
SENATE BILL 6515

State of Washington

66th Legislature

2020 Regular Session

By Senators Van De Wege, Randall, Mullet, Takko, Lovelett, Lias, Conway, Hasegawa, and Wilson, C.

Read first time 01/20/20. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to the medicaid payment methodology for skilled
2 nursing facilities; amending RCW 74.46.561; creating a new section;
3 and declaring an emergency.

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

5 **Sec. 1.** RCW 74.46.561 and 2019 c 301 s 1 are each amended to
6 read as follows:

7 (1) The legislature adopts a new system for establishing nursing
8 home payment rates beginning July 1, 2016. Any payments to nursing
9 homes for services provided after June 30, 2016, must be based on the
10 new system. The new system must be designed in such a manner as to
11 decrease administrative complexity associated with the payment
12 methodology, reward nursing homes providing care for high acuity
13 residents, incentivize quality care for residents of nursing homes,
14 and establish minimum staffing standards for direct care.

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

18 (3) The direct care component must include the direct care and
19 therapy care components of the previous system, along with food,
20 laundry, and dietary services. Direct care must be paid at a fixed
21 rate, based on one hundred percent or greater of statewide case mix

1 neutral median costs, but shall be set so that a nursing home
2 provider's direct care rate does not exceed one hundred eighteen
3 percent of its base year's direct care allowable costs except if the
4 provider is below the minimum staffing standard established in RCW
5 74.42.360(2). Direct care must be performance-adjusted for acuity
6 every six months, using case mix principles. Direct care must be
7 regionally adjusted using county wide wage index information
8 available through the United States department of labor's bureau of
9 labor statistics. There is no minimum occupancy for direct care. The
10 direct care component rate allocations calculated in accordance with
11 this section must be adjusted to the extent necessary to comply with
12 RCW 74.46.421.

13 (4) The indirect care component must include the elements of
14 administrative expenses, maintenance costs, and housekeeping services
15 from the previous system. A minimum occupancy assumption of ninety
16 percent must be applied to indirect care. Indirect care must be paid
17 at a fixed rate, based on ninety percent or greater of statewide
18 median costs. The indirect care component rate allocations calculated
19 in accordance with this section must be adjusted to the extent
20 necessary to comply with RCW 74.46.421.

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

25 (a) Beginning July 1, 2016, the fair rental rate allocation for
26 each facility must be determined by multiplying the allowable nursing
27 home square footage in (c) of this subsection by the RSMMeans rental
28 rate in (d) of this subsection and by the number of licensed beds
29 yielding the gross unadjusted building value. An equipment allowance
30 of ten percent must be added to the unadjusted building value. The
31 sum of the unadjusted building value and equipment allowance must
32 then be reduced by the average age of the facility as determined by
33 (e) of this subsection using a depreciation rate of one and one-half
34 percent. The depreciated building and equipment plus land valued at
35 ten percent of the gross unadjusted building value before
36 depreciation must then be multiplied by the rental rate at seven and
37 one-half percent to yield an allowable fair rental value for the
38 land, building, and equipment.

39 (b) The fair rental value determined in (a) of this subsection
40 must be divided by the greater of the actual total facility census

1 from the prior full calendar year or imputed census based on the
2 number of licensed beds at ninety percent occupancy.

3 (c) For the rate year beginning July 1, 2016, all facilities must
4 be reimbursed using four hundred square feet. For the rate year
5 beginning July 1, 2017, allowable nursing facility square footage
6 must be determined using the total nursing facility square footage as
7 reported on the medicaid cost reports submitted to the department in
8 compliance with this chapter. The maximum allowable square feet per
9 bed may not exceed four hundred fifty.

10 (d) Each facility must be paid at eighty-three percent or greater
11 of the median nursing facility RSMeans construction index value per
12 square foot. The department may use updated RSMeans construction
13 index information when more recent square footage data becomes
14 available. The statewide value per square foot must be indexed based
15 on facility zip code by multiplying the statewide value per square
16 foot times the appropriate zip code based index. For the purpose of
17 implementing this section, the value per square foot effective July
18 1, 2016, must be set so that the weighted average fair rental value
19 rate is not less than ten dollars and eighty cents per patient day.
20 The capital component rate allocations calculated in accordance with
21 this section must be adjusted to the extent necessary to comply with
22 RCW 74.46.421.

23 (e) The average age is the actual facility age reduced for
24 significant renovations. Significant renovations are defined as those
25 renovations that exceed two thousand dollars per bed in a calendar
26 year as reported on the annual cost report submitted in accordance
27 with this chapter. For the rate beginning July 1, 2016, the
28 department shall use renovation data back to 1994 as submitted on
29 facility cost reports. Beginning July 1, 2016, facility ages must be
30 reduced in future years if the value of the renovation completed in
31 any year exceeds two thousand dollars times the number of licensed
32 beds. The cost of the renovation must be divided by the accumulated
33 depreciation per bed in the year of the renovation to determine the
34 equivalent number of new replacement beds. The new age for the
35 facility is a weighted average with the replacement bed equivalents
36 reflecting an age of zero and the existing licensed beds, minus the
37 new bed equivalents, reflecting their age in the year of the
38 renovation. At no time may the depreciated age be less than zero or
39 greater than forty-four years.

