) contract or an individual contract. The CASPER staffing data do not include "private duty" nursing staff reimbursed by a resident or his/her family. Also not included are hospice staff and feeding assistants.

A set of exclusion criteria are used to identify facilities with unreliable CASPER staffing data, and neither staffing data nor a staffing rating are reported for these facilities (displaying "Data Not Available" on the Nursing Home Compare website. The exclusion criteria are intended to identify facilities with unreliable CASPER staffing data and facilities with outlier staffing levels.

The resident census, used in the denominator of the staffing calculations, uses data reported in block F78 of the CMS-672 form. This includes the total residents in the nursing facility and the number for whom a bed is being maintained on the day the nursing home survey begins (bed-holds). Bed-holds typically involve residents temporarily away in a hospital or on leave. The CMS-671 form separately collects hours for full-time, part-time, and contract staff. These hours are converted to full-time equivalents (FTE), which are summed across full time, part time and contract staff and converted to hours per resident per day (HRD) as follows:

HRD = total hours for each nursing discipline/resident census/14 days

This calculation is done separately for RNs, LPNs and Nurse Aides as described above, and all three of these are summed to calculate total nursing hours.

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[1] Kramer AM, Fish R. "The Relationship Between Nurse Staffing Levels and the Quality of Nursing Home Care." Chapter 2 in Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report. Abt Associates, Inc., Winter 2001.

Case-Mix Adjustment

The measures are adjusted for case-mix differences based on the Resource Utilization Group (RUG-III) case-mix system. Data from the CMS Staff Time Measurement Studies were used to measure the number of RN, LPN, and nurse aide minutes associated with each RUG-III group (using the 53 group version of RUG-III). Case- mix adjusted measures of hours per resident day were calculated for each facility for each staff type using this formula:

$$\text{Hours}_{\text{Adjusted}} = (\text{Hours}_{\text{Reported}}/\text{Hours}_{\text{Expected}}) * \text{Hours}_{\text{National Average}}$$

where $\text{Hours}_{\text{National Average}}$ is the mean across all facilities of the reported hours per resident day for a given staff type. The expected values are based on the distribution of residents by RUG-III group in the quarter closest to the date of the most recent standard survey (when the staffing data were collected) and measures of the expected RN, LPN, and nurse aide hours that are based on data from the CMS 1995 and 1997 Staff Time Measurement Studies (see Table A1). The distribution of residents by RUG-III group is determined using the most recent MDS assessment for current residents of the nursing home on the last day of the quarter.

The data used in the RUG calculations are based on a summary of MDS information for residents currently in the nursing home. The MDS assessment information for each active nursing home resident is consolidated to create a profile of the most recent standard information for the resident. An active resident is defined as a resident who, on the last day of the quarter, has no discharge assessment and whose most recent MDS transaction is less than 180 days old (this allows for 93 days between quarterly assessments, 14 days for completion, 31 days for submission after completion, and about one month grace period for late assessments). The active resident information can represent a composite of items taken from the most recent comprehensive, full, quarterly, PPS, and admission MDS assessments. Different items may come from different assessments. The intention is to create a profile with the most recent standard information for an active resident, regardless of source of information. These data are used to place each resident in a RUG category.

For the Five-Star rating, a "draw" of the most recent RUG category distribution data is done for every nursing facility on the last business day of the last month of each quarter. The Five-Star rating makes use of the distribution for the quarter in which the staffing data were collected. For each facility, a "target" date that is 7 days prior to the most recent standard survey date is assigned. The rationale for this target is that the staffing data reported for CASPER covers the two-week period prior to the survey, with 7 days being the midpoint of that interval. If RUG data are available for the facility for the quarter containing that survey "target" date, that quarter of RUG data is used for the case mix adjustment. In instances when the quarter of RUG data containing the survey target date is not available for a given facility, the quarter of available RUG data that is closest to that target date - either before or after – is selected. Closest is defined as having the smallest absolute value for the difference between the survey target date and the midpoint of the available RUG quarter(s). If the RUG data for the quarter in which the survey was conducted becomes available subsequently, the staffing rating will be recalculated to reflect these more appropriate data, and this might change the staffing rating. The staffing rating calculated using staffing data and RUG data from the same quarter will be held constant for a nursing home until new staffing data are collected for the facility.

Expected hours are calculated by summing the nursing times (from the CMS Time Study) connected to each RUG category across all residents in the category and across all categories. The hours are then

divided by the number of residents included in the calculations. The result is the "expected" number of hours for the nursing home.

The "reported" hours are those reported by the facility on the CMS-671 form for their most recent survey, while the "national average" hours (shown in Table 3) represent the unadjusted national mean of the reported hours across all facilities for December, 2011. .

Table 3
National Average Hours per Resident Day Used To Calculate Adjusted Staffing (as of April 2012)

Type of staff	National average hours per resident per day
Total nursing staff (Aides + LPNs + RNs)	4.0309
Registered nurses	0.7472

The calculations of "expected", "reported", and "national average" hours are performed separately for RNs and for all staff delivering nursing care (RNs, LPNs, and CNAs). Adjusted hours are also calculated for both groups using the formula discussed earlier in this section.

A downloadable file that contains the "expected" , "reported" and case-mix adjusted hours used in the staffing calculations is available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html . The file, referred to as the "Expected and Adjusted Staff Time Values Data Set", contains data for both RNs and total staff for each individual nursing home.

Scoring Rules

The two staffing measures (RN and total nursing staff) are given equal weight. For each of RN staffing and total staffing, a 1 to 5 rating is assigned based on a percentile-based method (where percentiles are based on the distribution for freestanding facilities[2]) (Table 4). For each facility, the overall Staffing Rating is assigned based on the combination of the two staffing ratings (Table 5).

The percentile cut points (data boundaries between each star category) were determined using the data available as of December 2011. This was the first update of the cut points since December 2008 and was necessary because of changes in the expected staffing due to MDS 3.0. The cut points were set so that the changes in expected staffing due to MDS 3.0 would not impact the overall distribution of the five-star ratings; that is, they were selected so that the proportion of nursing homes in each rating category would initially (i.e. for April 2012) be the same as it was in December 2011. CMS will evaluate whether further rebasing is needed on an annual basis. A major advantage of using fixed cut-points is that it allows the distribution of staffing ratings to change over time. Nursing homes that seek to improve their staffing rating, for example, can ascertain the increased levels at which they would earn a higher star rating for the staffing domain.

[2] The distribution for freestanding facilities was used because of concerns about the reliability of staffing data for some hospital-based facilities.

