
SENATE BILL 5569

State of Washington

66th Legislature

2019 Regular Session

By Senators Keiser, Rivers, Van De Wege, McCoy, and Kuderer; by request of Department of Social and Health Services

Read first time 01/24/19. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to the nursing facility medicaid payment system;
2 amending RCW 74.46.561 and 74.46.501; and adding a new section to
3 chapter 74.46 RCW.

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

5 **Sec. 1.** RCW 74.46.561 and 2017 c 286 s 2 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 (~~RS means~~)
28 RSMMeans rental rate in (d) of this subsection and by the number of
29 licensed beds yielding the gross unadjusted building value. An
30 equipment allowance of ten percent must be added to the unadjusted
31 building value. The sum of the unadjusted building value and
32 equipment allowance must then be reduced by the average age of the
33 facility as determined by (e) of this subsection using a depreciation
34 rate of one and one-half percent. The depreciated building and
35 equipment plus land valued at ten percent of the gross unadjusted
36 building value before depreciation must then be multiplied by the
37 rental rate at seven and one-half percent to yield an allowable fair
38 rental value for the 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 (~~(RS—means)~~) RSMeans construction
12 index value per square foot (~~(for Washington state)~~). The department
13 may use updated (~~(RS—means)~~) RSMeans construction index information
14 when more recent square footage data becomes available. The statewide
15 value per square foot must be indexed based on facility zip code by
16 multiplying the statewide value per square foot times the appropriate
17 zip code based index. For the purpose of implementing this section,
18 the value per square foot effective July 1, 2016, must be set so that
19 the weighted average (~~(FRV—[fair rental value])~~) fair rental value
20 rate is not less than ten dollars and eighty cents (~~(ppd—[per patient~~
21 ~~day])~~) per patient day. The capital component rate allocations
22 calculated in accordance with this section must be adjusted to the
23 extent necessary to comply with RCW 74.46.421.

24 (e) The average age is the actual facility age reduced for
25 significant renovations. Significant renovations are defined as those
26 renovations that exceed two thousand dollars per bed in a calendar
27 year as reported on the annual cost report submitted in accordance
28 with this chapter. For the rate beginning July 1, 2016, the
29 department shall use renovation data back to 1994 as submitted on
30 facility cost reports. Beginning July 1, 2016, facility ages must be
31 reduced in future years if the value of the renovation completed in
32 any year exceeds two thousand dollars times the number of licensed
33 beds. The cost of the renovation must be divided by the accumulated
34 depreciation per bed in the year of the renovation to determine the
35 equivalent number of new replacement beds. The new age for the
36 facility is a weighted average with the replacement bed equivalents
37 reflecting an age of zero and the existing licensed beds, minus the
38 new bed equivalents, reflecting their age in the year of the
39 renovation. At no time may the depreciated age be less than zero or
40 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 (~~(CMS [centers for medicare and medicaid services])~~) centers for
30 medicare and medicaid services quality data. Point thresholds for
31 each quality measure must be established using the corresponding
32 statistical values for the quality measure (~~((QM))~~) point
33 determinants of eighty (~~((QM))~~) quality measure points, sixty (~~((QM))~~)
34 quality measure points, forty (~~((QM))~~) quality measure points, and
35 twenty (~~((QM))~~) quality measure points, identified in the most recent
36 available five-star quality rating system technical user's guide
37 published by the center for medicare and medicaid services.

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

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

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

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

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

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

1 (i) The quality incentive rates must be adjusted semiannually on
2 July 1 and January 1 of each year using, at a minimum, the most
3 recent available three-quarter average ((~~CMS [centers for medicare~~
4 ~~and medicaid services]~~)) centers for medicare and medicaid services
5 quality data.

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

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

22 (7) Reimbursement of the safety net assessment imposed by chapter
23 74.48 RCW and paid in relation to medicaid residents must be
24 continued.

25 (8) The direct care and indirect care components must be rebased
26 in even-numbered years, beginning with rates paid on July 1, 2016.
27 Rates paid on July 1, 2016, must be based on the 2014 calendar year
28 cost report. On a percentage basis, after rebasing, the department
29 must confirm that the statewide average daily rate has increased at
30 least as much as the average rate of inflation, as determined by the
31 skilled nursing facility market basket index published by the centers
32 for medicare and medicaid services, or a comparable index. If after
33 rebasing, the percentage increase to the statewide average daily rate
34 is less than the average rate of inflation for the same time period,
35 the department is authorized to increase rates by the difference
36 between the percentage increase after rebasing and the average rate
37 of inflation.

38 (9) The direct care component provided in subsection (3) of this
39 section is subject to the reconciliation and settlement process
40 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to

1 rules established by the department, funds that are received through
2 the reconciliation and settlement process provided in RCW
3 74.46.022(6) must be used for technical assistance, specialized
4 training, or an increase to the quality enhancement established in
5 subsection (6) of this section. The legislature intends to review the
6 utility of maintaining the reconciliation and settlement process
7 under a price-based payment methodology, and may discontinue the
8 reconciliation and settlement process after the 2017-2019 fiscal
9 biennium.

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

17 **Sec. 2.** RCW 74.46.501 and 2016 c 131 s 5 are each amended to
18 read as follows:

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

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

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

35 (3) Both the facility average and the medicaid average case mix
36 indexes shall be determined by multiplying the case mix weight of
37 each resident, or each medicaid resident, as applicable, by the
38 number of days, as defined in this section and as applicable, the

1 resident was at each particular case mix classification or group, and
2 then averaging.

3 (4) In determining the number of days a resident is classified
4 into a particular case mix group, the department shall determine a
5 start date for calculating case mix grouping periods as specified by
6 rule.

7 (5) The cutoff date for the department to use resident assessment
8 data, for the purposes of calculating both the facility average and
9 the medicaid average case mix indexes, and for establishing and
10 updating a facility's direct care component rate, shall be ~~((one
11 month and one day after the end of the quarter for which the resident
12 assessment data applies))~~ on the first business day following the
13 date on which the data is made available.

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

32 (b) The facility average case mix index used to establish each
33 nursing facility's direct care component rate shall be based on an
34 average of calendar quarters of the facility's average case mix
35 indexes from the four calendar quarters occurring during the cost
36 report period used to rebase the direct care component rate
37 allocations as specified in RCW 74.46.561.

38 (c) The medicaid average case mix index used to update or
39 recalibrate a nursing facility's direct care component rate
40 semiannually shall be from the calendar six-month period commencing

1 nine months prior to the effective date of the semiannual rate. For
2 example, July 1, 2010, through December 31, 2010, direct care
3 component rates shall utilize case mix averages from the October 1,
4 2009, through March 31, 2010, calendar quarters, and so forth.

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

7 Services provided by or through facilities of the Indian health
8 service or facilities operated by a tribe or tribal organization
9 pursuant to 42 C.F.R. Part 136 may be paid at the applicable rates
10 published in the federal register or at a cost-based rate applicable
11 to such types of facilities as approved by the centers for medicare
12 and medicaid services and may be exempted from the rate determination
13 set forth in this chapter. The department may enact emergency rules
14 to implement this section.

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