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

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

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

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

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

27 (c) The facility quality score must be point based, using at a
28 minimum the facility's most recent available three-quarter average
29 centers for medicare and medicaid services quality data. Point
30 thresholds for each quality measure must be established using the
31 corresponding statistical values for the quality measure point
32 determinants of eighty quality measure points, sixty quality measure
33 points, forty quality measure points, and twenty quality measure
34 points, identified in the most recent available five-star quality
35 rating system technical user's guide published by the center for
36 medicare and medicaid services.

37 (d) Facilities meeting or exceeding the highest performance
38 threshold (top level) for a quality measure receive twenty-five
39 points. Facilities meeting the second highest performance threshold
40 receive twenty points. Facilities meeting the third level of

1 performance threshold receive fifteen points. Facilities in the
2 bottom performance threshold level receive no points. Points from all
3 quality measures must then be summed into a single aggregate quality
4 score for each facility.

5 (e) Facilities receiving an aggregate quality score of eighty
6 percent of the overall available total score or higher must be placed
7 in the highest tier (tier V), facilities receiving an aggregate score
8 of between seventy and seventy-nine percent of the overall available
9 total score must be placed in the second highest tier (tier IV),
10 facilities receiving an aggregate score of between sixty and sixty-
11 nine percent of the overall available total score must be placed in
12 the third highest tier (tier III), facilities receiving an aggregate
13 score of between fifty and fifty-nine percent of the overall
14 available total score must be placed in the fourth highest tier (tier
15 II), and facilities receiving less than fifty percent of the overall
16 available total score must be placed in the lowest tier (tier I).

17 (f) The tier system must be used to determine the amount of each
18 facility's per patient day quality incentive component. The per
19 patient day quality incentive component for tier IV is seventy-five
20 percent of the per patient day quality incentive component for tier
21 V, the per patient day quality incentive component for tier III is
22 fifty percent of the per patient day quality incentive component for
23 tier V, and the per patient day quality incentive component for tier
24 II is twenty-five percent of the per patient day quality incentive
25 component for tier V. Facilities in tier I receive no quality
26 incentive component.

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

30 (h) Facilities with insufficient three-quarter average centers
31 for medicare and medicaid services quality data must be assigned to
32 the tier corresponding to their five-star quality rating. Facilities
33 with a five-star quality rating must be assigned to the highest tier
34 (tier V) and facilities with a one-star quality rating must be
35 assigned to the lowest tier (tier I). The use of a facility's five-
36 star quality rating shall only occur in the case of insufficient
37 centers for medicare and medicaid services minimum data set
38 information.

39 (i) The quality incentive rates must be adjusted semiannually on
40 July 1 and January 1 of each year using, at a minimum, the most

1 recent available three-quarter average centers for medicare and
2 medicaid services quality data.

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

9 (k) Beginning July 1, 2017, the percentage of direct care staff
10 turnover must be added as a quality measure using the centers for
11 medicare and medicaid services' payroll-based journal and nursing
12 home facility payroll data. Turnover is defined as an employee
13 departure. The department must determine the quality incentive
14 thresholds for this quality measure using data from the centers for
15 medicare and medicaid services' payroll-based journal, unless such
16 data is not available, in which case the department shall use direct
17 care staffing turnover data from the most recent medicaid cost
18 report.

19 (7) Reimbursement of the safety net assessment imposed by chapter
20 74.48 RCW and paid in relation to medicaid residents must be
21 continued.

22 (8) The direct care and indirect care components must be rebased
23 ~~((in even-numbered years, beginning with rates paid on July 1, 2016.~~
24 ~~Rates paid on July 1, 2016, must be based on the 2014 calendar year~~
25 ~~cost report. On a percentage basis, after rebasing, the department~~
26 ~~must confirm that the statewide average daily rate has increased at~~
27 ~~least as much as the average rate of inflation, as determined by the~~
28 ~~skilled nursing facility market basket index published by the centers~~
29 ~~for medicare and medicaid services, or a comparable index. If after~~
30 ~~rebasing, the percentage increase to the statewide average daily rate~~
31 ~~is less than the average rate of inflation for the same time period,~~
32 ~~the department is authorized to increase rates by the difference~~
33 ~~between the percentage increase after rebasing and the average rate~~
34 ~~of inflation)) for the month following the effective date of this~~
35 ~~section through June 30, 2020, using 2018 calendar year cost report~~
36 ~~information. Beginning July 1, 2020, and annually thereafter, rates~~
37 ~~paid shall be established using the most recent adjusted cost report~~
38 ~~information available. The most recent adjusted cost report~~
39 ~~information shall be the base year costs. The department shall use~~
40 ~~the most recent calendar year twelve-month average consumer price~~

1 index for all urban consumers (CPI-U) as published by the United
2 States bureau of labor statistics to further modify the direct care
3 and indirect care components of the base year costs to recognize
4 economic trends and cost changes.

5 (9) The direct care component provided in subsection (3) of this
6 section is subject to the reconciliation and settlement process
7 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
8 rules established by the department, funds that are received through
9 the reconciliation and settlement process provided in RCW
10 74.46.022(6) must be used for technical assistance, specialized
11 training, or an increase to the quality enhancement established in
12 subsection (6) of this section. The legislature intends to review the
13 utility of maintaining the reconciliation and settlement process
14 under a price-based payment methodology, and may discontinue the
15 reconciliation and settlement process after the 2017-2019 fiscal
16 biennium.

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

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

27 NEW SECTION. **Sec. 3.** This act is necessary for the immediate
28 preservation of the public peace, health, or safety, or support of
29 the state government and its existing public institutions, and takes
30 effect immediately.

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