
BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: S-4847.2/20 2nd draft

ATTY/TYPIST: AV:eab

BRIEF DESCRIPTION: Ensuring the continued viability of skilled nursing facilities.

1 AN ACT Relating to ensuring the continued viability of skilled
2 nursing facilities; amending RCW 74.46.561; creating new sections;
3 and declaring an emergency.

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

5 NEW SECTION. **Sec. 1.** The legislature finds that skilled nursing
6 facilities play a critical role in the continuum of care services for
7 elderly and disabled Washingtonians. The legislature concurs with the
8 long-term care ombuds that the present funding system, which pays
9 facilities based on costs that are several years out-of-date, is
10 unsustainable and has failed facilities, residents, and families. To
11 stem further facility closures, ensure the continued viability of
12 this critical component of long-term care, and enable residents to
13 receive top-level care, the legislature intends to act on the
14 recommendation of the long-term care ombuds for immediate revisions
15 of funding to more accurately and timely reflect facility costs.

16 **Sec. 2.** RCW 74.46.561 and 2019 c 301 s 1 are each amended to
17 read as follows:

18 (1) The legislature adopts a new system for establishing nursing
19 home payment rates beginning July 1, 2016. Any payments to nursing
20 homes for services provided after June 30, 2016, must be based on the

1 new system. The new system must be designed in such a manner as to
2 decrease administrative complexity associated with the payment
3 methodology, reward nursing homes providing care for high acuity
4 residents, incentivize quality care for residents of nursing homes,
5 and establish minimum staffing standards for direct care.

6 (2) The new system must be based primarily on industry-wide
7 costs, and have three main components: Direct care, indirect care,
8 and capital.

9 (3) The direct care component must include the direct care and
10 therapy care components of the previous system, along with food,
11 laundry, and dietary services. Direct care must be paid at a fixed
12 rate, based on one hundred percent or greater of statewide case mix
13 neutral median costs, but shall be set so that a nursing home
14 provider's direct care rate does not exceed one hundred eighteen
15 percent of its base year's direct care allowable costs except if the
16 provider is below the minimum staffing standard established in RCW
17 74.42.360(2). Direct care must be performance-adjusted for acuity
18 every six months, using case mix principles. Direct care must be
19 regionally adjusted using county wide wage index information
20 available through the United States department of labor's bureau of
21 labor statistics. There is no minimum occupancy for direct care. The
22 direct care component rate allocations calculated in accordance with
23 this section must be adjusted to the extent necessary to comply with
24 RCW 74.46.421.

25 (4) The indirect care component must include the elements of
26 administrative expenses, maintenance costs, and housekeeping services
27 from the previous system. A minimum occupancy assumption of ninety
28 percent must be applied to indirect care. Indirect care must be paid
29 at a fixed rate, based on ninety percent or greater of statewide
30 median costs. The indirect care component rate allocations calculated
31 in accordance with this section must be adjusted to the extent
32 necessary to comply with RCW 74.46.421.

33 (5) The capital component must use a fair market rental system to
34 set a price per bed. The capital component must be adjusted for the
35 age of the facility, and must use a minimum occupancy assumption of
36 ninety percent.

37 (a) Beginning July 1, 2016, the fair rental rate allocation for
38 each facility must be determined by multiplying the allowable nursing
39 home square footage in (c) of this subsection by the RSMMeans rental
40 rate in (d) of this subsection and by the number of licensed beds

1 yielding the gross unadjusted building value. An equipment allowance
2 of ten percent must be added to the unadjusted building value. The
3 sum of the unadjusted building value and equipment allowance must
4 then be reduced by the average age of the facility as determined by
5 (e) of this subsection using a depreciation rate of one and one-half
6 percent. The depreciated building and equipment plus land valued at
7 ten percent of the gross unadjusted building value before
8 depreciation must then be multiplied by the rental rate at seven and
9 one-half percent to yield an allowable fair rental value for the
10 land, building, and equipment.

11 (b) The fair rental value determined in (a) of this subsection
12 must be divided by the greater of the actual total facility census
13 from the prior full calendar year or imputed census based on the
14 number of licensed beds at ninety percent occupancy.

15 (c) For the rate year beginning July 1, 2016, all facilities must
16 be reimbursed using four hundred square feet. For the rate year
17 beginning July 1, 2017, allowable nursing facility square footage
18 must be determined using the total nursing facility square footage as
19 reported on the medicaid cost reports submitted to the department in
20 compliance with this chapter. The maximum allowable square feet per
21 bed may not exceed four hundred fifty.