Table 4

National Star Cut Points for Staffing Measures, Based on Case-Mix Adjusted Hours per Resident Day (updated April 2012)

Staff type	1 star	2 stars lower	2 stars upper	3 stars lower	3 stars upper	4 stars lower	4 stars upper	5 stars
RN	< 0.283	≥0.283	< 0.379	≥0.379	< 0.513	≥0.513	< 0.710	≥0.710
Total	< 3.262	≥3.262	< 3.661	≥3.661	< 4.173	≥4.173	< 4.418	≥4.418

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

Rating Methodology

Facility ratings for overall staffing are based on the combination of RN and total nurse (RNs, LPNs, LVNs, and CNAs) staffing ratings as shown in Table 5. To receive a five-star rating, facilities must meet or exceed the five-star level for both RN and total staffing. To receive a four-star staffing rating, facilities must receive at least a three-star rating on both RN and total nurse staffing and must receive a rating of four or five stars on one of these domains.

Table 5

Staffing Points and Rating (updated February 2015)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥4.418
1	<0.283	★	★	★★	★★	★★★
2	0.283 – 0.378	★	★★	★★★	★★★	★★★
3	0.379 – 0.512	★★	★★★	★★★	★★★★	★★★★
4	0.513 – 0.709	★★	★★★	★★★★	★★★★	★★★★
5	≥0.710	★★★	★★★	★★★★	★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

Quality Measure Domain

A set of quality measures (QMs) has been developed from Minimum Data Set (MDS)-based indicators to describe the quality of care provided in nursing homes. These measures address a broad range of functioning and health status in multiple care areas. The facility rating for the QM domain is based on performance on a subset of 11 (out of 18) of the QMs currently posted on Nursing Home Compare. The measures were selected based on their validity and reliability, the extent to which facility practice may affect the measure, statistical performance, and importance. As of February 2015, two measures for use of antipsychotic medications (one for short-stay residents and one for long-stay residents), have been incorporated into the Five-Star Rating System.

Long-Stay Residents:

- Percent of residents whose need for help with activities of daily living has increased
- Percent of high risk residents with pressure ulcers (sores)
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with a urinary tract infection
- Percent of residents who self-report moderate to severe pain
- Percent of residents experiencing one or more falls with major injury
- Percent of residents who received an antipsychotic medication

Short-stay residents:

- Percent of residents with pressure ulcers (sores) that are new or worsened
- Percent of residents who self-report moderate to severe pain
- Percent of residents who newly received an antipsychotic medication

Table 6 contains more information on these measures. Technical specifications for the complete set of QMs are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User's-Manual-V80.pdf

Values for three of the QMs (catheter, the long-stay pain measure, and short-stay pressure ulcers) are risk adjusted, using resident-level covariates that adjust for factors associated with differences in the score for the QM. For example, the catheter risk-adjustment model is based on an indicator of bowel incontinence or pressure sores on the prior assessment. The risk-adjusted QM score is adjusted for the specific risk for that QM in the nursing facility. The risk-adjustment methodology is described in more detail in the Quality Measure Users' Manual available on the CMS website referenced in the last paragraph. It is important to note that the regression models used in the risk adjustment are not refit each time the QMs are updated. It is assumed that the relationships do not change, so the coefficients from the most recent "fitting" of the model are used along with the most recent QM data. The covariates and the coefficients used in the risk-adjustment models are reported in Table A-2 in the Appendix.

Ratings for the QM domain are calculated using the three most recent quarters for which data are available. This time period specification was selected to increase the number of assessments available for calculating the QM rating, increasing the stability of estimates and reducing the amount of missing data. The adjusted three-quarter QM values for each of the eleven QMs used in the five-star algorithm are computed as follows:

$$QM_{3Quarter} = [(QM_{Q1} * D_{Q1}) + (QM_{Q2} * D_{Q2}) + (QM_{Q3} * D_{Q3})]/(D_{Q1} + D_{Q2} + D_{Q3})$$

Where QM_{Q1}, QM_{Q2}, and QM_{Q3} correspond to the adjusted QM values for the three most recent quarters and D_{Q1}, D_{Q2}, and D_{Q3} are the denominators (number of eligible residents for the particular QM) for the same three quarters.

Table 6
MDS-Based Quality Measures

Measure	Comments
Long-Stay Measures:	
Percent of residents whose need for help with activities of daily living has increased[1]	This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment. This is a change measure that reflects worsening performance on at least 2 late loss ADLs by one functional level or on one late loss ADL by more than one functional level compared to the prior assessment. The late loss ADLs are bed mobility, transfer, eating, and toileting. Maintenance of ADLs is related to an environment in which the resident is up and out of bed and engaged in activities. The CMS Staffing Study found that higher staffing levels were associated with lower rates of increasing dependence in activities of daily living.
Percent of high-risk residents with pressure ulcers	This measure captures the percentage of long-stay, high-risk residents with Stage II-IV pressure ulcers. Residents at high risk for pressure ulcers are those who are impaired in bed mobility or transfer, who are comatose, or who suffer from malnutrition.
Percent of residents who have/had a catheter inserted and left in their bladder	This measure reports the percentage of residents who have had an indwelling catheter in the last 7 days. Indwelling catheter use may result in complications, like urinary tract or blood infections, physical injury, skin problems, bladder stones, or blood in the urine.
Percent of residents who were physically restrained	This measure reports the percent of long-stay nursing facility residents who are physically restrained on a daily basis. A resident who is restrained daily can become weak, lose his or her ability to go to the bathroom without help, and develop pressure ulcers or other medical complications.
Percent of residents with a urinary tract infection	This measure reports the percent of long-stay nursing facility residents who have had a urinary tract infection within the past 30 days. Urinary tract infections can often be prevented through hygiene and drinking enough fluid. Urinary tract infections are relatively minor but can lead to more serious problems and cause complications like delirium if not treated.
Percent of residents who self-report moderate to severe pain	This measure captures the percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible pain in the last 5 days.
Percent of residents experiencing one or more falls with major injury	This measure reports the percent of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period (one full calendar year).
Percent of residents who received an antipsychotic medication	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period. Reducing the rate of antipsychotic medication use has been the focus of several CMS initiatives. The Food and Drug Administration (FDA) has warned that antipsychotic medications can have significant side effects and are associated with an increased risk of death when used in elderly patients with dementia
Short-Stay Measures	
Percent of residents with pressure ulcers that are new or worsened	This measure captures the percentage of short-stay residents with new or worsening Stage II-IV pressure ulcers.
Percent of residents who self-report moderate to severe pain	This measure captures the percent of short stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.
Percent of residents who newly received an antipsychotic medication	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.

