
SUBSTITUTE SENATE BILL 5311

State of Washington

67th Legislature

2021 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Rivers, Conway, Muzzall, and Van De Wege)

READ FIRST TIME 02/08/21.

1 AN ACT Relating to adjusting the skilled nursing medicaid rate
2 methodology; and amending RCW 74.46.561.

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

4 **Sec. 1.** RCW 74.46.561 and 2020 c 357 s 918 are each amended to
5 read as follows:

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

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

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

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

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

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

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

38 (b) The fair rental value determined in (a) of this subsection
39 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[s]))
36 centers for 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) (a) ((The direct care and indirect care components must be
23 rebased in even-numbered years, beginning with rates paid on July 1,
24 2016. Rates paid on July 1, 2016, must be based on the 2014 calendar
25 year cost report. On a percentage basis, after rebasing, the
26 department must confirm that the statewide average daily rate has
27 increased at least as much as the average rate of inflation, as
28 determined by the skilled nursing facility market basket index
29 published by the centers for medicare and medicaid services, or a
30 comparable index. If after rebasing, the percentage increase to the
31 statewide average daily rate is less than the average rate of
32 inflation for the same time period, the department is authorized to
33 increase rates by the difference between the percentage increase
34 after rebasing and the average rate of inflation.)) Beginning in
35 fiscal year 2022, direct and indirect care rates shall be rebased
36 every year. For example, direct and indirect care rates paid in
37 fiscal year 2022 shall be rebased using the calendar year 2019 cost
38 reports.~~

39 ~~(b) ((It is the intention of the legislature that direct and
40 indirect care rates paid in fiscal year 2022 will be rebased using~~

1 ~~the calendar year 2019 cost reports.~~) For fiscal year 2021, in
2 addition to the rates generated by (a) of this subsection, an
3 additional adjustment is provided as established in this subsection
4 (8)(b). Beginning May 1, 2020, and through June 30, 2021, the
5 calendar year costs must be adjusted for inflation by a twenty-four
6 month consumer price index, based on the most recently available
7 monthly index for all urban consumers, as published by the bureau of
8 labor statistics. It is also the intent of the legislature that,
9 starting in fiscal year 2022, a facility-specific rate add-on equal
10 to the inflation adjustment that facilities received solely in fiscal
11 year 2021, must be added to the rate.

12 (c) ~~((To determine the necessity of regular inflationary
13 adjustments to the nursing facility rates, by December 1, 2020, the
14 department shall provide the appropriate policy and fiscal committees
15 of the legislature with a report that provides a review of rates paid
16 in 2017, 2018, and 2019 in comparison to costs incurred by nursing
17 facilities.))~~ Beginning July 1, 2021, through June 30, 2022, the
18 calendar year costs must be adjusted for inflation by a 24-month
19 average consumer price index, based on the most recently available
20 monthly index for all urban consumers in the medical expenditure
21 category of nursing homes and adult day services, as published by the
22 bureau of labor statistics.

23 (d) Beginning July 1, 2022, the calendar year costs must be
24 adjusted for inflation by a 24-month average consumer price index,
25 based on the most recently available monthly index for all urban
26 consumers, as published by the bureau of labor statistics.

27 (9) The direct care component provided in subsection (3) of this
28 section is subject to the reconciliation and settlement process
29 provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to
30 rules established by the department, funds that are received through
31 the reconciliation and settlement process provided in RCW
32 74.46.022(6) must be used for technical assistance, specialized
33 training, or an increase to the quality enhancement established in
34 subsection (6) of this section. The legislature intends to review the
35 utility of maintaining the reconciliation and settlement process
36 under a price-based payment methodology, and may discontinue the
37 reconciliation and settlement process after the 2017-2019 fiscal
38 biennium.

39 (10) Compared to the rate in effect June 30, 2016, including all
40 cost components and rate add-ons, no facility may receive a rate

1 reduction of more than one percent on July 1, 2016, more than two
2 percent on July 1, 2017, or more than five percent on July 1, 2018.
3 To ensure that the appropriation for nursing homes remains cost
4 neutral, the department is authorized to cap the rate increase for
5 facilities in fiscal years 2017, 2018, and 2019.

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