22 (d) Each facility must be paid at eighty-three percent or greater
23 of the median nursing facility RSMeans construction index value per
24 square foot. The department may use updated RSMeans construction
25 index information when more recent square footage data becomes
26 available. The statewide value per square foot must be indexed based
27 on facility zip code by multiplying the statewide value per square
28 foot times the appropriate zip code based index. For the purpose of
29 implementing this section, the value per square foot effective July
30 1, 2016, must be set so that the weighted average fair rental value
31 rate is not less than ten dollars and eighty cents per patient day.
32 The capital component rate allocations calculated in accordance with
33 this section must be adjusted to the extent necessary to comply with
34 RCW 74.46.421.

35 (e) The average age is the actual facility age reduced for
36 significant renovations. Significant renovations are defined as those
37 renovations that exceed two thousand dollars per bed in a calendar
38 year as reported on the annual cost report submitted in accordance
39 with this chapter. For the rate beginning July 1, 2016, the
40 department shall use renovation data back to 1994 as submitted on

1 facility cost reports. Beginning July 1, 2016, facility ages must be
2 reduced in future years if the value of the renovation completed in
3 any year exceeds two thousand dollars times the number of licensed
4 beds. The cost of the renovation must be divided by the accumulated
5 depreciation per bed in the year of the renovation to determine the
6 equivalent number of new replacement beds. The new age for the
7 facility is a weighted average with the replacement bed equivalents
8 reflecting an age of zero and the existing licensed beds, minus the
9 new bed equivalents, reflecting their age in the year of the
10 renovation. At no time may the depreciated age be less than zero or
11 greater than forty-four years.

12 (f) A nursing facility's capital component rate allocation must
13 be rebased annually, effective July 1, 2016, in accordance with this
14 section and this chapter.

15 (g) For the purposes of this subsection (5), "RSMeans" means
16 building construction costs data as published by Gordian.

17 (6) A quality incentive must be offered as a rate enhancement
18 beginning July 1, 2016.

19 (a) An enhancement no larger than five percent and no less than
20 one percent of the statewide average daily rate must be paid to
21 facilities that meet or exceed the standard established for the
22 quality incentive. All providers must have the opportunity to earn
23 the full quality incentive payment.

24 (b) The quality incentive component must be determined by
25 calculating an overall facility quality score composed of four to six
26 quality measures. For fiscal year 2017 there shall be four quality
27 measures, and for fiscal year 2018 there shall be six quality
28 measures. Initially, the quality incentive component must be based on
29 minimum data set quality measures for the percentage of long-stay
30 residents who self-report moderate to severe pain, the percentage of
31 high-risk long-stay residents with pressure ulcers, the percentage of
32 long-stay residents experiencing one or more falls with major injury,
33 and the percentage of long-stay residents with a urinary tract
34 infection. Quality measures must be reviewed on an annual basis by a
35 stakeholder work group established by the department. Upon review,
36 quality measures may be added or changed. The department may risk
37 adjust individual quality measures as it deems appropriate.

38 (c) The facility quality score must be point based, using at a
39 minimum the facility's most recent available three-quarter average
40 centers for medicare and medicaid services quality data. Point

1 thresholds for each quality measure must be established using the
2 corresponding statistical values for the quality measure point
3 determinants of eighty quality measure points, sixty quality measure
4 points, forty quality measure points, and twenty quality measure
5 points, identified in the most recent available five-star quality
6 rating system technical user's guide published by the center for
7 medicare and medicaid services.

8 (d) Facilities meeting or exceeding the highest performance
9 threshold (top level) for a quality measure receive twenty-five
10 points. Facilities meeting the second highest performance threshold
11 receive twenty points. Facilities meeting the third level of
12 performance threshold receive fifteen points. Facilities in the
13 bottom performance threshold level receive no points. Points from all
14 quality measures must then be summed into a single aggregate quality
15 score for each facility.

16 (e) Facilities receiving an aggregate quality score of eighty
17 percent of the overall available total score or higher must be placed
18 in the highest tier (tier V), facilities receiving an aggregate score
19 of between seventy and seventy-nine percent of the overall available
20 total score must be placed in the second highest tier (tier IV),
21 facilities receiving an aggregate score of between sixty and sixty-
22 nine percent of the overall available total score must be placed in
23 the third highest tier (tier III), facilities receiving an aggregate
24 score of between fifty and fifty-nine percent of the overall
25 available total score must be placed in the fourth highest tier (tier
26 II), and facilities receiving less than fifty percent of the overall
27 available total score must be placed in the lowest tier (tier I).

28 (f) The tier system must be used to determine the amount of each
29 facility's per patient day quality incentive component. The per
30 patient day quality incentive component for tier IV is seventy-five
31 percent of the per patient day quality incentive component for tier
32 V, the per patient day quality incentive component for tier III is
33 fifty percent of the per patient day quality incentive component for
34 tier V, and the per patient day quality incentive component for tier
35 II is twenty-five percent of the per patient day quality incentive
36 component for tier V. Facilities in tier I receive no quality
37 incentive component.

38 (g) Tier system payments must be set in a manner that ensures
39 that the entire biennial appropriation for the quality incentive
40 program is allocated.