[1]Indicates ADL QM as referenced in scoring rules
Sources: Based on information from the AHRQ Measures Clearinghouse and the NHVBP Draft Design Report and the MDS 3.0 Quality Measures User's Manual.

Scoring Rules

Consistent with the specifications used for *Nursing Home Compare,* long-stay measures are included in the score if the measure can be calculated for at least 30 residents assessments (summed across three quarters of data to enhance measurement stability). Short-stay measures are included in the score only if data are available for at least 20 residents' assessments.

For each measure, 20 to 100 points are assigned based on facility performance, with the points determined in the following way:

- For long-stay ADL worsening, long-stay pressure ulcers, long-stay catheter, long-stay urinary tract infections, long-stay pain, long-stay injurious falls, and short-stay pain: facilities are grouped into quintiles based on the distribution of the QM. The quintiles are assigned 20 points for the poorest performing quintile, 100 points for the best performing quintile, and 40, 60 or 80 points for the second, third and fourth quintiles respectively.
- The physical restraint and short-stay pressure ulcer QMs are treated slightly differently because they have low prevalence – specifically, substantially more than 20 percent (i.e. a quintile) of nursing homes have zero percent rates on these measures.
    - For the restraint QM, facilities achieving the best possible score on the QM (i.e. zero percent of residents triggering the QM) are assigned 100 points; this is about 60 percent of facilities (or 3 quintiles). The remaining facilities are divided into two evenly sized groups, (each with about 20 percent of nursing homes); the poorer performing group is assigned 20 points, and the better performing group is assigned 60 points.
    - The short-stay pressure ulcer QM is treated similarly: facilities achieving the best possible score on the QM (i.e. zero percent of residents triggering the QM) are assigned 100 points; this is about one-third of nursing homes. The remaining facilities are divided into three evenly sized groups, (each with about 23 percent of nursing homes) and assigned 25, 50 or 75 points.;.
- The two quality measures that are newly included in the QM rating as of February 2015 – short-stay and long-stay antipsychotic medication use – are also treated somewhat differently than the QMs that were already part of the rating:
    - For the long-stay antipsychotic medication QM, facilities are divided into five groups based on the national distribution of the measure: the top-performing 10 percent of facilities receive 100 points; the poorest performing 20 percent of facilities receive 20 points; and the middle 70 percent of facilities are divided into three equally sized groups (each including approximately 23.3 percent of nursing homes) and receive 40, 60 or 80 points.
    - The short-stay antipsychotic medication QM is treated similarly; however, because approximately 20 percent of facilities achieve the best possible score on this QM (i.e. zero percent of residents triggering the QM), these facilities all receive 100 points; the poorest performing 20 percent of facilities receive 20 points; and the remaining facilities are divided into three equally sized groups (each including approximately 20 percent of nursing homes) and receive 40, 60 or 80 points.

All of the 11 QMs are given equal weight. The points are summed across all QMs to create a total score for each facility. The total possible score ranges between 220 and 1100 points.

Note that the quintiles are based on the national distribution for all of the QMs except for the ADL measure. For the ADL measure, quintiles are set on a State -specific basis using the State distribution.

The ADL measure is based on the within-State distribution because this measure appears to be particularly influenced by differences in state Medicaid policies governing long term care.

Cut points for the QMs were set based on the QM distributions averaged across the third and fourth quarters of 2013 and the first quarter of 2014. Note that the cut points are determined prior to any imputation for missing data (see discussion below). Also, the state-specific cut points for the ADL QMs are created for states/territories that have at least five facilities with a non-imputed value for that QM. In the rare case a State does not satisfy this criterion, the national distribution for that QM is used to set the cut points for that State. The cut points for the QMs are shown in the Appendix (Tables A3-A4).

Missing Data and Imputation

Some facilities have missing data for one or more QM, usually because of an insufficient number of residents available for calculating the QM. Missing values are imputed based on the statewide average for the measure. The imputation strategy for these missing values depends on the pattern of missing data.

- For facilities that have data for at least four of the eight long-stay QMs, missing values are imputed based on the statewide average for the measure. Points are then assigned according to the quintile-based cut points described above.
- For facilities that have data on two of three short-stay QMs, missing values are imputed based on the statewide average for the measure. Points are then assigned according to the percentile-based cut points described above.
- The QM rating for facilities with data on three or fewer long-stay QMs is based on the short-stay measures only. Mean values for the missing long-stay QMs are not imputed.
- Similarly, the QM rating for facilities with data on zero or one short-stay QM is based on the long-stay measures only. Mean values for the missing short-stay QMs are not imputed.

Based on these rules, after imputation, facilities that receive a QM rating are in one of the following categories:

- They have points for all of the QMs.
- They have points for only the eight long-stay QMs (long-stay facilities).
- They have points for only the three short-stay QMs (short-stay facilities)
- No values are imputed for nursing homes with data on fewer than four long-stay QMs and fewer than two short-stay QMs. No QM rating is generated for these nursing homes.

So that all facilities are scored on the same 1100 point scale, points are rescaled for long and short-stay facilities:

- If the facility has data for only the three short-stay measures (total of 300 possible points), its score is multiplied by 1100/300.
- If the facility has data for only the eight long-stay measures (total of 800 possible points), its score is multiplied by 1100/800.

Rating Methodology

Once the summary QM score is computed for each facility as described above, the five-star QM rating is assigned, according to the point thresholds shown in Table 7. These thresholds were set so that the overall proportion of nursing homes would be approximately 25 percent 5-star, 20 percent for each of 2, 3

and 4-stars and 15 percent 1-star in February 2015 when the antipsychotic QMs are first included in the QM rating and hence rebasing was required. The cut points associated with these star ratings will be held constant for a period of at one year, allowing the distribution of the QM rating to change over time.

Table 7
Star Cut-points for MDS Quality Measure Summary Score (updated February 2015)

QM Rating	Point Range for MDS Quality Measure Summary Score (updated February 2015)
★	225 – 544
★★	545 – 629
★★★	630 – 689
★★★★	690 – 759
★★★★★	760 – 1,100

Overall Nursing Home Rating (Composite Measure)

Based on the five-star rating for the health inspection domain, the direct care staffing domain and the MDS quality measure domain, the overall five-star rating is assigned in five steps as follows:

Step 1: Start with the health inspection five-star rating.

Step 2: Add one star to the Step 1 result if staffing rating is four or five stars *and greater than* the health inspection rating; subtract one star if staffing is one star. The overall rating cannot be more than five stars or less than one star.

Step 3: Add one star to the Step 2 result if quality measure rating is five stars; subtract one star if quality measure rating is one star. The overall rating cannot be more than five stars or less than one star.

Step 4: If the health inspection rating is one star, then the overall quality rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.

Step 5: If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall quality rating is three stars.

The rationale for upgrading facilities in Step 2 that receive either a four- or five-star rating for staffing (rather than limiting the upgrade to those with five stars) is that the criteria for the staffing rating is quite stringent. However, requiring that the staffing rating be greater than the health inspection rating in order for the score to be upgraded ensures that a facility with four stars on health inspections and four stars on staffing (and more than one star on MDS) does not receive a five-star overall rating.

The rationale for limiting upgrades in Step 4 is that two self-reported data domains should not significantly outweigh the rating from actual onsite visits from trained surveyors who have found very serious quality of care problems. And since the health inspection rating is heavily weighted toward the most recent findings, a one-star health rating reflects both a serious and recent finding.

The rationale for limiting the overall rating of a Special Focus Facility (SFF) in Step 5 is that the three data domains are weighted toward the most recent results and do not fully take into account the history of some nursing homes that exhibit a long history of "yo-yo" or "in and out" compliance with federal safety and quality of care requirements. Such history is a characteristic of the SFF nursing homes. While we wish the three individually-reported data sources to reflect the most recent data so that consumers can be aware that such facilities may be improving, we are capping the overall rating out of caution that the prior "yo-yo" pattern could be repeated. Once the facility graduates from the SFF initiative by sustaining improved compliance for about 12 months, we remove our cap for the former SFF nursing home, both figuratively and literally.

The method for determining the overall nursing home rating does not assign specific weights to the health inspection, staffing, and QM domains. The health inspection rating is the most important dimension in determining the overall rating, but, depending on their performance on the staffing and QM domains, the overall rating for a facility may be up to two stars higher or lower than its health inspection rating.

If the facility has no health inspection rating, no overall rating is assigned. If the facility has no health inspection rating because it is too new to have two standard surveys, no ratings for any domain are displayed.

Change in Nursing Home Rating

Facilities may see a change in their overall rating for a number of reasons. Because the overall rating is based on three individual domains, a change in any one of the domains can affect the overall rating.

A change in a domain can happen for several reasons.

New Data for the Facility

First of all, new data for the facility may change the rating. When a facility has a health inspection survey, either a standard survey or as a result of a complaint, the deficiency data from the survey will become part of the calculation for the health inspection rating. The data will be included as soon as they become part of the CMS database. The timing for this may vary but depends on having a complete survey package for the state to upload to the database. Additional survey data may be added to the database because of complaint surveys or outcomes of revisits or Informal Dispute Resolutions (IDR) or Independent Informal Dispute Resolutions (IIDR). These data may not be added in the same cycle as the standard survey data.

Another reason the health inspection data (and therefore the rating) for a facility may change is the "aging" of one or more complaint deficiencies. Specifically, complaint surveys are assigned to a time period based on the calendar year in which the complaint survey occurred. Thus, when a complaint deficiency ages into a prior period, it receives less weight in the scoring process and thus the score may change.

CASPER staffing data are collected at the time of the health inspection survey, so new staffing data will be added for a facility approximately annually. The case-mix adjustment for the staffing data is based on MDS assessment data for the current residents of the nursing home on the last day of the quarter in which the staffing data were collected (i.e. the quarter closes to the standard survey date). If the RUG data for the quarter in which the staffing data were collected are not available for a given facility, the quarter of available RUG data closest to the survey target date - either before or after – is selected. If the RUG data

for the quarter in which the survey was conducted becomes available subsequently, the staffing rating will be recalculated to reflect these more appropriate data, and this might change the staffing rating. The staffing rating calculated using staffing data and RUG data from the same quarter will be held constant for a nursing home until new staffing data are collected for the facility.

Quality Measure data are updated on Nursing Home Compare on a quarterly basis, and the nursing home QM rating is updated at the same time. The updates occur mid-month in January, April, July, and October. Changes in the quality measures may change the star rating.

Changes in Data for Other Facilities

Because the cut-points between star categories for the health inspection rating are based on percentile distributions that are not fixed, those cut-points may vary slightly depending on the current facility distribution in the database. However, while the cut-points for the health inspection ratings may change from month to month, the rating for a given facility is held constant until there is a change in the weighted health inspection score for that facility. Events that could change the health inspection score include:

- A new health inspection survey
- New complaint information
- A 2nd, 3rd or 4th revisit
- Resolution of an Informal Dispute Resolutions (IDR) or Independent Informal Dispute Resolutions (IIDR) resulting in changes to the scope and/or severity of deficiencies, or
- The "aging" of complaint deficiencies

Cut-points are fixed (starting April 2012) for the staffing measures (both RN and overall) as well as for the individual QMs and the QM rating (starting February 2015).

Appendix

Table A1 RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates					
1995-1997 Time Study Average Times (Minutes)					
RUG-53	Resident Specific Time + Non-Resident Specific Time Minutes				
Group	STAFF TYPE				Total Minutes
	RN	LPN	Nurse Total	AIDE	All Staff Types
REHAB & EXTENSIVE					
RUX	160.67	84.89	245.56	200.67	446.22
RUL	127.90	59.19	187.10	134.57	321.67
RVX	137.28	58.33	195.61	167.54	363.15
RVL	128.93	47.75	176.67	124.30	300.97
RHX	130.42	48.69	179.12	155.39	334.50
RHL	117.25	69.00	186.25	127.00	313.25
RMX	163.88	91.36	255.24	195.76	450.99
RML	166.61	62.68	229.29	147.07	376.36
RLX	116.87	55.13	172.00	132.63	304.63
REHABILITATION					
REHAB ULTRA HIGH					
RUC	100.75	46.03	146.78	174.86	321.64
RUB	84.12	34.94	119.06	123.13	242.19
RUA	64.98	39.49	104.47	97.91	202.38
REHAB VERY HIGH					
RVC	93.31	50.21	143.52	163.59	307.10
RVB	85.90	42.54	128.44	138.37	266.81
RVA	72.04	26.53	98.56	103.49	202.05
REHAB HIGH					
RHC	94.85	45.04	139.89	166.48	306.37
RHB	100.85	34.80	135.65	130.40	266.05
RHA	89.76	27.51	117.27	102.59	219.85
REHAB MEDIUM					
RMC	78.01	49.35	127.37	172.16	299.53
RMB	88.69	38.05	126.73	140.23	266.96
RMA	94.15	34.41	128.55	116.54	245.10
REHAB LOW					
RLB	69.38	46.52	115.91	196.33	312.24
RLA	60.88	33.02	93.89	124.29	218.18