1 (h) Facilities with insufficient three-quarter average centers
2 for medicare and medicaid services quality data must be assigned to
3 the tier corresponding to their five-star quality rating. Facilities
4 with a five-star quality rating must be assigned to the highest tier
5 (tier V) and facilities with a one-star quality rating must be
6 assigned to the lowest tier (tier I). The use of a facility's five-
7 star quality rating shall only occur in the case of insufficient
8 centers for medicare and medicaid services minimum data set
9 information.

10 (i) The quality incentive rates must be adjusted semiannually on
11 July 1 and January 1 of each year using, at a minimum, the most
12 recent available three-quarter average centers for medicare and
13 medicaid services quality data.

14 (j) Beginning July 1, 2017, the percentage of short-stay
15 residents who newly received an antipsychotic medication must be
16 added as a quality measure. The department must determine the quality
17 incentive thresholds for this quality measure in a manner consistent
18 with those outlined in (b) through (h) of this subsection using the
19 centers for medicare and medicaid services quality data.

20 (k) Beginning July 1, 2017, the percentage of direct care staff
21 turnover must be added as a quality measure using the centers for
22 medicare and medicaid services' payroll-based journal and nursing
23 home facility payroll data. Turnover is defined as an employee
24 departure. The department must determine the quality incentive
25 thresholds for this quality measure using data from the centers for
26 medicare and medicaid services' payroll-based journal, unless such
27 data is not available, in which case the department shall use direct
28 care staffing turnover data from the most recent medicaid cost
29 report.

30 (7) Reimbursement of the safety net assessment imposed by chapter
31 74.48 RCW and paid in relation to medicaid residents must be
32 continued.

33 (8) The direct care and indirect care components must be rebased
34 ~~((in even-numbered years, beginning with rates paid on July 1, 2016.~~
35 ~~Rates paid on July 1, 2016, must be based on the 2014 calendar year~~
36 ~~cost report. On a percentage basis, after rebasing, the department~~
37 ~~must confirm that the statewide average daily rate has increased at~~
38 ~~least as much as the average rate of inflation, as determined by the~~
39 ~~skilled nursing facility market basket index published by the centers~~
40 ~~for medicare and medicaid services, or a comparable index. If after~~

1 ~~rebasings, the percentage increase to the statewide average daily rate~~
2 ~~is less than the average rate of inflation for the same time period,~~
3 ~~the department is authorized to increase rates by the difference~~
4 ~~between the percentage increase after rebasing and the average rate~~
5 ~~of inflation.)) for the month following the effective date of this~~
6 ~~section through June 30, 2020, using 2018 calendar year cost report~~
7 ~~information. Beginning July 1, 2020, and annually thereafter, rates~~
8 ~~paid must be rebased using the most recent calendar year cost report~~
9 ~~information available. The most recent rebased cost rates must be the~~
10 ~~base year costs. The department must adjust the direct care and~~
11 ~~indirect care components of the base year costs to reflect~~
12 ~~inflationary costs for the eighteen-month period that occurs between~~
13 ~~the base year costs and the actual rate year. This inflationary~~
14 ~~adjustment must be calculated as the twelve month percentage change~~
15 ~~in the consumer price index for all urban consumers (CPI-U) in the~~
16 ~~medical expenditure category of nursing homes and adult day services,~~
17 ~~starting with the most recent December index available, as published~~
18 ~~by the United States bureau of labor statistics.~~

19 (9) The direct care component provided in subsection (3) of this
20 section is subject to the reconciliation and settlement process
21 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
22 rules established by the department, funds that are received through
23 the reconciliation and settlement process provided in RCW
24 74.46.022(6) must be used for technical assistance, specialized
25 training, or an increase to the quality enhancement established in
26 subsection (6) of this section. The legislature intends to review the
27 utility of maintaining the reconciliation and settlement process
28 under a price-based payment methodology, and may discontinue the
29 reconciliation and settlement process after the 2017-2019 fiscal
30 biennium.

31 (10) Compared to the rate in effect June 30, 2016, including all
32 cost components and rate add-ons, no facility may receive a rate
33 reduction of more than one percent on July 1, 2016, more than two
34 percent on July 1, 2017, or more than five percent on July 1, 2018.
35 To ensure that the appropriation for nursing homes remains cost
36 neutral, the department is authorized to cap the rate increase for
37 facilities in fiscal years 2017, 2018, and 2019.

1 NEW SECTION. **Sec. 3.** Any savings as a result of
2 overappropriations associated with the rebase for fiscal year 2021
3 shall be utilized for the purposes of this act.

4 NEW SECTION. **Sec. 4.** This act is necessary for the immediate
5 preservation of the public peace, health, or safety, or support of
6 the state government and its existing public institutions, and takes
7 effect immediately.

--- **END** ---