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Table A1 RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates					
1995-1997 Time Study Average Times (Minutes)					
RUG-53	Resident Specific Time + Non-Resident Specific Time Minutes				
Group	STAFF TYPE				Total Minutes
	RN	LPN	Nurse Total	AIDE	All Staff Types
EXTENSIVE					
SE3	143.56	101.33	244.89	193.50	438.39
SE2	108.52	86.06	194.58	163.54	358.12
SE1	80.79	57.68	138.47	191.79	330.26
SPECIAL					
SSC	72.9	64.3	137.20	184.1	321.30
SSB	70.9	55.0	125.90	172.4	298.30
SSA	91.7	41.7	133.40	130.4	263.80
CLINICALLY COMPLEX					
CC2	85.2	42.50	127.70	191.1	318.80
CC1	55.7	57.70	113.40	176.9	290.30
CB2	61.5	41.80	103.30	159.0	262.30
CB1	59.0	36.20	95.20	147.3	242.50
CA2	58.8	43.30	102.10	130.3	232.40
CA1	59.7	37.60	97.30	103.3	200.60
IMPAIRED COGNITION					
IB2	40.0	32.0	72.00	137.2	209.20
IB1	39.0	32.0	71.00	130.0	201.00
IA2	38.0	27.0	65.00	100.0	165.00
IA1	33.0	26.0	59.00	96.0	155.00
BEHAVIOR					
BB2	40.0	30.0	70.00	136.0	206.00
BB1	38.0	28.0	66.00	130.0	196.00
BA2	38.0	30.0	68.00	90.0	158.00
BA1	34.0	25.0	59.00	73.5	132.50

Table A1 RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates					
1995-1997 Time Study Average Times (Minutes)					
RUG-53	Resident Specific Time + Non-Resident Specific Time Minutes				
Group	STAFF TYPE				Total Minutes
	RN	LPN	Nurse Total	AIDE	All Staff Types
PHYSICAL FUNCTION					
PE2	37.0	32.0	69.00	184.8	253.80
PE1	37.0	29.4	66.40	181.6	248.00
PD2	36.0	25.0	61.00	170.0	231.00
PD1	36.0	27.6	63.60	160.0	223.60
PC2	25.6	32.8	58.40	154.4	212.80
PC1	45.1	20.6	65.70	124.2	189.90
PB2	28.0	36.8	64.80	80.6	145.40
PB1	27.5	27.7	55.20	93.9	149.10
PA2	31.9	30.6	62.50	72.9	135.40
PA1	28.2	29.8	58.00	72.8	130.80

Table A2
Coefficients for Risk-Adjustment Model

Quality Measure/Covariate	Constant (Intercept)	Coefficient
Percent of long-stay residents who had a catheter inserted and left in their bladder	-3.645993	
1. Indicator of frequent bowel incontinence on prior assessment		0.545108
2. Indicator of pressure sores at stages II, III, or IV on prior assessment		1.967017
Percent of long-stay residents who self-report moderate to severe pain	-2.428281	
1. Indicator of independence or modified independence in daily decision making on the prior assessment		1.044019
Percent of short-stay residents with pressure ulcers that are new or worsened	-5.204646	
1. Indicator of requiring limited or more assistance in bed mobility on the initial assessment		1.013114
2. Indicator of bowel incontinence at least occasionally on initial assessment		0.835473
3. Indicator of diabetes or peripheral vascular disease on the initial assessment		0.412676
4. Indicator of low body mass index on the initial assessment		0.373643

Source: http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/NHQIQMUsersManual.pdf

Table A3
National Ranges for Point Values for Non-ADL QMs (updated February 2015)

Quality Measure	# of QM Points is...	For QM values between...	and...
Moderate to Severe Pain (long-stay)	100	0.00000000	0.02115460
	80	0.02115461	0.04816983
	60	0.04816984	0.07929856
	40	0.07929857	0.12534518
	20	0.12534519	1.00000000
High Risk Pressure Ulcers (long-stay)	100	0.00000000	0.02659575
	80	0.02659576	0.04489800
	60	0.04489801	0.06372548
	40	0.06372549	0.08949414
	20	0.08949415	1.00000000
Catheter (long-stay)	100	0.00000000	0.01041907
	80	0.01041908	0.02108049
	60	0.02108050	0.03237411
	40	0.03237412	0.04785475
	20	0.04785476	1.00000000
Urinary Tract Infection (long-stay)	100	0.00000000	0.02127661
	80	0.02127662	0.04050634
	60	0.04050635	0.06083648
	40	0.06083649	0.08982036
	20	0.08982037	1.00000000
Physical Restraints (long-stay)	100	0.00000000	0.00000000
	60	0.00000001	0.01851848
	20	0.01851849	1.00000000
Injurious Falls (long-stay)	100	0.00000000	0.01142857
	80	0.01142858	0.02259883
	60	0.02259884	0.03424656
	40	0.03424657	0.05000000
	20	0.05000001	1.00000000

Quality Measure	# of QM Points is...	For QM values between...	and...
Antipsychotic Medications (long-stay)	100	0.00000000	0.08088236
	80	0.08088237	0.14285715
	60	0.14285716	0.19642856
	40	0.19642857	0.26775956
	20	0.26775957	1.00000000
Moderate to Severe Pain (short-stay)	100	0.00000000	0.08333332
	80	0.08333333	0.14634145
	60	0.14634146	0.20720723
	40	0.20720724	0.28215770
	20	0.28215771	1.00000000
New or Worsening Pressure Ulcers (short-stay)	100	0.00000000	0.00000000
	75	0.00000001	0.00674135
	50	0.00674136	0.01477029
	25	0.01477030	1.00000000
Antipsychotic Medications (short-stay)	100	0.00000000	0.00000000
	80	0.00000001	0.01351350
	60	0.01351351	0.02336446
	40	0.02336447	0.03821657
	20	0.03821658	1.00000000

Table A4. State-Specific Ranges for Point Values for ADL Decline (long-stay)
(Updated February 2015)

State	Ranges for each point Category on the ADL QM									
	100 points		80 points		60 points		40 points		20 points	
	From...	To...	From...	To...	From...	To...	From...	To...	From...	To...
Alabama	0.0	0.07462682	0.07462683	0.10373443	0.10373444	0.13698632	0.13698633	0.18442622	0.18442623	1.0
Alaska	0.0	0.08333334	0.08333335	0.10937501	0.10937502	0.14044942	0.14044943	0.15483872	0.15483873	1.0
Arizona	0.0	0.08974361	0.08974362	0.13223142	0.13223143	0.15966387	0.15966388	0.21500000	0.21500001	1.0
Arkansas	0.0	0.08928570	0.08928571	0.12448132	0.12448133	0.16129031	0.16129032	0.22169810	0.22169811	1.0
California	0.0	0.05944055	0.05944056	0.09090910	0.09090911	0.12048195	0.12048196	0.16883118	0.16883119	1.0
Colorado	0.0	0.09999997	0.09999998	0.13294797	0.13294798	0.16363636	0.16363637	0.21951217	0.21951218	1.0
Connecticut	0.0	0.12385324	0.12385325	0.15178573	0.15178574	0.18243242	0.18243243	0.21999999	0.22000000	1.0
Delaware	0.0	0.10714288	0.10714289	0.16666665	0.16666666	0.17977529	0.17977530	0.20100502	0.20100503	1.0
D.C	0.0	0.05208335	0.05208336	0.08441560	0.08441561	0.11786370	0.11786371	0.24242427	0.24242428	1.0
Florida	0.0	0.08235296	0.08235297	0.11475409	0.11475410	0.14242425	0.14242426	0.17999998	0.17999999	1.0
Georgia	0.0	0.10596025	0.10596026	0.14184396	0.14184397	0.17570095	0.17570096	0.22748814	0.22748815	1.0
Hawaii	0.0	0.06578951	0.06578952	0.09782609	0.09782610	0.11428571	0.11428572	0.15999999	0.16000000	1.0
Idaho	0.0	0.09230769	0.09230770	0.13461539	0.13461540	0.17687075	0.17687076	0.20987654	0.20987655	1.0
Illinois	0.0	0.09356723	0.09356724	0.13389123	0.13389124	0.16778522	0.16778523	0.21428570	0.21428571	1.0
Indiana	0.0	0.11688313	0.11688314	0.15517238	0.15517239	0.19607843	0.19607844	0.23437500	0.23437501	1.0
Iowa	0.0	0.10273973	0.10273974	0.13541666	0.13541667	0.16822430	0.16822431	0.20338983	0.20338984	1.0
Kansas	0.0	0.10000000	0.10000001	0.14503816	0.14503817	0.18055555	0.18055556	0.21969698	0.21969699	1.0
Kentucky	0.0	0.10563381	0.10563382	0.14999999	0.15000000	0.18226601	0.18226602	0.22950822	0.22950823	1.0
Louisiana	0.0	0.12138727	0.12138728	0.17229730	0.17229731	0.20338986	0.20338987	0.24796749	0.24796750	1.0
Maine	0.0	0.08571429	0.08571430	0.10526315	0.10526316	0.13846152	0.13846153	0.19000000	0.19000001	1.0
Maryland	0.0	0.11945392	0.11945393	0.15593223	0.15593224	0.19740256	0.19740257	0.24444442	0.24444443	1.0
Massachusetts	0.0	0.09677420	0.09677421	0.12406018	0.12406019	0.14814816	0.14814817	0.18390804	0.18390805	1.0
Michigan	0.0	0.09633031	0.09633032	0.12574849	0.12574850	0.15584418	0.15584419	0.18939395	0.18939396	1.0
Minnesota	0.0	0.10791365	0.10791366	0.13114757	0.13114758	0.15211268	0.15211269	0.18032789	0.18032790	1.0
Mississippi	0.0	0.12389385	0.12389386	0.16062180	0.16062181	0.19354838	0.19354839	0.23118280	0.23118281	1.0
Missouri	0.0	0.08163262	0.08163263	0.11666666	0.11666667	0.15573770	0.15573771	0.20370372	0.20370373	1.0
Montana	0.0	0.08641977	0.08641978	0.12903227	0.12903228	0.16842106	0.16842107	0.21276599	0.21276600	1.0
Nebraska	0.0	0.10909090	0.10909091	0.13265308	0.13265309	0.17142858	0.17142859	0.20707070	0.20707071	1.0
Nevada	0.0	0.10810810	0.10810811	0.14473685	0.14473686	0.17241379	0.17241380	0.26056338	0.26056339	1.0
New Hampshire	0.0	0.13803682	0.13803683	0.17094018	0.17094019	0.19384617	0.19384618	0.22807020	0.22807021	1.0
New Jersey	0.0	0.08333334	0.08333335	0.12195121	0.12195122	0.15510206	0.15510207	0.20967742	0.20967743	1.0
New Mexico	0.0	0.12751677	0.12751678	0.15724814	0.15724815	0.19298243	0.19298244	0.23469386	0.23469387	1.0
New York	0.0	0.09011627	0.09011628	0.12231760	0.12231761	0.15286627	0.15286628	0.19306931	0.19306932	1.0

State	Ranges for each point Category on the ADL QM									
	100 points		80 points		60 points		40 points		20 points	
	From...	To...	From...	To...	From...	To...	From...	To...	From...	To...
North Carolina	0.0	0.13469385	0.13469386	0.17467247	0.17467248	0.20720722	0.20720723	0.25000000	0.25000001	1.0
North Dakota	0.0	0.11111112	0.11111113	0.14173229	0.14173230	0.17431192	0.17431193	0.21523179	0.21523180	1.0
Ohio	0.0	0.09359606	0.09359607	0.12738856	0.12738857	0.16000000	0.16000001	0.19834712	0.19834713	1.0
Oklahoma	0.0	0.07480314	0.07480315	0.11450381	0.11450382	0.15454543	0.15454544	0.20930237	0.20930238	1.0
Oregon	0.0	0.06818184	0.06818185	0.11392406	0.11392407	0.14018692	0.14018693	0.17857142	0.17857143	1.0
Pennsylvania	0.0	0.11111109	0.11111110	0.13769754	0.13769755	0.16382253	0.16382254	0.20557492	0.20557493	1.0
Rhode Island	0.0	0.08936169	0.08936170	0.13157895	0.13157896	0.15831135	0.15831136	0.20061728	0.20061729	1.0
South Carolina	0.0	0.09251102	0.09251103	0.12757204	0.12757205	0.16000001	0.16000002	0.19555555	0.19555556	1.0
South Dakota	0.0	0.13227513	0.13227514	0.15702480	0.15702481	0.17605633	0.17605634	0.21428571	0.21428572	1.0
Tennessee	0.0	0.10126583	0.10126584	0.14379086	0.14379087	0.17391304	0.17391305	0.21212123	0.21212124	1.0
Texas	0.0	0.13664599	0.13664600	0.17560976	0.17560977	0.21416232	0.21416233	0.26086957	0.26086958	1.0
Utah	0.0	0.07258066	0.07258067	0.11403511	0.11403512	0.14179106	0.14179107	0.17857143	0.17857144	1.0
Vermont	0.0	0.12280704	0.12280705	0.17328519	0.17328520	0.20430108	0.20430109	0.24475523	0.24475524	1.0
Virginia	0.0	0.12380953	0.12380954	0.15942025	0.15942026	0.19338424	0.19338425	0.23275865	0.23275866	1.0
Washington	0.0	0.08571427	0.08571428	0.11442788	0.11442789	0.14432991	0.14432992	0.18357488	0.18357489	1.0
West Virginia	0.0	0.13513512	0.13513513	0.17452828	0.17452829	0.20481926	0.20481927	0.24691357	0.24691358	1.0
Wisconsin	0.0	0.09963100	0.09963101	0.12987011	0.12987012	0.15517240	0.15517241	0.19262294	0.19262295	1.0
Wyoming	0.0	0.09399480	0.09399481	0.13281251	0.13281252	0.16587676	0.16587677	0.20779220	0.20779221	1.0

Due to the small number of facilities, the cut-points for Guam, Puerto Rico, and the Virgin Islands are based on the national distribution of the ADL quality measure score.

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1274

Chapter 2, Laws of 2015

64th Legislature
2015 2nd Special Session

NURSING HOME RATES--VALUE-BASED SYSTEM

EFFECTIVE DATE: 7/1/2015

Passed by the House June 24, 2015
Yeas 95 Nays 2

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate June 26, 2015
Yeas 44 Nays 0

BRAD OWEN

President of the Senate

Approved June 30, 2015 3:53 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1274** as passed by House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

June 30, 2015

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1274

Passed Legislature - 2015 2nd Special Session

State of Washington 64th Legislature 2015 2nd Special Session

By House Appropriations (originally sponsored by Representatives Cody, Jinkins, Johnson, Harris, and Tharinger)

READ FIRST TIME 06/24/15.

AN ACT Relating to implementing a value-based system for nursing home rates; amending RCW 74.46.431, 74.46.501, and 74.42.360; adding new sections to chapter 74.46 RCW; creating a new section; repealing RCW 74.46.431, 74.46.435, 74.46.506, 74.46.508, 74.46.511, 74.46.515, and 74.46.521; providing effective dates; providing an expiration date; and declaring an emergency.

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

Sec. 1. RCW 74.46.431 and 2013 2nd sp.s. c 3 s 1 are each amended to read as follows:

(1) Nursing facility medicaid payment rate allocations shall be facility-specific and shall have six components: Direct care, therapy care, support services, operations, property, and financing allowance. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) Component rate allocations in therapy care and support services for all facilities shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for essential community providers shall be based upon a minimum facility occupancy of eighty-

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seven percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for small nonessential community providers shall be based upon a minimum facility occupancy of ninety-two percent of licensed beds, regardless of how many beds are set up or in use. Component rate allocations in operations, property, and financing allowance for large nonessential community providers shall be based upon a minimum facility occupancy of ninety-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

(3) Information and data sources used in determining medicaid payment rate allocations, including formulas, procedures, cost report periods, resident assessment instrument formats, resident assessment methodologies, and resident classification and case mix weighting methodologies, may be substituted or altered from time to time as determined by the department.

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the direct care component rate allocation shall be rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the direct care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for

calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the therapy care component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the therapy care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Therapy care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the therapy care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be

applied solely or compounded to the therapy care component rate allocation established in accordance with this chapter.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the support services component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the support services component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Support services component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the support services component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the support services component rate allocation established in accordance with this chapter.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Effective July 1, 2009, the operations component rate allocation shall be cost rebased, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, ((~~2015~~)) 2017. Beginning July 1, ((~~2015~~)) 2017, the operations care component rate allocation shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year ((~~2013~~)) 2015 is used for July 1, ((~~2015~~)) 2017, through June 30, ((~~2017~~)) 2019, and so forth.

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic

trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter.

(8) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(9) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: Inflation adjustments for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(10) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

(11) Effective July 1, 2010, there shall be no rate adjustment for facilities with banked beds. For purposes of calculating minimum occupancy, licensed beds include any beds banked under chapter 70.38 RCW.

(12) Facilities obtaining a certificate of need or a certificate of need exemption under chapter 70.38 RCW after June 30, 2001, must have a certificate of capital authorization in order for (a) the

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depreciation resulting from the capitalized addition to be included in calculation of the facility's property component rate allocation; and (b) the net invested funds associated with the capitalized addition to be included in calculation of the facility's financing allowance rate allocation.

Sec. 2. RCW 74.46.501 and 2013 2nd sp.s. c 3 s 2 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 74.46.431 and 74.46.506, 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, ((~~2013~~)) 2015, through June 30, ((~~2015~~)) 2017, the department shall calculate rates using the medicaid average case mix scores effective for January 1, ((~~2013~~)) 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, ((~~2015~~)) 2017, direct care cost per case mix unit shall be calculated by utilizing ((~~2013~~)) 2015 direct care costs, patient days, and ((~~2013~~)) 2015 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 74.46.431.

(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.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.46 RCW to read as follows:

(1) For fiscal year 2016 and subject to appropriation, the department shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2015, using the payment methodology defined in this chapter, to the facility-based rates in effect June 30, 2010. If the facility-based payment rate calculated

on July 1, 2015, is smaller than the facility-based payment rate on June 30, 2010, the difference must be provided to the individual nursing facilities as an add-on per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, for fiscal year 2016, if it is found that the direct care rate for any facility calculated under this chapter is greater than the direct care rate in effect on June 30, 2010, then the facility must receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than it has in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6).

NEW SECTION. **Sec. 4.** A new section is added to chapter 74.46 RCW 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 of facility-wide case mix neutral median costs. Direct care must be performance-adjusted for acuity every six months, using case mix principles. Direct care must be regionally adjusted for nonmetropolitan and metropolitan statistical areas. There is no minimum occupancy for direct care.

(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 of facility-wide median

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costs. Indirect care must be regionally adjusted for nonmetropolitan and metropolitan statistical areas.

(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.

(6) A quality incentive must be offered as a rate enhancement beginning July 1, 2016. An enhancement no larger than five 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. The department must recommend four to six measures to become the standard for the quality incentive, and must describe a system for rewarding incremental improvement related to these four to six measures, within the report to the legislature described in section 6 of this act. Infection rates, pressure ulcers, staffing turnover, fall prevention, utilization of antipsychotic medication, and hospital readmission rates are examples of measures that may be established for the quality incentive.

(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. 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

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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.

NEW SECTION. **Sec. 5.** A new section is added to chapter 74.46 RCW to read as follows:

The department shall adopt rules as are necessary and reasonable to effectuate and maintain the new system for establishing nursing home payment rates described in section 4 of this act and the minimum staffing standards described in RCW 74.42.360. The rules must be consistent with the principles described in section 4 of this act and RCW 74.42.360. In adopting such rules, the department shall solicit the opinions of nursing facility providers, nursing facility provider associations, nursing facility employees, and nursing facility consumer groups.

NEW SECTION. **Sec. 6.** (1) The department of social and health services shall facilitate a work group process to propose modifications to the price-based nursing facility payment methodology outlined in section 4 of this act and the minimum staffing standards outlined in RCW 74.42.360. The department shall keep a public record of comments submitted by stakeholders throughout the work group process. The work group shall consist of nursing facility provider associations, a representative from a not-for-profit hospital system that operates three or more nursing facilities and is not a member of either statewide nursing facility provider association, nursing facility employees, consumer groups, worker representatives, and the office of financial management. The department shall make its final recommendations to the appropriate legislative committees by January

2, 2016, and shall include a dissent report if agreement is not achieved among stakeholders and the department. The department shall include at least one meeting dedicated to review and analysis of other states with price-based methodologies and must include information on how well each state is achieving quality care outcomes and any specific quality metrics targeted for enhanced payments in comparison to the price-based rates paid to that state's nursing facilities.

(2) This section expires August 1, 2016.

Sec. 7. RCW 74.42.360 and 1979 ex.s. c 211 s 36 are each amended to read as follows:

(1) The facility shall have staff on duty twenty-four hours daily sufficient in number and qualifications to carry out the provisions of RCW 74.42.010 through 74.42.570 and the policies, responsibilities, and programs of the facility.

(2) The department shall institute minimum staffing standards for nursing homes. Beginning July 1, 2016, facilities must provide a minimum of 3.4 hours per resident day of direct care. Direct care includes registered nurses, licensed practical nurses, and certified nursing assistants. The minimum staffing standard includes the time when such staff are providing hands-on care related to activities of daily living and nursing-related tasks, as well as care planning. The legislature intends to increase the minimum staffing standard to 4.1 hours per resident day of direct care, but the effective date of a standard higher than 3.4 hours per resident day of direct care will be identified if and only if funding is provided explicitly for an increase of the minimum staffing standard for direct care.

(a) The department shall establish in rule a system of compliance of minimum direct care staffing standards by January 1, 2016. Oversight must be done at least quarterly using nursing home facility census and payroll data.

(b) The department shall establish in rule by January 1, 2016, a system of financial penalties for facilities out of compliance with minimum staffing standards. Beginning July 1, 2016, pursuant to rules established by the department, funds that are received from financial penalties must be used for technical assistance, specialized training, or an increase to the quality enhancement established in section 4 of this act.

(3) Large nonessential community providers must have a registered nurse on duty directly supervising resident care twenty-four hours per day, seven days per week.

(4) Essential community providers and small nonessential community providers must have a registered nurse on duty directly supervising resident care a minimum of sixteen hours per day, seven days per week, and a registered nurse or a licensed practical nurse on duty directly supervising resident care the remaining eight hours per day, seven days per week.

NEW SECTION. **Sec. 8.** A new section is added to chapter 74.46 RCW to read as follows:

A separate nursing facility quality enhancement account is created in the custody of the state treasurer. Beginning July 1, 2015, all receipts from the reconciliation and settlement process provided in RCW 74.46.022(6), as described within section 4 of this act, must be deposited into the account. Beginning July 1, 2016, all receipts from the system of financial penalties for facilities out of compliance with minimum staffing standards, as described within RCW 74.42.360, must be deposited into the account. Only the secretary, or the secretary's designee, may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. The department shall use the special account only for technical assistance for nursing facilities, specialized training for nursing facilities, or an increase to the quality enhancement established in section 4 of this act.

NEW SECTION. **Sec. 9.** The following acts or parts of acts, as now existing or hereafter amended are each repealed, effective June 30, 2016:

(1) RCW 74.46.431 (Nursing facility medicaid payment rate allocations—Components—Minimum wage—Rules) and 2015 1st sp.s. c . . . s 1 (section 1 of this act), 2013 2nd sp.s. c 3 s 1, 2011 1st sp.s. c 7 s 1, 2010 1st sp.s. c 34 s 3, 2009 c 570 s 1, 2008 c 263 s 2, 2007 c 508 s 2, 2006 c 258 s 2, 2005 c 518 s 944, 2004 c 276 s 913, 2001 1st sp.s. c 8 s 5, 1999 c 353 s 4, & 1998 c 322 s 19;

(2) RCW 74.46.435 (Property component rate allocation) and 2011 1st sp.s. c 7 s 2, 2010 1st sp.s. c 34 s 5, 2001 1st sp.s. c 8 s 7, 1999 c 353 s 10, & 1998 c 322 s 29;

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(3) RCW 74.46.506 (Direct care component rate allocations—Determination—Quarterly updates—Fines) and 2011 1st sp.s. c 7 s 7, 2010 1st sp.s. c 34 s 12, 2007 c 508 s 3, 2006 c 258 s 6, & 2001 1st sp.s. c 8 s 10;

(4) RCW 74.46.508 (Direct care component rate allocation—Increases—Rules) and 2010 1st sp.s. c 34 s 13, 2003 1st sp.s. c 6 s 1, & 1999 c 181 s 2;

(5) RCW 74.46.511 (Therapy care component rate allocation—Determination) and 2010 1st sp.s. c 34 s 14, 2008 c 263 s 3, 2007 c 508 s 4, & 2001 1st sp.s. c 8 s 11;

(6) RCW 74.46.515 (Support services component rate allocation—Determination—Emergency situations) and 2011 1st sp.s. c 7 s 8, 2010 1st sp.s. c 34 s 15, 2008 c 263 s 4, 2001 1st sp.s. c 8 s 12, 1999 c 353 s 7, & 1998 c 322 s 27; and

(7) RCW 74.46.521 (Operations component rate allocation—Determination) and 2011 1st sp.s. c 7 s 9, 2010 1st sp.s. c 34 s 16, 2007 c 508 s 5, 2006 c 258 s 7, 2001 1st sp.s. c 8 s 13, 1999 c 353 s 8, & 1998 c 322 s 28.

NEW SECTION. **Sec. 10.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2015.

Passed by the House June 24, 2015.
Passed by the Senate June 26, 2015.
Approved by the Governor June 30, 2015.
Filed in Office of Secretary of State June 30, 2015.

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